NATIONAL QUALITY FORUM

IN-PERSON MEETING FOR THE CHILD HEALTH QUALITY MEASURES STEERING COMMITTEE

November 8-9, 2010

Committee Members: Thomas McInerny, MD (co-chair); Marina Weiss, PhD (co-chair); Martha Bergren, RN, DNS, NCSN; Sarah Brown, MSPH; Carroll Carlson, RN, BSN; Alex Chen, MD, MS; David Clarke, MD; Nancy Fisher, MD, MPH; Faye Gary, EdD, RN; James Glauber, MD, MPH; Margarita Hurtado, PhD, MHS; Kathy Jenkins, MD, MPH; Allan Lieberthal, MD; Marlene Miller, MD, MSc; Donna Persaud, MD; James Quirk, MD, PhD; Goutham Rao, MD; Ellen Schwalenstocker, PhD, MBA; Bonnie Zima, MD, MPH

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Audience: Julie Belelieu, Child and Adolescent Psychiatry at Columbia University; Sean Currigan, MPH, American College of Obstetricians and Gynecologists; Lekisha Daniel-Robertson, MSPH, Centers for Medicare & Medicaid Services; Denise Dougherty, PhD, Agency for Healthcare Research and Quality; Irene Forsman, MS, RN, Health Resources and Services Administration; Edwin Lomotan, MD, Agency for Healthcare Research and Quality; Anja Peersen, RN, MSN, CPHQ, Oregon Health and Science University; Karen Pierce, MD, American Psychiatric Association; Robert Plovnick, MD, MS, The American Psychiatric Association; Michele Puryear, MD, PhD, Health Resources and Services Administration; Arthur Shepard, MD, HCA-Trident Health System; Alan Zuckerman, MD, National Library of Medicine

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INTRODUCTIONS AND DISCLOSURE OF INTEREST

Steering Committee co-chairs Dr. McInerny and Dr. Weiss welcomed Committee members and led the introductions of participants. National Quality Forum (NQF) managing director for performance measures, Heidi Bossley, led the Committee through disclosure of interests. None of the Steering Committee members offered any disclosures relating to the development of the candidate measures to be discussed.

CHILD HEALTH QUALITY MEASURES PROJECT GOALS

NQF senior director Dr. Winkler and project manager Ms. Theberge provided a brief overview of the project's goals and timeline. Dr. Winkler answered questions on measure evaluation and the NQF process. The Committee was advised that this project is funded by the Department of Health and Human Services (HHS) and has the following goals:

- to identify, evaluate, and endorse 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;
- to identify gaps in existing measures and recommend potential measures to fill those gaps; and
- to increase NQF's portfolio of child health measures for use in programs such as the Children's Health Insurance Program Reauthorization Act (CHIPRA) or Medicaid, or by states.

The project includes measures from the CHIPRA Core Measures Set that NQF has not previously endorsed.

Ms. Theberge reported that the project received 75 measure submissions. The Committee was asked to review 44 of these measures at the meeting and the remainder during follow-up conference calls. The measures and Committee members were split into four groups for preliminary review. The Committee voted on each of the four main criteria (Importance to Measure and Report, Scientific Acceptability, Usability, and Feasibility) and the overall Recommendation for Endorsement.

DISCUSSION OF SUBMITTED MEASURES

Perinatal Care and Newborn Screening

1391: Perinatal care: Frequency of ongoing prenatal care (National Committee for Quality Assurance, NCQA)

The Committee generally agreed on the importance of prenatal care but questioned whether the timing and distribution of visits or the pure number of visits is more predictive of positive health

outcomes. Committee members asked why the measure has five categories (numbers of visits) rather than a simple yes/no criterion requiring everyone to meet the same threshold. The Committee was concerned about the variability in reimbursement as a determinant of visit frequency and how case mix in a particular practice influences a provider's score on this measure. They also questioned feasibility of data collection since bundled or global payments are changing billing practices. Despite the fact the measure has been used in the Healthcare Effectiveness Data and Information Set (HEDIS), results are not presented, and information on testing was not provided. Some Committee members argued that this measure is a crude, poorly researched instrument and that there has been opportunity for better objective testing. The Committee requested that information on reliability testing be provided.

1391	**Yes**	**No**		
Importance	19	0		
	Completely	**Partially**	**Minimally**	**Not at all**
Scientific Acceptability		14	4	0
Usability	8	8	1	0
Feasibility	6	13	0	0
	Yes	**No**	**Abstain**	
Recommend for Endorsement	16	3		

1517: Perinatal care: Timeliness of prenatal care and postpartum care (NCQA)

The developer clarified that this measure is intended to measure the timeliness of the prenatal visits and the postpartum visit separately, in two rates. Committee members recognized that the postpartum visit is underutilized, especially among Medicaid patients, most likely due to a combination of a lack of education on the importance of these visits and the logistical challenges of getting to a visit. In commercial insurance populations, there are greater rates of postpartum visits, but the visits may not be as comprehensive as they could be. Committee members raised concerns about the lack of specificity for services that should be provided at the visit, including family planning/contraceptive use counseling, maternal depression screening, or follow-up screening for gestational diabetes. NCQA explained that they are interested in moving away from visit-based measures and examining the content of visits, but feasibility considerations led them to develop the visit measure and they are encouraging health plans to collect data by race/ethnicity so that measures can be stratified.

1517	**Yes**	**No**		
Importance	18	0		
	Completely	**Partially**	**Minimally**	**Not at all**
Scientific Acceptability	5	11	1	0
Usability	6	10	1	0
Feasibility	11	7	0	0
	Yes	**No**	**Abstain**	
Recommend for Endorsement	17	1	0	

1382: Percentage of low birthweight births (Division of Vital Statistics)

This population-level indicator is analyzed at the state or regional level, includes all births within the region, and can be stratified by any data collected on the birth certificate. The Committee agreed that caring for low birthweight babies is a major cost issue in healthcare but pointed out that the measure captures two populations (growth restricted neonates and premature babies), which have different causes and outcomes. The developer responded positively when Committee members asked whether several stratifications to the measure were possible: singletons and multiple births; and <1500 grams and 1500-2500 grams. The Committee discussed the sociological implications of stratified data and new research indicating that genetic markers may be better indicators for low birthweight risk than race/ethnicity. The Committee asked the developer about the accuracy of birth certificate data, and the developer reported that race/ethnicity are self-reported by the mother, and there is strong evidence that the birth weights are accurate. The Committee discussed stratifying this measure by the mother's age, as younger teens are less likely to receive prenatal care, but decided that determining the best age stratification was beyond the scope of this group.

1382	**Yes**	**No**		
Importance	18	0		
	Completely	**Partially**	**Minimally**	**Not at all**
Scientific Acceptability	18	0	0	0
Usability	12	6	0	0
Feasibility	18	0	0	0
	Yes	**No**	**Abstain**	
Recommend for Endorsement	18	0		

The Committee recommended that the measure be stratified by singleton versus multiple births, and birthweights of less than 1500 grams versus more than 1500 grams.

1417: Screening for hyperbilirubinemia in term and near term neonates (Hospital Corporation of America)

The Committee did not see the justification for a universal screening for hyperbilirubinemia since the condition is rare and the screening is costly. In addition, while the American Academy of Pediatrics (AAP) recommends a systematic assessment of risk screening before discharge, neither the AAP nor the U.S. Preventive Services Taskforce (USPSTF) recommend a universal blood screening. The measure developer stated that a visual diagnosis of this condition is not valid, and that this measure is useful to ensure that a health system has functioning protocols for testing newborns, training providers, and contacting patients for follow-up. Committee members would like to see a study showing the importance of screening at discharge, including the consequences of false positive screening results. After extensive discussion on testing methods and prevalence, the Committee decided this measure did not pass the importance criteria.

