Comments on the general draft report
Comment By
Name: Ms. Maureen Dailey, DNSc, RN
Organization: American Nurses Association

Date - Time: Mar 17, 2011 - 06:01 PM

Comments

The American Nurses Association respectfully submits the following comments:

t is not clear as to how all the pieces of data for these measures get put together in a cogent way that consumers, and primarily providers/ACOs, etc. can create new knowledge. Specifically, would analysis of data collected with these measures create knowledge that would drive the strategies for how clinicians and teams can seek to improve patient outcomes?

If coding is used to capture much of the data, then how would the contributions of the inter-professional team be efficiently captured in areas like depression screening etc. Multiple clinician types are educated and trained to screen for depression across the continuum of care. If depression screening is only linked to codes, then duplicate screening may occur and missing data would be problematic.

There is a continuum of applications for quality measures that NQF has identified from quality improvement to public reporting. It is important to differentiate how measures were intended to be used and test these measures in regional health improvement collaboratives across payers to assess for downstream impact.

The measure set does not contain robust outcome measures (e.g., reduction in suicide rate for teenagers, a population at high risk).

1334: Children Who Received Preventive Dental Care
Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

Date - Time: Mar 17, 2011 - 05:41 PM

Comments

Similar information is collected as part of the CMS 416 form which captures information on the EPSDT benefit provided.

1333: Children Who Receive Family-Centered Care
Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

Date - Time: Mar 17, 2011 - 05:40 PM

Comments

This is an important topic area, but we agree with comments that it may be duplicative of data collected through Medical Homes CAHPS.

1330: Children With a Usual Source for Care When Sick
Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

Date - Time: Mar 17, 2011 - 05:40 PM

Comments

This is an important topic, but we agree with need to capture care provided at urgent care centers.

1337: Children With Inconsistent Health Insurance Coverage in the Past 12 Months

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

Date - Time: Mar 17, 2011 - 05:39 PM

Comments

Consistent coverage is a big challenge for our Medicaid children. We are concerned that the survey does not distinguish between public and private health plans.

1340: Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care
Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

Date - Time: Mar 17, 2011 - 05:38 PM

Comments

Ensuring a smooth transitioning into adult medicine is such a difficult, yet extremely important thing to do for child with special health care needs—very good to start looking at this from a measurement perspective.

1391: Frequency of Ongoing Prenatal Care
Comment By
Name: Dr. Elisabeth Howard, Ph.D, CNM
Organization: American College of Nurse-Midwives

Date - Time: Mar 17, 2011 - 05:30 PM

Comments

ACNM recognizes that timing of prenatal care, quality of care, and inclusion of postpartum visits is important. Number of visits alone does not seem adequate as a measure.

1382: Percentage of low birthweight births
Comment By
Name: Dr. Elisabeth Howard, Ph.D, CNM
Organization: American College of Nurse-Midwives

Date - Time: Mar 17, 2011 - 05:24 PM

Comments

ACNM supports this measure as an overall indicator of newborn health

---

Comments on the general draft report
Comment By
Name: Dr. Elisabeth Howard, Ph.D, CNM
Organization: American College of Nurse-Midwives

Date - Time: Mar 17, 2011 - 05:16 PM

Comments
While the language in the document generally reflects and respects the diversity of workforce composition, pg. 6 PNC providers are referred to as "obstetricians". Whereas ACOG guidelines are referred to, USPHS should be included.

1412: Pre-School Vision Screening in the Medical Home
Comment By
Name: Dr. Beth A. Kneib, OD
Organization: American Optometric Association

Date - Time: Mar 17, 2011 - 05:02 PM

Comments

The AOA recommends that NQF revise or replace this measure with one that is appropriate for this measure set. AOA's objections are: 1.) If this set of measures is for *all* children, then it should not be specific to the medical home. If this set of measures *is* for medical homes, then all of the (other) measures should be framed in terms of the medical home. NQF states, "This project will target measures that could be used in public reporting at the population level on a range of topics, including prevention and screening, access to care, safety, prenatal/perinatal care, and patient experience with care." The "medical home" is not the delivery model of care for all children, and 2.) The majority of vision screenings fail to adequately screen children with undiagnosed /untreated vision problems including amblyopia, strabismus and significant refractive errors. Screening tests can lead to false negatives (low sensitivity), do not assure treatment, and sometimes exclude difficult to screen children that may be more likely to have vision problems.

The AOA strongly believes vision and eye health diagnosis can only be determined from a comprehensive eye examination provided by an optometrist or ophthalmologist, and vision screenings will fail to identify defects and will not lead to treatment. Inclusion of this measure, as it is written, will impede efforts to achieve quality improvements in children's visual health.

1517: Prenatal & Postpartum Care
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 05:00 PM

Comments

Measures #1391, #1517, #1397, and #1401 require medical chart review, which will be burdensome to providers and health plans.

Given the reliance on medical chart review for all the individual perinatal measures with the exception of #1382, we request that the developers clarify the feasibility of implementing this measure for physician practices that do not have electronic medical records.

1364: Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation
Comment By
Name: Janet Sullivan, MD
Organization: Hudson Health Plan

Date - Time: Mar 17, 2011 - 04:57 PM

Comments

Hudson supports the intent of this measure, to improve the quality of mental health services for children. However, as specified the measure would be applicable to both PCPs and mental health professionals and could have the undesired effect of decreasing screening rates for depression. If a PCP performed a PHQ9, identified and diagnosed a child as depressed and then referred the child for additional care that PCP would fail this measure. Hudson recommends this measure not be applicable to primary care for that reason.

1401: Maternal Depression Screening
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:57 PM

Comments

Measures #1391, #1517, #1397, and #1401 require medical chart review, which will be burdensome to providers and health plans.

Given the reliance on medical chart review for all the individual perinatal measures with the exception of #1382, we request that the developers clarify the feasibility of implementing this measure for physician practices that do not have electronic medical records.

1397: Sudden Infant Death Syndrome Counseling
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:56 PM

Comments

Measures #1391, #1517, #1397, and #1401 require medical chart review, which will be burdensome to providers and health plans.

Given the reliance on medical chart review for all the individual perinatal measures with the exception of #1382, we request that the developers clarify the feasibility of implementing this measure for physician practices that do not have electronic medical records.

1395: Chlamydia Screening and Follow Up
Comment By
Name: Janet Sullivan, MD
Organization: Hudson Health Plan

Date - Time: Mar 17, 2011 - 04:53 PM

Comments

As specified this measure adds tremendous burden to a measure that is already difficult for many reasons. Hudson would recommend at a minimum that administrative specifications be added to reduce the burden of collecting the components adressing treatment or referral. Specifically, if an antibiotic appropriate for treating chlamydia was dispensed or if a subsequent visit to an OB-GYN or a follow up lab test was performed.

1361: Intervention no later than 6 months of age (EHDI-4a)
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:49 PM

Comments

We are supportive of hearing screening measures, but recommend that measures #1354, #1357, #1360, and 1361 be harmonized and re-specified as single measure that tracks newborn hearing at the hospital, after discharge, after 3 months, and after 6 months where an intervention is required.

1360: Audiological Evaluation no later than 3 months of age (EHDI-3)
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:48 PM

Comments

We are supportive of hearing screening measures, but recommend that measures #1354, #1357, #1360, and 1361 be harmonized and re-specified as single measure that tracks newborn hearing at the hospital, after discharge, after 3 months, and after 6 months where an intervention is required.

1340: Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care
Comment By
Name: Dr. Michael P. Phelan, MD
Organization: Cleveland Clinic

Date - Time: Mar 17, 2011 - 04:48 PM

Comments

While a smooth transition of patients with special healthcare needs from pediatricians to adult care providers is extremely important, we are concerned that this metric, as written, may not provide an adequate reflection of the care these patients receive. The proposed measure looks at the counseling given to patients between the ages of 12 and 17 years of age. Many pediatric providers continue to see their patients into young adulthood, especially those with special needs; thus, in many practices, having these conversations 10 years prior is not necessary. In addition, the Healthcare Reform Act now allows children to stay on their parents' insurance up to the age of 26 YO, so discussing healthcare coverage in the teen years may be premature. Finally, healthcare providers may have some these conversations with families but may not be documenting the discussion or all the elements of the discussion. As practices transition to become Medical Home providers, these elements can be incorporated into templates for well child care visits for children with special healthcare needs, but retrospective chart reviews may lead to a false assumption that these discussions do not happen as frequently as they actually do because of failure to document. Moreover could this metric be re-written to include an older age group?

1357: Outpatient hearing screening of infants who did not complete screening before hospital discharge (EHDI-1c)
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:47 PM

Comments

We are supportive of hearing screening measures, but recommend that measures #1354, #1357, #1360, and 1361 be harmonized and re-specified as single measure that tracks newborn hearing at the hospital, after discharge, after 3 months, and after 6 months where an intervention is required.

1514: Healthy Physical Development by 18 years of age
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:28 PM

Comments

We recognize that childhood obesity has become a significant public health and economic concern to our health care system and support the development of measures that seek to address these concerns.

Data collection for measures, #1396, #1512, and #1514 is burdensome. Health plans may be able to document that a patient received a physical, but tracking the counseling component of these measures will require medical chart review. We would also underscore that the USPTF has noted that there is not sufficient evidence to indicate that intense counseling is effective, therefore the value of adding counseling components to these candidate measures is unclear, and the specifications, burdensome to providers.

1512: Healthy Physical Development by 13 years of age
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:27 PM

Comments

We recognize that childhood obesity has become a significant public health and economic concern to our health care system and support the development of measures that seek to address these concerns.

Data collection for measures, #1396, #1512, and #1514 is burdensome. Health plans may be able to document that a patient received a physical, but tracking the counseling component of these measures will require medical chart review. We would also underscore that the USPTF has noted that there is not sufficient evidence to indicate that intense counseling is effective, therefore the value of adding counseling components to these candidate measures is unclear, and the specifications, burdensome to providers.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

1506: Immunizations by 18 years of age
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:26 PM

Comments

We support the immunization measures provided that they are aligned with NCQA 2012 HEDIS specifications.

1391: Frequency of Ongoing Prenatal Care
Comment By
Name: Ms. Jennifer Boka
Organization: National Association for Healthcare Quality

Date - Time: Mar 17, 2011 - 04:24 PM

Comments

NAHQ encourages the measure developer to more completely define provider and the circumstances of a measure when the delivering provider is not the "traditional" or planned provider. This occurs often in tertiary High risk facilities where the provider may have provided care for the patient previously.

1419: Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:23 PM

Comments

The assessment of dental services is an important consideration for children's health. With respect to measure # 1419, data collection may be a challenge across different health plans' products. In addition, it is more appropriate to track fluoride varnish in the context of the well child visit and not limit to EPSDT examinations. Also, not all health plans cover this particular service, so availability of data to calculate this measure may be an issue. For example, children's dental visits are often bundled services and are billed as one service on administrative claims forms. In order to assess if the dental preventive services are specifically delivered, the physician would have to document this in the medical record. We recommend that this measure include Well child visits only.

1365: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
Comment By
Name: Dr. Robert M. Plovnick
Organization: American Psychiatric Institute for Research and Education

On Behalf Of
Name: Robert Plovnick
Organization: American Psychiatric Institute for Research and Education

Date - Time: Mar 17, 2011 - 04:19 PM

Comments

The American Psychiatric Association/American Psychiatric Institute for Research and Education recommend this measure for endorsement. While evidence linking suicide risk assessment to outcomes is limited, the increased risk of suicide in patients with major depressive disorder justifies a screening quality indicator that raises awareness of the concern while accommodating for clinical discretion in how best to meet the needs of the individual patient. We believe the measure developer, the PCPI, has adequately addressed the concerns raised by the NQF workgroup by clarifying the definition of a suicide risk assessment and addressing the feasibility of collecting data in an EHR.

1407: Immunizations by 13 years of age
Comment By

Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:18 PM

Comments

We support the immunization measures provided that they are aligned with NCQA 2012 HEDIS specifications.

1396: Healthy Physical Development by 6 years of age

Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:10 PM

Comments

We recognize that childhood obesity has become a significant public health and economic concern to our health care system and support the development of measures that seek to address these concerns.

Data collection for measures, #1396, #1512, and #1514 is burdensome. Health plans may be able to document that a patient received a physical, but tracking the counseling component of these measures will require medical chart review. We would also underscore that the USPTF has noted that there is not sufficient evidence to indicate that intense counseling is effective, therefore the value of adding counseling components to these candidate measures is unclear, and the specifications, burdensome to providers.

1395: Chlamydia Screening and Follow Up

Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:08 PM

Comments

With respect to measure #1395, Chlamydia screening and follow up, there is some concern across the physician community in the display of this measure, particularly, as the current measure specifications may result in the measure being applied to the under 18 population. In addition, this measure applies universally as opposed to being specified for an at risk population. The Centers for Disease Control and Prevention's (CDC) guidelines recommend screening based on risk factors. This measure should be harmonized with CDC guidelines.

1392: Well-Child Visits in the First 15 Months of Life

Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:06 PM

Comments

We support NQF's inclusion of Care Visit measures that are indicated for both commercial and Medicaid populations, and encourages NQF to continue supporting measures that strive to align specifications across both commercial and Medicaid populations. We would encourage measure developers to clarify the level of reliability testing that has occurred or is anticipated.

Well-child care visits are currently collected and reported by Medicaid health plans and are important metrics that assess access to preventive care.

1391: Frequency of Ongoing Prenatal Care

Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 04:01 PM

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Comments

#1391 – This measure is applicable for both commercial and Medicaid populations and should be considered for both populations.

Measures #1391, #1517, #1397, and #1401 require medical chart review, which will be burdensome to providers and health plans.

Given the reliance on medical chart review for all the individual perinatal measures with the exception of #1382, we request that the developers clarify the feasibility of implementing this measure for physician practices that do not have electronic medical records.

1388: Annual Dental Visit
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 03:58 PM

Comments

With respect to measure #1388, the denominator should specify whether the patient is enrolled in a dental plan.

1388: Annual Dental Visit
Comment By
Name: Dr. Thomas James, III, MD
Organization: Humana Inc.

Date - Time: Mar 17, 2011 - 03:58 PM

Comments

This may require chart audit from the dental providers as there may not be records in pediatrician offices nor claims from health plans

---

1448: Developmental Screening in the First Three Years of Life
Comment By
Name: Janet Sullivan, MD
Organization: Hudson Health Plan

Date - Time: Mar 17, 2011 - 03:53 PM

Comments

Developmental screening using a standardized tool is an important measure. From our experience testing an earlier version of NQF #1399 Hudson knows that there is much room for improvement in this standard. We agree with those who have stated that NQF should endorse one measure for developmental screening. NQF #1448 has the advantage of allowing claims data which could reduce reporting burden. Some reviewers have stated that #1448 also identifies children who have been screened according to clinical guidelines, 3 times by age 3. However, as currently specified measure #1448 does NOT assess for multiple screenings. The specifications look only for 1 screening since birth at each of 3 age levels. These two measures could be harmonized and the desire to motivate multiple screening could be addressed by a single measure which:

1--allow claims data for numerator compliance as in #1448

2--reports 3 different levels of compliance: % children with one screening, % children with two screenings and % children with 3 screenings

3--specify that the measure could be collected for 2 year olds or three year olds. This would allow the collection of one 2 year old denominator for health plans reporting HEDIS but would also be a measure that could be used for 3 year olds by clinicians or community measurement programs.

1381: Asthma Emergency Department Visits
Comment By
Name: Ms. Carmella Bocchino, MBA, RN

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 03:43 PM

Comments

The intent of measure # 1381 should be to measure control of asthma. It is unclear from the measure specifications how the look-back period is defined, and it would be helpful for the measure developer to provide clarification. In order to capture patients with a prior diagnosis of asthma that had an ER visit, it may be necessary to require two years of data to have sufficient time to capture that prior visit with the ICD-9 code for asthma, since that condition is often a seasonal condition.

1354: Hearing screening prior to hospital discharge (EHDI-1a)
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 03:39 PM

Comments

We are supportive of hearing screening measures, but recommend that measures #1354, #1357, #1360, and 1361 be harmonized and re-specified as single measure that tracks newborn hearing at the hospital, after discharge, after 3 months, and after 6 months where an intervention is required.

1351: Proportion of infants covered by Newborn Bloodspot Screening (NBS)
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 03:35 PM

Comments

With respect to measure # 1351, States' public health agencies may have different methods for collecting the data for this measure which can result in inconsistent implementation.

1349: Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 03:34 PM

Comments

While we are supportive of measure #1349, we note that this measure relies on data reported from parent surveys. Responses can therefore be subjective, especially for questions that relate to height and weight measurements.

1346: Children Who Are Exposed To Secondhand Smoke Inside Home
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 03:29 PM

Comments

Although this measure is reported by patients, health plans are supportive of measures that increase awareness of the harm of tobacco exposure.

1337: Children With Inconsistent Health Insurance Coverage in the Past 12 Months
Comment By

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 03:27 PM

Comments

With respect to measure #1337, the measure developer should clarify the reliability of a survey tool in capturing the data required for this measure.

1401: Maternal Depression Screening
Comment By
Name: Janet Sullivan, MD
Organization: Hudson Health Plan

Date - Time: Mar 17, 2011 - 03:26 PM

Comments

This measure is clinically important but problematic in implementation at the physician level. The measure specifies that data may be obtained from the child's or the mother's chart but pediatric practices will not have maternal charts. Results from practices caring for the child only could not reasonably be compared to results from practices caring for both mother and child.
This measure is more reasonably applicable at the health plan or community level.

This measure will drive increased screening for maternal depression. Increased screening is of value. A subsequent measure could address treatment. The words "proper follow-up performed" should be deleted from the brief measure description, it is not supported in the numerator specifications.

1381: Asthma Emergency Department Visits
Comment By
Name: Dr. Thomas James, III, MD
Organization: Humana Inc.

Date - Time: Mar 17, 2011 - 03:19 PM

Comments

The concept of appropriate asthma management is quite important; and using ER (or urgent care) vistis as a marker of an inadequate care management outcome, are both very important. Our concern comes from reading the definitions in the numerator and denominator which are not clear. It would appear that the initial presentation of previously undiagnosed asthma could initiate an episode and create a care failure. Cough-varient asthma is a not uncommon presentation that should trigger a diagnosis of asthma and aligning the patient with a physician who can build a relationship and a treatemnt strategy.

Rather than as worded, we would recommend that the ER visit serve as the anchor either for a look-back period over a 24 month period; or a become the trigger for a 12 or 24 month prospective time period.

Comments on the general draft report
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Mar 17, 2011 - 03:13 PM

Comments

Thank you for the opportunity to provide comments on the NQF Child Health Measures Report. We support NQF's efforts to advance the measurement of child health across a full continuum of conditions and settings, and particularly in identified gap areas, such as quality of well child care, dental care, and acute care for children.

We commend the NQF for including measures specifically tailored to measuring clinical care within innovative delivery models, such as Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes.

Comments on the general draft report
Comment By

On Behalf Of

Name: Dr. Dale Lupu, PhD
Organization: American Academy of Hospice and Palliative Medicine
Date - Time: Mar 17, 2011 - 03:12 PM

Name: Ron Crossno, MD President
Organization: American Academy of Hospice & Palliative Medicine

Comments

AAHPM comments, last page.

References 8-11 for previous comments.

8 Wolfe J, Hammel JF, Edwards KE, Duncan J, Comeau M, Breyer J, Aldridge S, Grier HE, Berde C, Dussel V, Weeks JC. Easing of suffering in children with cancer at the end of life: A follow-up study. Journal of Clinical Oncology. 2008;26(10):1717-1723.

9 Hays RM, Valentine J, Haynes G, Geyer JR, Villareale N, McKinstry B, et al. The Seattle Pediatric Palliative Care Project: effects on family satisfaction and health-related quality of life. Journal of palliative medicine. 2006 Jun ;9(3):716-28.

10 Cooley WC, McAllister JW, Sherrieb K, Kuhlthau K. Improved outcomes associated with medical home implementation in pediatric primary care. Pediatrics. 2009 Jul ;124(1):358-64.

11 Farmer JE, Clark MJ, Drewel EH, Swenson TM, Ge B. Consultative Care Coordination Through the Medical Home for CSHCN: A Randomized Controlled Trial. Maternal and child health journal. 2010 Aug

---

Comments on the general draft report

Comment By
Name: Dr. Dale Lupu, PhD
Organization: American Academy of Hospice and Palliative Medicine

On Behalf Of
Name: Ron Crossno, MD President
Organization: American Academy of Hospice & Palliative Medicine

Date - Time: Mar 17, 2011 - 03:10 PM

Comments

AAHPM comments continued.

References 1-7 for previous comments:

1 Heron M, Sutton PD, Xu J, Ventura SJ, Strobino DM, Guyer B. Annual summary of vital statistics: 2007. Pediatrics. 2010 Jan ;125(1):4-15.

3 Friebert S. NHPCO facts and figures: pediatric palliative and hospice care in America. National Hospice and Palliative Care Organization, April 2009.

3 Feudtner C, Christakis DA, Connell FA, Study AP-based, State W. Pediatric Deaths Attributable to Complex Chronic Conditions: Pediatrics. 2008.

4 Field MJ, Behrman RE, Institute of Medicine (U.S.). Committee on Palliative and End-of-Life Care for Children and Their Families. *When children die : improving palliative and end-of-life care for children and their families*. Washington, D.C.: National Academy Press; 2003

5 Starmer AJ, Duby JC, Slaw KM, Edwards A, Leslie LK. Pediatrics in the year 2020 and beyond: preparing for plausible futures. *Pediatrics.* Nov 2010;126(5):971-981.

6 Burns KH, Casey PH, Lyle RE, Bird TM, Fussell JJ, Robbins JM. Increasing prevalence of medically complex children in US hospitals. *Pediatrics.* Oct 2010;126(4):638-646.

7 Simon TD, Berry J, Feudtner C, Stone BL, Sheng X, Bratton SL, Dean JM, Srivastava R.
Children With Complex Chronic Conditions in Inpatient Hospital Settings in the United States, *Pediatrics.* Oct 2010; 126: 647 - 655. 3.

1361: Intervention no later than 6 months of age (EHDI-4a)

Comment By
Name: Ms. Jean Brereton
Organization: American Academy of Otolaryngology-Head and

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Neck Surgery

Date - Time: Mar 17, 2011 - 03:09 PM

Comments

The American Academy of Otolaryngology-Head and Neck Surgery is supportive of the measure, but has concerns with the feasibility of tracking the measure.

1360: Audiological Evaluation no later than 3 months of age (EHDI-3)
Comment By
Name: Ms. Jean Brereton
Organization: American Academy of Otolaryngology-Head and Neck Surgery

Date - Time: Mar 17, 2011 - 03:08 PM

Comments

The American Academy of Otolaryngology-Head and Neck Surgery is supportive of the measure. However, the measure may be difficult to report on in areas where there is a lack of pediatric audiological services available.

Comments on the general draft report
Comment By
Name: Dr. Dale Lupu, PhD
Organization: American Academy of Hospice and Palliative Medicine

On Behalf Of
Name: Ron Crossno, MD President
Organization: American Academy of Hospice & Palliative Medicine

Date - Time: Mar 17, 2011 - 03:07 PM

Comments

AAHPM comments continued....

These domains embrace important priorities of the medical home model such as the need to identify vulnerable populations eligible for palliative care, facilitate access to palliative care experts, support individualized care planning and care coordination, ensure comfort from distressing symptoms, optimize quality of life, promote interdisciplinary care, guarantee comfort at the end of life, and support bereaved family members after the death of a child.

We stress that developing, testing, and deploying measures that address these domains in medically fragile children should be a high priority. While a pediatric agenda may be included as a component of subsequent NQF efforts to develop measures of quality palliative and end-of-life care, we believe that inclusion of such measures as part of the National Voluntary Consensus Standards for Child Health Quality Measures is of utmost importance to: 1) generate the tension needed for meaningful positive change in the quality of care provided for medically fragile children in the modern pediatric medical home; and 2) guarantee full integration of pediatric services geared towards comfort, quality of life, and end-of-life care for the most vulnerable population of children with special health care needs.

1357: Outpatient hearing screening of infants who did not complete screening before hospital discharge (EHDI-1c)
Comment By
Name: Ms. Jean Brereton
Organization: American Academy of Otolaryngology-Head and Neck Surgery

Date - Time: Mar 17, 2011 - 03:07 PM

Comments

The American Academy of Otolaryngology- Head and Neck Surgery is supportive of the measure. However, the Academy has concerns in regards to tracking the measure and who is responsible for obtaining the information. Typically, if a child fails a newborn hearing screen he/she is referred to an outside provider for a repeat screen. Depending on several factors- family location, insurance coverage, wait time for audiology visit, etc., the family could end up going to any one of a number of locations for the screen. A great deal of effort and cost would need to go into the tracking process, unless the infants were in a closed medical system, i.e. Kaiser, or in a system where electronic medical records flowed easily between various organizations.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Comments on the general draft report

Comment By
Name: Dr. Dale Lupu, PhD
Organization: American Academy of Hospice and Palliative Medicine

On Behalf Of
Name: Ron Crossno, MD President
Organization: American Academy of Hospice & Palliative Medicine

Date - Time: Mar 17, 2011 - 03:06 PM

Comments

AAHPM comments continued...

In pediatrics, integration of quality palliative care practices into the ongoing care of children with cancer and other life-threatening conditions, is an effective strategy to improve the quality of their care.[i] [ii] Children with special health care needs (CSHCN) are likely to benefit even more by early involvement with palliative care providers in their medical homes.[iii] [iv] Regardless of a child's diagnosis or location of care, NQF-endorsed measures specific to palliative care needs will help both pediatric and palliative care providers monitor and improve the care of vulnerable children at all stages of the illness trajectory.

Specifically, the following palliative care domains are notably absent from the list of 41 recommended measures:

- Patient experience with care
- Access to hospice and palliative care, including in the prenatal period
- Advance care planning and ethical decision making
- Assessment and management of physical and psychological symptoms.
- Assessment and management of emotional, social, and spiritual care needs.
- Care coordination and continuity, including care transitions
- End-of-life care
- Bereavement care

Comments on the general draft report

Comment By
Name: Dr. Dale Lupu, PhD
Organization: American Academy of Hospice and Palliative Medicine

On Behalf Of
Name: Ron Crossno, MD President
Organization: American Academy of Hospice & Palliative Medicine

Date - Time: Mar 17, 2011 - 03:04 PM

Comments

AAHPM comments continued...

