National Quality Forum

National Voluntary Consensus Standards for Patient Outcomes
Child Health

Proposed Measures to be Submitted
(01/08/2010)

No.	*Type	Measure Title
1.	O	Standardized mortality ratio for neonates undergoing non-cardiac surgery
2.	O	Standardized adverse event ratio for children and adults undergoing cardiac catheterization for congenital heart disease
3.	O	Ventricular Shunt Malfunction in Children
4.	O	Validated family-centered survey questionnaire for parent's and patients experiences during inpatient pediatric hospital stays
5.	O	Normal Term Neonatal Outcome
6.	O	AD quality of life
7.	O	AD quality of care
8.	O	Number of school days missed due to illness
9.	O	Unmet health needs
10.	O	Medical home
11.	O	Effective care coordination when needed
12.	O	Children live in safe communities
13.	O	Children attend safe schools
14.	O	Children live in neighborhoods with certain essential amenities
15.	O	Common Pediatric Surgical Urgent Care
16.	O	Inpatient Care of the Injured Child
17.	O	Pediatric Solid Tumor Oncology
18.	O	Risk-adjusted central line associated blood-stream infections in a pediatric cardiac intensive care unit
19.	O	Effects of condition on daily life
20.	O	Receipt of needed mental health care
21.	O	Inadequate insurance coverage for optimal health of child

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No.	*Type	Measure Title
22.	O	Professional fluoride treatment per patient annual rate
23.	O	Continuity of Care
24.	O	Receipt of needed mental health care
25.	O	Children who take medication for ADHD, emotional or behavioral issues
26.	O	No problems obtaining referrals when needed
27.	O	Prevalence of children with special health care needs
28.	O	Children live in supportive neighborhoods
29.	O	Child physical activity
30.	O	Exposure to secondhand smoke inside home
31.	O	Standardized developmental and behavioral screening
32.	O	Provider engages parent around child health concerns
33.	O	Preventive dental visits
34.	O	Preventive medical visits
35.	O	Parent report of BMI status
36.	O	Conditions
37.	O	Care provided by family
38.	O	Family-centered care
39.	O	Usual source for sick and well care
40.	O	AD care plan
41.	O	New patient retention
42.	O	Personal doctor or nurse
43.	O	Standardized developmental and behavioral screening
44.	O	Provider engages parent around child health concerns
45.	O	Positive social skills

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46.	O	A copy of a summary of the patient's neonatal hospital course should be in the patient's primary care provider's medical record
47.	O	Summary of the neonatal hospital course should include gestational age at birth
48.	O	Summary of the neonatal hospital course should include birth weight
49.	O	Summary of the neonatal hospital course should include discharge weight
50.	O	Summary of the neonatal hospital course should include discharge head circumference
51.	O	Summary of the neonatal hospital course should include days on supplemental oxygen or gestational age off oxygen
52.	O	Summary of the neonatal hospital course should include date and results of last metabolic screen
53.	O	Summary of the neonatal hospital course should include date and results of last hearing screen
54.	O	Summary of the neonatal hospital course should date and results of last retinal examination
55.	O	Summary of the neonatal hospital course should include date and results of last cranial imaging
56.	O	Summary of the neonatal hospital course should include date and result of worst/significant abnormality in cranial imaging
57.	O	Summary of the neonatal hospital course should include date and results of last hematologic assessment
58.	O	Summary of the neonatal hospital course should include dietary intake at discharge (i.e., breast milk or formula; other nutritional supplements)
59.	O	Summary of the neonatal hospital course should immunization status
60.	O	Summary of the neonatal hospital course should include problem list (diagnosis, medication [including oxygen], and referrals)
61.	O	Summary of the neonatal hospital course should include Palivizumab (Synagis) date(s)
62.	O	Summary of the neonatal hospital course should include psychosocial history
63.	O	Head circumference should be measured and plotted at every health maintenance visit up to the visit at age 2
64.	O	Height and weight should be measured and plotted at every health maintenance visit
65.	O	Parents of all VLBW infants should be counseled regarding sleep position in the prevention of SIDS within 1 month of discharge from the nursery, unless the infant is discharged after 6 mo adjusted age
66.	O	Parents of all VLBW infants should be counseled regarding hazards of environmental tobacco smoke within 2 months of discharge from the nursery
67.	O	Children who are younger than 2 years as of November 1 and have required medical therapy (supplemental oxygen, bronchodilator, diuretic, or corticosteroid therapy) for chronic lung disease after May 1 should receive appropriate doses of Palivizumab (Synagis) with the first dose given before November 1