1417	**Yes**	**No**
Importance	1	15

1351: Proportion of infants covered by newborn bloodspot screening (HRSA)

This population-level measure aligns with the Healthy People 2020 goals for newborn screening, as well as the Secretary's Advisory Committee on Heritable Disorders, Bright Futures, and the Affordable Health Care Act Prevention Guidelines. The measure also meets state screening requirements (including allowing a parental waiver to opt out) and includes a minimum of 26 disorders screened as established by state law. While the Maternal and Child Health Bureau (MCHB) version of this measure has been used for 20 years, the submitted measure has not been tested in this format, nor has it previously been tied to birth certificates. The Committee members were concerned about the lack of testing for this measure, and the potential health and financial impacts of allowing opt-outs. In addition, one Committee member raised concerns about confidentiality and genetic discrimination, but as the collected information is covered under the Health Insurance Portability and Accountability Act (HIPPA), the group decided this was not a concern.

1351	**Yes**	**No**		
Importance	17	0		
	Completely	**Partially**	**Minimally**	**Not at all**
Scientific Acceptability	7	10	0	0
Usability	8	9	0	0
Feasibility	8	9	0	0
	Yes	**No**	**Abstain**	
Recommend for Endorsement	16	0	1	

1403: Newborn bloodspot screening (NCQA)

The Committee was very concerned that this measure assesses whether the bloodspot screening was performed at six months instead of within a few weeks after birth. As the purpose of the measure is to assess the transfer of results of the hospital testing to the primary care outpatient provider, the Committee was concerned since feasibility relies on written chart abstraction (data may be difficult to find) and electronic health records (EHRs) would need a dedicated field. The Committee also questioned whether the lack of newborn testing is captured, what happens when a child shifts between providers, and how the state knows where to send the results. Committee members were advised that states typically have well-organized systems for immediate follow-up of the rare abnormal result. In addition, the measure is not harmonized with other similar measures that use the concept of a medical home and the denominator is not well specified. The developer explained that while the screening should happen right away, the measure is tied to a greater framework of well-child care that identified six months as a key milestone age, and that it was more feasible to collect this data at six months. The developer also explained that the denominator should be viewed as addressing system-level issues.

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1403	Yes	No	Abstain	
Importance	15	0	2	
	Completely	Partially	Minimally	Not at all
Scientific Acceptability	0	7	10	0
Usability	0	9	8	0
Feasibility	0	1	16	0
	Yes	No	Abstain	
Recommend for Endorsement	0	15	2	

1397: Sudden Infant Death Syndrome counseling (NCQA)

While the Committee agreed Sudden Infant Death Syndrome (SIDS) counseling is important, they raised a number of concerns about this measure, including: the lack of reliability testing; that it is not stratified by disparities; and that the measure description includes "follow-up" but the measure itself only covers counseling. While the measure provides guidelines for counseling, there is no recommended tool or specification for what counseling entails. The Committee's most significant concern was timing; ideally, counseling should occur before hospital discharge, similar to when breastfeeding counseling occurs. Counseling by six months is too late. The developer explained that the six-month mark had to do with the sampling methodology but that the timeframe could be tightened to the first pediatric visit. The Committee voted that this measure passed the importance criteria, but requested that the developer revise the timing and bring it back to the Committee. The developer agreed to look at the timing and attempt to have counseling performed by hospital discharge if possible; if not, then by the first pediatric visit.

1397	Yes	No	Abstain
Importance	13	0	2

1401: Maternal depression screening (NCQA)

The Committee agreed this is an important issue with long-term implications for the health and development of the child and the mother. The Committee's main concern with this measure was who is responsible for screening mothers—pediatricians, OB/GYNs, or primary care providers. The Committee was concerned that a lack of clarity may lead to a duplication of services, or worse, no screening because everyone assumes the responsibility is someone else's. In addition, psychological issues have the added complication that providers need informed consent from patients in order to share this information with responsible parties. The developer suggested that all providers are responsible for screening. The Committee asked if there was evidence that screening leads to effective treatment, and noted that the USPTF has given depression screening a B rating. The Committee discussed the link between screening and the outcome (treatment, etc.) and expressed concern that there is no system in place to automatically treat women who are diagnosed with depression, and that mental health services are pricey and difficult for many to access. The developer indicated that these facts explain why the measure is only about

screening, and does not include follow-up. There was concern about "stressing the pediatric system" with this type of measure if there is not proper infrastructure to address abnormal screens. Several Committee members strongly recommended the measure in part because it would lead to a better understanding of how many women have maternal depression, and could therefore push the health industry to provide adequate care services and the development of more effective treatment and intervention programs. Due to lack of services, many pediatricians currently become de facto mental health providers. The Committee decided that as a child health measure, the issue of importance is how the child is impacted by the diagnosis, and that screening for depression should be part of an environmental screen that includes other problems, similar to lead screening. In response to questions, the developer did not address instances when the caregiver is not the mother even though they had discussed including this in the exclusion criteria but deemed it unnecessary. A Committee member asked if it was possible to perform this measure without chart review, but the developer explained they had considered that but overruled it since the codes available were not specific enough.

1401	**Yes**	**No**		
Importance	18	0		
	Completely	**Partially**	**Minimally**	**Not at all**
Scientific Acceptability	2	15	1	0
Usability	0	14	4	0
Feasibility	0	12	5	0
	Yes	**No**	**Abstain**	
Recommend for Endorsement	17	1	0	

Hearing Screening Measures

The following measures of hearing screening were initially reviewed by a Hearing and Vision Technical Advisory Panel (TAP) with expertise in hearing screening. The TAP provided initial ratings of the sub-criteria. The Appendix contains the TAP comments and ratings of the sub-criteria.

1354: Hearing screening prior to hospital discharge (EHDI-1a) (Centers for Disease Control and Prevention, CDC)

This measure is presented in two forms—the population-level measure that has been collected and reported on for more than a decade by states and nationally by the Centers for Disease Control and Prevention (CDC) and new EHR specifications. The Committee agreed that early intervention improves developmental and social outcomes for children; this measure has typically high performance; and that appropriate follow-up is the biggest concern. The developers advised that although performance has been high in the past decade, small and rural hospitals may have trouble with this measure due to lack of equipment and trained personnel.

1354	Yes	No		
Importance	17	0		
	Comple	Partially	Minimally	Not at all
Scientific Acceptability	15	2	0	0
Usability	12	4	1	0
Feasibility	13	4	0	0
	Yes	No	Abstain	
Recommend for Endorsement	16*	0	0	

*numbers do not match in all votes because some Committee members did not vote at all times

1356: **Hearing screening refer rate at hospital discharge (EHDI-1b) (CDC)**

This new measure is the follow-up to the prior measure, 1354, and is intended to measure whether a child was automatically referred for follow-up after failing or not completing the newborn hearing screening. The Committee found the wording and definition of "refer" to be confusing. The developer explained that "refer" in this context means "fail screen." The developer explained that this measure would identify problems with the screening protocols or the machines. The Committee concluded that this was a quality control measure and not a performance metric.

1356	Yes	No
Importance	1	15

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

The developer advised that hearing screening within 30 days is CDC's national objective and that the rate of newborns who are not screened varies by state and may be as high as six percent. Data are collected nationally though the state-level data are governed by local legislation. The denominator population includes all babies born within a practice. The Committee wanted to know who is responsible for ensuring that the screen is completed. The developer responded that the hospital is generally responsible for completing the screening, but this does vary by state, and the primary care physician (PCP) is usually involved. The developer clarified that the measure includes children who are born outside the hospital.

1357	Yes	No		
Importance	16	1		
	Completely	Partially	Minimally	Not at all
Scientific Acceptability	1	16	0	0
Usability	0	15	2	0
Feasibility	0	7	9	0
	Yes	No	Abstain	
Recommend for Endorsement	15	2	0	

1358: Infants identified with risk factors for hearing loss within the medical home (EHDI-2a) (CDC)

This new, untested EHR measure is one in a group of measures addressing hearing screening and follow-up. The developer clarified that this measure aims to identify children who originally passed a screen who have progressive or late onset hearing loss and that the Joint Committee on Infant Hearing named this as an important area and recommended that all children with certain risk factors be referred for follow-up. Committee members questioned how well risk factors identify infants that should be evaluated. The Committee was not familiar with the standardized tools for hearing loss listed in the document, and thought that they may not be used regularly by PCPs. They were concerned about the usability of the measure, since it depends on picking up information that is actionable, and whether the data is easily identifiable within the chart. They also noted that the time window for the measure varies and were confused about the target age range.