In the U.S. 53,000 children die annually[1] [i] and approximately 500,000 children are living with serious and life-threatening conditions that need palliative care integrated into their treatment[ii]. Of particular relevance is the fact that children with chronic, complex illness comprise an ever-growing proportion of patients cared for in pediatric inpatient settings as well as by community practitioners.[iii] Emerging evidence suggests that the care of these children is becoming increasingly complex.[iv] [v] For example, hospitalization rates among children with chronic, complex illness increased by almost 100 percent.[vi] [vii] Parallel to this growth in patient population, the field of pediatric palliative care has grown substantially as well over the last 15 years. Physicians specializing in pediatric palliative care may now obtain board certification and accredited fellowship training is increasing in availability.

(AAHPM comments continue on next comment...)

[1] In 2007, there were a total of 29,241 infant deaths and 23,976 deaths of children and adolescents age 1-19. Unintentional injuries accounted for 42% of all deaths and intentional injuries (suicide, homicide) account for another 11% leaving about half of all child and adolescent deaths from illness. Children and adolescent deaths are 30.7 per 100,000 population.

Comments on the general draft report

Comment By
Name: Dr. Dale Lupu, PhD
Organization: American Academy of Hospice and Palliative

On Behalf Of
Name: Ron Crossno
Organization: American Academy of Hospice & Palliative

Medicine Date Medicine

- Time: Mar 17, 2011 - 03:02 PM

Comments

Overall, AAHPM agrees with selection of the 41 measures recommended for endorsement. We especially appreciate the inclusion of chronic disease and family-centered care focus areas. However, we note that none of these new measures specifically address the palliative care needs of children with special health care needs (CSHCN). The existing set of 85+ NQF endorsed pediatric and perinatal measures is also mostly silent in regards to palliative care for children. Thus, the NQF pediatric measure set will still have a major gap in palliative care, even once the new measures are approved.

We request that the report note the gap in pediatric palliative care measures and that it recognize pediatric palliative care as an important area for quality measurement and monitoring that should be addressed as soon as possible. Palliative and end-of-life care is one of the priority areas of the NQF, and should be a priority focus area for future Child Health Quality Measures.

(AAHPM comments continue on next comment...)

1354: Hearing screening prior to hospital discharge (EHDI-1a)
Comment By
Name: Ms. Jean Brereton
Organization: American Academy of Otolaryngology-Head and Neck Surgery

Date - Time: Mar 17, 2011 - 02:56 PM

Comments

The American Academy of Otolaryngology-Head and Neck Surgery is supportive of the measure. However, the Academy suggests adding not just the percentage of newborns screened, but also the percentage who passed their hearing screening. The expansion of the measure would allow for measuring testing protocol and/or equipment. For example, if a hospital reported that only 50% of newborns passed the screening test then there is a problem with the testing protocol and/or equipment.

1402: Newborn Hearing Screening
Comment By
Name: Ms. Jean Brereton
Organization: American Academy of Otolaryngology-Head and Neck Surgery

Date - Time: Mar 17, 2011 - 02:56 PM

Comments

The American Academy of Otolaryngology-Head and Neck Surgery is supportive of the measure. However, the Academy has concerns with how the measure and data would be tracked in the current healthcare environment.

1354: Hearing screening prior to hospital discharge (EHDI-1a)
Comment By
Name: Dr. Thomas James, III, MD
Organization: Humana Inc.

Date - Time: Mar 17, 2011 - 02:55 PM

Comments

Measures #1402,1354,1357, and 1360 all address the very important role of screening and diagnosis. Humana agrees with Dr. Rosof that the first three of these are markers of the team effort within the hospital and providers, whereas we do see #1361 as a clinician measure.

The number of these separate measures diminishes the impact that could be achieved by a single measure of the outcomes of

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

hearing screening with the steps for referral. Humana would recommend returning these to the measure developer to produce a composite, strong measure that can be more impactful than the sum of the four individual metrics.

1552: Blood Pressure Screening by age 13

Comment By
Name: Mr. Ian Corbridge, MPH, RN
Organization: Health Resources and Services Administration

On Behalf Of
Name: Ian Corbridge
Organization: Health Resources and Service Administration

Date - Time: Mar 17, 2011 - 02:45 PM

Comments

HRSA strongly recommends the endorsement of two of the three measures that do not have a consensus endorsement. Those measures are 1365: *Suicide risk assessment* and 1552: *Blood pressure screening by age 13*. Regarding measure 1552, there are emerging recommendations that children and adolescents receive blood pressure screening at each healthcare encounter and the measurement becomes a routine vital sign. We recommend at a minimum that there be a concerted effort to screen youth by age 13 for hypertension and thereby prevent sequelae. The Healthy People 2020 goals measures screening starting at age 8 for children. We agree with the committee that blood pressure results in children are not straightforward and it should be the blood pressure percentile. This measure needs more clarification.

1517: Prenatal & Postpartum Care

Comment By
Name: Dr. Thomas James, III, MD
Organization: Humana Inc.

Date - Time: Mar 17, 2011 - 02:45 PM

Comments

This is a composite measure with Rate 1 being a measure of percentage of women with a first trimester visit. Health plans have been able to capture this information using administrative data. However with Rate 2 on Post-partum care, there may or may not be the ability to capture this information if the physician is on a global pregnancy fee schedule. Would recommend these be two separate measures, or else be measures for doctors but not insurers

---

1365: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Comment By
Name: Mr. Ian Corbridge, MPH, RN
Organization: Health Resources and Services Administration

On Behalf Of
Name: Ian Corbridge
Organization: Health Resources and Service Administration

Date - Time: Mar 17, 2011 - 02:44 PM

Comments

HRSA strongly recommends the endorsement of two of the three measures that do not have a consensus endorsement. Those measures are 1365: *Suicide risk assessment* and 1552: *Blood pressure screening by age 13*. Regarding measure 1365, we agree with the Committee's concerns around the potential legal implications for physicians and that the screening tool needs to be clarified, but find value in a measure that address suicide risk for this population.

1448: Developmental Screening in the First Three Years of Life

Comment By
Name: Mr. Ian Corbridge, MPH, RN
Organization: Health Resources and Services Administration

On Behalf Of
Name: Ian Corbridge
Organization: The Health Resources and Service Administration

Date - Time: Mar 17, 2011 - 02:42 PM

Comments

Measures NQF 1448: *Developmental screening in the first three years of life* and NQF 1399: *Developmental screening by 2 years of age*, have overlapping ages. HRSA respectfully requests that NQF provide clarification on the rational for two measures with overlapping ages. Confusion or reporting burden could be simplified if only one measure related to developmental screening was

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

endorsed.

1399: Developmental Screening by 2 Years of Age

Comment By
Name: Mr. Ian Corbridge, MPH, RN
Organization: Health Resources and Services Administration

On Behalf Of
Name: Ian Corbridge
Organization: The Health Resources and Service Administration

Date - Time: Mar 17, 2011 - 02:41 PM

Comments

Measures NQF 1448: *Developmental screening in the first three years of life* and NQF 1399: *Developmental screening by 2 years of age*, have overlapping ages. HRSA respectfully requests that NQF provide clarification on the rational for two measures with overlapping ages. Confusion or reporting burden could be simplified if only one measure related to developmental screening was endorsed.

1351: Proportion of infants covered by Newborn Bloodspot Screening (NBS)

Comment By
Name: Mr. Ian Corbridge, MPH, RN
Organization: Health Resources and Services Administration

On Behalf Of
Name: Ian Corbridge
Organization: The Health Resources and Service Administration

Date - Time: Mar 17, 2011 - 02:38 PM

Comments

The Health Resources and Service Administration supports the endorsement of the NQF measure 1351: *Proportion of infants covered by newborn bloodspot screening*.

Comments on the general draft report

Comment By
Name: Mr. Ian Corbridge, MPH, RN
Organization: Health Resources and Services Administration

On Behalf Of
Name: Ian Corbridge
Organization: The Health Resources and Service Administration

Date - Time: Mar 17, 2011 - 02:36 PM

Comments

The Health Resources and Service Administration (HRSA) facilitates a critical role in ensuring the health and well-being of children and adolescents across the Nation and is pleased to comment on the National Quality Forum's (NQF) *National Voluntary Consensus Standards for Child Health Quality Measures: A Consensus Report*. We commend NQF and the Committee for their effort in helping to fill an important gap in the quality enterprise and support the Committee's recommendations. While we support the work of the Committee, HRSA respectfully submits the following comments.

1391: Frequency of Ongoing Prenatal Care

Comment By
Name: Dr. Thomas James, III, MD
Organization: Humana Inc.

Date - Time: Mar 17, 2011 - 02:35 PM

Comments

Humana is supportive of this measure and would encourage its expansion beyond Medicaid but also include commerically insured patients.

Comments on the general draft report

Comment By

Name: Dr. Thomas James, III, MD
Organization: Humana Inc.

Date - Time: Mar 17, 2011 - 02:30 PM

Comments

We at Humana are very pleased to see the number and breath of measures for children's health, and commend the National Quality Forum for its attention to ensuring a health younger generation. The roles of measures, as discussed in CSAC, is for population health imprevment through physician/provider self-improvement, parent recognition of high quality care with engagement of the provider, parent selection of higher quality practitioners, and for network management by payers and insurers. Given the multitude of reasons, there need to be measures that employ different tools. Some of these measures can be drawn only from chart extraction or EHRs, others from claims data or clinically enriched claims data, and some from parent/patient survey. each as strengths and weaknesses. Humana is paying most attention in comments to those measures derived from claims or enrichied claims data; and encourages the development of mesures that can be obtained via interoperable EHRs.

1419: Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers

Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

On Behalf Of
Name: Carolyn Reynolds
Organization: Intermountain Healthcare

Date - Time: Mar 17, 2011 - 01:05 PM

Comments

I am concerned about the dental measures as there is a proposal for preventive dental care to be given by medical care provider – not sure that our community is near ready to take this on.

Comments on the general draft report

Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

On Behalf Of
Name: Carolyn Reynolds
Organization: Intermoutain Healthcare

Date - Time: Mar 17, 2011 - 01:04 PM

Comments

Intermountain Supports the development of pediatric measures. Overall, there are some general concern about the measures as proposed that incude the following:

-
  - In some of the measures there is reference to medical home but it is my belief that the number of "medical home" practices is still small. The measures should apply to primary care providers of all types e.g. pediatricians and family medicine providers. That being said, I am concerned that it will be difficult to gather the information through the disparate electronic and paper systems that are utilized in PCP offices.Measures need to be specific around the type of provider and setting of the data. In an complex integrated healthcare system such as Intermountain with affiliations to a University setting, the measures do not lend themselves to easy data acquisition
  - Some of the proposed measures are very similar to each other e.g. 1448, 1399, 1385 – developmental screening; 1392 & 1516 – well child visits; 1332 – children with preventive visits = concept for measurement is good but we really need only one measure for this concept
  - There is a group of measure around behavioral health – some of this screening is performed by PCP but the diagnosis part is conducted by behavioral health subspecialists – our electronic systems do not connect well enough to coordinate this between the settings.

1381: Asthma Emergency Department Visits

Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

On Behalf Of
Name: Carolyn Reynolds
Organization: Intermountain Healthcare

Date - Time: Mar 17, 2011 - 12:55 PM

Comments

This measure does not meet the criteria for importance since it includes even one ED visit. The measure should only involve 2 or more ED visits since the goal of asthma therapy is to reduce exacerbations and therefore frequent ED visits. In addition, this measure assesses only the outcome of asthma therapy but does not include asthma care processes that may affect ED visits, as assessed by the following measures that we suggest:

1. Percentage of patients with asthma admitted to the ED who received chronic severity assessment (or who had documentation of chronic severity assessment in the medical records.

2. Percentage of patients with poorly controlled asthma admitted to the ED who received appropriate controller medications.

3. Percentage of patients/parents with asthma admitted to the ED who participated in asthma education class.

4. Percentage of patients/parents with asthma admitted to the ED who received a scheduled follow-up appointment with a primary care provider or an asthma specialist at discharge.

5. Percentage of patients with asthma admitted to the ED who received a written asthma action with instructions regarding use of rescue medications, how to avoid asthma triggers, how to recognize and handle acute asthma exacerbations, and how and when to seek emergency care

---

1394: Depression Screening By 13 years of age
Comment By
Name: Janet Sullivan, MD
Organization: Hudson Health Plan

Date - Time: Mar 17, 2011 - 12:55 PM

Comments

Agree with the recommendation that the list of approved screening tools be expanded to include all evidence-based tools validated to screen for symptoms of depression, rather than limiting the list to depression-specific screening tools.

1346: Children Who Are Exposed To Secondhand Smoke Inside Home

Comment By	On Behalf Of
Name: Ms. Jan A. Orton, MS, RN, CPHQ	Name: Carolyn Reynolds
Organization: Intermountain Healthcare	Organization: Intermountain Healthcare

Date - Time: Mar 17, 2011 - 12:54 PM

Comments

We are against including it as a quality measure. Based on existing data, this information will be inaccurate if collected from parents. Maybe a better tool is to measure urine cotinine level as a surrogate assessment of second-hand exposure. But, measuring cotinine level may not be cost effective unless evaluation is focused, for instance, on patients with frequent asthma admissions for whom identifying exposure to secondhand smoking may be helpful.

1349: Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)

Comment By	On Behalf Of
Name: Ms. Jan A. Orton, MS, RN, CPHQ	Name: Carolyn Reynolds
Organization: Intermountain Healthcare	Organization: Intermountain Healthcare

Date - Time: Mar 17, 2011 - 12:53 PM

Comments

This measure should not be based on parental report (usually inaccurate) but on actual measurement. Therefore, we suggest that this measure be changed to the following: Age and gender specific calculation of BMI based on documentation in the medical record. This measure should also include information about whether obesity was reported as a problem and whether it was addressed by the provider or a referral was obtained.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

1396: Healthy Physical Development by 6 years of age

Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

On Behalf Of
Name: Carolyn Reynolds
Organization: Intermountain Healthcare

Date - Time: Mar 17, 2011 - 12:52 PM

Comments

These are important measures since obesity has become a public health problem in the US.

However, there is not basis to stratify this preventive measure in 3 age categories unless the goal is to report and compare performance by age category. Assessment of BMI for instance should be encouraged at every child wellness visit. Many studies are confirming the importance of BMI assessment. The goal of this measure should be to encourage providers to assess and address risk factors associated with obesity. Therefore, these measures should be combined to include all age group starting from age 2 (due to CDC BMI for age data).

These comments also apply to 1512, and 1514.

1552: Blood Pressure Screening by age 13

Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

On Behalf Of
Name: Carolyn Reynolds
Organization: Intermountain Healthcare

Date - Time: Mar 17, 2011 - 12:51 PM

Comments

These are important and acceptable measures that will easily feasible for reporting. However, we do not see the rationale for having 2 separate age groups (age 13 and age 18). Measurement of blood pressure should be encouraged at every child wellness visit. Therefore these 2 measures should be combined to create a single measure. In addition, this measure should also encourage assessment of risk factors associated with high blood pressure for patients who will be found to have elevated high blood pressure. Just reporting if the blood pressure was measured is not meaningful. This information should also be specified based on age, sex and height to facilitate interpretation.

These comments also apply to 1553

1385: Developmental screening using a parent completed screening tool (Parent report, Children 0-5)

Comment By
Name: Janet Sullivan, MD
Organization: Hudson Health Plan

Date - Time: Mar 17, 2011 - 12:49 PM

Comments

Developmental screening is highly important but this measure which requires the use of only one of the available standardized screening tools is not the best measure available. There may be many reasons, including parental literacy, why a health care professional treating small children would prefer another standardized tool.

1357: Outpatient hearing screening of infants who did not complete screening before hospital discharge (EHDI-1c)

Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

On Behalf Of
Name: Carolyn Reynolds
Organization: Intermountain Healthcare

Date - Time: Mar 17, 2011 - 12:49 PM

Comments

Based on information provided by the measure developer, the rate of children not screened is only 6 percent. Therefore, we do not see the rationale for recommending it as a quality measure. With only 6% of patients not being screened, there is less

room from improvement. There may also not be significant variation across settings. Although this measure is scientifically acceptable, it does not meet the criteria of importance based on data provided by the measure developer. Collecting such a measure may not be cost effective.

1397: Sudden Infant Death Syndrome Counseling

Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

On Behalf Of
Name: Carolyn Reynolds
Organization: Intermountain Healthcare

Date - Time: Mar 17, 2011 - 12:48 PM

Comments

The rate of SIDS picks between 2-3 months. Therefore, we support use of 4 weeks in the numerator of the measurement specification. But, we are concerned about using 6 month age criteria in the denominator of the measurement specification. This time frame may be too late if the intend of the measurement if to decrease the frequency of SIDS. We will recommend decreasing the time frame in the denominator to 3 months. Therefore the measure will be described as: The percentage of children who turned 3 months old during the measurement year and who had Sudden Infant Death Syndrome (SIDS) counseling within 4 weeks of birth.

1391: Frequency of Ongoing Prenatal Care

Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

On Behalf Of
Name: Carolyn Reynolds
Organization: Intermountain Healthcare

Date - Time: Mar 17, 2011 - 12:46 PM

Comments

Stratification of this measure in 5 categories is not necessary. Some categories just capture failure. Instead, this measure should encourage healthcare organizations to achieve higher standard or care. Therefore, we will recommend that this measure be changed to a single measure assessing the percentage of Medicaid deliveries ….. that received >= 80 percent of expected prenatal visits. This number can be used as a benchmark for healthcare organizations and providers to achieve. This will more likely improve outcomes and justify the rationale for the measure.

1349: Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)

Comment By
Name: Ms. Jennifer Knorr
Organization: National Association of Pediatric Nurse Practitioners

Date - Time: Mar 17, 2011 - 09:26 AM

Comments

Evidence shows inaccurate perception and report of child's BMI by parent and of older children of their own height and weight and should not be used.

1348: Children Age 6-17 Years who Engage in Weekly Physical Activity

Comment By
Name: Ms. Jennifer Knorr
Organization: National Association of Pediatric Nurse Practitioners

On Behalf Of
Name: Andrea Kline
Organization: National Association of Pediatric Nurse Practitioners

Date - Time: Mar 17, 2011 - 09:25 AM

Comments

Adequate explanation should be provided in what constitutes vigorous activity and may not be accurate

---

1514: Healthy Physical Development by 18 years of age
Comment By
Name: Ms. Jennifer Knorr
Organization: National Association of Pediatric Nurse Practitioners

Date - Time: Mar 17, 2011 - 09:07 AM

Comments
BMI assessment is a useful tool to discuss approximate bodyfat and to show a trend. It can and should be started at age 2 on all children. While counseling is not evidence based there are recommendations that can be made in each category of physical activity, nutrition, and screen time. These recommendations can be found at: http://pediatrics.aappublications.org/cgi/reprint/120/Supplement_4/S164

1512: Healthy Physical Development by 13 years of age
Comment By
Name: Ms. Jennifer Knorr
Organization: National Association of Pediatric Nurse Practitioners

Date - Time: Mar 17, 2011 - 09:06 AM

Comments

BMI assessment is a useful tool to discuss approximate bodyfat and to show a trend. It can and should be started at age 2 on all children. While counseling is not evidence based there are recommendations that can be made in each category of physical activity, nutrition, and screen time. These recommendations can be found at: http://pediatrics.aappublications.org/cgi/reprint/120/Supplement_4/S164

1365: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association

On Behalf Of
Name: Ardis D. Hoven, MD
Organization: American Medical Association

Date - Time: Mar 17, 2011 - 09:06 AM

Comments

The AMA supports the recommendation of this measure for endorsement. This measure fills an important gap in care. In 2006, suicide was the third leading cause of death for young people ages 15 to 24, accounting for 12% of all deaths annually.[i] Research has shown that patients with major depressive disorder are at a high risk for suicide, which makes this assessment a critical aspect of care that should be evaluated at each visit.

We request that this measure be recommended for endorsement by this Steering Committee.

[i]Centers for Disease Control and Prevention (CDC). Suicide: Facts at a Glance. CDC; Summer 2009. http://www.cdc.gov/violenceprevention. Accessed August 25, 2010

1514: Healthy Physical Development by 18 years of age
Comment By
Name: Ms. Jennifer Knorr
Organization: National Association of Pediatric Nurse Practitioners

Date - Time: Mar 17, 2011 - 09:06 AM

Comments
BMI assessment is a useful tool to discuss approximate bodyfat and to show a trend. It can and should be started at age 2 on all children. While counseling is not evidence based there are recommendations that can be made in each category of physical activity, nutrition, and screen time. These recommendations can be found at: http://pediatrics.aappublications.org/cgi/reprint/120/Supplement_4/S164

1507: Risky Behavior Assessment or Counseling by Age 18 Years

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association

On Behalf Of
Name: Ardis D. Hoven, MD
Organization: American Medical Association

Date - Time: Mar 17, 2011 - 09:05 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at “higher” levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that “clinician” be removed as a level of accountability for these measures.

1506: Immunizations by 18 years of age

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association

On Behalf Of
Name: Ardis D. Hoven, MD
Organization: American Medical Association

Date - Time: Mar 17, 2011 - 09:05 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at “higher” levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that “clinician” be removed as a level of accountability for these measures.

1552: Blood Pressure Screening by age 13

Comment By
Name: Ms. Jennifer Knorr
Organization: National Association of Pediatric Nurse Practitioners

Date - Time: Mar 17, 2011 - 09:05 AM

Comments

Disagree and believe that this would be an integral assessment that technically should be done even earlier than age 13.
Guidelines on pediatric blood pressure can be found at:

http://www.nhlbi.nih.gov/guidelines/hypertension/child_tbl.htm

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

The American Heart Association recommends initial blood pressure screening to occur at age 3yrs.

1419: Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers

Comment By	On Behalf Of
Name: Dr. Mark S. Antman, DDS, MBA	Name: Ardis D. Hoven, MD
Organization: American Medical Association	Organization: American Medical Association

Date - Time: Mar 17, 2011 - 09:04 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at “higher” levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that “clinician” be removed as a level of accountability for these measures.

1412: Pre-School Vision Screening in the Medical Home

Comment By	On Behalf Of
Name: Dr. Mark S. Antman, DDS, MBA	Name: Ardis D. Hoven, MD
Organization: American Medical Association	Organization: American Medical Association

Date - Time: Mar 17, 2011 - 09:04 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at “higher” levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that “clinician” be removed as a level of accountability for these measures.

1407: Immunizations by 13 years of age

Comment By	On Behalf Of
Name: Dr. Mark S. Antman, DDS, MBA	Name: Ardis D. Hoven, MD
Organization: American Medical Association	Organization: American Medical Association

Date - Time: Mar 17, 2011 - 09:03 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who

would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1419: Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers
Comment By
Name: Ms. Jennifer Knorr
Organization: National Association of Pediatric Nurse Practitioners

Date - Time: Mar 17, 2011 - 09:03 AM

Comments

that both AAP and the American Academy of Family Physicians (AAFP) support provision of FV to high-risk children by medical providers. This measure was recommended for time-limited endorsement and meets the National Priority of population health.
I am especially excited about seeing this measure. To answer the last committee's concern, the Fluoride varnish is usually applied to children under 3 years of age- at least in Ohio that is what we can bill for Medicaid. As stated before, fewer than 3% of Medicaid children see a dentist before the age of three, but 78% of children under 3 years of age see a primary health care provider (USDHHS, 2003). I am not sure what is meant by a time-limited endorsement- I don't believe that this should be time limited as there are very few dentists that see children under three no matter what their insurance is- but especially high risk children who can't afford dental care. This problem is not an easy fix and won't go away over night- so please to not make this time limited. Poor and minority children under 5 years of age are significantly less likely to have preventive or restorative dental visits, and to have more unmet treatment needs and more caries than non-minority children or those from higher incomes. Minority and low-income groups have barriers to dental services due to limited resources, competing family needs, and challenges related to providers and insurance.

1406: Risky Behavior Assessment or Counseling by Age 13 Years
Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association

On Behalf Of
Name: Ardis D. Hoven, MD
Organization: American Medical Association

Date - Time: Mar 17, 2011 - 09:03 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1402: Newborn Hearing Screening
Comment By

On Behalf Of

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association

Name: Ardis D. Hoven, MD
Organization: American Medical Association

Date - Time: Mar 17, 2011 - 09:02 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at “higher” levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that “clinician” be removed as a level of accountability for these measures.

1401: Maternal Depression Screening

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association

On Behalf Of
Name: Ardis D. Hoven, MD
Organization: American Medical Association

Date - Time: Mar 17, 2011 - 09:02 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at “higher” levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that “clinician” be removed as a level of accountability for these measures.

1395: Chlamydia Screening and Follow Up

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association

On Behalf Of
Name: Ardis D. Hoven, MD
Organization: American Medical Association

Date - Time: Mar 17, 2011 - 09:01 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at “higher” levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1335: Children Who Have Dental Decay or Cavities
Comment By
Name: Ms. Jennifer Knorr
Organization: National Association of Pediatric Nurse Practitioners

Date - Time: Mar 17, 2011 - 09:01 AM

Comments

Make the ages 1-21 with this measure. We realize some of these age groups might not be available. Some members work at homeless shelters and see many children with dental caries- in fact it is the most prevalent problem they see and hardest to access the dental care needed. The mothers are well aware that their children have cavities. In addition, fewer than 3% of Medicaid children see a dentist before the age of three, but 78% of children under 3 years of age see a primary health care provider (USDHHS, 2003). So if children have not seen a dentist, they probably have seen a primary health care provider that has assessed their oral health and told them their child has cavities. In the US, 20% of US children and adolescents experience 80% of all dental decay. Poor and/or minority families are affected most (USDHHS, 2001), with preschool children having increasing rates of dental caries compared to other age groups (CDC, 2007).

1361: Intervention no later than 6 months of age (EHDI-4a)
Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association

On Behalf Of
Name: Ardis D. Hoven, MD
Organization: American Medical Association

Date - Time: Mar 17, 2011 - 09:00 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1360: Audiological Evaluation no later than 3 months of age (EHDI-3)
Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association

On Behalf Of
Name: Ardis D. Hoven, MD
Organization: American Medical Association

Date - Time: Mar 17, 2011 - 08:59 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

best represented at “higher” levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that “clinician” be removed as a level of accountability for these measures.

1337: Children With Inconsistent Health Insurance Coverage in the Past 12 Months

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association

On Behalf Of
Name: Ardis D. Hoven, MD
Organization: American Medical Association

Date - Time: Mar 17, 2011 - 08:59 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at “higher” levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that “clinician” be removed as a level of accountability for these measures.

1334: Children Who Received Preventive Dental Care

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association

On Behalf Of
Name: Ardis D. Hoven, MD
Organization: American Medical Association

Date - Time: Mar 17, 2011 - 08:58 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at “higher” levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that “clinician” be removed as a level of accountability for these measures.