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68.	O	Children who have chronic lung disease and are discharged on supplemental oxygen should have an interim history performed at least monthly until they are off supplemental oxygen
69.	O	Children who have chronic lung disease and are discharged on supplemental oxygen should have a weight measurement performed at least monthly until they are off supplemental oxygen
70.	O	Children who have chronic lung disease and are discharged on supplemental oxygen should have a pulse oximetry reading performed at rest at least monthly until they are off supplemental oxygen
71.	O	Children who have chronic lung disease and are discharged on supplemental oxygen should have a pulse oximetry reading performed during feeding at least monthly until they are off supplemental oxygen
72.	O	Children who show poor weight gain (average of <20g/d) during the first month after discharge from the nursery should have a specific follow-up plan documented in the chart
73.	O	All VLBW infants should receive supplemental iron (as an iron supplement or iron-fortified formula) started by 2 months of age
74.	O	Findings of the ophthalmologic examination for retinopathy of prematurity (ROP) should be recorded using the International Classification of ROP
75.	O	The discharge summary should include the schedule for the first post discharge pediatric ophthalmologic follow-up, if indicated
76.	O	The primary care provider (PCP) should document whether the first ophthalmologic follow-up visit occurred on schedule
77.	O	If on a routine clinic visit between birth to 3 years of age any ophthalmologic morbidity is documented, the patient should be seen by an ophthalmologist within 1 month
78.	O	The PCP should document whether children who receive a diagnosis of a vision problem are receiving appropriate interventions
79.	O	An ophthalmologic examination should be performed at least once between ages 1 and 2 by an ophthalmologist
80.	O	An ophthalmologic examination should be performed at least once between ages 3 and 4
81.	O	An ophthalmologic examination should be performed at least once between ages 4 and 5
82.	O	An ophthalmologic examination should be performed at least once between ages 5 and 6
83.	O	In the absence of a formal developmental evaluation, the assessment of speech and language development as defined by a developmental screening test should be documented at least once between ages 1 and 2
84.	O	In the absence of a formal developmental evaluation, the assessment of speech and language development as defined by a developmental screening test should be documented at least once between ages 2 and 3
85.	O	In the absence of a formal developmental evaluation, the assessment of speech and language development as defined by a developmental screening test should be documented at least once between ages 3 and 4
86.	O	In the absence of a formal developmental evaluation, the assessment of speech and language development as defined by a developmental screening test should be

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		documented at least once between ages 4 and 5
87.	O	For children who are younger than 3 years and have suspected language developmental delay, a specific intervention (watchful waiting with re-evaluation, hearing assessment, and/or specific speech and language testing, or a specific intervention program) should be started within 2 months of the suspect or abnormal finding
88.	O	For all infants who have risk factors for hearing loss and passed the inpatient universal newborn hearing screen, a diagnostic hearing test should be performed by 12 months chronological age
89.	O	For infants who did not pass the inpatient universal newborn hearing screen, a hearing diagnostic should be completed within 3 months of the failed screen
90.	O	For infants who did not receive inpatient universal newborn hearing screen, a hearing diagnostic should be completed within 1 month of discharge from the nursery
91.	O	For infants with a diagnosis of a nonconductive hearing loss, rehabilitation should be started by 6 months of chronologic age
92.	O	For children between ages 0 and 3, a formal developmental evaluation should be performed at least once between 9 and 15 months corrected age
93.	O	For children between ages 0 and 3, a formal developmental evaluation should be performed at least once between 21 and 30 months corrected age
94.	O	For children between ages 0 and 3, a formal developmental evaluation should be performed within 2 months of a suspect or abnormal developmental screening test (e.g., abnormal Bayley Infant Neurodevelopment Screener)
95.	O	In the absence of a formal developmental evaluation, the presence or absence of parental concerns and a multidimensional developmental screening test should be documented using standardized instruments at least once during the first 6 months
96.	O	In the absence of a formal developmental evaluation, the presence or absence of parental concerns and a multidimensional developmental screening test should be documented using standardized instruments at least once during the second 6 months
97.	O	In the absence of a formal developmental evaluation, the presence or absence of parental concerns and a multidimensional developmental screening test should be documented using standardized instruments at least once between ages 1 and 2
98.	O	In the absence of a formal developmental evaluation, the presence or absence of parental concerns and a multidimensional developmental screening test should be documented using standardized instruments at least once between ages 2 and 3
99.	O	In the absence of a formal developmental evaluation, the presence or absence of parental concerns and a multidimensional developmental screening test should be documented using standardized instruments at least once between ages 3 and 4
100.	O	In the absence of a formal developmental evaluation, the presence or absence of parental concerns and a multidimensional developmental screening test should be documented using standardized instruments at least once between ages 4 and 5
101.	O	A structured, age-appropriate neuromotor assessment should be performed by corrected age at least once during the first six months
102.	O	A structured, age-appropriate neuromotor assessment should be performed by corrected age at least once during the second six months
103.	O	A structured, age-appropriate neuromotor assessment should be performed by corrected age at least once between ages 1 and 2

