NATIONAL QUALITY FORUM

Measure Evaluation 4.1
December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized)**:** Complete all <mark>yellow highlighted</mark> areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: *If there is no TAP or workgroup, the SC also evaluates the subcriteria (<mark>yellow</mark> highlighted areas).*

Steering Committee: Complete all <mark>pink</mark> highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) **NQF Review #:** 1330   **NQF Project:** Child Health Quality Measures 2010

MEASURE DESCRIPTIVE INFORMATION
De.1 Measure Title: Children With a Usual Source for Care When Sick
De.2 Brief description of measure: Whether child has a source of care that is known and continuous (categorized as a doctor´s office, hospital outpatient department, clinic or health center, school, friend or relative, some other place, or a telephone advice line)
1.1-2 Type of Measure: Process **De.3 If included in a composite or paired with another measure, please identify composite or paired measure**
De.4 National Priority Partners Priority Area: Population health **De.5 IOM Quality Domain:** Patient-centered **De.6 Consumer Care Need:** Staying healthy

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	**NQF Staff**
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.* **A.1** Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes **A.2** Indicate if Proprietary Measure (*as defined in measure steward agreement*): Proprietary measure **A.3** Measure Steward Agreement: Government entity and in the public domain - no agreement necessary **A.4** Measure Steward Agreement attached:	**A** Y☐ N☐
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least	**B** Y☐

every 3 years. Yes, information provided in contact section	N☐
C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ►**Purpose:**	**C** Y☐ N☐
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. **D.1 Testing:** Yes, fully developed and tested **D.2** Have NQF-endorsed measures been reviewed to identify if there are similar or related measures? Yes	**D** Y☐ N☐
(for NQF staff use**) Have all conditions for consideration been met?** **Staff Notes to Steward** (*if submission returned*)**:**	**Met** Y☐ N☐
Staff Notes to Reviewers (*issues or questions regarding any criteria*)**:**	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. *Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.* (evaluation criteria) **1a. High Impact**	**Eval Rating**
(for NQF staff use) **Specific NPP goal:**	
1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers **1a.2** **1a.3 Summary of Evidence of High Impact:** Nationally, 93.1% of children 0-17 years have a usual source for sick care. The importance of having a usual source of care has been recognized by the U.S. Department of Health and Human Services Healthy People 2020 (AHS HP 2020-6 Increase the proportion of persons who have a specific source of ongoing care). Having a usual source for care is also a critical component of the medical home, which has been recognized as an objective by the U.S. Department of Health and Human Services' Healthy people 2010. Additionally, medical home is one of the 18 national performance measures established for the state Title V programs it administers. Having a usual source for care is especially important for children with special health care needs, who require additional therapy and services and who benefit from having a specific source of care who knows them well. **1a.4 Citations for Evidence of High Impact:** Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website. www.nschdata.org Duke NN, Scal PB. Adult Care Transitioning for Adolescents with Special Health Care Needs: A Pivotal Role for Family Centered Care. Matern Child Health J. 2009.	**1a** C☐ P☐ M☐ N☐

Falik M. Needleman J. Wells BL. Korb J. (2001). Ambulatory care sensitive hospitalizations and emergency visits: Experiences of Medicaid patients using federally qualified health centers. Medical Care. 39(6):551-61.

Flores G, Tomany-Korman SC. The language spoken at home and disparities in medical and dental health, access to care, and use of services in US children. Pediatrics. 2008;121(6):e1703-14.

Friedlaender EY. Rubin DM. Alpern ER. Mandell DS. Christian CW. Alessandrini EA. (2005). Patterns of health care use that may identify young children who are at risk for maltreatment. Pediatrics. 116(6):1303-8

Lotstein DS, Ghandour R, Cash A, McGuire E, Strickland B, Newacheck P. Planning for health care transitions: results from the 2005-2006 National Survey of Children With Special Health Care Needs. Pediatrics. 2009;123(1):e145-52.

Raphael JL, Zhang Y, Liu H, Tapia CD, Giardino AP. Association of medical home care and disparities in emergency care utilization among children with special health care needs. Acad Pediatr. 2009;9(4):242-248.

Strickland BB, Singh GK, Kogan MD, Mann MY, van Dyck PC, Newacheck PW. Access to the medical home: new findings from the 2005-2006 National Survey of Children with Special Health Care Needs. Pediatrics. 2009;123(6):e996-1004.

U.S. Department of Health and Human Services. Healthy People 2010. Conference Edition. Washington, DC. 2000.

U.S. Department of Health and Human Services. Healthy People 2020. http://www.healthypeople.gov/HP2020/.

Weitzman, M, Byrd, R, & Auinger, P. (1999). Black and white middle class children who have private health insurance in the United States.

Yu SM, Singh GK. Household language use and health care access, unmet need, and family impact among CSHCN. Pediatrics. 2009;124 Suppl 4:S414-9.

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Health care providers, public health professionals and population-based health analysts can all benefit from knowing whether or not children have a usual source for sick care. The measure also has the benefit of comparing children across populations or demographic groups.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
There is a broad range in the prevalence of children who have a usual source for sick care, from 87.2% in Nevada to 98.0% in New Hampshire.

1b.3 Citations for data on performance gap:
Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website. www.nschdata.org

1b.4 Summary of Data on disparities by population group:
The proportion of children who have a usual source for sick care varies by race, 96.8% for white children, 89.4% for black children and 85.3% for Hispanic children.