Comments on the general draft report

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association

Date - Time: Mar 17, 2011 - 08:57 AM

Comments

The American Medical Association (AMA) is pleased to comment on the National Quality Forum’s (NQF) *National Voluntary*

Consensus Standards for Child Health Quality Measures: A Consensus Report. Robust clinical performance measures for children and adolescents can help fill an important gap in the quality enterprise. We commend the NQF for helping to sustain the public's focus on issues of quality and patient safety for the child and adolescent population. While we support a number of the measures recommended in this report we respectfully submit the following comments.

1334: Children Who Received Preventive Dental Care
Comment By
Name: Ms. Jennifer Knorr
Organization: National Association of Pediatric Nurse Practitioners

Date - Time: Mar 17, 2011 - 08:55 AM

Comments

Again- make the ages 1-21. Assess what kind of insurance they have- if any. 96% of dental care is from private insurance or self- pay. This means that only 4-5% of dental care is from public insurance such as Medicaid. Fewer than 3% of Medicaid children see a dentist before age 3 and 25% of poor children have not seen a dentist before entering kindergarten (USDHHS, 2000). Profound disparities exist in the level of dental services obtained by children, especially the poor. Of particular concern is the low rate of early detection and preventive care for 3 yr old and younger children eligible for Medicaid oral health benefits. Even when Medicaid provides dental services, only 33% of eligible children get preventive or restorative dental service due to a shortage of dentists who accept Medicaid and who are willing to treat children (Vargas & Ronzio, 2006; dela Cruz, et al., 2004; National Call to Action, 2008). Dentists only receive 60% of dental services billed to Medicaid and, depending on the procedures, may not receive any compensation. Projected Medicaid and State Children's Health Insurance Program cuts are expected to cause one million or more children to lose health coverage that paid for dental health. Uninsured children are 6 times more likely to lack a source of dental care than insured children and four times as likely to have unmet dental needs (Newacheck et al., 2003).

1388: Annual Dental Visit
Comment By
Name: Ms. Jennifer Knorr
Organization: National Association of Pediatric Nurse Practitioners

On Behalf Of
Name: Andrea Kline
Organization: National Association of Pediatric Nurse Practitioners

Date - Time: Mar 17, 2011 - 08:51 AM

Comments

The ages should be 1-21 on this measure. Also the fact that this only includes children with dental insurance coverage is concerning. Access to dental care is a BIG problem especially with the poor children. There are many working poor families without dental coverage that never see the dentist- this needs to be measured!!! Our members see these children in the safety net clinics where they work- there are 12 year old children that have never seen a dentist- when they do have a problem they go to the ER and it is too late to repair and often very costly. Children who receive early preventive dental care have 40% lower dental costs over their lifetime than those who do not receive this care (Sinclair & Edelstein, 2005).

1365: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:47 AM

Comments

[continued]

[i]Gelenberg AJ, Freeman MP, Markowitz JC, et al; American Psychiatric Association Work Group on Major Depressive Disorder. Practice guideline for the treatment of patients with major depressive disorder. 3rd ed. http://www.psychiatryonline.com/pracGuide/pracGuideTopic_7.aspx. Published October 2010. Accessed Nov. 24, 2010.

[ii]American Academy of Child and Adolescent Psychiatry (AACAP). Practice parameters for the assessment and treatment of children and adolescents with depressive disorders. *J. Am. Acad. Child Adolesc. Psychiatry*, 2007;46(11):1503-1526. Available at: http://www.aacap.org/galleries/PracticeParameters/Vol%2046%20Nov%202007.pdf.
[iii]McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. The quality of health care delivered to adults in the United States. New England Journal of Medicine. 2003;348(26):2635-2645.
[iv]DobschaSK, Gerrity MS, Corson K, Bahr A, Cuilwik NM. Measuring adherence to depression treatment guidelines in a VA primary care clinic. Gen Hosp Psychiatry. 2003;25:230-7.
[v]Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: A review of the evidence. Am J Psychiatry 2002; 159:909-916.
[vi]Centers for Disease Control and Prevention (CDC). Suicide: Facts at a Glance. CDC; Summer 2009. http://www.cdc.gov/violenceprevention. Accessed Aug 25, 2010.

1365: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Comment By	On Behalf Of
Name: Dr. Mark S. Antman, DDS, MBA	Name: Bernard M. Rosof, MD, MACP
Organization: American Medical Association-Physician Consortium for Performance Improvement	Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:46 AM

Comments

[continued]

We have provided terms for Suicide Risk Assessment (procedure), Suicide Risk Findings, and Suicide Risk Scale, where the standardized scales for suicide risk assessment available within SNOMED-CT have been identified. Any of the 3 types of terms—the procedure, the findings (results of the suicide risk assessment) or a completed Scale itself—would indicate that a Suicide Risk Assessment has been performed.

Finally, the Work Group would like to restate the importance of this measure. In 2006, suicide was the third leading cause of death for young people ages 15 to 24, accounting for 12% of all deaths annually.[vi] Research has shown that patients with major depressive disorder are at a high risk for suicide, which makes this assessment a critical aspect of care that should be evaluated at each visit.

We request that this measure be recommended for endorsement by this Steering Committee.

1365: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Comment By	On Behalf Of
Name: Dr. Mark S. Antman, DDS, MBA	Name: Bernard M. Rosof, MD, MACP
Organization: American Medical Association-Physician Consortium for Performance Improvement	Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:45 AM

Comments

[continued]

The EHR specifications submitted by the PCPI identify the data elements required for collection of the measure using the standard coding terminologies named by the Office of the National Coordinator for Health IT. The PCPI recognizes the variability in EHR system implementations across the nation and that not all systems may be using SNOMED-CT (or other standard terminologies) natively. To use a terminology “natively” means that the standard code is captured (on the back-end of the system), at the point of clinical documentation. Systems that do not use SNOMED-CT natively have the capability to *map* the coding used within their systems to the allowable codes included in the quality measure specifications.

Regarding the EHR specifications submitted for this measure, SNOMED-CT concepts have been identified for the concept of Suicide Risk Assessment. While individual practices may have their own customized templates for Suicide Risk Assessment within the EHR, the results of these templates can be *mapped* on the back end of the system to the standardized terminologies identified in the measure specifications.

1365: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Comment By	On Behalf Of

Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement
Date - Time: Mar 17, 2011 - 08:45 AM

Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Comments
[continued]

With regard to the request for additional data regarding a documented opportunity for improvement, data specific to the pediatric population is lacking in the medical literature. Nevertheless, data for the adult population is compelling and indicates a significant opportunity for improvement. According to a study analyzing the quality of health care in the United States, only about 25.8% of patients with depression had documentation of the presence or absence of suicidal ideation during the first or second diagnostic visit. 76.11% of those patients who have suicidality were asked if they have specific plans to carry out suicide.[iii] A 2003 study reviewed medical records to assess the degree to which providers adhered to depression guidelines in a VA primary care setting. Providers documented exploration for suicidal ideation in 57% of the records.[iv] Additionally, the importance of the assessment is underscored by research that indicates that the majority of individuals who die by suicide do make contact with primary care providers and mental health services. More specifically, within a month before their suicide, 45% of suicide victims had contact with primary care providers and one in five had contact with mental health services.[v]

1365: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:45 AM

Comments
[Continued]

Numerator: Patient visits with an assessment for suicide risk*

The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. Suicide risk assessment can include "specific inquiry about suicidal thoughts, intent, plans, means, and behaviors; identification of specific psychiatric symptoms (eg, psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas; assessment of past and, particularly, recent suicidal behavior; delineation of current stressors and potential protective factors (eg, positive reasons for living, strong social support); and identification of any family history of suicide or mental illness."* *[i]*** *"Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can [also] be used."* ***[ii]***

1365: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:44 AM

Comments
In particular with regards to the measure numerator statement, although the specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient, the Work Group agreed to provide greater clarity regarding its intent and to provide additional direction consistent with clinical practice guidelines from the APA and AACAP for the treatment of patients with MDD. The following additional information will be added to the measure documentation and specifications:

1365: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Date - Time: Mar 17, 2011 - 08:43 AM

Comments
The PCPI Child and Adolescent Major Depressive Disorder Work Group thanks the NQF Steering Committee for their thorough review and consideration of NQF #1365 measure. Based on the Steering Committee's comments we received during the measure review process, we subsequently provided additional clarification and rationales for the measure. We are providing a summary of this information during this public comment period.

1507: Risky Behavior Assessment or Counseling by Age 18 Years

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:40 AM

Comments
Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1506: Immunizations by 18 years of age

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:40 AM

Comments
Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1419: Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:39 AM

Comments
Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who

would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1412: Pre-School Vision Screening in the Medical Home

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:38 AM

Comments
Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1407: Immunizations by 13 years of age

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:38 AM

Comments
Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1406: Risky Behavior Assessment or Counseling by Age 13 Years

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:37 AM

Comments
Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1402: Newborn Hearing Screening

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:35 AM

Comments
Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1401: Maternal Depression Screening

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:34 AM

Comments
Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1395: Chlamydia Screening and Follow Up

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:34 AM

Comments
Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who

would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1361: Intervention no later than 6 months of age (EHDI-4a)

Comment By	On Behalf Of
Name: Dr. Mark S. Antman, DDS, MBA	Name: Bernard M. Rosof, MD, MACP
Organization: American Medical Association-Physician Consortium for Performance Improvement	Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:32 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1360: Audiological Evaluation no later than 3 months of age (EHDI-3)

Comment By	On Behalf Of
Name: Dr. Mark S. Antman, DDS, MBA	Name: Bernard M. Rosof, MD, MACP
Organization: American Medical Association-Physician Consortium for Performance Improvement	Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:32 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at "higher" levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that "clinician" be removed as a level of accountability for these measures.

1357: Outpatient hearing screening of infants who did not complete screening before hospital discharge (EHDI-1c)

Comment By	On Behalf Of
Name: Dr. Mark S. Antman, DDS, MBA	Name: Bernard M. Rosof, MD, MACP
Organization: American Medical Association-Physician Consortium for Performance Improvement	Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:31 AM

Comments

Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at “higher” levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that “clinician” be removed as a level of accountability for these measures.

1354: Hearing screening prior to hospital discharge (EHDI-1a)

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:30 AM

Comments
Measures #1354, 1357, 1360, 1361, 1395, 1401, 1402, 1406, 1407, 1412, 1419, 1506, and 1507 are being put forward as appropriate for accountability at the clinician level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals, that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at “higher” levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care.

We recommend that “clinician” be removed as a level of accountability for these measures.

1382: Percentage of low birthweight births

Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Mar 17, 2011 - 08:30 AM

Comments

Childbirth Connection strongly supports inclusion of this measure, which reflects a core newborn health indicator.

Comments on the general draft report

Comment By
Name: Dr. Mark S. Antman, DDS, MBA
Organization: American Medical Association-Physician Consortium for Performance Improvement

On Behalf Of
Name: Bernard M. Rosof, MD, MACP
Organization: Physician Consortium for Performance Improvement

Date - Time: Mar 17, 2011 - 08:29 AM

Comments
The Physician Consortium for Performance Improvement® (PCPI) is pleased to comment on the National Quality Forum’s (NQF) *National Voluntary Consensus Standards for Child Health Quality Measures: A Consensus Report*. Robust clinical performance measures for children and adolescents can help fill an important gap in the quality enterprise. We commend the NQF for helping to sustain the public’s focus on issues of quality and patient safety for the child and adolescent population. While we support a number of the measures recommended in this report we respectfully submit the following comments.

1517: Prenatal & Postpartum Care

Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Mar 17, 2011 - 08:28 AM

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Comments

Childbirth Connection is concerned that a measure of having a postpartum visit does not meet the criterion of driving for high performance. We hope that composite measures of the quality of postpartum care and better measures of the quality of prenatal care will be available in the future. Because this measure assesses timeliness of prenatal care (versus mere fact of prenatal care) and is a composite of both prenatal and postpartum care, we prefer it to the “frequency of ongoing prenatal care” that is also being considered here.

1397: Sudden Infant Death Syndrome Counseling
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Mar 17, 2011 - 08:27 AM

Comments

Childbirth Connection strongly supports the decision to alter this measure to focus on counseling at an earlier age.

1391: Frequency of Ongoing Prenatal Care
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Mar 17, 2011 - 08:26 AM

Comments

Childbirth Connection is concerned that a measure of having prenatal visits does not meet the criterion of driving for high performance. We hope that composite measures of the quality of prenatal care and measures of the outcome of prenatal care will be available in the future. Because the “Prenatal and postpartum care” measure also considered here assesses timeliness of prenatal care (versus mere fact of prenatal care) and is a composite of both prenatal and postpartum care, we prefer it to “frequency of ongoing prenatal care.”

1401: Maternal Depression Screening
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Mar 17, 2011 - 08:25 AM

Comments

Childbirth Connection strongly supports this measure, which has the potential to favorably impact both childbearing women and their infants. We agree that screening for maternal depression is the responsibility of both maternal and newborn caregivers. While mental health services are not always readily available, mothers with depression should be encouraged to seek timely treatment. PPD treatment is effective in reducing or resolving depression in an notable proportion of women.

Comments on the general draft report
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Mar 17, 2011 - 08:24 AM

Comments

Childbirth Connection strongly supports this project to provide complementary measures to the initial core CHIPRA measure set. The focus on pediatric measures complements NQF's growing portfolio of adult measures.

There is a need to harmonize measures addressing similar topics and avoid unnecessary complexity. The Committee and developers should also consider combining related measures. A single composite measure would be preferable to multiple overlapping or similar measures.

1346: Children Who Are Exposed To Secondhand Smoke Inside Home

Comment By	On Behalf Of
Name: Dr. Michael P. Phelan, MD	Name: Cleveland Clinic
Organization: Cleveland Clinic	Organization: Cleveland Clincic

Date - Time: Mar 16, 2011 - 04:15 PM

Comments

The measure as written is simply looking at whether pediatric patients are exposed to smoke. We were concerned that a better measure would be if the exposed childs parent was actually given counceling or not when identified.

Comments on the general draft report

Comment By

Name: Ms. Junelle Speller

Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 04:04 PM

Comments

The American Academy of Pediatrics (AAP) urges the revision of the screening measures to reflect annual assessment as recommended by Bright Futures and align with the United States Preventive Services Task Force (USPSTF) standards, where applicable. Additionally, we strongly recommend explicit instructions that these screening measures and subsequent follow-up be conducted within the medical home. The AAP also urges the NQF to include autism screening in the measure set to reflect the Bright Futures' recommendations of standardized autism screening at 18 and 24 months.

Comments on the general draft report

Comment By

Name: Ms. Junelle Speller

Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:57 PM

Comments

The American Academy of Pediatrics encourages the NQF to include measures on safety (ie, safety belts helmets, driving safety, guns, and violence). The Centers for Disease Control and Prevention has identified six health behaviors that contribute the most to adolescent and adult morbidity and mortality, and Bright Futures guidelines has prioritized these for school age and adolescent visits: physical activity and nutrition; sexuality related behaviors; substance abuse; safety; and mental health . The NQF measures include all of these priorities except safety. The next edition of the Child Health Quality Measure set should include measures related to safety and injury prevention.

Comments on the general draft report

Comment By

Name: Ms. Junelle Speller

Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:57 PM

Comments

There is a paucity of measures that address disparities, particularly for children from abusive families or foster homes, undocumented children (several millions), and children living in inner-city and rural areas with insufficient resources and poor access to health care. The measure set also lacks indirect measures of health such as measurement of school health and performance and the use of family intactness or structure and support for the consideration of the child mental health determinants.

Comments on the general draft report
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:57 PM

Comments

The American Academy of Pediatrics recommends that palliative care measures be included in the Child Health Quality Measure set. Inclusion of palliative care seems particularly germane, given that palliative and end-of-life care is one of the core focus areas of the NQF-convened National Priorities Partnership. Palliative care is a cross-cutting discipline and a board certified medical specialty, for which the AAP offers specific guidance for palliative care for children (Committee on Bioethics and Committee on Hospital Care. Palliative Care for Children. *Pediatrics*. 2000;106(2): 351-357). The AAP encourages the NQF to make palliative care a priority focus area for the next iteration of the Child Health Quality Measure set.

1340: Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:55 PM

Comments

The 2005-2006 administration of this survey revealed that discussions between the clinician and parent/child about transitioning to adult care or encouraging the youth to take more responsibility for his/her care often do not occur. Moreover, there is significant variation among states and the affected population groups on this measure, with lower income Black or Hispanic families reporting markedly less support. While recognition of the importance of this issue has increased in recent years (eg, the National Committee for Quality Assurance Patient-Centered Medical Home [PCMH] 2011 standards includes development of a written care plan for transitioning patients as one factor for which a practice can earn credit toward PCMH recognition), greater improvement is needed. A population-based measure such as this does not help pinpoint particular practices that need help; however, inclusion of this measure in the overall Child Health Measure set will provide some useful data.

1506: Immunizations by 18 years of age
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:54 PM

Comments

The American Academy of Pediatrics recommends that this measure be updated regularly to reflect current immunization schedules accurately.

1507: Risky Behavior Assessment or Counseling by Age 18 Years
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:54 PM

Comments

The American Academy of Pediatrics recommends that these measures reflect the Bright Futures recommendation for annual assessment of risky behavior.

1406: Risky Behavior Assessment or Counseling by Age 13 Years
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:53 PM

Comments

The American Academy of Pediatrics recommends that these measures reflect the Bright Futures recommendation for annual assessment of risky behavior.

1515: Depression Screening By 18 years of age
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:53 PM

Comments

The American Academy of Pediatrics (AAP) suggests that these measures include an expanded list of validated, evidence-based tools to screen for depression or set a requirement for the use of evidence- based tools. Many pediatricians are currently utilizing evidence-based standardized screens, such as the Pediatric Symptom Checklist (PSC) or the Strengths and Difficulties Questionnaire (SDQ), which screen for a broad range of attention, externalizing and internalizing symptoms of mental health disorders, including symptoms of depression.

In July 2010, the AAP Task Force on Mental Health published a supplement to *Pediatrics* that provided resources for mental health care. Tools included were the rationale for the case of routine mental health screening[1]and a chart of mental health screening and assessment tools for the pediatric primary care setting.[2]

---

[1]AAP Task Force on Mental Health. The case for routine mental health screening. *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit*. American Academy of Pediatrics: Elk Grove Village, IL; 2010.

[2]AAP Task Force on Mental Health. Mental health screening and assessment tools for primary care. *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit*. American Academy of Pediatrics: Elk Grove Village, IL; 2010.

1394: Depression Screening By 13 years of age
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:51 PM

Comments

The American Academy of Pediatrics (AAP) suggests that these measures include an expanded list of validated, evidence-based tools to screen for depression or set a requirement for the use of evidence- based tools. Many pediatricians are currently utilizing evidence-based standardized screens, such as the Pediatric Symptom Checklist (PSC) or the Strengths and Difficulties Questionnaire (SDQ), which screen for a broad range of attention, externalizing and internalizing symptoms of mental health disorders, including symptoms of depression.

In July 2010, the AAP Task Force on Mental Health published a supplement to *Pediatrics* that provided resources for mental health care. Tools included were the rationale for the case of routine mental health screening[1]and a chart of mental health screening and assessment tools for the pediatric primary care setting.[2]

---

[1]AAP Task Force on Mental Health. The case for routine mental health screening. *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit*. American Academy of Pediatrics: Elk Grove Village, IL; 2010.

[2]AAPTask Force on Mental Health. Mental health screening and assessment tools for primary care. *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit*. American Academy of Pediatrics: Elk Grove Village, IL; 2010.

1381: Asthma Emergency Department Visits
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:49 PM

Comments

The American Academy of Pediatrics suggests that urgent care visits be added to this measure. Although urgent care and after-hour centers manage sick children, these sites often are not counted.

1349: Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:48 PM

Comments

BMI is embedded in child/adolescent electronic health records, and there are several measures at the practice level to pick up this information. Population survey data may have limited application here, especially as the NQF draft report notes, parents might not consistently report accurate measurements.

Although the intent of this measure is consistent with the American Academy of Pediatrics (AAP) position, there is lack of evidence and specificity for physical activity counseling. The AAP suggests the inclusion of citation of the American College of Sports Medicine for physical activity guidelines, particularly "Physical Activity and Bone Health," which addresses adolescent ages (Strong WB, Malina RM, Blimkie CJ, Daniels SR, Dishman RK, Gutin B,

Hergenroeder AC, Must A, Nixon PA, Pivarnik JM, Rowland T, Trost S, Trudeau F.

Evidence based physical activity for school-age youth. *J Pediatr*. 2005

Jun;146(6):732-7. Review. PubMed PMID: 15973308).

1346: Children Who Are Exposed To Secondhand Smoke Inside Home
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:47 PM

Comments

The American Academy of Pediatrics suggests that this measure include the presence of a smoker living in the household and omit "smoking inside the home." Even if smoking does not occur inside the home, the presence of a smoker living in the household creates opportunity for second- and third-hand smoke.

1395: Chlamydia Screening and Follow Up
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:47 PM

Comments

The American Academy of Pediatrics recommends that this measure align with standards established by the USPSTF and Bright Futures, which recommends Chlamydia screening for males and females. The AAP also is concerned with the measure's use of the Health Effectiveness Data Information Set (HEDIS) definition of sexual activity that includes use of oral contraceptive pills evidence pregnancy test not followed by accutane or radiation. This definition may not fully capture sexually active patients who do not meet the HEDIS criteria.

1335: Children Who Have Dental Decay or Cavities
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:46 PM

Comments

Tooth decay (dental caries) affects children in the United States more than any other chronic infectious disease. It should be pointed out that Bright Futures is focused on oral health risk assessment, which would include examining the teeth for white spots and obvious decay in infants ages six and nine months to identify those who need an earlier referral. This measure does not clearly specify the type of clinician who will perform this assessment. If pediatricians are to conduct this surveillance, then they may need additional training in order to obtain accurate results.

1334: Children Who Received Preventive Dental Care
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:46 PM

Comments

Access to dental care for children, even routine preventive care, is an ongoing problem in many communities. This population-based measure can be helpful in identifying the extent of the problem within a given community or state and encourage action by policy makers and the public health leadership to address the problem.

1385: Developmental screening using a parent completed screening tool (Parent report, Children 0-5)
Comment By
Name: Ms. Junelle Speller
Organization: American Academy of Pediatrics

Date - Time: Mar 16, 2011 - 03:45 PM

Comments

The American Academy of Pediatrics suggests that the measure either omit reference to the screening tool, Parents' Evaluation of Developmental Status (PEDS), and offer clinicians the option of using any validated tool, or replace it with the Ages and Stages Questionnaire. According to the National Developmental Surveillance and Screening Policy Implementation Pilot (D-PIP) (King et al, "Implementing Developmental Screening and Referrals: Lessons Learned From a National Project," *Pediatrics* Feb 2010), there are various issues with use of the PEDS tool including much lower pediatrician referral rates after a failed PEDS. The D-PIP suggested that this was due to clinicians who did not believe the results of a failed PEDS.

1395: Chlamydia Screening and Follow Up
Comment By
Name: Dr. Thomas James, III, MD
Organization: Humana Inc.

Date - Time: Mar 16, 2011 - 02:57 PM

Comments

Humana has several concerns with the way the measure is presented but not with the concept, so recommends that the measure be refered to the developer for further consideration:

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

1.) The measure requires chart review to ascertain whether the woman has been sexually active. this makes this a difficult measure until it is available as an e-measure.

2.) The definition of sexually active includes the use of oral contraceptives. While the majority of OC users are sexually active, there are those adolescents who are not sexually active and who take OC for control of other conditions such as dysmenorrhagia or acne.

3.) Out health plan experience is that pediatricians particularly are reluctant to screen all patients on OC if they are not sexually active for a variety of legitimate reasons. We received a number of strong comments when we included this measure in our reporting vehicles.

1365: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Comment By	On Behalf Of
Name: Dr. Bruce Bagley, MD	Name: Bruce Bagley, M.D.
Organization: American Academy of Family Physicians	Organization: American Academy of Family Physicians

Date - Time: Mar 15, 2011 - 04:52 PM

Comments

We support the use of this measure because the demoninator is children and adolescents with a diagnosis of major depressive disorder. In this group it is extremely important to identify and assess suicidal ideation and act on the results if necessary.

1382: Percentage of low birthweight births

Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 06:05 PM

Comments

We support the measure of low birthweight babies but feel that this measure would more accurately reflect preventable causes of low birthweight if these criteria were limited to children without complicating factors such as extreme prematurity, multiple gestation, or genetic disorders that do not represent preventable causes of low birthweight. We do recognize the cutoff of 2,500 grams in this measure as being more indicative of preventable causes than very low birth weight.

1337: Children With Inconsistent Health Insurance Coverage in the Past 12 Months

Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:41 PM

Comments

We strongly support all three of the proposed measures for access to family centered primary care.

1330: Children With a Usual Source for Care When Sick

Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:41 PM

Comments

We strongly support all three of the proposed measures for access to family centered primary care.

1361: Intervention no later than 6 months of age (EHDI-4a)
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare
Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:40 PM

Comments

Having worked to improved newborn hearing screening rates for many years, we strongly support these measures. The key limitation we see is the lack of attention to special populations such as babies who spent a significant period of time in the NICU, and are therefore at higher risk for hearing loss. The current standard of care is documentation of screening by 1 month of age with full audiologic evaluation by 3 months of age for those who did not pass. At six months, every child who has been identified as having hearing loss should have been referred to early intervention services.

1360: Audiological Evaluation no later than 3 months of age (EHDI-3)
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare
Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:40 PM

Comments

Having worked to improved newborn hearing screening rates for many years, we strongly support these measures. The key limitation we see is the lack of attention to special populations such as babies who spent a significant period of time in the NICU, and are therefore at higher risk for hearing loss. The current standard of care is documentation of screening by 1 month of age with full audiologic evaluation by 3 months of age for those who did not pass. At six months, every child who has been identified as having hearing loss should have been referred to early intervention services.

1354: Hearing screening prior to hospital discharge (EHDI-1a)
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare
Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:39 PM

Comments

Having worked to improved newborn hearing screening rates for many years, we strongly support these measures. The key limitation we see is the lack of attention to special populations such as babies who spent a significant period of time in the NICU, and are therefore at higher risk for hearing loss. The current standard of care is documentation of screening by 1 month of age with full audiologic evaluation by 3 months of age for those who did not pass. At six months, every child who has been identified as having hearing loss should have been referred to early intervention services.

1357: Outpatient hearing screening of infants who did not complete screening before hospital discharge (EHDI-1c)
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare
Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:39 PM

Comments

Having worked to improved newborn hearing screening rates for many years, we strongly support these measures. The key limitation we see is the lack of attention to special populations such as babies who spent a significant period of time in the NICU, and are therefore at higher risk for hearing loss. The current standard of care is documentation of screening by 1 month of age

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

with full audiologic evaluation by 3 months of age for those who did not pass. At six months, every child who has been identified as having hearing loss should have been referred to early intervention services.