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104.	O	A structured, age-appropriate neuromotor assessment should be performed by corrected age at least once between ages 2 and 3
105.	O	A structured, age-appropriate neuromotor assessment should be performed by corrected age at least once between ages 4 and 5
106.	O	If the structured neuromotor examination or the formal developmental evaluation is suspect or abnormal, then a specific intervention (watchful waiting with re-evaluation, specialist consultation, or a specific intervention program) should be started within 2 months of the suspect or abnormal finding
107.	O	If a professional who is performing the neuromotor examination recommends physical therapy or occupational therapy for the patient, then interventions should be started within 2 months of the recommendation
108.	O	If parents express concerns about their child's behavior, then a specific intervention (watchful waiting with re-evaluation, primary care management, referral to a specialist, or referral to a specific intervention program) should be started within 2 months
109.	O	Children who are born <1000g and/or <28 wk gestation should be referred to the school system or a child developmental specialist for a psychoeducational assessment between ages 3 and 5 unless it has already occurred
110.	O	By the next health maintenance visit after referral of a child for psychoeducational testing, the primary care provider should document the result of the referral and/or assessment and any planned interventions
111.	O	The following family demographic characteristics (maternal age, marital status, health insurance information, education, number of children in the household, and child's primary care giver) should be noted in the chart at least once in the first year
112.	O	The following family demographic characteristics (maternal age, marital status, health insurance information, education, number of children in the household, and child's primary care giver) should be noted in the chart at least once between ages 1 and 3
113.	O	The following family demographic characteristics (maternal age, marital status, health insurance information, education, number of children in the household, and child's primary care giver) should be noted in the chart at least once between ages 3 and 5
114.	O	Family psychosocial evaluations including the presence or absence of substance abuse should be noted at least once by age 3
115.	O	For families with social risk(s) as defined by psychosocial indicators 66-69, a specific intervention (re-evaluation, primary care management, referral to a specialist, or referral to a specific intervention program) should be started within 1 month of the psychosocial assessment
SURVEYS		
116.	O	Standardized developmental and behavioral screening
117.	O	Parental experience with completing a standardized developmental or behavioral screening
118.	O	Family-Centered Care (FCC): Average proportion of recommended aspects of family-centered care regularly received
119.	O	Family-Centered Care (FCC): Proportion of children whose parents routinely receive family-centered care
120.	O	Children with special health care needs

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No.	*Type	Measure Title
121.	O	Healthcare provider engagement with parent during the well-child visit to ensure health promotion informational needs are met.
122.	O	Parent engagement in prepare for well-child visit
123.	O	Parent promotion of child's development
124.	O	Children at risk for developmental, behavioral or social delays.
125.	O	Helpfulness of Care Provided: Proportion of children whose parents reported care provided was helpful or very helpful on core aspects of preventive and developmental health care
126.	O	Effect of Care Provided on Parental Confidence: Proportion of children whose parents reported care had a positive influence on their confidence in parenting their child and managing their responsibilities
127.	O	Children with special health care needs
128.	O	Adolescent experience with preventive care communication
129.	O	Helpfulness of counseling for adolescents on preventive care issues.
130.	O	Teen health status and life satisfaction.
131.	O	Teen participation in risky behaviors
132.	O	adolescent connected to school
133.	O	Youth engagement in life
134.	O	Youth sense of confidence in life

***Type:** O=outcomes