1358	Yes	No
Importance	1	15

1359: Infants identified with risk factors for hearing loss and have an audiological diagnosis (EHDI-2b) (CDC)

The developer withdrew this measure at the meeting because it is the follow-up to the previous measure, 1358.

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

Similar to measure 1354, this is a population-level measure that has been reported by states and nationally for more than a decade. The measure specifications also include a new EHR version. The Committee liked that this measure addresses follow-up after screening.

1360	Yes	No		
Importance	15	0		
	Complete	Partially	Minimally	Not at all
Scientific Acceptability	15	2	0	0
Usability	14	2	0	0
Feasibility	16	1	0	0
	Yes	No	Abstain	
Recommend for Endorsement	17	0	0	

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

The measure developer advised the Committee that this measure is intended to focus on children with permanent hearing loss. While the title states “intervention,” it actually means referral to services. The Committee was interested in follow-up actually occurring rather than a referral being made. The developer explained that the Health Insurance Portability and Accountability

Act (HIPPA) legislation makes it difficult to get information about referrals, so that follow-up can take longer than it should. The ideal is that infants are screened within one month of birth, diagnosed by three months, and interventions are in place by six months. One Committee member was concerned about the burden of reporting on a large number of measures on a similar topic; the developer explained they are developing EHR codes to avoid undue burden on the providers.

1361	**Yes**	**No**		
Importance	17	0		
	Completely	**Partially**	**Minimally**	**Not at all**
Scientific Acceptability	1	15	0	0
Usability	6	9	2	0
Feasibility	0	15	2	0
	Yes	**No**	**Abstain**	
Recommend for Endorsement	15	2	0	

1362: Referral to intervention within 48 hours (EHDI-4b) (CDC)

The Committee was concerned that 48 hours may not be a realistic amount of time for a referral to be completed, particularly if the original appointment was on a Friday afternoon. Concerns were raised about accountability and the possibility that the differing standards for children under six months could confuse providers. They were curious why diagnosis could take up to three months, but intervention needed to happen so quickly. The developer explained federal legislation requires that a referral be made within 48 hours, and then evaluation must be completed within 45 days, according to the Individuals Disabilities Education Act (IDEA). An audiologist should make a diagnosis, send a report to the PCP, and make a referral to a specialist within 48 hours.

1362	**Yes**	**No**	**Abstain**	
Importance	9	6	1	
	Completely	**Partially**	**Minimally**	**Not at all**
Scientific Acceptability	0	9	6	0
Usability	0	7	8	0
Feasibility	3	4	10	0
	Yes	**No**	**Abstain**	
Recommend for Endorsement	3	11	2	

1402: Newborn hearing screening (NCQA)

The developer clarified that this measure assesses the transfer of information about hearing screening from the hospital to the PCP. The Committee was concerned that this measure specifies screening by six months of age; they felt that screening by three months would be more appropriate. The developer explained that they had tested the measure at three and six months, and the labor and delivery discharge summary is where this screening data would be captured.

They also explained they had worked with the CDC to ensure this measure is harmonized with the other hearing screening measures. The developer offered to change the specifications to three months if the Committee thought that would be a stronger measure. The Committee voted on the condition that the measure specifications be changed.

1402	Yes	No		
Importance	17	0		
	Comple	Partially	Minimally	Not at all
Scientific Acceptability	7	9	1	
Usability	4	13	0	
Feasibility		12	4	
	Yes	No	Abstain	
Recommend for Endorsement	17	0		

Developmental Screening

1448: Developmental screening in the first three years of life (Child and Adolescent Health Measurement Initiative, CAHMI)

This measure identifies those at risk for developmental delays, and is intended for use at the population (state) level. The numerator is specified for either claims or medical chart data. The developer collaborated with NCQA to harmonize this measure with their autism screen measure; although developmental screening may include autism screening, it does not include a specific tool for autism.

1448	Yes	No		
Importance	16	0		
	Completely	Partially	Minimally	Not at all
Scientific Acceptability	0	15	1	0
Usability	0	16	0	0
Feasibility	0	13	3	0
	Yes	No	Abstain	
Recommend for Endorsement	15	1	0	

1399: Developmental screening by 2 years of age (NCQA)

This measure addresses developmental screening and follow-up between 6 months, 12 months, and 2 years of age. It is harmonized with and complimentary with CAHMI measure 1448, although 1448 is specified at the health plan or population level and 1399 is specified at the provider level. This measure is exclusively based on chart review. The developer explained that the measure submission form needed some corrections, and that it did not clearly explain that care can be provided by mid-level providers (i.e., nurse practitioners) as well as physicians. One Committee member suggested that the measure be expanded to age three, because age two is too young to pick up delays in some children, such as speech delays that can be difficult to pick up in immigrant children who may be learning multiple languages. The Committee asked about

excluding patients who are already enrolled in early intervention programs. The developer explained that it would be difficult to exclude patients in intervention programs, due to the challenges in capturing data or poor documentation but said they could be an "exception." The developer explained the difference between *exclusion* and *exception*: an exclusion is never appropriate in the denominator but an exception may be appropriate some of the time. The further explained that the age ranges chosen were based on a comprehensive set of services that should be provided by age two.

1399	**Yes**	**No**	**Abstain**	
Importance	13	0	1	
	Completely	**Partially**	**Minimally**	**Not at all**
Scientific Acceptability	0	13	1	0
Usability	0	14	1	0
Feasibility	0	14	1	0
	Yes	**No**	**Abstain**	
Recommend for Endorsement	13	0	2	

1341: Autism screening (NCQA)

A multi-stakeholder group worked with NCQA to develop this measure. One Committee member liked this measure because this type of screening gets children "in the system" so they can be monitored and followed up appropriately; however, another Committee member was concerned that while the screen was well defined, the follow-up was not. The Committee agreed that this measure is important, but the "Achilles' heel of autism" is the lack of clear evidence on the best way to treat it once a child screens positively, and the link of screening to outcome is weak. The Committee raised a number of concerns, including that the measure did not recommend a single tool but instead a list without any guidance on the pros and cons of each tool; that there is no information on disparities; that screening by age two is too early to catch all cases; and that the burden of chart review is a feasibility problem. In addition, the Committee was concerned about the lack of documented reliability testing, and validity testing was simply face validity by an expert panel. The developer explained that the measure should read "screening with standardized tool" and should not include "follow-up," and offered to update the measure form accordingly. They also explained that they listed tools cited by the American Academy of Pediatrics, considering the cost of the tools and their availability in the recommendations, and they offered to provide information about the sensitivity and specificity of the tools that had not been detailed in the form. Finally, they explained that the Bright Futures guidelines recommend a screen between 18 and 24 months. The child psychiatrist on the Committee explained that currently the autism diagnosis criteria are still poorly specified, and the existing evidence is weak. The evidence for the measure was primarily drawn from the autism spectrum disorder literature because of the lack of autism specific evidence, and she suggested that the measure is premature due to this lack of evidence and the need for a better global system.