1402: Newborn Hearing Screening
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:38 PM

Comments

For measure #1402, we would want specification to be clear that this measure refers only to the look back period for chart review rather than the time at which diagnostic assessment should be performed.

1364: Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:37 PM

Comments

We believe this measure is the first step in measuring the quality of care for depressed children and adolescents and should be approved. However, including appropriate treatment in a bundled measure would be a more accurate reflection of care quality. Because this measure is collected at the Individual Clinician level, we feel that inclusion of treatment in this measure would be feasible.

1381: Asthma Emergency Department Visits
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:35 PM

Comments

We are in favor of the inclusion of Emergency Department use as a measure of comprehensive asthma care.

1335: Children Who Have Dental Decay or Cavities
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:34 PM

Comments

Measures 1388, 1334, and 1335 are important measures of the quality of dental care and we strongly support them.

1334: Children Who Received Preventive Dental Care
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Date - Time: Mar 10, 2011 - 05:34 PM

Comments

Measures 1388, 1334, and 1335 are important measures of the quality of dental care and we strongly support them.

1388: Annual Dental Visit
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:33 PM

Comments

Measures 1388, 1334, and 1335 are important measures of the quality of dental care and we strongly support them.

1419: Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:33 PM

Comments

We are supportive of this endorsement of flouride varnish and the use of a provisional designation of this measure as this will require further testing in part given the logistical and financial barriers to the primary care provision of varnish.

1517: Prenatal & Postpartum Care
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:31 PM

Comments

We support the measurement of prenatal and believe that this measure is a more holistic measure of pregnancy care as it pertains to child health than measure 1391.

1391: Frequency of Ongoing Prenatal Care
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:30 PM

Comments

We support the measurement of prenatal care but believe that measure 1517, Prenatal and Postpartum Care is a more holistic measure of pregnancy care as it pertains to child health.

1515: Depression Screening By 18 years of age
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:30 PM

Comments

We strongly support measures 1394 and 1515 as they are supported by the USPSTF recommendations.

1394: Depression Screening By 13 years of age
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare
Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:29 PM

Comments

We strongly support measures 1394 and 1515 as they are supported by the USPSTF recommendations.

1401: Maternal Depression Screening
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare
Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:29 PM

Comments

We strongly support the measurement of maternal depression screening. We believe the measure, as written, is the first step in a more comprehensive screening process that would span the first year of a child's life.

1340: Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare
Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:24 PM

Comments

We feel it is important to assess transition planning in CSHCN. However, there is little evidence about the elements that comprise effective transition. Therefore, we support the measure on a provisional basis, with the understanding that it should be tailored as more evidence about effective transition becomes available.

1365: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare
Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:23 PM

Comments

We support the assessment of suicide risk but believe that limiting it to children with MDD makes the measure too dependent on consistent screening and accurate diagnosis. NICHQ would more strongly support a measure that includes screening for suicide risk for every child and adolescent that screens positive for depression during preventive care.

1406: Risky Behavior Assessment or Counseling by Age 13 Years

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:18 PM

Comments

We support measure 1406 as assessment and counseling of risky behaviors is an integral part of preventive care in children and adolescents.

1448: Developmental Screening in the First Three Years of Life
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:18 PM

Comments

We support measure 1448 over measure 1399 as we believe that the use of a standardized screening tool is an important component of developmental screening. In addition, early detection and intervention leads to better developmental outcomes, causing us to support repeat screening at 12, 24, and 36 months over the presence of a single screen by age 2.

Comments on the general draft report
Comment By
Name: Katherine Rogers
Organization:

Date - Time: Mar 10, 2011 - 05:17 PM

Comments

We at the National Alliance to Advance Adolescent Health and our partner organizations, including Partnership for Prevention, Mental Health America, and adolescent health clinics Corner Health and The SPOT at the Washington University Medical Center, are very pleased that the NQF is focusing on measures pertaining to adolescents, and to have the opportunity to comment on the adolescent measures that are part of the National Voluntary Consensus Standards for Child Health Quality Measures. The efforts that the NQF has made to incorporate various stakeholder perspectives in the development of these proposed child health standards are very important.

Our comments primarily concern the measurement year and lack of reference to treatment or follow-up for adolescents with depression and high risk behaviors. In addition, however, we want to request that measures for children extend to age 21, consistent with Medicaid and the EPSDT program and also Bright Futures.

1407: Immunizations by 13 years of age
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:16 PM

Comments

Although we strongly support this measure, the American Academy of Pediatrics and others have recommended the use of HPV vaccine in males. We therefore endorse expanding this measure to include the percent of all children age 13 who have received HPV vaccination, in addition to the other vaccines listed.

1552: Blood Pressure Screening by age 13
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:15 PM

Comments

We strongly support blood pressure screening in children. However, we believe this measure only represents the first step in diagnosis of hypertension. We would more strongly support a measure that includes accurate diagnosis and intervention for children with abnormal screening blood pressures.

1395: Chlamydia Screening and Follow Up
Comment By
Name: Dr. Charles Homer, MD
Organization: National Initiative for Children's Healthcare Quality (NICHQ)

Date - Time: Mar 10, 2011 - 05:14 PM

Comments

We strongly believe that this measure, chlamydia screening and follow up, would be a much better measure if it included males as well as females. Young men are often silent carriers of chlamydia infection and must be included in addition to women to strengthen the impact of screening, counseling, and treatment interventions.

1553: Blood Pressure Screening by age 18
Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Julio Abreu
Organization: Mental Health America

Date - Time: Mar 10, 2011 - 05:12 PM

Comments

Noting that Bright Futures calls for annual blood pressure screening, we ask that an ad hoc review of the measure be conducted to consider if the rate of blood pressure screening should be measured annually or at least if there should be an additional measurement year.

1553: Blood Pressure Screening by age 18
Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Ellen Clement
Organization: The Corner Health Center

Date - Time: Mar 10, 2011 - 05:12 PM

Comments

Noting that Bright Futures calls for annual blood pressure screening, we ask that an ad hoc review of the measure be conducted to consider if the rate of blood pressure screening should be measured annually or at least if there should be an additional measurement year.

1337: Children With Inconsistent Health Insurance Coverage in the Past 12 Months
Comment By
Name: Ms. Tanya Alteras, MPP
Organization: National Partnership for Women & Families

On Behalf Of
Name: Tanya Alteras
Organization: Consumer-Purchaser Disclosure Project

Date - Time: Mar 10, 2011 - 05:11 PM

Comments

While we agree with the steering committee that this is highly important data, there are already-existing mechanisms that states have used for years to collect this information, the most well-known being the Current Population Survey, which does an annual assessment on this question.

1553: Blood Pressure Screening by age 18

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Susan Maloney
Organization:	Organization: Partnership for Prevention

Date - Time: Mar 10, 2011 - 05:11 PM

Comments

Noting that Bright Futures calls for annual blood pressure screening, we ask that an ad hoc review of the measure be conducted to consider if the rate of blood pressure screening should be measured annually or at least if there should be an additional measurement year.

1552: Blood Pressure Screening by age 13

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Susan Maloney
Organization:	Organization: Partnership for Prevention

Date - Time: Mar 10, 2011 - 05:11 PM

Comments

Noting that Bright Futures calls for annual blood pressure screening, we ask that an ad hoc review of the measure be conducted to consider if the rate of blood pressure screening should be measured annually or at least if there should be an additional measurement year.

1552: Blood Pressure Screening by age 13

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Ellen Clement
Organization:	Organization: The Corner Health Center

Date - Time: Mar 10, 2011 - 05:10 PM

Comments

Noting that Bright Futures calls for annual blood pressure screening, we ask that an ad hoc review of the measure be conducted to consider if the rate of blood pressure screening should be measured annually or at least if there should be an additional measurement year.

1333: Children Who Receive Family-Centered Care

Comment By	On Behalf Of
Name: Ms. Tanya Alteras, MPP	Name: Tanya Alteras
Organization: National Partnership for Women & Families	Organization: Consumer-Purchaser Disclosure Project

Date - Time: Mar 10, 2011 - 05:10 PM

Comments

We feel that this measure appears to be very duplicative of a measure that was endorsed last month, OT3-045-10, “Measure of Medical Home for Children and Adolescents.” We ask NQF to clarify how this measure would be distinguishable from the already-endorsed measure.

1552: Blood Pressure Screening by age 13

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Julio Abreu
Organization:	Organization: Mental Health America

Date - Time: Mar 10, 2011 - 05:10 PM

Comments

Noting that Bright Futures calls for annual blood pressure screening, we ask that an ad hoc review of the measure be conducted to consider if the rate of blood pressure screening should be measured annually or at least if there should be an additional measurement year.

1514: Healthy Physical Development by 18 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Julio Abreu
Organization: Mental Health America

Date - Time: Mar 10, 2011 - 05:09 PM

Comments

Because of the very high rates of overweight and obesity among adolescents and Bright Futures recommendations for annual BMI testing, we suggest an ad hoc review of the measure to determine if the measure be used annually or at least if it should be used at an additional point in time during adolescence.

1346: Children Who Are Exposed To Secondhand Smoke Inside Home

Comment By
Name: Ms. Tanya Alteras, MPP
Organization: National Partnership for Women & Families

On Behalf Of
Name: Tanya Alteras
Organization: Consumer-Purchaser Disclosure Project

Date - Time: Mar 10, 2011 - 05:09 PM

Comments

This is a population-level measure with no clear actionable follow-up, and we do not feel that this rises to the standard of NQF endorsement.

1514: Healthy Physical Development by 18 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Ellen Clement
Organization: The Corner Health Center

Date - Time: Mar 10, 2011 - 05:08 PM

Comments

Because of the very high rates of overweight and obesity among adolescents and Bright Futures recommendations for annual BMI testing, we suggest an ad hoc review of the measure to determine if the measure be used annually or at least if it should be used at an additional point in time during adolescence.

1349: Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)

Comment By
Name: Ms. Tanya Alteras, MPP
Organization: National Partnership for Women & Families

On Behalf Of
Name: Tanya Alteras
Organization: Consumer-Purchaser Disclosure Project

Date - Time: Mar 10, 2011 - 05:07 PM

Comments

We feel that this is a population survey measure that will not add value to the NQF portfolio, or to the quality measurement enterprise, due to the evidence (as reflected by the steering committee's deliberations) that parental data is often inaccurate. Given that there is already a clinician-level measure of child/adolescent obesity and BMI that is included in Stage 1 of the Meaningful Use program, we do not support endorsement of this measure.

1514: Healthy Physical Development by 18 years of age

Name: Katherine Rogers
Organization:

On Behalf Of
Name: Susan Maloney
Organization: Partnership for Prevention

Date - Time: Mar 10, 2011 - 05:07 PM

Comments

Because of the very high rates of overweight and obesity among adolescents and Bright Futures recommendations for annual BMI testing, we suggest an ad hoc review of the measure to determine if the measure be used annually or at least if it should be used at an additional point in time during adolescence.

1512: Healthy Physical Development by 13 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Susan Maloney
Organization: Partnership for Prevention

Date - Time: Mar 10, 2011 - 05:07 PM

Comments

Because of the very high rates of overweight and obesity among adolescents and Bright Futures recommendations for annual BMI testing, we suggest an ad hoc review of the measure to determine if the measure be used annually or at least if it should be used at an additional point in time during adolescence.

1512: Healthy Physical Development by 13 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Ellen Clement
Organization: The Corner Health Center

Date - Time: Mar 10, 2011 - 05:06 PM

Comments

Because of the very high rates of overweight and obesity among adolescents and Bright Futures recommendations for annual BMI testing, we suggest an ad hoc review of the measure to determine if the measure be used annually or at least if it should be used at an additional point in time during adolescence.

1340: Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care

Comment By
Name: Ms. Tanya Alteras, MPP
Organization: National Partnership for Women & Families

On Behalf Of
Name: Tanya Alteras
Organization: Consumer-Purchaser Disclosure Project

Date - Time: Mar 10, 2011 - 05:06 PM

Comments

We support measure 1340 – children with special health care needs to receive services needed for transition to adult care (NSCSHCN survey). The 2005-2006 administration of this survey provides insight into the discussions between providers and parents/children related to the challenges involved in transitioning a child with special health needs to adult care. The survey also provides information on why that transition does not always occur smoothly. Moreover, there is significant variation – among states, and among the affected population groups – on this measure, with lower income Black or Hispanic families reporting markedly less transition support. While recognition of the importance of this issue has increased in recent years – for example, NCQA's PCMH 2011 standards includes development of a written care plan for transitioning patients as one factor for which a practice can earn credit toward PCMH recognition – much more improvement is needed. A population-based measure such as this does not help pinpoint particular practices that need help, but in the absence of such a measure, we would support endorsing this one.

1512: Healthy Physical Development by 13 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Julio Abreu
Organization: Mental Health America

Date - Time: Mar 10, 2011 - 05:06 PM

Comments

Because of the very high rates of overweight and obesity among adolescents and Bright Futures recommendations for annual BMI testing, we suggest an ad hoc review of the measure to determine if the measure be used annually or at least if it should be used at an additional point in time during adolescence.

1506: Immunizations by 18 years of age

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Julio Abreu
Organization:	Organization: Mental Health America

Date - Time: Mar 10, 2011 - 05:05 PM

Comments

To ensure that adolescents receive all of the recommended doses of childhood vaccines (Hepatitis B series, Polio series, MMR series, and varicella series) and receive vaccines specific for adolescents (Tdap, MCV4, HPV), we suggest an ad hoc review to consider the annual documentation of recommended immunizations or at least documentation at an additional point in time during adolescence.

Comments on the general draft report

Comment By	On Behalf Of
Name: Ms. Tanya Alteras, MPP	Name: Tanya Alteras
Organization: National Partnership for Women & Families	Organization: Consumer-Purchaser Disclosure Project

Date - Time: Mar 10, 2011 - 05:03 PM

Comments

As per our prior comment on oral health measures, access to dental care for children, even routine preventive care, is an ongoing problem in many communities, and poor access to oral health early on in life can lead to health problems that plague individuals their entire lives. The two population-level measures are highly actionable and will help states and localities identify the extent of the problem within a given community and encourage action by policy makers and the public health leadership to address the problem. Also, we highlight our strong support for measure 1419, Primary Caries Prevention Intervention as Part of a Well/Ill Child Care Offered by Primary Care Medical Providers (submitted by the University of MN). Primary care providers in many communities are being trained to do caries prevention, due to the tremendous shortage of dentists, particularly for Medicaid patients. In addition, this measure reflects the idea that dental care IS primary care.

1506: Immunizations by 18 years of age

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Ellen Clement
Organization:	Organization: The Corner Health Center

Date - Time: Mar 10, 2011 - 05:03 PM

Comments

To ensure that adolescents receive all of the recommended doses of childhood vaccines (Hepatitis B series, Polio series, MMR series, and varicella series) and receive vaccines specific for adolescents (Tdap, MCV4, HPV), we suggest an ad hoc review to consider the annual documentation of recommended immunizations or at least documentation at an additional point in time during adolescence.

1506: Immunizations by 18 years of age

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Susan Maloney
Organization:	Organization: Partnership for Prevention

Date - Time: Mar 10, 2011 - 05:03 PM

Comments

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

To ensure that adolescents receive all of the recommended doses of childhood vaccines (Hepatitis B series, Polio series, MMR series, and varicella series) and receive vaccines specific for adolescents (Tdap, MCV4, HPV), we suggest an ad hoc review to consider the annual documentation of recommended immunizations or at least documentation at an additional point in time during adolescence.

Comments on the general draft report

Comment By
Name: Ms. Tanya Alteras, MPP
Organization: National Partnership for Women & Families

On Behalf Of
Name: Tanya Alteras
Organization: Consumer-Purchaser Disclosure Project

Date - Time: Mar 10, 2011 - 05:02 PM

Comments

Oral Health Measures: We support all the measures related to oral health care:

§ 1388: Annual dental visit (NCQA, clinician level)

§ 1334: Children who received preventive dental care (CAHMI, population health)

§ 1335: Children who have dental decay or cavities (CAHMI, population health)

§ 1419: Primary Caries Prevention Intervention (UMN, clinician level)

Comments on the general draft report

Comment By
Name: Ms. Tanya Alteras, MPP
Organization: National Partnership for Women & Families

On Behalf Of
Name: Tanya Alteras
Organization: Consumer-Purchaser Disclosure Project

Date - Time: Mar 10, 2011 - 05:02 PM

Comments

Measures of Patient-Centered Care: We view the following measures submitted by NCQA as being meaningful from the perspective of consumers and purchasers wishing to collect better information on whether children and adolescents are receiving comprehensive, patient-centered care. All of these measures can be used at the practice/clinic level and clinical level, and indicate whether high quality, timely preventive care is being provided.

§ 1397 – SIDS counseling

§ 1401 – maternal depression screening

§ 1402 – newborn hearing screening

§ 1399 – developmental screening and follow-up by age 2

§ 1553 – blood pressure screening, age 18

§ 1395 – chlamydia screening and follow-up, age 18

§ 1396, 1512, 1514 –assessment of healthy physical development, three different age groups

§ 1407 and 1506 – updated composite of adequacy of adolescent immunization status to include HPV

§ 1294 and 1515 – depression screen, using one of identified screening tools, two adolescent age groups

§ 1406 and 1507 – counseling for risky behavior, two adolescent age groups

---

1407: Immunizations by 13 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Susan Maloney
Organization: Partnership for Prevention

Date - Time: Mar 10, 2011 - 05:02 PM

Comments

To ensure that adolescents receive all of the recommended doses of childhood vaccines (Hepatitis B series, Polio series, MMR series, and varicella series) and receive vaccines specific for adolescents (Tdap, MCV4, HPV), we suggest an ad hoc review to consider the annual documentation of recommended immunizations or at least documentation at an additional point in time during adolescence.

1407: Immunizations by 13 years of age

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Ellen Clement
Organization:	Organization: The Corner Health Center

Date - Time: Mar 10, 2011 - 05:01 PM

Comments

To ensure that adolescents receive all of the recommended doses of childhood vaccines (Hepatitis B series, Polio series, MMR series, and varicella series) and receive vaccines specific for adolescents (Tdap, MCV4, HPV), we suggest an ad hoc review to consider the annual documentation of recommended immunizations or at least documentation at an additional point in time during adolescence.

1407: Immunizations by 13 years of age

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Julio Abreu
Organization:	Organization: Mental Health America

Date - Time: Mar 10, 2011 - 05:01 PM

Comments

To ensure that adolescents receive all of the recommended doses of childhood vaccines (Hepatitis B series, Polio series, MMR series, and varicella series) and receive vaccines specific for adolescents (Tdap, MCV4, HPV), we suggest an ad hoc review to consider the annual documentation of recommended immunizations or at least documentation at an additional point in time during adolescence.

1507: Risky Behavior Assessment or Counseling by Age 18 Years

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Julio Abreu
Organization:	Organization: Mental Health America

Date - Time: Mar 10, 2011 - 04:59 PM

Comments

Recognizing the national emphasis on prevention and the fact that Bright Futures calls for risky behavior assessments annually, we suggest an ad hoc review of the measure to determine if it should be used annually or at least if the measure should be used at an additional point in time during adolescence. The review should also consider the need for documentation of a follow-up plan for those found to be at high risk.

1507: Risky Behavior Assessment or Counseling by Age 18 Years

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Ellen Clement
Organization:	Organization: The Corner Health Center

Date - Time: Mar 10, 2011 - 04:58 PM

Comments

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Recognizing the national emphasis on prevention and the fact that Bright Futures calls for risky behavior assessments annually, we suggest an ad hoc review of the measure to determine if it should be used annually or at least if the measure should be used at an additional point in time during adolescence. The review should also consider the need for documentation of a follow-up plan for those found to be at high risk.

1507: Risky Behavior Assessment or Counseling by Age 18 Years

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Susan Maloney
Organization:	Organization: Partnership for Prevention

Date - Time: Mar 10, 2011 - 04:58 PM

Comments

Recognizing the national emphasis on prevention and the fact that Bright Futures calls for risky behavior assessments annually, we suggest an ad hoc review of the measure to determine if it should be used annually or at least if the measure should be used at an additional point in time during adolescence. The review should also consider the need for documentation of a follow-up plan for those found to be at high risk.

1406: Risky Behavior Assessment or Counseling by Age 13 Years

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Susan Maloney
Organization:	Organization: Partnership for Prevention

Date - Time: Mar 10, 2011 - 04:57 PM

Comments

Recognizing the national emphasis on prevention and the fact that Bright Futures calls for risky behavior assessments annually, we suggest an ad hoc review of the measure to determine if it should be used annually or at least if the measure should be used at an additional point in time during adolescence. The review should also consider the need for documentation of a follow-up plan for those found to be at high risk.

1406: Risky Behavior Assessment or Counseling by Age 13 Years

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Ellen Clement
Organization:	Organization: The Corner Health Center

Date - Time: Mar 10, 2011 - 04:57 PM

Comments

Recognizing the national emphasis on prevention and the fact that Bright Futures calls for risky behavior assessments annually, we suggest an ad hoc review of the measure to determine if it should be used annually or at least if the measure should be used at an additional point in time during adolescence. The review should also consider the need for documentation of a follow-up plan for those found to be at high risk.

1406: Risky Behavior Assessment or Counseling by Age 13 Years

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Julio Abreu
Organization:	Organization: Mental Health America

Date - Time: Mar 10, 2011 - 04:56 PM

Comments

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Recognizing the national emphasis on prevention and the fact that Bright Futures calls for risky behavior assessments annually, we suggest an ad hoc review of the measure to determine if it should be used annually or at least if the measure should be used at an additional point in time during adolescence. The review should also consider the need for documentation of a follow-up plan for those found to be at high risk.

1515: Depression Screening By 18 years of age

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Julio Abreu
Organization:	Organization: Mental Health America

Date - Time: Mar 10, 2011 - 04:54 PM

Comments

Because of the high prevalence of depression during adolescence, we recommend that an ad hoc review be conducted to consider the annual use of the measure, as called for in Bright Futures, or the use of the measure at an additional point in time during adolescence. With respect to the list of approved screening tools specified in the measure, we recommend also that the review consider either expanding the list to include all evidence- based tools validated to screen for depression or instead simply set a requirement for the use of evidence- based tools. It would also be important for the ad hoc review to address the need for a requirement of documentation of a follow-up plan to bring the measure in line with the USPSTF recommendations.

1515: Depression Screening By 18 years of age

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Ellen Clement
Organization:	Organization: The Corner Health Center

Date - Time: Mar 10, 2011 - 04:53 PM

Comments

Because of the high prevalence of depression during adolescence, we recommend that an ad hoc review be conducted to consider the annual use of the measure, as called for in Bright Futures, or the use of the measure at an additional point in time during adolescence. With respect to the list of approved screening tools specified in the measure, we recommend also that the review consider either expanding the list to include all evidence- based tools validated to screen for depression or instead simply set a requirement for the use of evidence- based tools. It would also be important for the ad hoc review to address the need for a requirement of documentation of a follow-up plan to bring the measure in line with the USPSTF recommendations.

1515: Depression Screening By 18 years of age

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Susan Maloney
Organization:	Organization: Partnership for Prevention

Date - Time: Mar 10, 2011 - 04:53 PM

Comments

Because of the high prevalence of depression during adolescence, we recommend that an ad hoc review be conducted to consider the annual use of the measure, as called for in Bright Futures, or the use of the measure at an additional point in time during adolescence. With respect to the list of approved screening tools specified in the measure, we recommend also that the review consider either expanding the list to include all evidence- based tools validated to screen for depression or instead simply set a requirement for the use of evidence- based tools. It would also be important for the ad hoc review to address the need for a requirement of documentation of a follow-up plan to bring the measure in line with the USPSTF recommendations.

1394: Depression Screening By 13 years of age

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Susan Maloney
Organization:	Organization: Partnership for Prevention

Date - Time: Mar 10, 2011 - 04:51 PM

Comments

Because of the high prevalence of depression during adolescence, we recommend that an ad hoc review be conducted to consider the annual use of the measure, as called for in Bright Futures, or the use of the measure at an additional point in time during adolescence. With respect to the list of approved screening tools specified in the measure, we recommend also that the review consider either expanding the list to include all evidence- based tools validated to screen for depression or instead simply set a requirement for the use of evidence- based tools. It would also be important for the ad hoc review to address the need for a requirement of documentation of a follow-up plan to bring the measure in line with the USPSTF recommendations.

Comments on the general draft report

Comment By	On Behalf Of
Name: Ms. Tanya Alteras, MPP	Name: Tanya Alteras
Organization: National Partnership for Women & Families	Organization: Consumer-Purchaser Disclosure Project

Date - Time: Mar 10, 2011 - 04:51 PM

Comments

We do not oppose endorsement of measures 1391 (frequency of prenatal care), 1392 (well-child visits in first 15 months of life), or 1516 (well-child visits with primary care provider, ages 3-6), and understand that NQF endorsement of these measures will ease their implementation as part of the CHIPRA core measure set. These are NCQA HEDIS measures that are already being used by many states and health plans, and to not provide them with NQF endorsement would not be productive, in our opinion. However, we do want to note that these are the types of measures that we feel do not – as currently structured – provide the field with meaningful information on whether appropriate care was provided to mothers or children. While they quantify the number of visits a person had, and therefore provide a rough indicator of access, they tell nothing about the quality of those visits. That is a significant gap in measurement that we would like to see added to the recommendations in this report, and advocated for by all stakeholders.

1394: Depression Screening By 13 years of age

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Ellen Clement
Organization:	Organization: The Corner Health Center

Date - Time: Mar 10, 2011 - 04:51 PM

Comments

Because of the high prevalence of depression during adolescence, we recommend that an ad hoc review be conducted to consider the annual use of the measure, as called for in Bright Futures, or the use of the measure at an additional point in time during adolescence. With respect to the list of approved screening tools specified in the measure, we recommend also that the review consider either expanding the list to include all evidence- based tools validated to screen for depression or instead simply set a requirement for the use of evidence- based tools. It would also be important for the ad hoc review to address the need for a requirement of documentation of a follow-up plan to bring the measure in line with the USPSTF recommendations.

Comments on the general draft report

Comment By	On Behalf Of
Name: Ms. Tanya Alteras, MPP	Name: Tanya Alteras
Organization: National Partnership for Women & Families	Organization: Consumer-Purchaser Disclosure Project

Date - Time: Mar 10, 2011 - 04:50 PM

Comments

While we support the majority of measures in this project, there are a number of measures which we feel do not add significant value to the NQF portfolio, and we do not believe they should be endorsed. These include population health measures that are not necessarily actionable by states or counties (i.e. measure of second-hand smoke exposure in the home) and measures that duplicate data that is already being collected (i.e. inconsistent health coverage over the course of 12 months, measure of family-centered medical home care). We look forward to continuing to work with NQF as we advocate for the transition away from these process measures, and into the realm of measures of patient-reported outcomes, functional status, and experience of care.

1394: Depression Screening By 13 years of age

Comment By	On Behalf Of

Name: Katherine Rogers
Organization:

Name: Julio Abreu
Organization: Mental Health America

Date - Time: Mar 10, 2011 - 04:49 PM

Comments

Because of the high prevalence of depression during adolescence, we recommend that an ad hoc review be conducted to consider the annual use of the measure, as called for in Bright Futures, or the use of the measure at an additional point in time during adolescence. With respect to the list of approved screening tools specified in the measure, we recommend also that the review consider either expanding the list to include all evidence- based tools validated to screen for depression or instead simply set a requirement for the use of evidence- based tools. It would also be important for the ad hoc review to address the need for a requirement of documentation of a follow-up plan to bring the measure in line with the USPSTF recommendations.

Comments on the general draft report

Comment By
Name: Ms. Tanya Alteras, MPP
Organization: National Partnership for Women & Families

On Behalf Of
Name: Tanya Alteras
Organization: Consumer-Purchaser Disclosure Project

Date - Time: Mar 10, 2011 - 04:49 PM

Comments

The Consumer-Purchaser Disclosure Project appreciates the opportunity to comment on the children's health quality measures currently in the consensus development process pipeline. We agree with NQF and AHRQ that there are a number of gaps in available measures on the quality of care provided to children. From preventive and primary care to care for special health care needs populations, the quality measurement enterprise has to play "catch up" to develop measures that will allow the field to understand and address how care is delivered to children and adolescents so as to improve outcomes, improve access, and move the needle in terms of cost containment. We are supportive of the majority of the 41 measures recommended by the steering committee for endorsement, with specific comments provided below. In particular, we would like to highlight our strong support for the measures related to dental care, maternal and child depression screening, and transition to adult health care services for children with special health care needs, all areas where there is evidence of variation in quality.

1506: Immunizations by 18 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Katie Plax
Organization: The SPOT Teen Health Center, Washington University Medical Center

Date - Time: Mar 10, 2011 - 04:47 PM

Comments

To ensure that adolescents receive all of the recommended doses of childhood vaccines (Hepatitis B series, Polio series, MMR series, and varicella series) and receive vaccines specific for adolescents (Tdap, MCV4, HPV), we suggest an ad hoc review to consider the annual documentation of recommended immunizations or at least documentation at an additional point in time during adolescence.

1407: Immunizations by 13 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Katie Plax
Organization: The SPOT Teen Health Center, Washington University Medical Center

Date - Time: Mar 10, 2011 - 04:44 PM

Comments

To ensure that adolescents receive all of the recommended doses of childhood vaccines (Hepatitis B series, Polio series, MMR series, and varicella series) and receive vaccines specific for adolescents (Tdap, MCV4, HPV), we suggest an ad hoc review to consider the annual documentation of recommended immunizations or at least documentation at an additional point in time during adolescence.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

1553: Blood Pressure Screening by age 18

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Katie Plax
Organization: The SPOT Teen Health Center, Washington University Medical Center

Date - Time: Mar 10, 2011 - 04:40 PM

Comments

Noting that Bright Futures calls for annual blood pressure screening, we ask that an ad hoc review of the measure be conducted to consider if the rate of blood pressure screening should be measured annually or at least if there should be an additional measurement year.

1552: Blood Pressure Screening by age 13

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Katie Plax
Organization: The SPOT Teen Health Center, Washington University Medical Center

Date - Time: Mar 10, 2011 - 04:39 PM

Comments

Noting that Bright Futures calls for annual blood pressure screening, we ask that an ad hoc review of the measure be conducted to consider if the rate of blood pressure screening should be measured annually or at least if there should be an additional measurement year.

1514: Healthy Physical Development by 18 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Katie Plax
Organization: The SPOT Teen Health Center, Washington University Medical Center

Date - Time: Mar 10, 2011 - 04:38 PM

Comments

Because of the very high rates of overweight and obesity among adolescence and Bright Futures recommendations for annual BMI testing, we suggest an ad hoc review of the measure to determine if the measure be used annually or at least if it should be used at an additional point in time during adolescence.

1512: Healthy Physical Development by 13 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Katie Plax
Organization: The SPOT Teen Health Center, Washington University Medical Center

Date - Time: Mar 10, 2011 - 04:37 PM

Comments

Because of the very high rates of overweight and obesity among adolescence and Bright Futures recommendations for annual BMI testing, we suggest an ad hoc review of the measure to determine if the measure be used annually or at least if it should be used at an additional point in time during adolescence.

1507: Risky Behavior Assessment or Counseling by Age 18 Years

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Katie Plax
Organization: The SPOT Teen Health Center, Washington

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

University Medical Center

Date - Time: Mar 10, 2011 - 04:36 PM

Comments

Recognizing the national emphasis on prevention and the fact that Bright Futures calls for risky behavior assessments annually, we suggest an ad hoc review of the measure to determine if it should be used annually or at least if the measure should be used at an additional point in time during adolescence. The review should also consider the need for documentation of a follow-up plan for those found to be at high risk.

1406: Risky Behavior Assessment or Counseling by Age 13 Years

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Katie Plax
Organization:	Organization: The SPOT Teen Health Center, Washington University Medical Center

Date - Time: Mar 10, 2011 - 04:35 PM

Comments

Recognizing the national emphasis on prevention and the fact that Bright Futures calls for risky behavior assessments annually, we suggest an ad hoc review of the measure to determine if it should be used annually or at least if the measure should be used at an additional point in time during adolescence. The review should also consider the need for documentation of a follow-up plan for those found to be at high risk.

1515: Depression Screening By 18 years of age

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Katie Plax
Organization:	Organization: The SPOT Teen Health Center, Washington University Medical Center

Date - Time: Mar 10, 2011 - 04:34 PM

Comments

Because of the high prevalence of depression during adolescence, we recommend that an ad hoc review be conducted to consider the annual use of the measure, as called for in Bright Futures, or the use of the measure at an additional point in time during adolescence. With respect to the list of approved screening tools specified in the measure, we recommend also that the review consider either expanding the list to include all evidence- based tools validated to screen for depression or instead simply set a requirement for the use of evidence- based tools. It would also be important for the ad hoc review to address the need for a requirement of documentation of a follow-up plan to bring the measure in line with the USPSTF recommendations.

1394: Depression Screening By 13 years of age

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Katie Plax
Organization:	Organization: The SPOT Teen Health Center, Washington University Medical Center

Date - Time: Mar 10, 2011 - 04:33 PM

Comments

Because of the high prevalence of depression during adolescence, we recommend that an ad hoc review be conducted to consider the annual use of the measure, as called for in Bright Futures, or the use of the measure at an additional point in time during adolescence. With respect to the list of approved screening tools specified in the measure, we recommend also that the review consider either expanding the list to include all evidence- based tools validated to screen for depression or instead simply set a requirement for the use of evidence- based tools. It would also be important for the ad hoc review to address the need for a requirement of documentation of a follow-up plan to bring the measure in line with the USPSTF recommendations.

1395: Chlamydia Screening and Follow Up

Comment By	On Behalf Of

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Name: Katherine Rogers
Organization:

On Behalf Of
Name: Susan Maloney
Organization: Partnership for Prevention

Date - Time: Mar 10, 2011 - 04:31 PM

Comments

Recognizing the very high rates of Chlamydia in adolescence, we ask that there be an ad hoc review of the measure to consider whether it should be used annually for sexually active females, as called for in Bright Futures, or at least if the measure should be used at an additional point in time during adolescence.

1395: Chlamydia Screening and Follow Up

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Ellen Clement
Organization: The Corner Health Center

Date - Time: Mar 10, 2011 - 04:30 PM

Comments

Recognizing the very high rates of Chlamydia in adolescence, we ask that there be an ad hoc review of the measure to consider whether it should be used annually for sexually active females, as called for in Bright Futures, or at least if the measure should be used at an additional point in time during adolescence.

1395: Chlamydia Screening and Follow Up

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Katie Plax
Organization: The SPOT Teen Health Center, Washington University Medical Center

Date - Time: Mar 10, 2011 - 04:29 PM

Comments

Recognizing the very high rates of Chlamydia in adolescence, we ask that there be an ad hoc review of the measure to consider whether it should be used annually for sexually active females, as called for in Bright Futures, or at least if the measure should be used at an additional point in time during adolescence.

1506: Immunizations by 18 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Harriette Fox
Organization: The National Alliance to Advance Adolescent Health

Date - Time: Mar 10, 2011 - 04:01 PM

Comments

To ensure that adolescents receive all of the recommended doses of childhood vaccines (Hepatitis B series, Polio series, MMR series, and varicella series) and receive vaccines specific for adolescents (Tdap, MCV4, HPV), we suggest an ad hoc review to consider the annual documentation of recommended immunizations or at least documentation at an additional point in time during adolescence.

1407: Immunizations by 13 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Harriette Fox
Organization: The National Alliance to Advance Adolescent Health

Date - Time: Mar 10, 2011 - 04:01 PM

Comments

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

To ensure that adolescents receive all of the recommended doses of childhood vaccines (Hepatitis B series, Polio series, MMR series, and varicella series) and receive vaccines specific for adolescents (Tdap, MCV4, HPV), we suggest an ad hoc review to consider the annual documentation of recommended immunizations or at least documentation at an additional point in time during adolescence.

1552: Blood Pressure Screening by age 13

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Harriette Fox
Organization: The National Alliance to Advance Adolescent Health

Date - Time: Mar 10, 2011 - 03:59 PM

Comments

Noting that Bright Futures calls for annual blood pressure screening, we ask that an ad hoc review of the measure be conducted to consider if the rate of blood pressure screening should be measured annually or at least if there should be an additional measurement year.

1553: Blood Pressure Screening by age 18

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Harriette Fox
Organization: The National Alliance to Advance Adolescent Health

Date - Time: Mar 10, 2011 - 03:58 PM

Comments

Noting that Bright Futures calls for annual blood pressure screening, we ask that an ad hoc review of the measure be conducted to consider if the rate of blood pressure screening should be measured annually or at least if there should be an additional measurement year.

1395: Chlamydia Screening and Follow Up

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Harriette Fox
Organization: The National Alliance to Advance Adolescent Health

Date - Time: Mar 10, 2011 - 03:57 PM

Comments

Recognizing the very high rates of Chlamydia in adolescence, we ask that there be an ad hoc review of the measure to consider whether it should be used annually for sexually active females, as called for in Bright Futures, or at least if the measure should be used at an additional point in time during adolescence.

1394: Depression Screening By 13 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Harriette Fox
Organization: The National Alliance to Advance Adolescent Health

Date - Time: Mar 10, 2011 - 03:56 PM

Comments

Because of the high prevalence of depression during adolescence, we recommend that an ad hoc review be conducted to consider the annual use of the measure, as called for in Bright Futures, or the use of the measure at an additional point in time during adolescence. With respect to the list of approved screening tools specified in the measure, we recommend also that the review consider either expanding the list to include all evidence- based tools validated to screen for depression or instead simply set a

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

requirement for the use of evidence- based tools. It would also be important for the ad hoc review to address the need for a requirement of documentation of a follow-up plan to bring the measure in line with the USPSTF recommendations.

1512: Healthy Physical Development by 13 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Harriette Fox
Organization: The National Alliance to Advance Adolescent Health

Date - Time: Mar 10, 2011 - 03:55 PM

Comments

Because of the very high rates of overweight and obesity among adolescence and Bright Futures recommendations for annual BMI testing, we suggest an ad hoc review of the measure to determine if the measure be used annually or at least if it should be used at an additional point in time during adolescence.

1514: Healthy Physical Development by 18 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Harriette Fox
Organization: The National Alliance to Advance Adolescent Health

Date - Time: Mar 10, 2011 - 03:54 PM

Comments

Because of the very high rates of overweight and obesity among adolescents and Bright Futures recommendations for annual BMI testing, we suggest an ad hoc review of the measure to determine if the measure be used annually or at least if it should be used at an additional point in time during adolescence.

1515: Depression Screening By 18 years of age

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Harriette Fox
Organization: The National Alliance to Advance Adolescent Health

Date - Time: Mar 10, 2011 - 03:53 PM

Comments

Because of the high prevalence of depression during adolescence, we recommend that an ad hoc review be conducted to consider the annual use of the measure, as called for in Bright Futures, or the use of the measure at an additional point in time during adolescence. With respect to the list of approved screening tools specified in the measure, we recommend also that the review consider either expanding the list to include all evidence- based tools validated to screen for depression or instead simply set a requirement for the use of evidence- based tools. It would also be important for the ad hoc review to address the need for a requirement of documentation of a follow-up plan to bring the measure in line with the USPSTF recommendations.

1507: Risky Behavior Assessment or Counseling by Age 18 Years

Comment By
Name: Katherine Rogers
Organization:

On Behalf Of
Name: Harriette Fox
Organization: The National Alliance to Advance Adolescent Health

Date - Time: Mar 10, 2011 - 03:46 PM

Comments

Recognizing the national emphasis on prevention and the fact that Bright Futures calls for risky behavior assessments annually, we suggest an ad hoc review of the measure to determine if it should be used annually or at least if the measure should be used at an additional point in time during adolescence. The review should also consider the need for documentation of a follow-up plan for

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

those found to be at high risk.

1406: Risky Behavior Assessment or Counseling by Age 13 Years

Comment By	On Behalf Of
Name: Katherine Rogers	Name: Harriette Fox
Organization:	Organization: The National Alliance to Advance Adolescent Health

Date - Time: Mar 10, 2011 - 03:45 PM

Comments

Recognizing the national emphasis on prevention and the fact that Bright Futures calls for risky behavior assessments annually, we suggest an ad hoc review of the measure to determine if it should be used annually or at least if the measure should be used at an additional point in time during adolescence. The review should also consider the need for documentation of a follow-up plan for those found to be at high risk.

1340: Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care

Comment By	On Behalf Of
Name: Ms. Ann Walls, M.Ed	Name: Ann Walls
Organization: Center for Medical Home Improvement	Organization: Got Transition, the National Health Care Transition Center

Date - Time: Mar 10, 2011 - 03:40 PM

Comments

The term "doctors" should be replaced by language that reflects a larger health care team, for example, "clinicians," "health care providers," or "doctors and other health care providers." Most of our reviewers preferred "clinicians."

The abbreviation CSHCN should be changed to YSHCN since this measure is targeting the care of youth and young adults not younger children. Use of the word "child" in the measure should be changed to "youth."

Change the age range to "age 15-20" though "12-20" would be acceptable. Legal status changes for most youth at age 18, however, the American Academy of Pediatrics considers 21 the upper age for pediatric care. Further, some of the questions in the numerator are very unlikely to be addressed in the younger adolescent (age 12 to 15).

The importance of youth meeting alone with their clinician is not acknowledged though it is considered a standard of care beginning at age 12. Add wording to the numerator such as "clinician talked individually with the patient (without parents or other caregivers) for at least part of the visit when doing so is developmentally appropriate."

Sample not only parents, but also youth and young adults. Sampling of youth should include youth with special health care needs including those in special education settings. Make explanatory guidance for public reviewers more transparent and user friendly.

1515: Depression Screening By 18 years of age

Comment By	On Behalf Of
Name: Ms. Jennifer Medicus	Name: Kristin Kroeger
Organization: AACAP	Organization: AACAP

Date - Time: Mar 09, 2011 - 05:05 PM

Comments

The American Academy of Child and Adolescent Psychiatry (AACAP) supports the endorsement of measures 1394 and 1515. These measures provide a tool to establish baseline measurements of the rate of depression screening in the pediatric population. However, AACAP recommends an ad hoc review of the measures to better capture the rate of screenings and to make the measure more effective overall. As clinical measures, AACAP understands the need to require the use of a standardized screening tool for inclusion in the numerator, however AACAP recommends that the list of approved screening tools either be expanded to include all evidence-based tools validated to screen for symptoms of depression, or remove specific recommended tools and instead provide a well-defined requirement for the use of validated, evidence-based screening tools. Additionally, reviewing the measure for the inclusion of annual screenings and requiring documentation of a follow up plan would help bring the measures in line with the USPSTF recommendations.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

1394: Depression Screening By 13 years of age

Comment By
Name: Ms. Jennifer Medicus
Organization: AACAP

On Behalf Of
Name: Kristin Kroeger
Organization: AACAP

Date - Time: Mar 09, 2011 - 05:05 PM

Comments

The American Academy of Child and Adolescent Psychiatry (AACAP) supports the endorsement of measures 1394 and 1515. These measures provide a tool to establish baseline measurements of the rate of depression screening in the pediatric population. However, AACAP recommends an ad hoc review of the measures to better capture the rate of screenings and to make the measure more effective overall. As clinical measures, AACAP understands the need to require the use of a standardized screening tool for inclusion in the numerator, however AACAP recommends that the list of approved screening tools either be expanded to include all evidence-based tools validated to screen for symptoms of depression, or remove specific recommended tools and instead provide a well-defined requirement for the use of validated, evidence-based screening tools. Additionally, reviewing the measure for the inclusion of annual screenings and requiring documentation of a follow up plan would help bring the measures in line with the USPSTF recommendations.

1364: Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation

Comment By
Name: Ms. Jennifer Medicus
Organization: AACAP

On Behalf Of
Name: Kristin Kroeger
Organization: AACAP

Date - Time: Mar 09, 2011 - 05:03 PM

Comments

The American Academy of Child and Adolescent Psychiatry (AACAP) supports the endorsement of measure 1364 and supports it as time-limited. We recognize that it is a practice-level measure and support an ad hoc review of the measure at the time that DSM-V is released to review any implications from the revised manual.

Comments on the general draft report

Comment By
Name: Ms. Jennifer Medicus
Organization: AACAP

On Behalf Of
Name: Kristing Kroeger
Organization: AACAP

Date - Time: Mar 09, 2011 - 05:02 PM

Comments

The American Academy of Child and Adolescent Psychiatry (AACAP) appreciates the opportunity to comment on the *Voluntary Consensus Standards*. We acknowledge the work of AHRQ and others identifying measure gaps in priority areas such as mental health and substance abuse. We also appreciate the recognition of NQF in their strategic directions to focus on outcome measurements and disparities. However, we note there is currently a dearth of measurements in mental health, outcomes and pediatric minority populations. For example, there are 3 measures for depression in the pediatric population but the measure for autism was not recommended for endorsement because of an ongoing need for research on screening and diagnostic criteria. Although there are some grants and funding opportunities to encourage development of measures from various agencies, there needs to be better outreach, education, and incentives by NQF and other gatekeepers of measure development, for organizations capable of developing measures to encourage focus on these areas.

1354: Hearing screening prior to hospital discharge (EHDI-1a)

Comment By
Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 08, 2011 - 10:32 AM

Comments

See Aetna comment under #1402. In addition, this is a test that is occurring during the newborn inpatient stay and health plans nor

clinicians will not receive a specific claim or revenue code billing for this service. Chart review will be disruptive, costly and a burden.

1553: Blood Pressure Screening by age 18

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 08, 2011 - 10:20 AM

Comments

Chart review will be disruptive, costly and a burden.

1552: Blood Pressure Screening by age 13

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 08, 2011 - 10:18 AM

Comments

Blood pressure needs to be assessed at preschool and pre-teen years besides adolescence. In addition, as NQF recognized there is no consensus regarding the interpretation of blood pressure results in children.

1515: Depression Screening By 18 years of age

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 03:42 PM

Comments

This measure should align with USPSTF guidelines which indicate screening for adolescents (12 – 18 years of age) "should be screened for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up." NCQA's proposed 2012 Risk Assessment/Counseling in Adolescent measure age range is 15-18.

1514: Healthy Physical Development by 18 years of age

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 03:40 PM

Comments

Aetna is supportive of this measure if it is aligned with the current NCQA Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) measure, e.g. ages 3-17. The proposed HEDIS 2012 includes the addition of "screen time counseling" as an additional numerator making this 100% medical record review. There is no evidence based recommendation or standard for what is appropriate screen time. Aetna suggests excluding the screen time component and then combine these three measures into one and age-stratifying the results. The combination into a single measure would allow for a single sample to be drawn.

1512: Healthy Physical Development by 13 years of age

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Date - Time: Mar 07, 2011 - 03:39 PM

Comments

Aetna is supportive of this measure if it is aligned with the current NCQA Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) measure, e.g. ages 3-17. The proposed HEDIS 2012 includes the addition of "screen time counseling" as an additional numerator making this 100% medical record review. There is no evidence based recommendation or standard for what is appropriate screen time. Aetna suggests excluding the screen time component and then combine these three measures into one and age-stratifying the results. The combination into a single measure would allow for a single sample to be drawn.

1506: Immunizations by 18 years of age

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 02:53 PM

Comments

Aetna is supportive of this measure if it is aligned with NCQA proposed 2012 updates to their Immunizations for Adolescents (IMA).

1448: Developmental Screening in the First Three Years of Life

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 02:51 PM

Comments

Aetna agrees that this measure could be beneficial, but it is a medical record review measure which is a costly data collection burden for health plans and disruptive for clinicians. There are specific standardized tools identified in the numerator, but it is not clear these are all the ones in use by pediatricians. As debated by the Steering Committee, should this be measured at age 2 or at age 3 as proposed by CAHMI measure #1448? We recommend there be only one measure - at age 2 or 3, but not two measures.

1419: Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 02:39 PM

Comments

While dental plan data can be used for this measure, this service may be provided at schools and not billed.

1412: Pre-School Vision Screening in the Medical Home

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 02:37 PM

Comments

This screening measure is not usually billed separately, i.e. this screening is not unbundled from annual physical exam. Billing practices are variable and therefore resulting rates may not be accurate or comparable.

1407: Immunizations by 13 years of age

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD

Organization: Aetna | Organization: Aetna

Date - Time: Mar 07, 2011 - 02:35 PM

Comments

Aetna is supportive of this measure if it is aligned with NCQA proposed 2012 updates to their Immunizations for Adolescents (IMA).

1406: Risky Behavior Assessment or Counseling by Age 13 Years

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 02:34 PM

Comments

Aetna disagrees with measurement of assessment OR counseling. The preferred outcome is that counseling has occurred when there is a positive assessment. An explanation as to what is an acceptable "standardized tool" is needed. In addition, it is not clear how often counseling diagnosis and procedure codes used to capture claims activity are billed for children. Specific codes are noted in the proposed HEDIS 2012 measure, but it appears that the proposed #1406 measure for NQF endorsement does not have these codes included.

1402: Newborn Hearing Screening

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 02:32 PM

Comments

Measures #1402, 1354, and 1357 appear to be overlapping measures for newborn hearing screening. Aetna recommends that the developers consider combining these into one measure, e.g. percentage of newborns who received the screening before hospital discharge or by 3 months old.

1399: Developmental Screening by 2 Years of Age

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 02:30 PM

Comments

Aetna agrees that this measure could be beneficial, but it is a medical record review measure which is a costly data collection burden for health plans and disruptive for clinicians. There are specific standardized tools identified in the numerator, but it is not clear these are all the ones in use by pediatricians. As debated by the Steering Committee, should this be measured at age 2 or at age 3 as proposed by CAHMI measure #1448? We recommend there be only one measure - at age 2 or 3, but not two measures.

1397: Sudden Infant Death Syndrome Counseling

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 02:28 PM

Comments

It will be disruptive, costly and a burden to collect paper medical record data.

1396: Healthy Physical Development by 6 years of age

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 02:26 PM

Comments

Aetna is supportive of this measure if it is aligned with the current NCQA Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) measure, e.g. ages 3-17. The proposed HEDIS 2012 includes the addition of "screen time counseling" as an additional numerator making this 100% medical record review. There is no evidence based recommendation or standard for what is appropriate screen time. Aetna suggests excluding the screen time component and then combine these three measures into one and age-stratifying the results. The combination into a single measure would allow for a single sample to be drawn.

1395: Chlamydia Screening and Follow Up

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 02:24 PM

Comments

Aetna is supportive of this measure if it is aligned with the current NCQA measure and ACOG guideline. This proposed measure specifically is screening by age 18 years. ACOG guideline requires that all sexually active women under age 25 be tested and not all women under 18 as this measure seems to suggest. As noted in multiple comments to NCQA on their HEDIS measure, the denominator includes "sexually active" females and that is not accurately defined by claims data or by medical record as patients do not accurately report their sexual activity. Therefore, it would be difficult to come to any clinical conclusions based on this measure.

1394: Depression Screening By 13 years of age

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 02:22 PM

Comments

This measure should align with USPSTF guidelines which indicate screening for adolescents (12 – 18 years of age) "should be screened for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up." NCQA's proposed 2012 Risk Assessment/Counseling in Adolescent measure age range is 15-18.

1391: Frequency of Ongoing Prenatal Care

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 02:20 PM

Comments

This measure is similar to the HEDIS measure. However, NCQA should consider reflecting the timing of the visits and not the number of visits. The timing of prenatal care has more impact on baby/mom health and as a result would be a more valuable measurement.

1388: Annual Dental Visit

Comment By	On Behalf Of

Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 02:18 PM

Comments

The denominator needs to include enrollment in a dental plan; i.e. measurement should be limited to inclusion in a dental plan and not in conjunction with the medical plan. Dental plans are not analogous to medical plans in terms of benefit management.

1382: Percentage of low birthweight births

Comment By
Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 02:15 PM

Comments

Measurers will need to be aware of potential double counting. In health plans the issue is that there might be more than one claim, under the mother ID# and/or a baby ID#.

Aetna suggests that in addition to measure #1382 (percentage of LBW infants) the measure developer should develop a measure for preterm deliveries, and more specifically deliveries at 38 and 39 weeks gestation. Given recent efforts to stop the practice of inducing labor in 39 week pregnancies, progress can only be measured with good indicators of the prevalence of these deliveries. Unfortunately, this proposed measure can only be detected through chart review.

1381: Asthma Emergency Department Visits

Comment By
Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 02:14 PM

Comments

This measure is for known asthmatics and the developer needs to ensure that specifications exclude the newly diagnosed asthma patient.

1364: Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation

Comment By
Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 02:11 PM

Comments

Chart review will be disruptive, costly and a burden.

1361: Intervention no later than 6 months of age (EHDI-4a)

Comment By
Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 02:09 PM

Comments

This requires the knowledge of the result of the hearing test. Chart review will be disruptive, costly and a burden.

1360: Audiological Evaluation no later than 3 months of age (EHDI-3)

Comment By

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 02:06 PM

Comments

This requires the knowledge of the result of the hearing test. Chart review will be disruptive, costly and a burden.

1357: Outpatient hearing screening of infants who did not complete screening before hospital discharge (EHDI-1c)

Comment By
Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 02:01 PM

Comments

This measure is dependent on adherence to the first office visit.