1341	Yes	No		
Importance	11	4		
	Completely	**Partially**	**Minimally**	**Not at all**
Scientific Acceptability	0	2	6	7
Usability	0	0	7	6
Feasibility	0	4	10	0
	Yes	**No**	**Abstain**	
Recommend for Endorsement	2	13	0	

1396: Healthy physical development by 6 years of age (NCQA)
1512: Healthy physical development by 13 years of age
1514: Healthy physical development by 18 years of age

Similar to many other measures submitted by this developer, these were submitted as three separate measures on one form for three age bands. The Committee agreed that every well-child visit should document body mass index (BMI), and that failing to talk to parents about abnormal weight is a problem. The Committee agreed that providers are missing opportunities to address the growing obesity problem. However, the Committee was unclear on the intent of this measure—increasing provider awareness or use of services? They were unsure whether counseling can affect the BMI outcome and were uncomfortable with the counseling requirements (including the definition of counseling), particularly since counseling is notorious for poor documentation. Committee members thought starting at age six is too late and the measure should start at age two or three. They also expressed concern with the four-part complex numerator and thought it would be make the feasibility challenging. The developer explained that each measure includes four separate rates (BMI assessment, nutrition counseling , physical activity, and screen times); all children are intended to be included in the counseling, not just those that are overweight. The four rates are intended to be computed separately so that a physician could pass some parts of the measure but not fail if they did not complete all four sections. The Committee and the developer agreed that the testing of the measure showed a selection bias; the samples came from a group that is motivated to improve quality and will score better than an average practice. The Committee preferred a measure in which BMI is measured every year, and an interpretation noted in the chart (healthy or unhealthy BMI), and that counseling be removed from the measure. The age bands would remain the same. The Committee voted on the importance of the three measures in one vote, and then agreed to defer the measures to allow the developer time to consider suggested changes.

1396, 1512, 1514	Yes	No
Importance	13	3

Preventive Care

1392: Well-child visits in the first 15 months of life (NCQA)
1516: The percentage of members 3-6 years of age who received one or more well-child visits with a PCP during the measurement year

The Committee wanted wording changed to include providers beyond physicians, such as registered nurse practitioners (RNPs) and physician's assistants (PAs); the developer explained that the measure is intended to include all types of primary care practitioners. The Committee also suggested using the term "medical home" to better harmonize with other measures. Committee members noted that this visit count measure conforms to the American Academy of Pediatrics' (AAP) and Bright Futures recommendations; it does not allow much flexibility or room for innovation in delivering well-child care. This measure is intended to be used at the health-plan level, for both commercial and Medicaid plans.

1392 and 1516	Yes	No		
Importance	16	0		
	Complete	Partially	Minimally	Not at all
Scientific Acceptability	5	9	2	0
Usability	6	9	1	0
Feasibility	2	12	3	0
	Yes	No	Abstain	
Recommend for Endorsement	14	2		

1411: Adolescent well care (NCQA)

The Committee agreed that adolescents require preventive medical services, but voiced a number of concerns about this measure, ranging from the lack of reliability testing; a lack of clarity on how to calculate the measure's algorithm; typographical errors in the denominator that change the meaning; whether this can be measured using claims-based data (do any of the codes represent "comprehensive visits" and how is that defined? Or do codes simply represent annual checkups?); no evidence that regular checkups lead to better outcomes; and problems with harmonization at the upper age limit of 18 versus 21 (the AAP defines adolescent differently than health plans). In addition, the Committee was concerned about holding doctors accountable for teenage behavior and non-compliance. The developer presented this measure as an access-to-care measure, and explained that it is a HEDIS measure using both medical record and claims data in both commercial and Medicaid populations. The intent is to continue the well-child care visits in the earlier measure (1392) to ensure that children are seen every year.

1411	Yes	No	Abstain
Importance	1	14	1

1390: Child and adolescents' access to primary care practitioners (NCQA)
This population-level measure is intended to measure whether or not children and adolescents have access to primary care practitioners—emergency visits do not count. The Committee was concerned that health plans and providers could be noncompliant when, ultimately, whether or not a child visits the doctor is out of their control. They also discussed, again, the issue of who is a PCP. While Committee members liked the intent of the measure, they thought that it is more accurately about utilization, not access.

1390	Yes	No		
Importance	7	7		
	Completely	Partially	Minimally	Not at all
Scientific Acceptability	0	3	10	1
Usability	0	5	9	0
Feasibility	11	2	1	0
	Yes	No	Abstain	
Recommend for Endorsement	4	10	0	

1353: Preventive services for children and adolescents: Children and adolescents on time with recommended immunizations (Institute for Clinical Systems Improvement)
This process measure addresses immunizations; it is unique among the vaccination measures because it addresses whether immunizations were received on time, rather than whether they were received by a certain age. A member of the Committee thought this measure was important because it helps combat myths about getting immunizations when children present for primary care; however, another member stated that it contained outdated exclusion criteria (for example, males are excluded from the HPV vaccination). Another member was concerned that it would be impossible for providers with new patients to meet timing demands for adolescents who have not had immunizations. The Committee thought the measure was unclear about exactly what "on time" means in this context, and was not sure the measure had been tested. The developer explained that organizations are using this data, but they have not examined the results; they are willing to do so if the Committee requests it. In addition, they stated that the measure is due to be updated in early 2011. The Committee voted to defer the measure until the new version is available, and requested that that submission specify more clearly how the measure would be calculated.

1404: Lead screening (NCQA)
The Committee noted that recommendations on lead screening are rapidly changing, and that NQF had reviewed this measure previously. This measure covers Medicaid children specifically. The Committee thought that while this measure holds health plans accountable, they have a limited ability to improve children's scores, since the real issue is lead abatement. While some states, such as New York, require lead screening, others do not, and lead is not an issue in all areas of the country. The CDC recommendations are to screen in areas where a problem exists.

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1404	Yes	No	Abstain
Importance	0	15	1

Mental and Behavioral Health

1394: Depression screening by 13 years of age (NCQA)
1515: Depression screening by 18 years of age
The AAP recently released a Mental Health Toolkit that supports primary care pediatricians appropriately treating adolescent depression, attention deficit hyperactivity disorder (ADHD), and other mental health disorders and are working to provide pediatricians with the tools they need to provide this kind of care, given the lack of mental health professionals. The Committee raised a number of concerns with this measure, including an inconsistency between the "target age range" and description of numerator (through age 18 or up to age 18?); whether it is useful to detect depression if there is no follow-up available; that the act of screening is not operationalized; that the evidence provided for importance was not entirely pertinent (some studies documented general mental health, others other mental health issues); and that reliability was not established, and the validity testing was limited to face validity. The developer explained that screening should be completed within the measurement year or the year prior. In field testing, they looked at the use of a standardized tool but did not find one (the Committee disagreed with the developer about this). The developer further explained that their measure advisory panel felt this was an important topic and wanted to get people to start documenting conversations about depression, even if no standardized tool exists yet; they see these measures as the beginning of being able to push the use of a standardized tool. The Committee recommended that the measures examine whether there was any documentation or inquiry about a patient's mental health status, and was the patient's mental health status screened with a standardized tool. The Committee deferred the measures to allow the developer time to assess the possibility of these changes.

1364: Child and adolescent major depressive disorder: Diagnostic evaluation (AMA PCPI)
This clinician-level measure uses DSM-IV criteria to diagnose major depressive disorder (MDD) in children and adolescents. While the measure lacks a treatment step, it is the first step to diagnosis and referral for counseling or prescription medication. One Committee member mentioned that the DSM-V is due to be released in 2013 and asked what the implications for the measure are if there are changes. NQF staff explained that an ad hoc review could be facilitated if/when new evidence is released. The Committee was concerned that the current DSM does not specify symptoms for children clearly enough, that the levels of scientific evidence for DSM-IV criteria vary, and there is a performance gap because not all psychiatrists use the DSM-IV criteria; however, the developer disagreed with the criticisms of the DSM-IV and said its criteria for depression had been validated in young children.

1364	Yes	No		
Importance	14			
	Completely	Partially	Minimally	Not at all
Scientific Acceptability	0	13	1	0
Usability	2	11	1	0
Feasibility	0	9	5	0
	Yes	No	Abstain	
Recommend for Endorsement	11	3	1	

1365: Suicide risk assessment (AMA PCPI)

This process measure is intended to measure whether suicide risk assessment was completed by providers, related to measure 1364. The Committee noted that the citations were based on adult studies, not adolescents, and found the linkages to better outcomes were lacking; in most suicides, the individual has seen a mental health professional in the last three weeks. Committee members expressed concerns about possible unintended consequences: what are legal implications for a physician that documents suicide risk but does not refer/follow up? Additionally, the assessment of suicide was not clearly specified, which makes standardization difficult—the Committee thought the measure needed clarification about screening tools for suicidal ideation and who is supposed to screen (i.e., mental health professional, emergency room (ER) physicians, etc.), and they wanted further information about how the measure should be used with EHRs. In response, the developer agreed the evidence was slim. They explained they had not specified a tool but instead intentionally left it broad so the provider could cater to the needs of the patient; they thought the best tool was discussion. Since this measure has not been tested, it is only eligible for time-limited endorsement.