1357: Outpatient hearing screening of infants who did not complete screening before hospital discharge (EHDI-1c)

Comment By
Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 01:55 PM

Comments

See Aetna comment under #1402. In addition, this is a test that is occurring during the newborn inpatient stay and health plans nor clinicians will not receive a specific claim or revenue code billing for this service. Chart review will be disruptive, costly and a burden.

1357: Outpatient hearing screening of infants who did not complete screening before hospital discharge (EHDI-1c)

Comment By
Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 01:53 PM

Comments

See Aetna comment under #1402. In addition, this is a test that is occurring during the newborn inpatient stay and health plans nor clinicians will not receive a specific claim or revenue code billing for this service. Chart review will be disruptive, costly and a burden.

1357: Outpatient hearing screening of infants who did not complete screening before hospital discharge (EHDI-1c)

Comment By
Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 01:52 PM

Comments

Measures #1402, 1354, and 1357 appear to be overlapping measures for newborn hearing screening. Aetna recommends that the developers consider combining these into one measure, e.g. percentage of newborns who received the screening before hospital discharge or by 3 months old.

1351: Proportion of infants covered by Newborn Bloodspot Screening (NBS)

Comment By

On Behalf Of

Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 01:49 PM

Comments

This measure may be difficult to measure accurately as there are states with mandatory repeat screens. This is a test that is occurring during the newborn inpatient stay and there may not be a specific claim or revenue code billing for this service. Chart review will be disruptive, costly and a burden.

1349: Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)

Comment By
Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 01:47 PM

Comments

It is not clear why measure #1339 (measure of BMI) is at the population level rather than at the clinician level. Measurement of height and weight in the physician's office is a better indicator of BMI than parental report. It is also unclear why this measure applies only for the 10 to 17 year age group when BMI could be a concern at a younger age. The measure should clearly define the periodicity for measuring BMI.

1348: Children Age 6-17 Years who Engage in Weekly Physical Activity

Comment By
Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 01:45 PM

Comments

This measure is based on patient survey on number of days of physical activity and minutes. It is not clear how accurate an assessment this would yield.

1332: Children Who Receive Preventive Medical Visits

Comment By
Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 01:41 PM

Comments

This measure seems duplicative of EPSDT measures. Aetna supports the use of the current NCQA HEDIS measure for well child.

Comments on the general draft report

Comment By
Name: Ms. Sheree Chin Ledwell, RN, MPH
Organization: Aetna

On Behalf Of
Name: Andrew Baskin, MD
Organization: Aetna

Date - Time: Mar 07, 2011 - 01:39 PM

Comments

There are number of measures submitted by NCQA, some of which are the same or similar to child health measures proposed by NCQA for HEDIS 2012. If the proposed measures are enhancements of older measures, the older measures should be retired. Where possible the NCQA measures should be aligned or harmonized with similar measures by other developers.

Comments on the general draft report

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 01:39 PM

Comments

Aetna recommends NQF endorse child health measures that include measures of disparities. The importance of capturing this information in the pediatric population can not be over emphasized. The U.S. pediatric population is the most racially and ethnically diverse age group. NQF should continue to build on the framework outlined in NQF's National Voluntary Consensus Standards for Healthcare Disparities. The recommended measures in that report did not include a large number of pediatric measures. However, there was a lengthy discussion of collection of race and ethnicity data and how to apply their recommended methods for data collection to measuring disparities in ambulatory care measures.

Comments on the general draft report

Comment By	On Behalf Of
Name: Ms. Sheree Chin Ledwell, RN, MPH	Name: Andrew Baskin, MD
Organization: Aetna	Organization: Aetna

Date - Time: Mar 07, 2011 - 01:39 PM

Comments

The majority of the proposed measures for NQF endorsement are largely dependent on medical record review, whether only chart review or hybrid data collection. This is a disruptive and burdensome process for practitioners and not just for health plans. Aetna recommends NQF continue to encourage measure developers to identify administrative specifications wherever possible. In addition, the physician community should be required to use CPT 2 coding; to date this is hardly in use. Without such a mandate rates based on CPT 2 are not comparable nor meaningful.

1448: Developmental Screening in the First Three Years of Life

Comment By	On Behalf Of
Name: Julie B. Doetsch, MA	Name: Deborah Saunders
Organization: Illinois Dept. of Healthcare and Family Services	Organization: Illinois Department of Healthcare and Family Services

Date - Time: Mar 07, 2011 - 11:06 AM

Comments

The Illinois Department of Healthcare and Family Services (HFS) is the single state agency responsible for administration of Title XIX (Medicaid), Title XXI, (Children's Health Insurance Program Reauthorization Act of 2009, or CHIPRA), and State-only funded coverage for children who do not qualify for either Title, all under the umbrella of the *All Kids* program. The current delivery systems show significant progress toward ensuring the primary care basics are being met (broad coverage; promotion of well-child services, including assuring objective developmental screening; and medical homes, via a primary care case management (PCCM) model).

HFS has a strong history of using data to drive quality and policy development. Our experience has shown performance enhancements can be realized by analyzing data using nationally recognized benchmarks and disseminating that information to primary care providers (PCPs). Because of that, we strongly support the inclusion of the measure 1448 related to Objective Developmental Screening.

Developmental Screening measure 1448 would be easily implemented as the numerator includes claims data as a source of information. Additionally, it follows Bright Futures guidelines that HFS encourages PCPs to follow. We do recommend, however, that code 96111 be recognized, that screenings for specific domains (such as social-emotional) be allowed, and that additional standardized tools be recognized.

Comments on the general draft report

Comment By	On Behalf Of
Name: Heidi P. Baskfield, JD	Name: Heidi Baskfield
Organization: The Children's Hospital Colorado	Organization: The Children's Hospital Colorado

Date - Time: Mar 06, 2011 - 11:46 PM

Comments

Recommendation 1:

The Children's Hospital Colorado recommends that the NQF consider making patient-provider interaction and care coordination measures a priority – namely, by including measures that reflect the interaction between families, their medical home, and hospital/specialty care. Such measures might include those related to capturing information regarding Emergency Department (ED) visits; ambulatory care sensitive admissions (ACSAs); hospital readmissions; duplication of services/testing; as well as measures of efficiency, such as lost parent work/child school time for health and health care.

Recommendation 2:

A "gap area" for prevention and screening generally remains – namely, measurement development related to school success, such as screening questions for school-age children or those children at high-risk of dropping-out of school, given the well-documented association between high risk health behaviors and school failure.

Recommendation 3:

Greater emphasis ought to similarly be placed on addressing nutritional issues *before* six years of age. Such measures include those pertaining to breastfeeding (beyond those already endorsed by the NQF, such as measure #0480 "Exclusive Breastfeeding at Discharge"), as well as measures that would serve to provide information on children over two years of age with Body Mass Index (BMI) of 95% or greater.

Comments on measures not recommended
Comment By
Name: Beth Crispin, MS
Organization: Seattle Children's Hospital

Date - Time: Mar 06, 2011 - 02:33 PM

Comments

We would like to suggest the following to be included in standards:

1. Injury prevention counseling provided to parents/ child e.g. life jacket, bike helmet, booster seat use.
2. Children have access to speciality care in their community (those with public, private or no insurance).
3. Child maltreatment/personal safety concerns in family
4. Access to help with parenting skills/training for parents
5. Housing status of child and family (i.e. safety, stability
6. Access to mental health services in community (for children/youth with public, private or no insurance

Sincerely,

Elizabeth Bennett, MPH, CHES

Director Guest Services, Partnerships and Advocacy

Beth Crispin, MS, Health Educator

Seattle Children's Hospital

1381: Asthma Emergency Department Visits
Comment By
Name: Mr. Jeff J. Maitland
Organization: American College of Chest Physicians

On Behalf Of
Name: Jeff Maitland
Organization: American College of Chest Physicians

Date - Time: Mar 04, 2011 - 10:34 AM

Comments

Approve with comments. On behalf of the American College of Chest Physicians (ACCP), the Quality Improvement Committee (QIC) appreciates the opportunity to submit comments on the Child Health Quality Measures. The QIC approves this measure as a whole but strongly recommends risk adjustment for asthma risk.

The QIC recommends risk adjustment for asthma risk because it is concerned with how the measure will be used for individual accountability. The QIC notes that patients with particularly difficult-to-manage cases of asthma may require frequent emergency department treatments and may discourage physicians from treating these types of patients, out of fear of the potential repercussions.

1346: Children Who Are Exposed To Secondhand Smoke Inside Home

Comment By	On Behalf Of
Name: Mr. Jeff J. Maitland	Name: Jeff Maitland
Organization: American College of Chest Physicians	Organization: American College of Chest Physicians

Date - Time: Mar 04, 2011 - 10:32 AM

Comments

Disapprove with comments. On behalf of the American College of Chest Physicians (ACCP), the Quality Improvement Committee (QIC) appreciates the opportunity to submit comments on the Child Health Quality Measures. While the QIC appreciates the concept of this measure, the QIC disapproves of this measure because it appears to be an epidemiological measure that is difficult to define. The QIC also notes that there is no feasible method to accurately measure this measure.

Comments on the general draft report

Comment By	On Behalf Of
Name: Ms. Kate Romanow, JD	Name: Kate Romanow
Organization: American Speech-Language-Hearing Association	Organization: Audiology Quality Consortium

Date - Time: Mar 01, 2011 - 02:11 PM

Comments

The Audiology Quality Consortium (AQC), a coalition of 10 audiology organizations, agrees with the NQF that the following measures should be endorsed:

1402: Newborn hearing screening; **1354**: Hearing screening prior to hospital discharge; **1357**: Outpt. hearing screening of infants; **1360**: Audiological eval. no later than 3 months; **1361**: Intervention no later than 6 months

Hearing is one of our most vital senses and any degree of hearing loss can potentially affect communication, learning, psychosocial development, and academic achievement. An infant needs to have its hearing screened at birth or soon thereafter, and intervention should happen early in life. By endorsing the above measures, NQF will help to ensure that children receive the care they need. Endorsing these measures is consistent with the Early Hearing Detection and Intervention Act (PL 111-337) that President Obama signed into law on December 22, 2010. The legislation supports the development of efficient models to ensure that newborns who are identified with hearing loss through screening receive follow-up by qualified health care providers.

Thank you for the opportunity to comment on child health quality measures. If you have any questions, please contact Kate Romanow at kromanow@asha.orgor by phone at 301-296-5671.

Comments on the general draft report

Comment By	On Behalf Of
Name: Ms. Kate Romanow, JD	Name: Kate Romanow
Organization: American Speech-Language-Hearing Association	Organization: American Speech-Language-Hearing Association

Date - Time: Mar 01, 2011 - 02:03 PM

Comments

The American Speech-Language-Hearing Association (ASHA) appreciates the opportunity to provide comments on the child health

quality measures that NQF is considering endorsing. We agree with the National Quality Forum (NQF) that the following measures should be endorsed:

· 1399 (developmental screening by 2 years of life)

· 1448 (developmental screening in the first 3 years of life)

Speech, language, and cognitive-communication disorders in children can affect the ability to talk, understand, read, write, and interact with others. The sooner these disorders and their underlying causes are identified, the sooner the child can receive intervention. Although NQF is not recommending endorsement of measure 1341 (autism screening), ASHA supports continued examination of literature regarding diagnostic criteria for autism and urges NQF to support measures regarding autism screening as the research evolves.

Thank you for the opportunity to comment on child health quality measures. If you have any questions, please contact Kate Romanow at kromanow@asha.orgor by phone at 301-296-5671.

1412: Pre-School Vision Screening in the Medical Home
Comment By
Name: Edward Schor, MD
Organization: The Commonwealth Fund

Date - Time: Feb 28, 2011 - 04:45 PM

Comments

Although it can be difficult to do vision testing at very young ages, techniques exist that are feasible to adopt in clinical practice. Certainly by the time of school entry, all children with a visual defect should have been identified and treatment should have been begun. Failure to complete this screening and initiate appropriate treatment can lead to both difficulty learning and irreversible visual defects. This is a reasonable and essential measure.

1399: Developmental Screening by 2 Years of Age
Comment By
Name: Edward Schor, MD
Organization: The Commonwealth Fund

Date - Time: Feb 28, 2011 - 04:41 PM

Comments

Routine surveillance of children's development is a core component of preventive child health care, but is done with substantial variability and thus is not a reliable method to identify children with or at risk for developmental delay. To assure that children with problems are identified, the AAP recommends structured developmental screening with a validated instrument at ages 9, 18 and 24 or 30 months. Thus, by 2 years of age, children ought to have had at least 2 and likely 3 events of developmental screening. The recommended measure of having at least one developmental screen by 2 years of age is clinically reasonable and easier to document than attesting to having had each of the recommended screens at each recommended age. It is a good and pragmatic measure.

1385: Developmental screening using a parent completed screening tool (Parent report, Children 0-5)
Comment By
Name: Edward Schor, MD
Organization: The Commonwealth Fund

Date - Time: Feb 28, 2011 - 04:34 PM

Comments

Child health care is distinguished from care of other populations by its focus on promoting children's development. Such promotion requires reliable and repeated assessment of children's developmental status. Previous practice relied heavily on unreliable clinical evaluation with the consequence that many children with developmental problems were identified after the time of optimal intervention. Parent completed screening instruments have been validated and demonstrated to be feasible to use in busy practices. State Medicaid programs and an increasing number of private insurers now reimburse practices for doing this screening. Research has found that the use of these screening instruments not only increases the rate of identification of young

children with or at risk for delays, but also identifies children at an earlier age when they are more likely to benefit from intervention programs, and has nearly tripled the rate of referral to such programs. The American Academy of Pediatrics has promulgated policy that recommends regular use of these instruments in child health care. Measuring the rate of screening is not only a good indicator of the quality of preventive child health care, but will serve as an inducement to improve that care.

1348: Children Age 6-17 Years who Engage in Weekly Physical Activity
Comment By
Name: Stephen J. Blumberg, PhD
Organization: National Center for Health Statistics

Date - Time: Feb 25, 2011 - 12:25 PM

Comments

I write to offer new information about the seasonal effects on reporting of physical activity, in response to the question from a Committee member (on line 793 of the draft report). Using restricted data files from the 2007 National Survey of Children's Health (NSCH), we can examine differences in reporting based on the date of the interview. Physical activity every day during the week prior to the interview was reported more often during the summer months (36.2% of children age 6-17 years) than during the winter (22.0%), spring (28.8%), or fall (26.3%). Physical activity 4 or more days during the prior week was reported less often during the winter months (57.0%) than during the spring (65.5%), summer (65.4%), or fall (64.8%).

At the National Center for Health Statistics, the staff of the State and Local Area Integrated Telephone Survey has conducted the NSCH since 2003. We would be happy to provide relevant background information from our experiences with any proposed child health quality measures that are drawn from the NSCH. Please let us know if we can provide such information to help your deliberative process.

This comment is submitted by Stephen J. Blumberg, Ph.D., Senior Scientist, State and Local Area Integrated Telephone Survey, NCHS, CDC.

1340: Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care

Comment By
Name: Eric B. Levey, M.D.
Organization: Kennedy Krieger Institute

On Behalf Of
Name: Eric Levey
Organization: Maryland, AAP

Date - Time: Feb 25, 2011 - 10:26 AM

Comments

I strongly support this measure on transition to adult care. However, I would change doctors (which is ambiguous) to physicians and other health care providers. Transition to adult care is a combined effort of primary care providers, office staff, nurses, specialists, therapists, etc. Should not limit this to "doctors."

I would also change age range to 14 - 21 years of age. Transition efforts should start earlier, but formal transition efforts and measurement should probably start at 14 years of age when the educational system also formally starts addressing transition issues, i.e. in IEPs. Should definitely continue the measure to at least 21 years of age, as most Title V CSHCN program include individuals up to 21, foster care programs go to 21, students with disabilities can stay in school until 21, many children's hospitals admit and treat patients until 21 and many pediatricians treat patients until 21 (or older). For many patients, transition to adult care is not complete until 25 years or older.

Eric Levey, MD, President, Maryland Chapter, American Academy of Pediatrics

---

1506: Immunizations by 18 years of age

Comment By
Name: Ms. Brittany Plavchak
Organization: sanofi pasteur

On Behalf Of
Name: David Greenberg
Organization: Sanofi Pasteur

Date - Time: Feb 24, 2011 - 02:29 PM

Comments

NQF# 1506 –Tdap Vaccination in Early Postpartum Period, *continued 3*:

Research suggests that, in up to 83% of infant pertussis cases for whom a source of infection can be found, a family member is

responsible for transmitting pertussis to the infant. Nearly all pertussis-related deaths in the US occur in infants who are either too young to receive infant DTaP vaccinations or are only partially immunized. To help prevent adolescents and adults from infection with pertussis and to help prevent transmission of pertussis to others, including unprotected infants, ACIP recommends that all persons 11-64 years of age be vaccinated with a one-time Tdap booster.

While the introduction of pertussis vaccines over 50 years ago led to a dramatic decline in the incidence of pertussis, significant outbreaks of pertussis have occurred in the U.S. in recent years. In 2004, 25,827 pertussis cases – 34% involving adolescents – were reported to the CDC through the passive National Notifiable Disease Surveillance System. A dramatic increase of pertussis cases has been documented in California, where there were 10 pertussis-related deaths in 2010, all among infants ≤ 2 months of age. Pertussis outbreaks have also been reported in upstate New York, Ohio, South Carolina, Michigan, and the Philadelphia suburbs. It is critical that the medical community support adolescent and postpartum vaccination to help reduce pertussis cases and serious complications, including deaths.

1506: Immunizations by 18 years of age

Comment By	On Behalf Of
Name: Ms. Brittany Plavchak	Name: David Greenberg
Organization: sanofi pasteur	Organization: Sanofi Pasteur

Date - Time: Feb 24, 2011 - 02:16 PM

Comments

NQF# 1506 –Tdap Vaccination in Early Postpartum Period, *continued 2:*

In line with JCAHO, ACOG, and other stakeholders who support postpartum immunization of adolescents who receive health care in hospital-based settings, NQF should adopt quality measures that endorse and measure such use in ambulatory, private, and public settings. Doing so will help to ensure that maternal Tdap immunization is uniformly implemented as a standard-of-care in a variety of health-care settings, to potentially help prevent pertussis in vulnerable infants who may not yet be protected from their own immunization.

Adolescent and adult mothers not yet immunized with Tdap vaccine are vulnerable to pertussis because protection from their childhood vaccinations has waned.These mothers may catch pertussis from others and, in turn, transmit the infection to their infants, who may be too young to have started or completed their infant Diphtheria, Tetanus, and acellular Pertussis (DTaP) vaccination series.

1506: Immunizations by 18 years of age

Comment By	On Behalf Of
Name: Ms. Brittany Plavchak	Name: David Greenberg
Organization: sanofi pasteur	Organization: Sanofi Pasteur

Date - Time: Feb 24, 2011 - 02:16 PM

Comments

NQF# 1506 –Tdap Vaccination in Early Postpartum Period, continued:

Numerous medical societies support the ACIP recommendation to immunize adolescents and adults (including females during the postpartum period) with pertussis-containing vaccine, notably – the American College of Obstetricians and Gynecologists, Society for Adolescent Health and Medicine, American Academy of Pediatrics, Infectious Diseases Society of America, and The Society for Healthcare Epidemiology of America.

Further, in its Tdap recommendations for hospitals, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recommends that all postpartum women – including adolescents – who have not previously received Tdap vaccine should be immunized as soon as feasible in the postpartum period. In March 2010, JCAHO launched a project to uncover evidence-based programs that improved Tdap vaccination of adolescent patients, and reflected best practices among health systems. JCAHO recently published findings from these case studies, highlighting results from 17 centers. In the first ~2 years after initiating a pertussis vaccination program at Texas Children's Hospital, 75% of women were immunized after delivery and before discharge from the hospital. In Othello, WA, Columbia Basin Health Association implemented a multi-component program that increased the postpartum Tdap vaccination rate from 2% to 85%.

1506: Immunizations by 18 years of age

Comment By	On Behalf Of

Name: Ms. Brittany Plavchak
Organization: sanofi pasteur

Name: David Greenberg
Organization: Sanofi Pasteur

Date - Time: Feb 24, 2011 - 02:14 PM

Comments

NQF# 1506 –Tdap Vaccination in Early Postpartum Period:

Sanofi Pasteur believes that NQF's adolescent quality measures should include Tdap vaccination in the early postpartum period of all adolescents who were not immunized prior to conception. Tdap vaccination in the immediate postpartum period will help prevent new mothers from acquiring pertussis and reduce transmission of pertussis from mothers to infants. Prominent objectives of the Healthy People 2020 initiative include a 10% reduction of pertussis cases among children under 1 year of age, and a ~50% reduction of cases among adolescents 11-18 years of age (Immunization and Infectious Diseases [IID] Objectives 1.6 and 1.7). Tdap vaccine should be administered before mothers are discharged from the hospital or birthing center, or as soon as possible after discharge (e.g., during the first post-delivery obstetrical examination or first well-baby visit). This recommendation for inpatient Tdap immunization is in line with the current recommendation for hepatitis B immunization of infants at birth.

1506: Immunizations by 18 years of age

Comment By
Name: Ms. Brittany Plavchak
Organization: sanofi pasteur

On Behalf Of
Name: David Greenberg
Organization: Sanofi Pasteur

Date - Time: Feb 24, 2011 - 02:06 PM

Comments

Overview, *continued*:

Expanding NQF# 1506 to include seasonal influenza vaccination for adolescents, HPV vaccination for adolescent girls, and Tdap vaccination for pregnant adolescents will help to achieve the Healthy People 2020 target of 80% vaccination coverage for MCV4, seasonal influenza, HPV, and Tdap among adolescents.

1506: Immunizations by 18 years of age

Comment By
Name: Ms. Brittany Plavchak
Organization: sanofi pasteur

On Behalf Of
Name: David Greenberg
Organization: Sanofi Pasteur

Date - Time: Feb 24, 2011 - 02:06 PM

Comments

Overview:

Sanofi Pasteur is in general agreement with NQF# 1506, but believes NQF should expand the measure to reflect current guidelines of the CDC's Advisory Committee on Immunization Practices (ACIP) for adolescents through 18 years of age. In addition to recommending the tetravalent meningococcal conjugate vaccine (MCV4) and the tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine for adolescents, NQF# 1506 should also include annual seasonal influenza vaccine for all adolescents and human papillomavirus (HPV) vaccine for adolescent girls.

In addition, NQF# 1506 should include Tdap vaccination during the early postpartum period for pregnant adolescents who were not immunized prior to conception. Tdap vaccination during preconception or immediately postpartum will help protect mothers against pertussis disease, as well as prevent the transmission of pertussis from mothers to their infants and other at-risk persons. In addition, maternal Tdap vaccination will help to achieve Healthy People 2020 objectives to reduce cases of pertussis by 10% among children under 1 year of age and by 50% among adolescents aged 11-18 years. In order to ensure that maternal Tdap immunization is uniformly implemented as a standard of care in all health care settings, NQF should also adopt quality measures that endorse and measure postpartum immunization of adolescents in hospital-based, ambulatory, private, and public settings.

1407: Immunizations by 13 years of age

Comment By
Name: Ms. Brittany Plavchak
Organization: sanofi pasteur

On Behalf Of
Name: David Greenberg
Organization: Sanofi Pasteur

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Date - Time: Feb 24, 2011 - 02:03 PM

Comments

Sanofi Pasteur is in general agreement with NQF# 1407, but believes NQF should expand the measure to include annual seasonal influenza vaccination for children and adolescents, as recommended by the CDC's Advisory Committee on Immunization Practices (ACIP). Expanding NQF# 1407 to reflect ACIP's recommendations for seasonal influenza will help to achieve the Healthy People 2020 target of 80% vaccination coverage for seasonal influenza among children and adolescents.

Comments on the general draft report

Comment By	On Behalf Of
Name: Ms. Brittany Plavchak	Name: David Greenberg, MD, FAAP
Organization: sanofi pasteur	Organization: Sanofi Pasteur

Date - Time: Feb 24, 2011 - 01:58 PM

Comments

NQF# 0038 - Compliance with Combination Vaccine Schedules, *continued 2*:

The CDC conducted a study of vaccination timeliness using data from the 2003 National Immunization Survey involving 14,810 children 24-35 months of age. The investigators evaluated the cumulative number of days undervaccinated for 6 vaccines: 4 doses of DTaP, 3 IPV, 3-4 Hib, 3 hepatitis B, 1 measles/mumps/rubella (MMR), and 1 varicella. Children were considered late if the vaccine was given more than 1 month after the recommended age and severely undervaccinated if the vaccine was more than 6 months delayed. The CDC reported that only 17% of children received all 6 of these vaccines on time. Children were undervaccinated for a mean of 172 days, taking into account all 6 vaccines through 24 months of age, and 37% were undervaccinated for more than 6 months for at least 1 vaccine.

Innovative combination vaccines offer protection for children against a wider range of infectious and potentially life-threatening diseases than ever before. Studies of children cared for in public and private healthcare settings have shown that the use of pediatric combination vaccines increases compliance and timeliness with the pediatric immunization schedule. Studies have also shown that infants who received combination vaccines had significantly higher rates of receiving all of their vaccinations on time in the first two years of life compared to infants given separate component vaccines.

Comments on the general draft report

Comment By	On Behalf Of
Name: Ms. Brittany Plavchak	Name: David Greenberg, MD, FAAP
Organization: sanofi pasteur	Organization: Sanofi Pasteur

Date - Time: Feb 24, 2011 - 01:56 PM

Comments

NQF# 0038 - Compliance with Combination Vaccine Schedules, *continued*:

NQF and NCQA support primary vaccination and measurement for all children with the ACIP-recommended vaccinations by two years of age.Completing primary vaccinations according to the recommended immunization schedule is important to increase protection against vaccine-preventable diseases and improve public health.

Data from the National Immunization Survey (NIS)demonstrate that a number of children receive their pediatric vaccinations over an extended time frame, which falls outside of the ACIP-recommended immunization schedule. NIS data show that a 15% drop-off occurs between the third and fourth doses of DTaP vaccine in children by 24 months of age. Children who have not received their fourth dose of DTaP by 24 months of age are at least six months behind the recommended immunization schedule, leaving them unnecessarily vulnerable to vaccine-preventable diseases. According to AAP, administering a combination vaccine may enhance timeliness and compliance with ACIP's recommended immunization schedule.

Comments on the general draft report

Comment By	On Behalf Of
Name: Ms. Brittany Plavchak	Name: David Greenberg, MD, FAAP
Organization: sanofi pasteur	Organization: Sanofi Pasteur

Date - Time: Feb 24, 2011 - 01:55 PM

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Comments

NQF #0038 - Compliance with Combination Vaccine Schedules:

The use of existing combination vaccines can improve compliance with the ACIP recommended pediatric immunization schedule, which leads to better overall health outcomes. Pediatric quality measures should be enhanced to favor the use of combination vaccines, such as DTaP-Inactivated Polio Vaccine (IPV)-Hib and DTaP-IPV-Hepatitis B vaccines, when possible, to help improve compliance with the primary pediatric immunization schedule. The goal of Healthy People 2020 is to reduce, eliminate, or maintain elimination of cases of vaccine-preventable diseases (IID-1), and to increase or maintain effective vaccination coverage levels (90%) among children aged 19-35 months for universally recommended vaccines (IID-7).

An ongoing challenge in promoting immunizations and public health is the issue of schedule compliance. The failure to adhere to the ACIP-recommended childhood and adolescent immunization schedules has resulted in outbreaks of potentially devastating infectious diseases. For example, outbreaks of pertussis began in 2010 and are still occurring in several regions of the U.S., as mentioned above.

Comments on the general draft report

Comment By
Name: Ms. Brittany Plavchak
Organization: sanofi pasteur

On Behalf Of
Name: David Greenberg, MD, FAAP
Organization: Sanofi Pasteur

Date - Time: Feb 24, 2011 - 01:53 PM

Comments

NQF# 0038 - Hepatitis B Immunization:

Sanof Pasteur agrees with NQF-endorsed Measure #0038, which measures the percentage of children who receive three doses of hepatitis B vaccine and other recommended vaccines by their second birthday. While hepatitis B vaccine is recommended for all infants at birth, adherence to this recommendation has not been applied effectively or consistently across the country: A recent survey found that approximately one-third of hospitals did not have written policies for implementing at least one official recommendation for reducing transmission of hepatitis B. In 2004, AAP began requiring hospitals to either administer hepatitis B vaccine at birth or provide written documentation or test results demonstrating that the mother is not infected with hepatitis B virus. This policy was issued in order to prevent transmission of hepatitis B to infants and, in turn, improve overall public health.

Comments on the general draft report

Comment By
Name: Ms. Brittany Plavchak
Organization: sanofi pasteur

On Behalf Of
Name: David Greenberg, MD, FAAP
Organization: Sanofi Pasteur

Date - Time: Feb 24, 2011 - 01:52 PM

Comments

NQF# 0038 - Annual Seasonal Influenza Immunization, *continued*:

Comments on the general draft report

Comment By
Name: Ms. Brittany Plavchak
Organization: sanofi pasteur

On Behalf Of
Name: David Greenberg, MD, FAAP
Organization: Sanofi Pasteur

Date - Time: Feb 24, 2011 - 01:50 PM

Comments

NQF# 0038 - Annual Seasonal Influenza Immunization:

Sanofi Pasteur encourages NQF to consider including annual seasonal influenza immunization in its quality measures.The Advisory Committee on Immunization Practices (ACIP) recommends 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza for the first time or who are otherwise considered naïve based on ACIP recommendations. Additionally, NCQA recently adopted the same recommendation into its childhood HEDIS measure. The minimum age for influenza vaccination is 6 months. Adding annual seasonal influenza vaccination to Measure #0038 will align this NQF quality measure with the goal set by Healthy People 2020, which targets an 80% annual rate for seasonal influenza immunization of

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

children 6 through 23 months of age (IID-12.1).

Comments on the general draft report

Comment By	On Behalf Of
Name: Ms. Brittany Plavchak	Name: David Greenberg, MD, FAAP
Organization: sanofi pasteur	Organization: Sanofi Pasteur

Date - Time: Feb 24, 2011 - 01:47 PM

Comments

Overview:

Sanofi Pasteur is one of the largest vaccine manufacturers in the world and appreciates the opportunity to provide input designed to improve NQF quality measures that protect public health. In general, Sanofi Pasteur believes NQF should expand #1407 to include annual seasonal influenza vaccination for children and adolescents, as recommended by the CDC's Advisory Committee on Immunization Practices (ACIP). In addition, Sanofi Pasteur believes NQF should expand #1506 to include annual seasonal influenza vaccination for all adolescents, HPV vaccination for adolescent girls, and Tdap vaccination during the early postpartum period for pregnant adolescents who were not immunized prior to conception.

While NQF# 0038 is not currently open for comment, Sanofi Pasteur encourages NQF to expand the measure to include annual seasonal influenza vaccination of children beginning at 6 months of age, as well as the use of existing combination vaccines (e.g., DTaP-Inactivated Polio Vaccine (IPV)-Hib and DTaP-IPV-Hepatitis B vaccines), when possible. The use of existing combination vaccines can improve compliance with ACIP's recommended pediatric immunization schedule, which in turn can increase protection against vaccine-preventable diseases and lead to better individual and public health outcomes.

1349: Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)
Comment By
Name: Stephen J. Blumberg, PhD
Organization: National Center for Health Statistics

Date - Time: Feb 23, 2011 - 05:55 PM

Comments

We write to offer new information about the validity of parent report of height and weight. Our own testing (Akinbami & Ogden, 2009) suggests that overall population-level prevalence estimates from parent report of height and weight are consistent with clinical measurements for children aged 10-17 years (but not for younger children). However, these analyses could not examine whether parent-reported height and weight were accurate for each child. This question was recently explored by Canadian researchers, led by Margot Shields at Statistics Canada. According to their manuscript (accepted for publication and due to be published in August 2011), "there were substantial misclassification errors by body mass index (BMI) category when based on parent-reported values." They concluded that "bias associated with parental reports...results in misclassification errors for obesity that in turn affect relationships with other variables," and that "direct measures are required to accurately determine obesity estimates and their relationships with health indicators in children." A preprint (unedited) copy of the manuscript can be provided to NQF upon request, provided that it will not be made public.

Comment submitted jointly by Stephen J. Blumberg, Ph.D., Senior Scientist, SLAITS; and Cynthia L. Ogden, PhD, MRP, (Acting) Analysis Branch Chief, DHANES; both from NCHS, CDC.

Comments on the general draft report
Comment By
Name: Stephen J. Blumberg, PhD
Organization: National Center for Health Statistics

Date - Time: Feb 23, 2011 - 05:39 PM

Comments

I write to correct a misstatement regarding the National Survey of Children's Health (NSCH) and the National Survey of Children with Special Health Care Needs (NS-CSHCN), at line 237 of the draft report. These national surveys are administered by the staff of the State and Local Area Integrated Telephone Survey (SLAITS) at the National Center for Health Statistics (NCHS). Persons affiliated with CAHMI have served as members of the surveys' Technical Expert Panels, which guide the development and testing

of specific questionnaire items. With only one exception, measures used in the national surveys are in the public domain and may be reproduced or copied without permission.

Data files and documentation from the national surveys are published for public use by NCHS. State-level results are published in chartbooks by the Maternal and Child Health Bureau, which sponsors the surveys. CAHMI uses the publicly available data files and chartbooks to develop the Data Resource Center for Child and Adolescent Health.

SLAITS staff would be happy to provide relevant background information from our experiences with any proposed child health quality measures that are drawn from the NSCH. Please let us know if we can provide such information to help your deliberative process.

This comment is submitted by Stephen J. Blumberg, Ph.D., Senior Scientist, State and Local Area Integrated Telephone Survey, NCHS, CDC.

1515: Depression Screening By 18 years of age

Comment By
Name: Ms. Julianna Belelieu
Organization: TeenScreen National Center at Columbia University

On Behalf Of
Name: Laurie Flynn
Organization: TeenScreen National Center for Mental Health Checkups at Columbia University

Date - Time: Feb 23, 2011 - 01:00 PM

Comments

The TeenScreen National Center for Mental Health Checkups at Columbia University strongly supports the endorsement of measures 1394 and 1515. These quality measures will provide a desperately needed tool to establish a baseline measurement of the rate of adolescent depression screening. However, the TeenScreen National Center would like to propose improvements to the measure specifications to allow these measures to more accurately capture the rate of depression screening. The requirement to use a standardized screening tool to qualify for inclusion in the numerator is essential, but the current list of approved screening tools consists exclusively of depression specific screens. Unfortunately, such specifications will fail to capture a very significant proportion of primary care providers who offer adolescent mental health screening to screen for depression and other mental disorders using broader mental health screens, such as the Pediatric Symptom Checklist (PSC). The TeenScreen Primary Care program has distributed mental health screening tools to more than 1,000 primary care sites; more than 80 percent of these request the PSC. The PSC is also widely used in the Massachusetts Medicaid program. Accordingly, we urge that the list of approved screening tools be expanded to include all evidence-based tools validated to screen for symptoms of depression, rather than limiting the list to depression-specific screening tools.

1394: Depression Screening By 13 years of age

Comment By
Name: Ms. Julianna Belelieu
Organization: TeenScreen National Center at Columbia University

On Behalf Of
Name: Laurie Flynn
Organization: TeenScreen National Center for Mental Health Checkups at Columbia University

Date - Time: Feb 23, 2011 - 12:58 PM

Comments

The TeenScreen National Center for Mental Health Checkups at Columbia University strongly supports the endorsement of measures 1394 and 1515. These quality measures will provide a desperately needed tool to establish a baseline measurement of the rate of adolescent depression screening. However, the TeenScreen National Center would like to propose improvements to the measure specifications to allow these measures to more accurately capture the rate of depression screening. The requirement to use a standardized screening tool to qualify for inclusion in the numerator is essential, but the current list of approved screening tools consists exclusively of depression specific screens. Unfortunately, such specifications will fail to capture a very significant proportion of primary care providers who offer adolescent mental health screening to screen for depression and other mental disorders using broader mental health screens, such as the Pediatric Symptom Checklist (PSC). The TeenScreen Primary Care program has distributed mental health screening tools to more than 1,000 primary care sites; more than 80 percent of these request the PSC. The PSC is also widely used in the Massachusetts Medicaid program. Accordingly, we urge that the list of approved screening tools be expanded to include all evidence-based tools validated to screen for symptoms of depression, rather than limiting the list to depression-specific screening tools.

1448: Developmental Screening in the First Three Years of Life

Comment By
Name: Gwen Smith
Organization: Illinois Department of Healthcare and Family Services

On Behalf Of
Name: Deborah Saunders
Organization: Illinois Department of Healthcare and Family Services

Date - Time: Feb 22, 2011 - 04:58 PM

Comments

Recommend that code 96111 also be included, that screenings for specific domains (such as social-emotional) be allowed and that additional standardized tools be recognized.

1419: Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers

Comment By
Name: Gwen Smith
Organization: Illinois Department of Healthcare and Family Services

On Behalf Of
Name: Deborah Saunders
Organization: Illinois Department of Healthcare and Family Services

Date - Time: Feb 22, 2011 - 04:57 PM

Comments

Recommend that the denominator be calculated using all enrolled children and that the age stratifications be reflective of the requirements of federal CMS 416 reporting (1-2, 3-5, 6-9, 10-14, 15-18, and 19-20).

1412: Pre-School Vision Screening in the Medical Home

Comment By
Name: Gwen Smith
Organization: Illinois Department of Healthcare and Family Services

On Behalf Of
Name: Deborah Saunders
Organization: Illinois Department of Healthcare and Family Services

Date - Time: Feb 22, 2011 - 04:55 PM

Comments

Recommend that children through age 6 be included, that codes 99172, 99173, 92002, 92004, 92012, and 92014 be recognized, and the denominator be calculated using all enrolled children of the specified age group.

1401: Maternal Depression Screening

Comment By
Name: Gwen Smith
Organization: Illinois Department of Healthcare and Family Services

On Behalf Of
Name: Deborah Saunders
Organization: Illinois Department of Healthcare and Family Services

Date - Time: Feb 22, 2011 - 04:51 PM

Comments

Recommend that both prenatal and postpartum screening be measured and postpartum screenings be measured up to a year after delivery.

Comments on the general draft report

Comment By
Name: Gwen Smith
Organization: Illinois Department of Healthcare and Family Services

On Behalf Of
Name: Deborah Saunders
Organization: Illinois Department of Healthcare and Family Services

Date - Time: Feb 22, 2011 - 04:42 PM

Comments

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Developmental Screening: Recommend that CPT code 96111 also be recognized, that screenings for specific domains (such as social-emotional) be allowed, and that additional standardized tools be recognized.

Maternal Depression Screening: Recommend that both prenatal and postpartum screening be measured and postpartum screenings be measued up to a year after delivery.

Pre-School Vision Screening in the Medical Home: Recommend that children through age 6 be included, that codes 99172, 99173, 92002, 92004, 92012, and 92014 be recognized, and the denominator be calculated using all enrolled children of the specified age group.

Primary Caries Prevention Intervention: Recommend that the denominator be calculated using all enrolled children and the age stratifications be reflective of the requirements of federal CMS 416 reporting (1-2, 315, 6-9, 10-14, 15-18, and 19-20).

Comments on measures not recommended
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:58 PM

Comments

We disagree to exclude:1341 The AAP has excellent resources on screening and early identification at www.medicalhomeinfo.org/training/cme/event3.aspx. Early identification and intervention is key for best outcomes. Some children, (esp. underserved), are diagnosed as late as age 5 on average.1344 The NSCSHCN indicates that specialty care is a concern (almost 300,000). Even if families can find specialists, it is even more difficult to access pediatric specialists. This is extremely important as some conditions affect children differently. 1347 There needs to be a measure on if children who needed mental health care were able to access it. According to NAMI, 21% of children ages 9-17 have a mental health diagnosis yet of those only 20% of children receive treatment annually. 1331 Again, data from the NSCSHCN indicated that this is a large area of concern for many families (almost 850,000). 1338 Research on EPSDT, early intervention, and prevention/wellness under healthcare reform all indicate the importance of early screening for cost effectiveness and best health outcomes. 1373 The momentum towards the patient and family centered medical home model shows that parents want to partner with professionals. Indeed research indicates that this again results in cost effectiveness and most importantly better health outcomes. This is particularly important for children with special healthcare needs.

1553: Blood Pressure Screening by age 18
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:42 PM

Comments

For the measure on blood pressure screening by age 18, we're unsure if this should be a priority area. However, recent findings indicated a 51% increase in stroke in those aged 15 and above so perhaps this can be done for children with other risk factors such as obesity, family history, etc.

1552: Blood Pressure Screening by age 13
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:41 PM

Comments

We are uncertain about this measure; see our comments above under blood pressure screening for age 18.

1516: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
Comment By

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Name: Ms. Lauren Agoratus
Organization:
Date - Time: Feb 16, 2011 - 01:40 PM

Comments

Same as 1392:

As stated above, Family Voices strongly supports wellness and prevention initiatives. We were pleased to see no family cost sharing for wellness under healthcare reform. We support these measures as both cost effective and improving outcomes.

1515: Depression Screening By 18 years of age
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:40 PM

Comments

Same as 1364:

Family Voices strongly supports all of the above mental health and prevention measures. There has been a tremendous increase in the calls we receive for children's mental health issues. We would highly recommend the use of Teen Screen (www.teenscreen.org) as an effective standardized screening tool for depression.

1514: Healthy Physical Development by 18 years of age
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:38 PM

Comments

Same as 1396:

Family Voices is concerned with wellness initiatives, particularly for children with special needs where so often the focus on the condition and wellness may be missed. We held Bright Futures focus groups, reviewed materials, and acted as mentor parents to assist families to help their children reach their goals regarding physical activity, nutrition, and "screen time" (computers, TV, videogames) and we were the only state to also offer this in Spanish. We strongly support all of these measures.

1512: Healthy Physical Development by 13 years of age
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:37 PM

Comments

Same as 1396:

Family Voices is concerned with wellness initiatives, particularly for children with special needs where so often the focus on the condition and wellness may be missed. We held Bright Futures focus groups, reviewed materials, and acted as mentor parents to assist families to help their children reach their goals regarding physical activity, nutrition, and "screen time" (computers, TV, videogames) and we were the only state to also offer this in Spanish. We strongly support all of these measures.

1507: Risky Behavior Assessment or Counseling by Age 18 Years
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:35 PM

Comments

Same as 1364:

Family Voices strongly supports all of the above mental health and prevention measures. There has been a tremendous increase in the calls we receive for children's mental health issues. We would highly recommend the use of Teen Screen (www.teenscreen.org) as an effective standardized screening tool for depression.

1506: Immunizations by 18 years of age
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:35 PM

Comments

Same as 1407:

SPAN strongly supports these measures of vaccine-preventable disease. We are part of the NJ Immunization Action Group initiated by PCORE. Besides working with PCORE on early immunization, we also previously had an adolescent immunization project (due to low EPSDT {Early Periodic Diagnostic Screening and Treatment} rates) with them and held statewide focus groups.

1448: Developmental Screening in the First Three Years of Life
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:34 PM

Comments

Same as 1385:

For the same reasons stated above for early intervention, we believe that developmental screening is key. SPAN was recently the recipient of the Integrated Systems Grant for children with autism and other developmental disabilities so this is a crucial area for us. We strongly support the initiatives on developmental screening.

1419: Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:33 PM

Comments

Same as 1334

Family Voices strongly supports these initiatives. Unfortunately many children, particularly those on Medicaid (one-third), do not receive adequate dental care, despite the mandate for EPSDT. Many families do not realize that the result of poor oral health could have consequences for general health.

1412: Pre-School Vision Screening in the Medical Home
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:32 PM

Comments

Again, SPAN strongly supports vision screening in keeping with our work on both early intervention and projects for children with sensory impairments. Family Voices agrees with the concept of the medical home developed by the American Academy of Pediatrics (AAP). We serve on the NJ AAP Council for Children with Disabilities. Also, SPAN's initial Integrated Systems Grant was done in collaboration with PCORE (Pediatric Council on Research and Education, non-profit arm of the AAP) as was our newer grant on developmental disabilities. We also serve on several PCORE committees for the medical home, immunizations, etc.

1407: Immunizations by 13 years of age
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:31 PM

Comments

SPAN strongly supports these measures of vaccine-preventable disease. We are part of the NJ Immunization Action Group initiated by PCORE. Besides working with PCORE on early immunization, we also previously had an adolescent immunization project (due to low EPSDT {Early Periodic Diagnostic Screening and Treatment} rates) with them and held statewide focus groups.

1406: Risky Behavior Assessment or Counseling by Age 13 Years
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:30 PM

Comments

Same as 1364:

Family Voices strongly supports all of the above mental health and prevention measures. There has been a tremendous increase in the calls we receive for children's mental health issues. We would highly recommend the use of Teen Screen (www.teenscreen.org) as an effective standardized screening tool for depression.

1402: Newborn Hearing Screening
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:28 PM

Comments

Same as 1351:

Family Voices @ SPAN is part of the NY Mid-Atlantic Consortium for newborn and genetic screening. SPAN also houses NJ Parent-to-Parent which has been very involved with the Early Hearing Detection and Intervention program as well as the DB Faces (Deaf Blind and Community Educational Supports) program. We strongly support the above initiatives on newborn screening, particularly hearing screening.

1399: Developmental Screening by 2 Years of Age
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:27 PM

Comments

Same as 1385:

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

For the same reasons stated above for early intervention, we believe that developmental screening is key. SPAN was recently the recipient of the Integrated Systems Grant for children with autism and other developmental disabilities so this is a crucial area for us. We strongly support the initiatives on developmental screening.

1396: Healthy Physical Development by 6 years of age
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:26 PM

Comments

Family Voices is concerned with wellness initiatives, particularly for children with special needs where so often the focus on the condition and wellness may be missed. We held Bright Futures focus groups, reviewed materials, and acted as mentor parents to assist families to help their children reach their goals regarding physical activity, nutrition, and “screen time” (computers, TV, videogames) and we were the only state to also offer this in Spanish. We strongly support all of these measures.

1395: Chlamydia Screening and Follow Up
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:25 PM

Comments

We are also unsure about the measure for Chlamydia screening by age 18 and would also suggest this is done with consideration of other risk factors such as age when the teen became sexually active.

1394: Depression Screening By 13 years of age
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:24 PM

Comments

Same as 1364: Family Voices strongly supports all of the above mental health and prevention measures. There has been a tremendous increase in the calls we receive for children’s mental health issues. We would highly recommend the use of Teen Screen (www.teenscreen.org) as an effective standardized screening tool for depression.

1392: Well-Child Visits in the First 15 Months of Life
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:23 PM

Comments

As stated above, Family Voices strongly supports wellness and prevention initiatives. We were pleased to see no family cost sharing for wellness under healthcare reform. We support these measures as both cost effective and improving outcomes.

1388: Annual Dental Visit
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:22 PM

Comments

Same as 1334:

Family Voices strongly supports these initiatives. Unfortunately many children, particularly those on Medicaid (one-third), do not receive adequate dental care, despite the mandate for EPSDT. Many families do not realize that the result of poor oral health could have consequences for general health.

1385: Developmental screening using a parent completed screening tool (Parent report, Children 0-5)
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:20 PM

Comments

For the same reasons stated above for early intervention, we believe that developmental screening is key. SPAN was recently the recipient of the Integrated Systems Grant for children with autism and other developmental disabilities so this is a crucial area for us. We strongly support the initiatives on developmental screening.

1381: Asthma Emergency Department Visits
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:19 PM

Comments

Family Voices supports this measure with a caution. We support monitoring asthma and preventing hospitalization but not penalizing families if the emergency room visits fall under the “prudent layperson” type of definition found in Medicaid for emergencies and should hold true for all types of insurance. Families who don’t have access to a primary care provider are most likely to overuse the emergency room.

1365: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:18 PM

Comments

We fully support including this measure; see our comments above under mental health.

1364: Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:17 PM

Comments

Family Voices strongly supports all of the above mental health and prevention measures. There has been a tremendous increase in the calls we receive for children’s mental health issues. We would highly recommend the use of Teen Screen (www.teenscreen.org) as an effective standardized screening tool for depression.

1361: Intervention no later than 6 months of age (EHDI-4a)
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:16 PM

Comments

In addition to newborn/hearing screening, Family Voices @ SPAN strongly supports early intervention for hearing loss. The Family Voices Coordinator and the Parent-to-Parent Coordinator serve on the Family Support Committee of the State Interagency Coordinating Council for early intervention. The Family Voices Coordinator also served on the SICC for many years. In addition, she and Diana Autin, the Executive Co-Director of SPAN, serve on the Part C Steering Committee. Research indicates that early intervention is cost effective and more importantly results in better health outcomes for children.

1360: Audiological Evaluation no later than 3 months of age (EHDI-3)
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:15 PM

Comments

Same as 1351: Family Voices @ SPAN is part of the NY Mid-Atlantic Consortium for newborn and genetic screening. SPAN also houses NJ Parent-to-Parent which has been very involved with the Early Hearing Detection and Intervention program as well as the DB Faces (Deaf Blind and Community Educational Supports) program. We strongly support the above initiatives on newborn screening, particularly hearing screening.

1357: Outpatient hearing screening of infants who did not complete screening before hospital discharge (EHDI-1c)
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:14 PM

Comments

Same as 1351: Family Voices @ SPAN is part of the NY Mid-Atlantic Consortium for newborn and genetic screening. SPAN also houses NJ Parent-to-Parent which has been very involved with the Early Hearing Detection and Intervention program as well as the DB Faces (Deaf Blind and Community Educational Supports) program. We strongly support the above initiatives on newborn screening, particularly hearing screening.

1354: Hearing screening prior to hospital discharge (EHDI-1a)
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:13 PM

Comments

Same as 1351: Family Voices @ SPAN is part of the NY Mid-Atlantic Consortium for newborn and genetic screening. SPAN also houses NJ Parent-to-Parent which has been very involved with the Early Hearing Detection and Intervention program as well as the DB Faces (Deaf Blind and Community Educational Supports) program. We strongly support the above initiatives on newborn screening, particularly hearing screening.

1351: Proportion of infants covered by Newborn Bloodspot Screening (NBS)
Comment By
Name: Ms. Lauren Agoratus
Organization:

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

Date - Time: Feb 16, 2011 - 01:12 PM

Comments

Family Voices @ SPAN is part of the NY Mid-Atlantic Consortium for newborn and genetic screening. SPAN also houses NJ Parent-to-Parent which has been very involved with the Early Hearing Detection and Intervention program as well as the DB Faces (Deaf Blind and Community Educational Supports) program. We strongly support the above initiatives on newborn screening, particularly hearing screening.

1349: **Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)**
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:10 PM

Comments

Closely related to the 3 measures above (1396, 1512, 1514), Family Voices is deeply concerned with the obesity epidemic in children resulting in the development of secondary conditions such as heart disease etc. With over 12% of preschoolers and 17% of school-age children being obese (not just overweight), we strongly endorse BMI documentation as a measure.

We are deeply concerned that there do not appear to be measures for diabetes which is unfortunately occurring in children in increasing numbers due to obesity. Unless this measure was addressed in previous versions, Family Voices strongly recommends that diabetes in children be monitored and addressed.

1348: **Children Age 6-17 Years who Engage in Weekly Physical Activity**
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:09 PM

Comments

We also support this measure; please see comments under physical activity measures above.

1346: **Children Who Are Exposed To Secondhand Smoke Inside Home**
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:08 PM

Comments

We understand the need for this measure, particularly in prevention of the development of asthma. However, this must be done in a culturally competent manner as we found in our focus groups of Spanish speaking families, that the women felt they couldn't tell their husbands not to smoke in their own home.

1340: **Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care**
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 01:07 PM

Comments

Family Voices strongly supports this measure as transition is an area of concern. Continuity of care is particularly important for children with special healthcare needs. We recently developed a factsheet for families to assist them with this process.

1337: Children With Inconsistent Health Insurance Coverage in the Past 12 Months
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 12:59 PM

Comments

This is an area of great concern and we support this measure. The NJ Hospital Association national conference on the uninsured showed that uninsured children are diagnosed 2 years later than their insured counterparts, when the condition is worse and more costly to treat. This results in health disparities of increased morbidity and mortality, particularly for underserved populations.

1335: Children Who Have Dental Decay or Cavities
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 12:58 PM

Comments

Same as 1334: Family Voices strongly supports these initiatives. Unfortunately many children, particularly those on Medicaid (one-third), do not receive adequate dental care, despite the mandate for EPSDT. Many families do not realize that the result of poor oral health could have consequences for general health.

1334: Children Who Received Preventive Dental Care
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 12:57 PM

Comments

Family Voices strongly supports these initiatives. Unfortunately many children, particularly those on Medicaid (one-third), do not receive adequate dental care, despite the mandate for EPSDT. Many families do not realize that the result of poor oral health could have consequences for general health.

1333: Children Who Receive Family-Centered Care
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 12:55 PM

Comments

Family Voices strongly supports family-centered care, which includes cultural competency and shared decision-making. Family-centered care in the medical home is the model for best practices. We support this measure fully. We would add consideration of health literacy as the single largest barrier to healthcare access.