1365	Yes	No		
Importance	14	0		
	Completely	Partially	Minimally	Not at all
Scientific Acceptability	0	5	6	3
Usability	0	5	7	2
Feasibility	0	0	13	1
	Yes	No	Abstain	
Recommend for Endorsement	7	6	1	

Given the lack of consensus, the Committee decided to request more information from the developer and then revisit the measure. The developer was asked to better specify "suicide risk," clarify how they will document the results, and provide additional information to support the measure's usefulness.

1406: Risky behavior assessment or counseling by age 13 years (NCQA)
1507: Risky behavior assessment or counseling by age 18 years

The Committee questioned whether these measures have been adequately tested, and thought that the sample was too small and may not have been varied enough. They also expressed concerns that these measures require adolescents to answer honestly, and thought that a paper screen may provide more honest results than a face-to-face screen. The developer explained that there are four rates included in these measures. Additionally, these measures were tested in the field as part of the composite measure, so the individual components were not tested alone. The Committee requested additional information on reliability testing.

1406, 1507	**Yes**	**No**		
Importance	14	0		
	Completely	**Partially**	**Minimally**	**Not at all**
Scientific Acceptability	0	8	6	0
Usability	0	6	8	0
Feasibility	0	8	6	0
	Yes	**No**	**Abstain**	
Recommend for Endorsement	13	1	0	

Dental Care

1419: Primary caries prevention intervention as part of well/ill child care as offered by primary care medical providers (University of Minnesota)
This measure evaluates how well primary care medical providers are providing preventive fluoride treatment for prevention of dental caries, at either the provider or health plan level. The Committee thought this measure would be both feasible and useful for encouraging more attention to dental care. Since many dentists do not take Medicaid patients, this measure addresses the need for increased access to preventive dental care. While the measure is currently in use in Minnesota, the Committee found the testing information provided to be limited and requested more information from the developer. They were confused by the denominator statement and the algorithm for calculation. The developer provided some verbal clarification and agreed to follow up after the meeting with a revised denominator. In addition, some were concerned about holding a primary care provider accountable for dental care and about the long-term strategy for holding dentists accountable for this care. They were also concerned that the target age was too large; many states do not support funding for care through age 20. The measure was deferred to allow the developer to clarify the numerator and denominator.

1405: Oral health access (NCQA)
This measure is part of NCQA's chart review composite measure. The Committee thought the target population would be too difficult to define for a provider-level measure; the developer agreed this was a challenge. They were also concerned about attribution, and suggested that the measure needed to be either expanded or limited.

1405	Yes	No		
Importance	15			
	Completely	**Partially**	**Minimally**	**Not at all**
Scientific Acceptability	0	11	5	0
Usability	2	5	9	0
Feasibility	0	8	8	0
	Yes	**No**	**Abstain**	
Recommend for Endorsement	7	8	0	

1388: Annual dental visit (NCQA)

This HEDIS measure uses claims data, and while it is currently in use, reliability testing information was not presented. While the Committee saw this as an opportunity for health plans to work with dental providers, they were concerned about holding health plans accountable for the measure, since they cannot control whether a child sees a dentist; they can only make recommendations. The developer clarified that this measure only includes children with insurance coverage.

1388	Yes	No		
Importance	15			
	Complet	**Partially**	**Minimally**	**Not at all**
Scientific Acceptability	8	8	0	0
Usability	0	15	1	0
Feasibility	4	11	1	0
	Yes	**No**	**Abstain**	
Recommend for Endorsement	14	1	1	

Emergency Care

1350: Emergency room visits (CAHMI)

This measure was submitted as a population measure collected at the state level and can be stratified. Emergency room (ER) visits are felt to be a proxy for poor quality of care. The measure is based on the National Survey of Children's Health and was included in the 2003 survey and will be on the 2011 survey, but was not collected in 2007. The Committee had several concerns about this measure, including that it only measures if the visit occurred and not if it was appropriate or not; that testing only included face validity; that reliability is subject to recall bias, since the measure is based on parent report; and that it may face feasibility issues due to cost. One Committee member stated that community health experts were especially interested in this measure as a way of measuring support systems within the community that act to decrease unnecessary ER visits (such as school nurses). The Committee agreed that the measure could provide a crude estimate over time to see if health reform is impacting ER visits, and could be interesting to collect, but ultimately they voted that this measure did not meet the importance criteria.

1350	Yes	No
Importance	5	10

1381: Asthma emergency department visits (Alabama Medicaid Agency)
This measure examines claims data at the population level, but the developer is interested in moving towards the provider level as it has already been used for quality improvement at the provider level. The Committee noted that the recent Child Health Outcomes project had recommended that a population-level asthma admission rate measure would be complimentary to this measure. The Committee liked that this measure looked at young children, and that the measure can be stratified by age. However, they were concerned that it is possible to misdiagnose viral wheezing as asthma, particularly in children under 5, and that this may pose a risk to validity. The developer responded that they had discussed this issue in developing the measure and that the intent was to capture as many asthma patients visiting the ER as possible. This measure was originally specified for ages 1-21, while the asthma admission measure is for ages 2-17; the developer agreed to revise the denominator to start at age 2 in order to harmonize the measure. The Committee voted to recommend the measure with the age harmonization.

1381	Yes	No		
Importance	14	1		
	Completely	Partially	Minimally	Not at all
Scientific Acceptability	0	12	3	0
Usability	2	10	3	0
Feasibility	11	4	0	0
	Yes	No	Abstain	
Recommend for Endorsement	12	3		

Vision Screening

1398: Vision screening by 6 years of age (NCQA)
1511: Vision screening by 13 years of age
1513: Vision screening by 18 years of age
The Committee reviewed the Hearing and Vision TAP's discussion of this measure. The Committee was concerned that this measure uses standard screening tools, which have low sensitivity (a high false negative rate) and may miss children who need follow-up. The measure has three age bands to fit within the other comprehensive well-child visits measures from NCQA, and is intended to address changes in vision that occur during childhood and adolescence, but the Committee thought the greatest impact was catching vision problems in young children (under age six).

1398: Vision screening by 6	Yes	No		
Importance	13	0		
	Complete	Partially	Minimally	Not at all
Scientific Acceptability	0	4	9	0
Usability	0	11	1	0
Feasibility	0	12	0	0
	Yes	No	Abstain	
Recommend for Endorsement	12	1		

The Committee unanimously agreed that the measures for vision screening at ages 13 and 18 years did not meet the importance criteria.

1412: Pre-school vision screening in the medical home (American Academy of Pediatrics)
As with the NCQA vision screening measure (1398), the Committee thought the validity of the recommended screening tests was still an issue. In addition, there were no current procedural terminology (CPT) codes to identify different types of vision screening. The TAP Chair stated that the TAP had preferred this measure due to the target of screening by age five instead of age six, but still had concerns, including that it was not clear how to capture patient or parent refusal of screenings, which is not included in the exclusion criteria, and whether or not the medical home was well described. In addition, this measure has not been fully tested.

1412	Yes	No		
Importance	13	0		
	Completely	Partially	Minimally	Not at all
Scientific Acceptability	0	9	2	0
Usability	0	10	2	0
Feasibility	2	9	0	0
	Yes	No	Abstain	
Recommend for Endorsement	12*	0		

*numbers do not match in all votes because some Committee members did not vote at all times

Following the vote, the Committee compared the two vision screening measures, 1398 (NCQA) and 1412 (AAP) to determine best in class. The differences between the two measures were clarified, including different exclusion criteria, the reference to the medical home, the age specifications, and the follow-up or lack thereof. The TAP had preferred the AAP measure. One Steering Committee member felt the NCQA measure was better specified and preferred it. Another Committee member preferred the AAP measure because it is seated in the medical home and he thought it meant children were less likely to fall through the cracks.