1332: Children Who Receive Preventive Medical Visits
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 12:54 PM

Comments

We strongly support this measure; see our comments above on wellness initiatives.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

1330: Children With a Usual Source for Care When Sick
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 12:50 PM

Comments

We strongly support this measure as well. Family Voices feels that the medical home and care coordination will result in more efficient care and improve health outcomes. This will also reduce unnecessary emergency room trips and prevent hospitalizations.

Comments on the general draft report
Comment By
Name: Ms. Lauren Agoratus
Organization:

Date - Time: Feb 16, 2011 - 12:47 PM

Comments

Family Voices is a national network that advocates to "keep families at the center of children's health care," with a special focus on behalf of children with special healthcare needs and their families. Our NJ Chapter is housed at SPAN, NJ's federally designated PTI Center which is also NJ's F2FHIC and a chapter of the Federation of Families for Children's Mental Health. As Family Voices focuses on children with special needs, our comments will reflect this. In general Family Voices-NJ supports the recommended Child Health Quality Measures. We were pleased to see the references to the CHIPRA core measures and well as the NSCSHC. We agree with the findings of AHRQ that identified gaps related to priority areas such as mental health, specialty services, well-child care, and dental. We appreciate that NQF has also identified gaps in the areas of child functioning, quality of life, caregiver experience, and health promotion. We understand that 41 measures were recommended, 7 which are time-limited, and 3 that moved forward without consensus. We also understand that the Steering Committee looked at 4 criteria: measure/report, scientific acceptability, usability, and feasibility. We agree that the 3 time limited measures should be based on gap areas, non-complex measures, and legislative mandate.

1332: Children Who Receive Preventive Medical Visits
Comment By
Name: Ms. Nan Streeter, MS, RN
Organization: Utah Department of Health

Date - Time: Feb 02, 2011 - 11:58 AM

Comments

How about changing the term from medical to health care visits?

1330: Children With a Usual Source for Care When Sick
Comment By
Name: Ms. Nan Streeter, MS, RN
Organization: Utah Department of Health

Date - Time: Feb 02, 2011 - 11:57 AM

Comments

Does this include ERs? Or, are you asking if a child has a medical home so to speak?

March 10, 2011

National Quality Forum
Attn: Suzanne Theberge, MPH, Project Manager, Performance Measures
601 13th Street NW
Suite 300 North
Washington, DC 20005

Re: Comments on National Voluntary Consensus Standards for Child Health Quality Measures, 2010

Dear Ms. Theberge:

The Children's Hospital Colorado appreciates the opportunity to comment on the National Quality Forum's (NQF) request for member and public input on its draft report titled, *National Voluntary Consensus Standards for Child Health Quality Measures, 2010: A Consensus Report*.

When it was founded in 1908 in Denver, Colorado, The Children's Hospital Colorado set out to be a leader in providing the best healthcare outcomes for children. That calling has consistently made us one of the top 10 children's hospitals in the nation and a place parents across the Rocky Mountain region have come to trust. Our modern-day mission is to improve the health of children through the provision of high-quality coordinated programs of patient care, education, research and advocacy. As a private, not-for-profit pediatric healthcare network, The Children's Hospital Colorado is committed to providing the best care in the most efficient manner to *all* children, including our most vulnerable. Over 42% of our patients come from families that are low income and/or Medicaid recipients.

It is within that context that The Children's Hospital Colorado stands uniquely positioned to offer comments to the NQF on the initial measures included in the draft report that are intended to be used for public reporting at the population level, such as by states – measures that target a number of conditions or cross-cutting areas applicable to Medicaid.

The Children's Hospital Colorado wholeheartedly agrees with the NQF that greater emphasis should be placed on measure development and endorsement in the area of child health quality. In general, we were pleased to see in the draft report that the NQF recommend measures in a number of categories – perinatal measures; newborn screening; hearing screening; developmental screening; vision screening; blood pressure screening; additional screening; weight/BMI/physical activity measures; immunization measures;

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

tobacco exposure measures; dental measures; mental health measures; care visit measures; and special needs measures.

Despite the comprehensive priority areas for which measures were proposed in the report, however, there still exist key "gap areas" whereby additional measures ought to be considered:

Recommendation 1:
The Children's Hospital Colorado recommends that the NQF consider making patient-provider interaction and care coordination measures a priority – namely, by including measures that reflect the interaction between families, their medical home, and hospital/specialty care. Such measures might include those related to capturing information regarding Emergency Department (ED) visits; ambulatory care sensitive admissions (ACSAs); hospital readmissions; duplication of services/testing; as well as measures of efficiency, such as lost parent work/child school time for health and health care.

Recommendation 2:
While the draft report does an exceptional job of addressing measure development around prevention and screening generally, one such "gap area" remains – namely, measurement development related to school success, such as screening questions for school-age children or those children at high-risk of dropping-out of school, given the well-documented association between high risk health behaviors and school failure.

Recommendation 3:
In general, while there are a number of measures included in the draft report that tackle important areas applicable to the Medicaid population regarding health promotion and prevention, such as measure #1396 "Healthy Physical Development by Six Years of Age (NCQA)", greater emphasis ought to similarly be placed on addressing nutritional issues *before* six years of age. Such measures include those pertaining to breastfeeding (beyond those already endorsed by the NQF, such as measure #0480 "Exclusive Breastfeeding at Discharge"), as well as measures that would serve to provide information on children over two years of age with Body Mass Index (BMI) of 95% or greater.

In closing, we commend the NQF Steering Committee for their tremendous work in putting forward 41 comprehensive child health measures for endorsement, and we kindly ask that the Committee in moving forward on this project consider additional measures in the above-referenced key "gap areas" not fully addressed in its underlying report. Again, we appreciate the opportunity to comment on the draft report. Should you have any questions about our comments, please feel free to contact Heidi Baskfield, Director of Public Affairs, at (720) 777-8526 or baskfield.heidi@tchden.org.

Sincerely,

Heidi Baskfield

Prevent Blindness America
100 Years. Our Vision Is Vision.®

211 West Wacker Drive
Suite 1700
Chicago, Illinois 60606

toll free 800.331.2020
local 312.363.6001
fax 312.363.6052

preventblindness.org

March 17, 2011

Dr. Helen Burstin
Senior Vice President for Performance Measures
National Quality Forum
601 13th Street, NW
Suite 500 North
Washington, DC 20005

Dear Dr. Burstin:

On behalf of Prevent Blindness America – the nation's leading non-profit, voluntary organization committed to preventing blindness and preserving sight – we would like to thank you and the staff of the National Quality Forum (NQF) for providing us the opportunity to comment on the importance of children's vision and eye health as it relates to the National Voluntary Consensus Standards for Child Health Quality Measures (CHQM).

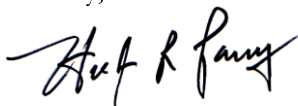
Vision disorders, including amblyopia, strabismus, and significant refractive errors, are among the most prevalent disabling childhood conditions in the United States. If not detected and treated early, these conditions can lead to permanent vision loss. Yet only 21% of preschool-age children have their vision screened, and only 14% of children receive comprehensive eye examinations before entering school. According to the Centers for Disease Control and Prevention, impaired vision can affect a child's cognitive, emotional, neurological and physical development. Requirements for preventive eye care prior to or during the school years vary broadly from state to state, with little consistency.

We thank you for your hard work and on-going commitment to advancing quality within our nation's health care systems. In response to the request for comments regarding the National Voluntary Consensus Standards for CHQM, we urge you to incorporate the following modification into "Pre-School Vision Screening in the Medical Home," Measure #1412.

We suggest that reporting be separated into two age groups: 1) birth to < 3years, 2) 3 to < 6 years. Existing evidence supports vision screening for children ages 3 to< 6 years, but is not currently available for children below the age of 3 years. Reporting by age group will allow differentiation between a relative lack of screening in the younger age groups compared with screening rates in the older age group. We believe this would represent a significant limitation of the measure that could be readily overcome by separate reporting.

We again thank the National Quality Forum for this important opportunity and encourage NQF to include children's vision and eye health measures within the Child Health Quality Measures. Prevent Blindness America encourages NQF to reach out to our organization as a willing partner for the NQF's work. In addition, we can offer the expertise of the National Expert Panel of the National Center for Children's Vision and Eye Health, and of our Scientific and Public Health committees, which are comprised of the nation's leading experts in vision and eye health research. Should you have any questions, or if we can be of any assistance, please do not hesitate to contact Andrea Densham, our Vice President of Public Health and Government Affairs at (312) 363-6032, or adensham@preventblindness.org. Prevent Blindness America looks forward to working with you and the staff of the National Quality Forum in the future.

Sincerely,



Hugh R. Parry
President & CEO
Prevent Blindness America

February 22, 2011

National Quality Forum (NQF)
Public Comment
601 13th Street NW, Suite 500 North
Washington DC 20005

Dear Colleagues,

In response to the National Quality Forum (NQF) invitation for public comment posted on February 1, 2011, regarding Child Health Quality Measures 2010, Sanofi Pasteur wishes to take this opportunity to express its support of NQF Measures #1407 and #1506 pertaining to child/adolescent immunization quality measures, and suggest several changes to better align the measures with current government guidelines.

Sanofi Pasteur is one of the largest vaccine manufacturers in the world and appreciates the opportunity to provide input designed to improve quality measures that protect public health. Our comments focus on the following recommendations:

1) NQF's Measure #1506 should reflect current guidelines of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) (http://www.cdc.gov/vaccines/recs/schedules/downloads/child/7-18yrs-schedule-pr.pdf) by including vaccines recommended for all adolescents through 18 years of age: Meningococcal conjugate vaccine, quadrivalent (MCV4); Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap); influenza vaccine (seasonal); and human papillomavirus vaccine (HPV) for girls.[1] Expanding this measure will also help achieve Healthy People 2020's new adolescent immunization goals.[2]

2) NQF's Measure #1506 should also include Tdap vaccination during the early postpartum period for pregnant adolescents who were not immunized prior to conception. Tdap vaccination during preconception or immediately postpartum will help to protect mothers against pertussis disease and prevent transmission of pertussis from mothers to their infants and other at-risk persons.

3) Measures #1407 and #1506 should include annual seasonal influenza vaccination of adolescents.

4) While NQF's endorsed Measure #0038 is not open for comment at this time, we would like to emphasize the importance of including yearly seasonal influenza vaccination of children.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

5) NQF should consider the inclusion of existing combination vaccines in NQF-endorsed Measure #0038 to improve compliance and timeliness with the recommended pediatric immunization schedule and promote better health outcomes. The National Committee for Quality Assurance (NCQA) has included combination vaccines in its childhood immunization HEDIS measure, and other accrediting bodies will look to NQF's measure for guidance.

Below are Sanofi Pasteur's recommendations and rationale for changes to the endorsed/proposed NQF measures:

1) Adolescents Immunization: We are in general agreement with NQF Measure #1506, which supports the inclusion of MCV4, routine booster Tdap, and other recommended vaccines by age 13 years. NCQA recently adopted a quality measure for MCV4 and Tdap vaccination by 13 years of age. NQF should expand the quality measure to include seasonal influenza vaccine, as well as HPV vaccination for girls, as recommended by ACIP (http://www.cdc.gov/vaccines/recs/schedules/downloads/child/7-18yrs-schedule-pr.pdf).[1] These modifications would support the Healthy People 2020 target of 80% vaccination coverage for MCV4, Tdap, and seasonal influenza vaccines among adolescents.[2]

2) Tdap Recommendation in the Early Postpartum Period: Sanofi Pasteur believes that NQF's adolescent quality measures should include Tdap vaccination in the early postpartum period of all adolescents who were not immunized prior to conception. Tdap vaccination in the immediate postpartum period will help prevent new mothers from acquiring pertussis and reduce transmission of pertussis from mothers to infants. Prominent objectives of the Healthy People 2020 initiative include a 10% reduction of cases of pertussis among children under 1 year of age, and an approximate 50% reduction of cases among adolescents 11-18 years of age (Immunization and Infectious Diseases [IID] Objectives 1.6 and 1.7).[2] Tdap vaccine should be administered before mothers are discharged from the hospital or birthing center, or as soon as possible after discharge (e.g., during the first post-delivery obstetrical examination or first well-baby visit). This recommendation for inpatient Tdap immunization is in line with the current recommendation for hepatitis B immunization of infants at birth.[3]

Numerous medical societies support the ACIP recommendation to immunize adolescents and adults (including females during the postpartum period) with pertussis-containing vaccine[4], notably – the American College of Obstetricians and Gynecologists (ACOG)[5], Society for Adolescent Health and Medicine (SAHM), American Academy of Pediatrics (AAP), Infectious Diseases Society of America (IDSA), and The Society for Healthcare Epidemiology of America (SHEA).[6]

Further, in its Tdap recommendations for hospitals, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recommends that all postpartum women – including adolescents – who have not previously received Tdap vaccine should be immunized as soon as feasible in the postpartum period. In March 2010, JCAHO launched a project to uncover evidence-based programs that improved Tdap vaccination of adolescent patients, and reflected best practices among health systems.[7] JCAHO recently published findings from these case studies, highlighting results from 17 centers. In the first ~2 years after initiating a pertussis vaccination program at Texas Children's Hospital, 75% of women were immunized after

delivery and before discharge from the hospital. In Othello, WA, Columbia Basin Health Association implemented a multi-component program (including education, a standing order for immunization, and an incentive program for nurses), which increased the postpartum Tdap vaccination rate from 2% to 85%.

In line with JCAHO, ACOG, and other stakeholders who support postpartum immunization of adolescents who receive health care in hospital-based settings, NQF should adopt quality measures that endorse and measure such use in ambulatory, private, and public settings. Doing so will help to ensure that maternal Tdap immunization is uniformly implemented as a standard-of-care in a variety of health-care settings, to potentially help prevent pertussis in vulnerable infants who may not yet be protected from their own immunization.

Adolescent and adult mothers not yet immunized with Tdap vaccine are vulnerable to pertussis because protection from their childhood vaccinations has waned.[8] These mothers may catch pertussis from others and, in turn, transmit the infection to their infants, who may be too young to have started or completed their infant Diphtheria, Tetanus, and acellular Pertussis (DTaP) vaccination series. Research suggests that, in up to 83% of infant pertussis cases for whom a source of the infection can be found, a family member is responsible for transmitting pertussis to the infant.[9] Nearly all pertussis-related deaths in the US occur in infants who are either too young to receive infant DTaP vaccinations or are only partially immunized.[10,11] To help prevent adolescents and adults from infection with pertussis and to help prevent transmission of pertussis to others, including unprotected infants, ACIP recommends that all persons 11-64 years of age be vaccinated with a one-time Tdap booster.[12]

While the introduction of pertussis vaccines over 50 years ago led to a dramatic decline in the incidence of pertussis, significant outbreaks of pertussis have occurred in the U.S. in recent years.[13] In 2004, 25,827 pertussis cases – 34% involving adolescents – were reported to the CDC through the passive National Notifiable Disease Surveillance System (NNDSS).[14,15] A dramatic increase of pertussis cases has been documented in California, where there were 10 pertussis-related deaths in 2010, all among infants ≤ 2 months of age. Pertussis outbreaks have also been reported in upstate New York, Ohio, South Carolina, Michigan, and the Philadelphia suburbs.[16-21] It is critical that the medical community support adolescent and postpartum vaccination to help reduce pertussis cases and serious complications, including deaths.

3) Immunization of Children Aged ≤2 Years: NQF should consider including annual seasonal influenza immunization in quality measures. ACIP recommends 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza for the first time or who are otherwise considered naïve based on ACIP recommendations.[3] Additionally, NCQA recently adopted the same recommendation into its childhood HEDIS measure. The minimum age for influenza vaccination is 6 months. Adding annual seasonal influenza vaccination to Measure #0038 will align this NQF quality measure with the goal set by Healthy People 2020, which targets an 80% annual rate for seasonal influenza immunization of children 6 through 23 months of age (IID-12.1).[2]

Influenza is a common cause of morbidity among children, with the highest rates of emergency department visits and hospitalizations occurring among children <2 years of age.[22] Rates of hospitalization for complications related to influenza among children < 2 years of age are comparable to the rates among adults

65 years of age and older. Although mortality is not a common outcome of influenza among children, reports of deaths have increased in recent years.[22] An estimated annual average of 92 influenza-associated deaths occurred among children aged <5 years during the 1990s. Of 153 laboratory-confirmed influenza-related pediatric deaths reported during the 2003–2004 influenza season, 96 (63%) deaths occurred among children aged <5 years and 61 (40%) among children aged <2 years. During April 2009–March 2010, over 300 pediatric deaths attributable to laboratory-confirmed 2009 pandemic H1N1 influenza were reported to CDC, and over 1,000 deaths are estimated to have occurred. By adding measures for influenza vaccination among young children, NQF would be supporting efforts to reduce the burden of influenza infection among this vulnerable population.

We agree with NQF-endorsed Measure #0038, which measures the percentage of children who receive three doses of hepatitis B vaccine and other recommended vaccines by their second birthday. While hepatitis B vaccine is recommended for all infants at birth, adherence to this recommendation has not been applied effectively or consistently across the country: A recent survey found that approximately one-third of hospitals did not have written policies for implementing at least one official recommendation for reducing transmission of hepatitis B.[23] In 2004, AAP began requiring hospitals to either administer hepatitis B vaccine at birth or provide written documentation or test results demonstrating that the mother is not infected with hepatitis B virus. This policy was issued in order to prevent transmission of hepatitis B to infants and, in turn, improve overall public health.

4) Compliance with Combination Vaccine Schedules: The use of existing combination vaccines can improve compliance with the recommended pediatric immunization schedule, which leads to better overall health outcomes. Pediatric quality measures should be enhanced to favor the use of combination vaccines, such as DTaP-Inactivated Polio Vaccine (IPV)-Hib and DTaP-IPV-Hepatitis B vaccines, when possible, to help improve compliance with the primary pediatric immunization schedule. The goal of Healthy People 2020 is to reduce, eliminate, or maintain elimination of cases of vaccine-preventable diseases (IID-1), and to increase or maintain effective vaccination coverage levels (90%) among children aged 19-35 months for universally recommended vaccines (IID-7).[2]

An ongoing challenge in promoting immunizations and public health is the issue of schedule compliance. The failure to adhere to the ACIP-recommended childhood and adolescent immunization schedules has resulted in outbreaks of potentially devastating infectious diseases. For example, outbreaks of pertussis began in 2010 and are still occurring in several regions of the U.S., as mentioned above.[16-21]

NQF and NCQA support primary vaccination and measurement for all children with the ACIP-recommended vaccinations by two years of age.[24,25] Completing primary vaccinations according to the recommended immunization schedule is important to increase protection against vaccine-preventable diseases and improve public health.

Data from the National Immunization Survey (NIS) demonstrate that a number of children receive their pediatric vaccinations over an extended time frame, which falls outside of the ACIP-recommended immunization schedule. NIS data show that a 15% drop-off occurs between the third and fourth doses of DTaP vaccine in children by 24 months of age.[26] Children who have not received their fourth dose of DTaP

by 24 months of age are at least six months behind the recommended immunization schedule, leaving them unnecessarily vulnerable to vaccine-preventable diseases.[3] According to AAP, administering a combination vaccine may enhance timeliness and compliance with ACIP's recommended immunization schedule.[27]

The CDC conducted a study of vaccination timeliness using data from the 2003 National Immunization Survey involving 14,810 children 24-35 months of age.[28] The investigators evaluated the cumulative number of days undervaccinated for 6 vaccines: 4 doses of DTaP, 3 IPV, 3-4 Hib, 3 hepatitis B, 1 measles/mumps/rubella (MMR), and 1 varicella. Children were considered late if the vaccine was given more than 1 month after the recommended age and severely undervaccinated if the vaccine was more than 6 months delayed. The CDC reported that only 17% of children received all 6 of these vaccines on time. Children were undervaccinated for a mean of 172 days, taking into account all 6 vaccines through 24 months of age, and 37% were undervaccinated for more than 6 months for at least 1 vaccine.

Innovative combination vaccines offer protection for children against a wider range of infectious and potentially life-threatening diseases than ever before. Studies of children cared for in public and private healthcare settings have shown that the use of pediatric combination vaccines increases compliance and timeliness with the pediatric immunization schedule. Studies have also shown that infants who received combination vaccines had significantly higher rates of receiving all of their vaccinations on time in the first two years of life compared to infants given separate component vaccines.[29,30]

Sanofi Pasteur appreciates the opportunity to submit comments and stands committed to working with NQF to improve public health and quality measures.

Sincerely,

David P. Greenberg, MD, FAAP
Sanofi Pasteur
Senior Director, Scientific and Medical Affairs
1 Discovery Drive
Swiftwater, Pennsylvania 18370

References

1. Centers for Disease Control and Prevention (CDC). Recommended immunization schedule for persons aged 7 through 18 years—United States 2011. http://www.cdc.gov/vaccines/recs/schedules/downloads/child/7-18yrs-schedule-pr.pdf. Accessed February 7, 2011.
2. Healthy People 2020 - improving the health of Americans. Immunizations and infectious diseases. http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=23. Accessed February 7, 2011.
3. CDC. Recommended immunization schedule for persons aged 0 through 6 years—United States 2011. http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable. Accessed February 7, 2011.
4. CDC. Prevention of pertussis, tetanus, and diphtheria among pregnant and postpartum women and their infants. Recommendations of the Advisory Committee on Immunization Practices (APIC). *MMWR*. 2008;57(RR-4):1-51.

5. ACOG Committee Opinion No. 438: Update on immunization and pregnancy: tetanus, diphtheria, and pertussis vaccination. *Obstet Gynecol*. 2009;114(2 Pt 1):398-400.
6. ACP-IDSA Joint statement of medical societies regarding adult vaccination by physicians. Nov. 2008. www.idsociety.org/workarea/showcontent.aspx?id=12348. Accessed February 7, 2011.
7. Joint Commission. Tdap vaccination strategies for adolescents and adults, including health care personnel. Strategies from research and practice. c. 2011. The Joint Commission: Oakbrook Terrace, IL. http://www.jointcommission.org/tdap/. Accessed February 7, 2011.
8. Wendelboe AM, Van Rie A, Salmaso S, Englund JA. Duration of immunity against pertussis after natural infection or vaccination. *Pediatr Infect Dis J*. 2005;24(5 Suppl):S58-61.
9. Wendelboe AM, Njamkepo E, Bourillon A, et al; Infant Pertussis Study Group. Transmission of *Bordetella pertussis* to young infants. *Pediatr Infect Dis J*. 2007;26(4):293-299.
10. CDC. Pertussis. In: *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 11th ed. Atkinson W, Wolfe S, Hamborsky J, McIntyre L (eds). Public Health Foundation: Washington DC, 2009. www.cdc.gov/vaccines/pubs/pinkbook/downloads/pert.pdf. Accessed February 7, 2011.
11. Healy CM, Munoz FM, Rench MA, Halasa NB, Edwards KM, Baker CJ. Prevalence of pertussis antibodies in maternal delivery, cord, and infant serum. *J Infect Dis*. 2004;190(2):335-340.
12. CDC. Recommended adult immunization schedule – United States, 2011. *MMWR*. 2011;60(4):1-4.
13 CDC. Pertussis–United States, 1997-2000. *MMWR.* 2002;51(4):73-76.
14. CDC. Preventing tetanus, diphtheria, and pertussis among adults: use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and Recommendation of ACIP, supported by the Healthcare Infection Control Practices Advisory Committee (HICPAC), for Use of Tdap Among Health-Care Personnel. *MMWR*. 2006;55(RR-17):1-37.
15. CDC. Final 2009 reports of Nationally Notifiable Infectious Diseases. *MMWR*. 2010;59(32):1027-1039.
16. California Department of Public Health. Pertussis report, 8/17/2010. http://www.cdph.ca.gov/programs/immunize/Documents/PertussisReport2011-01-07.pdf. Accessed February 7, 2011.
17. Michigan Department of Community Health. Pertussis (whooping cough) in Michigan. http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_4914-240419--,00.html. Accessed February 7, 2011.
18. New York Department of Health. State health commissioner urges vaccination for pertussis (whooping cough) as number of pertussis cases climbs above this period last year. http://www.nyhealth.gov/press/releases/2010/2010-09-24_pertussis.htm. Accessed February 7, 2011.
19. Ohio Department of Health. Pertussis (whooping cough). http://www.odh.ohio.gov/features/odhfeatures/pertussis.aspx. Accessed February 7, 2011.
20. Pennsylvania Department of Health. 2010– PAHAN – 0193 – 08 –05 – ADV - Pertussis. http://www.portal.health.state.pa.us/portal/server.pt/community/health_alert_network/14217. Accessed February 7, 2011.
21. South Carolina Department of Health and Environmental Control. Pertussis cases increasing, especially among infants. https://www.scdhec.gov/health/disease/han/docs/HAN-20100706-01.pdf. Accessed February 7, 2011.
22. CDC. Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP), 2010. MMWR. 2010;59(rr08);1-62.
23. Bayo CW, Wortley P, Wang SA, Jacques-Carroll L, Zhang F. Gaps in hospital policies and practices to prevent perinatal transmission of hepatitis B virus. *Pediatrics*. 2010;125(4):704-11.
24. National Committee for Quality Assurance. The State of Health Care Quality. 2010. http://www.ncqa.org/Portals/0/State%20of%20Health%20Care/2010/SOHC%202010%20-%20Full2.pdf. Accessed February 7, 2011.

sanofi pasteur
NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

25. National Quality Foundation. NQF-Endorsed® Standards. NQF # 0038. http://www.qualityforum.org/MeasureDetails.aspx?SubmissionId=395#k=immunization&e=1&st=1&sd=&s=n&so=a&p=1. Accessed February 7, 2011.
26. CDC. Estimated vaccination coverage with individual vaccines and selected vaccination series before 24 months of age by state and local area US, National Immunization Survey, Q1/2009-Q4/2009. http://www2a.cdc.gov/nip/coverage/nis/nis_iap2.asp?fmt=v&rpt=tab09_24mo_iap&qtr=Q1/2009-Q4/2009. Accessed February 7, 2011.
27. American Academy of Pediatrics. Combination vaccines for childhood immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). *Pediatrics*. 1999;103(5):1064-1077.
28. Luman ET, Barker LE, Shaw KM, McCauley MM, Buehler JW, Pickering LK. Timeliness of childhood vaccinations in the United States: days undervaccinated and number of vaccines delayed. *JAMA*. 2005;293(10):1204-1211
29. Happe LE, Lunacsek OE, Marshall GS, Lewis T, Spencer S. Combination vaccine use and vaccination quality in a managed care population. *Am J Manag Care*. 2007;13(9):506-512.
30. Happe LE, Lunacsek OE, Kruzikas DT, Marshall GS. Impact of a pentavalent combination vaccine on immunization timeliness in a state Medicaid population. *Pediatr Infect Dis J*. 2009;28(2):98-101.