	1398 (NCQA)	1412 (AAP)	Abstain
Recommend for Endorsement	2	9	2

PUBLIC COMMENT

- A developer advised that the Secretary's Advisory Committee on Heritable Disorders will be reviewing evidence on universal screening for hyperbilirubinemia in January.
- Another developer requested that the National Center for Health Statistics report include a recommendation that all states use the 2003 updated national birth certificate.

NEXT STEPS

Three conference calls are scheduled to discuss remaining measures and re-evaluate those measures that were deferred.NQF staff will follow up with the measure developers to respond to suggestions from the Committee. NQF staff will draft a meeting summary and send it to the Steering Committee for approval before posting it to the NQF web site.

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APPENDIX

CHILD HEALTH QUALITY MEASURES 2010
HEARING AND VISION TECHNICAL ADVISORY PANEL (TAP)
SUB-CRITERIA EVALUATION

Vision Measures

Measure 1398 - Vision Screening (NCQA)

IMPORTANCE TO MEASURE AND REPORT					
	Completely	Partially	Minimally	Did Not Meet	
1a Impact	0	4	1	0	
1b Gap	1	3	0	0	
1c Relation to Outcomes	0	2	3	0	

- Evidence provided in document clearly shows that impact would be much greater if screened at younger age. Also does not address which screening test to use, which likely will result in poorer tests being used, greatly reducing sensitivity and any impact. Does not address very poor follow-up on screenings which will reduce outcome of increased health.
- Important to report at ~ 6 years. Less important at 13 and 18 years
- Must better define screening; the three age cohorts make it difficult to operationalize this measure and is not convincing that the stated impact will be realized as such.
- This measure would be better if subdivided as the goals at different ages differ. Strength is the large number of potential positives. The impact of treatment is not known on a population basis. The lifelong impact of that intervention on quality of life is also not known, but consensus is that it is great.
- Strength: will advance vision screening reporting
  Weakness: lacks specificity

SCIENTIFIC ACCEPTABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
2a Specs	1	1	3	0	0
2b Reliability	1	2	1	1	0
2c Validity	1	2	2	0	0
2d Exclusions	0	1	2	0	2
2e Risk Adjustment	0	0	2	0	3
2f Meaningful Differences	1	1	3	0	0
2g Comparability	1	1	1	1	0
2h Disparities	0	1	1	2	1

- Specificity and testing good, but relies on chart review.
- The measures are screening and thus the weakness lies between screening and evaluations, which may realize the impact stated.
- Numerator needs actual time frame of one or two years as it is listed differently.
  Some of the discussion was about how screening was done. That appears to be beyond the main scope of this request to monitor or track performance of screening. A minimum type of testing could be added to the spec. Exclusions should include children receiving care in the last year, which of course makes this measure difficult to accomplish electronically.

USABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable

3a Distinctive	1	2	2	0	0
3b Harmonization	0	1	0	2	2
3c Added Value	0	1	2	1	1

- Low sensitivity of screening will result in majority of children with vision problems being passed inappropriately and given false sense of "having good vision." Most providers of this care do not understand this significant issue and it is not addressed at all in this measure.
- 6 years of age result has more value than 13 and 18 years of age.
- See above comments, the major issues listed above and per the TAP meeting preclude large usability of such.
- Need to harmonize first part with 1412.
  Data are missing.

FEASIBILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
4a Data a by-product of care	2	1	2	0	0
4b Electronic	0	2	2	1	0
4c Exclusions	0	1	3	0	1
4d Inaccuracies/ errors	1	0	3	1	0
4e Implementation	0	1	4	0	0

- Major weakness is need for chart review with inherent cost and inaccuracy. Data could be collected electronically from current CPT.
- Lack of EHR capability to collect the data significantly affects the feasibility of measuring compliance, etc.
- The problem will be how to find the exclusions—the main participants can be detected with normal claims.
- Strengths: none
  Weaknesses: Questions exist regarding compliance with chart review procedures

Measure 1412: Pre-school vision screening in the medical home (AAP)

IMPORTANCE TO MEASURE AND REPORT					
	Completely	Partially	Minimally	Did Not Meet	
1a Impact	1	4	0	0	
1b Gap	2	2	0	0	
1c Relation to Outcomes	1	3	1	0	

- Need to increase screening and outcome of early detection important
- USPTF is B largely because no outcomes study of interventions that were planned due to the results of screening.

SCIENTIFIC ACCEPTABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
2a Specs	0	4	1	0	0
2b Reliability	0	1	1	3	0
2c Validity	1	4	0	1	
2d Exclusions	0	0	3	2	0
2e Risk Adjustment	0	0	0	3	2
2f Meaningful Differences	0	0	1	4	0

2g Comparability	0	0	0	4	1
2h Disparities	0	0	1	4	0

- Indicate use of two worst screening methods with 70% under referral rates. No mention of this. There is significant disparity of care in minority populations, which is not mentioned.
- Testing may have been done outside the medical home. Specification would be more useful if age was specified as from fourth to sixth birthday. Exclusions not valid and make measurement more difficult. Application did not indicate any testing
- Why does the numerator specify medical home—could some other surrogate performance also impact numerator—for instance a child currently under care? Need discussion of what would be important difference in provision. Measure testing from claims data needs to be demonstrated.
- Too much missing data to determine

USABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
3a Distinctive	1	1	2	1	0
3b Harmonization	0	2	0	3	0
3c Added Value	0	2	0	2	1

- Under referral rate results in significant misleading of health status of vision in these children. Gain is about care for 10% of affected with misdiagnosis of 70%.
- Incomplete application
- Missing data prevents judgment.

FEASIBILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
4a Data a by-product of care	1	3	0	1	0
4b Electronic	0	3	0	2	0
4c Exclusions	0	1	2	1	1
4d Inaccuracies/ errors	1	2	1	2	0
4e Implementation	0	1	1	2	0

- Absolutely should not exclude difficult-to-screen children as they are very likely to have vision problems.
- Incomplete application
- Missing data prevent judgment.

Hearing Measures

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

IMPORTANCE TO MEASURE AND REPORT					
	Completely	Partially	Minimally	Did Not Meet	
1a Impact	4	0	0	0	
1b Gap	3	1	0	0	
1c Relation to Outcomes	3	1	0	0	

- The magnitude of the gap needs to be demonstrated. If one of the goals is to improve process then a deficit needs to be clearly shown.

- Strengths: Clear evidence to support that newborn hearing screening positively affects childhood language development outcomes. Weaknesses: Some hospitals in rural areas or with very small birthing rates may not participate; in addition to identification, other variables such as follow-up, timelines, quality of care also impact outcomes.

SCIENTIFIC ACCEPTABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
2a Specs	4	0	0	0	0
2b Reliability	4	0	0	0	0
2c Validity	4	0	0	0	0
2d Exclusions	2	0	0	0	2
2e Risk Adjustment	1	0	0	0	3
2f Meaningful Differences	4	0	0	0	0
2g Comparability	2	0	0	1	1
2h Disparities	2	0	0	1	1

- Clear simple measure. Used best in context of sequence of measures
- Very straightforward process driven measure
- Strengths: electronic reporting eliminates recording errors, large population database, measurement procedures straightforward; Weaknesses: potential recording errors

USABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
3a Distinctive	4	0	0	0	0
3b Harmonization	2	0	0	0	1
3c Added Value	2	0	0	0	1

Strengths: Broad acceptance by variety of health agencies (CDC, MCHB, Healthy People 2020); Weaknesses: none

FEASIBILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
4a Data a by-product of care	4	0	0	0	0
4b Electronic	4	0	0	0	0
4c Exclusions	2	0	0	1	1
4d Inaccuracies/ errors	3	1	0	0	0
4e Implementation	4	0	0	0	0

- Requires chart review. Recommended but often not included as a data element in paper charts or EHRs
- Seems they did this with chart review

Measure 1356 - Hearing screening refer rate at hospital discharge (EHDI-1b) (CDC)

IMPORTANCE TO MEASURE AND REPORT					
	Completely	Partially	Minimally	Did Not Meet	
1a Impact	3	1	0	0	
1b Gap	1	2	1	0	
1c Relation to Outcomes	1	3	0	0	

- More a measure of results than a performance measure. Can be used to detect outliers as a way of evaluating reliability of testing
- Like many hearing measures it seems important to do but exactly how this measure impacts the school aged problem is not clear beyond expert consensus. I also do not precisely understand the rationale for this one plus 1354. For instance this one is reporting those who fail the screening but is that really a measure that is needed? 1354 simply comments on completion of the test.
- Strengths: specificity

SCIENTIFIC ACCEPTABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
2a Specs	3	1	0	0	0
2b Reliability	2	2	0	0	0
2c Validity	2	1	0	0	0
2d Exclusions	1	0	1	0	2
2e Risk Adjustment	0	0	1	0	3
2f Meaningful Differences	1	1	2	0	0
2g Comparability	1	1	1	0	1
2h Disparities	0	0	2	0	2

More a measure of results than a performance measure. Can be used to detect outliers as a way of evaluating reliability of testing

USABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
3a Distinctive	2	0	2	0	0
3b Harmonization	0	1	2	0	1
3c Added Value	0	1	2	0	1

More a measure of results than a performance measure. Can be used to detect outliers as a way of evaluating reliability of testing

FEASIBILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
4a Data a by-product of care	3	0	1	0	0
4b Electronic	4	0	0	0	0
4c Exclusions	0	2	0	0	2
4d Inaccuracies/ errors	2	0	1	1	0
4e Implementation	3	1	0	0	0

- Just not sure what the gap here is that warrants all of these measures

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

IMPORTANCE TO MEASURE AND REPORT					
	Completely	Partially	Minimally	Did Not Meet	
1a Impact	4	0	0	0	
1b Gap	3	0	1	0	
1c Relation to	3	1	0	0	

Outcomes					

- This is one of a family of proposed measures to track the process breakdowns. If it can be done with electronic claims data it would seem to be okay. But I am very concerned that this measure requires linkages between inpatient and outpatient settings, which may have many data errors.
- Strengths: Clear evidence to support newborn hearing screening positively impacts childhood language development outcomes; Weaknesses: addressing populations that are least likely to return to hospital for screening (e.g., Hispanic, young, male), other variables impact outcomes such as follow-up, timelines, quality of providers.

SCIENTIFIC ACCEPTABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
2a Specs	4	0	0	0	0
2b Reliability	3	1	0	0	0
2c Validity	3	1	0	0	0
2d Exclusions	2	0	0	0	2
2e Risk Adjustment	1	0	0	0	2
2f Meaningful Differences	3	1	0	0	0
2g Comparability	2	0	0	1	1
2h Disparities	1	1	0	0	2

- Best seen as one of a sequence of measures
- Strengths: Electronic reporting eliminates most recording errors, large population base for comparison; Weaknesses: none

USABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
3a Distinctive	3	1	0	0	0
3b Harmonization	1	2	0	0	1
3c Added Value	1	1	0	0	1

Strengths: Broad acceptance by variety of health agencies (CDC, MCHB, Health People 2020)

FEASIBILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
4a Data a by-product of care	2	2	0	0	0
4b Electronic	3	1	0	0	0
4c Exclusions	1	2	0	0	1
4d Inaccuracies/ errors	3	1	0	0	0
4e Implementation	3	0	0	0	0

- Strengths: data available electronically, straightforward data collection methods/calculations, CDC-EHDI provides feedback report for states to compare results and to identify potential discrepancies.
- Weaknesses: outpatient hearing screening may not account for all infants.

Measure 1358 - Infants identified with risk factors for hearing loss within the medical home (EHDI-2a) (CDC)

IMPORTANCE TO MEASURE AND REPORT					
	Completely	Partially	Minimally	Did Not Meet	
1a Impact	2	3	0	0	
1b Gap	2	2	1	0	

1c Relation to Outcomes	2	3	0	0	

- Just not sure if there is a gap here that needs to be closed
- Strengths: clear evidence to support early identification of hearing loss results in better outcomes for language development; this tenet applies to delayed onset of hearing loss due to risk factors as well though depending on the age of onset, the expected outcomes may include other areas such as communication and educational achievement. Weaknesses: access to medical home by infants/toddlers/children may reduce effectiveness as well as medical home's ability to identify potential hearing loss.

SCIENTIFIC ACCEPTABILITY

	Completely	Partially	Minimally	Did Not Meet	Not Applicable
2a Specs	2	2	1	0	0
2b Reliability	2	2	1	0	0
2c Validity	2	1	1	0	0
2d Exclusions	0	2	0	0	3
2e Risk Adjustment	0	2	1	0	2
2f Meaningful Differences	1	2	0	0	1
2g Comparability	1	3	0	0	1
2h Disparities	0	3	0	0	2

- Does not measure what the developer intended. Does not measure whether a risk assessment was done unless a codable risk was found. Would need chart review of an element not usually included in paper chart or EHRs
- Using one data set—suggested for Hispanic patients experiencing a disparity in care delivery
- Strengths: Data collected from EHRs, measurement procedures straightforward, performance levels can be compared within states and nationally to identify potential problems; Weaknesses: does not measure appropriateness of intervention program, is face validity sufficient?

USABILITY

	Completely	Partially	Minimally	Did Not Meet	Not Applicable
3a Distinctive	1	3	1	0	0
3b Harmonization	0	3	1	0	1
3c Added Value	0	2	2	0	1

- Depends on if numerator is redefined
- Strengths: Published in AAP Recommendations for Preventative Pediatric Health Care; Weaknesses: harmonization in process but not completed

FEASIBILITY

	Completely	Partially	Minimally	Did Not Meet	Not Applicable
4a Data a by-product of care	2	1	2	0	0
4b Electronic	0	2	2	0	1
4c Exclusions	0	2	0	0	2
4d Inaccuracies/ errors	1	2	2	0	0
4e Implementation	1	2	2	0	0

- Some risk factors not captured in codes listed or codes available so will not be captured. Large discrepancy on tendency to code in this area only addressed as "pressure from local agencies." Will not allow national comparison but only local comparisons among providers.

- Internet not measurable electronically. Requires chart review of an element not often included in paper charts or EHRs
- Strengths: commitment from pertinent health organizations for this measure, audit process for quality control and identification of potential discrepancies in data; Weaknesses: potential recording errors without electronic data collection; are all infants captured in medical home data?

Measure 1359 - Infants identified with risk factors for hearing loss and have an audiological diagnosis (EHDI-2b) (CDC)

IMPORTANCE TO MEASURE AND REPORT					
	Completely	Partially	Minimally	Did Not Meet	
1a Impact	3	1	0	0	
1b Gap	1	2	1	0	
1c Relation to Outcomes	2	2	0	0	

Strengths: Audiological diagnosis is second step in 1-3-6 process and therefore required before the EDHI goals can be met. There is clear evidence that those meeting the EHDI standards have superior outcomes to those who do not; there is support from a variety of health agencies/organizations (AAP, CDC-EHDI, JCIH, USPSTF), Weaknesses: Even meeting the diagnosis goal (second step) desirable outcome dependent on quality of care and intervention services.

SCIENTIFIC ACCEPTABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
2a Specs	3	1	0	0	0
2b Reliability	2	1	1	0	0
2c Validity	1	2	1	0	0
2d Exclusions	0	1	0	0	3
2e Risk Adjustment	1	0	0	0	2
2f Meaningful Differences	2	2	0	0	0
2g Comparability	2	1	0	1	0
2h Disparities	0	1	0	1	2

- What if a patient identified never gets a diagnosis—does normal count?
- Strengths: Data collected from EHRs, measurement procedures straightforward, performance levels can be compared within states and nationally to identify potential problems; Weaknesses: does not measure appropriateness of intervention program, is face validity sufficient?

USABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
3a Distinctive	2	2	0	0	0
3b Harmonization	0	2	1	0	1
3c Added Value	1	1	1	1	0

Question 3C —missing data

FEASIBILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
4a Data a by-product of care	3	1	0	0	0
4b Electronic	2	0	0	1	1
4c Exclusions	0	1	0	0	3

4d Inaccuracies/ errors	3	1	0	0	0
4e Implementation	1	3	0	0	0
Strengths: audit process for quality control and identification of potential discrepancies; Weaknesses: electronic data reporting not available, may require additional cost to implement, limited data available from providers					

Measure 1360: Audiological evaluation no later than 3 months of age (EHDI-3) (CDC)

IMPORTANCE TO MEASURE AND REPORT					
	Completely	Partially	Minimally	Did Not Meet	
1a Impact	4	0	0	0	
1b Gap	3	0	1	0	
1c Relation to Outcomes	3	1	0	0	
Strengths: Clear evidence to support that early identification of hearing loss results in better outcomes for language development, audiological diagnosis to confirm hearing loss is critical step for early intervention; Weaknesses: access to appropriate diagnostic audiology services in some rural areas.					

SCIENTIFIC ACCEPTABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
2a Specs	4	0	0	0	0
2b Reliability	3	0	1	0	0
2c Validity	3	0	1	0	0
2d Exclusions	1	0	0	0	3
2e Risk Adjustment	1	0	0	0	2
2f Meaningful Differences	4	0	0	0	0
2g Comparability	2	0	1	0	1
2h Disparities	1	0	0	0	3

- Clear simple measure. Used best in context of sequence of measures
- Very straightforward process-driven measure.
- Strengths: electronic reporting eliminates recording errors, large population database, measurement procedures straightforward; Weaknesses: potential recording errors

USABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
3a Distinctive	4	0	0	0	0
3b Harmonization	2	0	1	0	1
3c Added Value	2	0	1	0	1
Strengths: Broad acceptance by variety of health agencies (CDC, MCHB, Healthy People 2020); Weaknesses: none					

FEASIBILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
4a Data a by-product of care	4	0	0	0	0
4b Electronic	4	0	0	0	0
4c Exclusions	1	0	0	0	3

4d Inaccuracies/ errors	3	1	0	0	0
4e Implementation	3	1	0	0	0

- Not at all certain the data collection measure is sufficiently inclusive
- Strengths: electronic data collection, audit process for quality control and identification of potential discrepancies; Weakness: potential recording errors

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

IMPORTANCE TO MEASURE AND REPORT					
	Completely	Partially	Minimally	Did Not Meet	
1a Impact	4	0	0	0	
1b Gap	3	1	0	0	
1c Relation to Outcomes	3	1	0	0	

- With all of these hearing measures there is no specific one linked to outcomes.
- Hearing loss and later school performance are linked and there is reasonable support to search for a measure of thoroughness of assessment. When does this need to be done? For instance does it have to be in the first six months of life?
- Strengths: This is the final step in the 1-3-6 process without which the goals of EDHI cannot be met; there is clear evidence to suggest those infants who meet these steps have superior language outcomes to those who do not; support from a variety of health organizations (JCIH, MCHB); Weaknesses: Even with meeting the referral to intervention goal, outcomes are dependent on the quality of the intervention, parental compliance, appropriate amplification; routine measures of early intervention benchmarks should be required to assure the goals of intervention are met.

SCIENTIFIC ACCEPTABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
2a Specs	4	0	0	0	0
2b Reliability	2	2	0	0	0
2c Validity	2	1	0	0	1
2d Exclusions	2	0	0	0	2
2e Risk Adjustment	1	0	0	0	2
2f Meaningful Differences	3	0	0	0	0
2g Comparability	2	0	0	1	1
2h Disparities	1	0	0	1	2

- Clear simple measure. Used best in context of sequence of measures
- Very straightforward process-driven measure.
- Strengths: electronic reporting eliminates recording errors, large population database, measurement procedures straightforward; Weaknesses: potential recording errors

USABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
3a Distinctive	4	0	0	0	0
3b Harmonization	2	0	1	0	1
3c Added Value	2	0	1	0	1

FEASIBILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
4a Data a by-	4	0	0	0	0

product of care					
4b Electronic	3	1	0	0	0
4c Exclusions	2	0	0	0	2
4d Inaccuracies/ errors	3	1	0	0	0
4e Implementation	3	1	0	0	0
Strengths: Electronic data collection, audit process for quality control and identification of potential discrepancies; commitment from variety of health organizations for this goal; Weaknesses: potential recording errors					

Measure 1362 - Referral to intervention within 48 hours (EHDI-4b) (CDC)

IMPORTANCE TO MEASURE AND REPORT					
	Completely	Partially	Minimally	Did Not Meet	
1a Impact	2	1	1	0	
1b Gap	2	0	2	0	
1c Relation to Outcomes	1	2	1	0	

- Definition of referral unclear—referral sent or patient seen. Referral often not recorded as a data element in EHR
- Grade B USPHTF evidence for all of the hearing measures.
- Strength: Provides continuity of care from assessment to services as required by IDEA Part C.

SCIENTIFIC ACCEPTABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
2a Specs	2	2	0	0	0
2b Reliability	1	2	1	0	0
2c Validity	1	2	1	0	0
2d Exclusions	1	0	0	0	3
2e Risk Adjustment	1	0	0	0	3
2f Meaningful Differences	1	1	1	0	0
2g Comparability	0	1	2	1	0
2h Disparities	0	0	2	0	2

- Assuming "referral" means referral sent (not patient having been seen), act of referring usually not a data element in EHRs and may require chart review
- Not at all certain if EHR data will be compatible

USABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
3a Distinctive	1	0	3	0	0
3b Harmonization	0	1	2	0	1
3c Added Value	0	1	2	1	0
To the extent data is collected accurately					

FEASIBILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
4a Data a by-product of care	1	1	2	0	0
4b Electronic	1	1	1	1	0

4c Exclusions	0	0	1	0	3
4d Inaccuracies/ errors	1	0	3	0	0
4e Implementation	1	0	3	0	0
Process of sending a referral not usually a data element in EHRs					

Measure 1402 - Newborn hearing screening (NCQA)

IMPORTANCE TO MEASURE AND REPORT					
	Completely	Partially	Minimally	Did Not Meet	
1a Impact	3	0	0	0	
1b Gap	3	0	0	0	
1c Relation to Outcomes	2	1	0	0	

- Description does not make clear that this is a care-coordination measure.
- Strength: Measurement requirement provides accountability measure at critical age. Weakness: The six month criterion is less stringent that the nationally accepted norm of one month (CDC-EHDI).

SCIENTIFIC ACCEPTABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
2a Specs	2	2	0	0	0
2b Reliability	2	2	0	0	0
2c Validity	2	1	0	0	0
2d Exclusions	1	0	0	0	2
2e Risk Adjustment	1	0	0	0	2
2f Meaningful Differences	2	1	0	0	0
2g Comparability	1	1	1	0	0
2h Disparities	2	0	0	0	1

- It was not clear that purpose is to ensure that PCP knows newborn screening result. Requires manual chart review
- 2a4—I do not understand this denominator spec. Why does 12 months enter in here if the exams are needed by 6 months of age?

USABILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
3a Distinctive	4	0	0	0	0
3b Harmonization	1	0	1	1	1
3c Added Value	1	1	1	1	0
N/A					

FEASIBILITY					
	Completely	Partially	Minimally	Did Not Meet	Not Applicable
4a Data a byproduct of care	2	1	1	0	0
4b Electronic	1	1	1	1	0

4c Exclusions	1	0	0	3	0
4d Inaccuracies/ errors	1	1	1	0	0
4e Implementation	1	1	2	0	0
• Requires chart review. Recommended but often not included as a data element in paper charts or EHRs • Seems they did this with chart review					