1b.5 Citations for data on Disparities:
Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website. www.nschdata.org

Flores G, Tomany-Korman SC. The language spoken at home and disparities in medical and dental health, access to care, and use of services in US children. Pediatrics. 2008;121(6):e1703-14.

1b
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M ☐
N ☐

1c. Outcome or Evidence to Support Measure Focus **1c.1 Relationship to Outcomes (***For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population***):** Outcomes are relevant to the target population for purposes of quality improvement. Measurement and receipt of high quality care can only be strenghtened with expansion of evidence based quality indicators. All children with special health care needs need accessible, quality health care. **1c.2-3. Type of Evidence:** Other Population Based Research **1c.4 Summary of Evidence (***as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome***):** Youth with a usual source of care (vs. not) are more likely to receive counseling on future health needs (47.4 vs. 33.6%) and take responsibility for their own care (79.3 vs. 64.4%). (Duke & Scal) Having a usual source of care is a fundamental component of the medical home, which impacts whether families experience delayed or forgone care, unmet health care needs, number of missed school days, and unmet needs for family support services. A significantly greater proportion of children without a medical home were reported as having forgone or delayed care (11.7%), compared with children with a medical home (4.1%). (Strickland) **1c.5 Rating of strength/quality of evidence (***also provide narrative description of the rating and by whom***):** **1c.6 Method for rating evidence:** **1c.7 Summary of Controversy/Contradictory Evidence:** **1c.8 Citations for Evidence (***other than guidelines***):** **1c.9 Quote the Specific guideline recommendation (***including guideline number and/or page number***):** **1c.10 Clinical Practice Guideline Citation:** **1c.11 National Guideline Clearinghouse or other URL:** **1c.12 Rating of strength of recommendation (***also provide narrative description of the rating and by whom***):** **1c.13 Method for rating strength of recommendation (***If different from USPSTF system, also describe rating and how it relates to USPSTF***):** **1c.14 Rationale for using this guideline over others:**	4 **1c** C☐ P☐ M☐ N☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Importance to Measure and Report*?	**1**
Steering Committee: Was the threshold criterion, *Importance to Measure and Report*, met? **Rationale:**	**1** Y☐ N☐
2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES	
Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)	**Eval Ratin g**

2a. MEASURE SPECIFICATIONS

S.1 Do you have a web page where current detailed measure specifications can be obtained?
S.2 If yes, provide web page URL:

2a. Precisely Specified

2a.1 Numerator Statement (*Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome***):**
Child has a usual source source of care when child is sick or parent needs advice about child´s health

2a.2 Numerator Time Window (*The time period in which cases are eligible for inclusion in the numerator***):**
Encounter or point in time

2a.3 Numerator Details (*All information required to collect/calculate the numerator, including all codes, logic, and definitions***):**
Child has a usual source of care-- a doctor´s office, hospital outpatient department, clinic or health center, school, friend or relative, some other place, or a telephone advice line.

2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured***):**
Children age 0-17 years

2a.5 Target population gender: Female, Male
2a.6 Target population age range: Children age 0-17 years

2a.7 Denominator Time Window (*The time period in which cases are eligible for inclusion in the denominator***):**

2a.8 Denominator Details (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions***):**
Children age 0-17 years

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population***):** Children over 17 years of age are excluded from the denominator.

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions***):**
If child is over 17 years of age, excluded from the denominator.

2a.11 Stratification Details/Variables (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions***):**
No stratification is required.

When the Usual Source of Sick Care measure was administered in its most recent form, in the 2007 NSCH, the survey included a number of child demographic variables that allow for stratification of the findings by possible vulnerability:
• Age
• Gender
• Geographic location- State, HRSA Region, National level Rural Urban Commuter Areas (RUCA)
• Race/ethnicity
• Health insurance- type, consistency
• Primary household language
• Household income
• Special Health Care Needs- status and type

2a.12-13 Risk Adjustment Type: No risk adjustment necessary

2a.14 Risk Adjustment Methodology/Variables (*List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method***):**

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-Children who have a usual place to go when child is sick or parent needs advice about child´s health (K4Q01= Yes) and the place he/she most often goes to is a doctor´s office (K4Q02=1), hospital outpatient department (K4Q02=3), clinic or health center (K4Q02=4), school (nurse´s office, athletic trainer´s office, etc) (K4Q02=5), friend or relative (K4Q02=6), some other place (K4Q02=8), or a telephone advice line (K4Q02=8 and K4Q03= "telephone advice line" or equivalent) are defined as having a usual source of care.
-Children who do not have a usual source of care (K4Q01= No) or that the place of care is a hospital emergency room (K4Q02=2), is located outside the U.S. (K4Q02=7), or the child does not go to one place most often (K4Q02=9), are defined as not having a usual source of care.

2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score: Rate/proportion
2a.20 Interpretation of Score: Better quality = Higher score
2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**

2a.22 Describe the method for discriminating performance *(e.g., significance testing)***:**

2a.23 Sampling (Survey) Methodology *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)*:
Best guideline to follow is the survey methodology used in the 2007 National Survey of Children´s Health.

The goal of the NSCH sample design was to generate samples representative of populations of children within each state. An additional goal of the NSCH was to obtain state-specific sample sizes that were sufficiently large to permit reasonably precise estimates of the health characteristics of children in each state.
To achieve these goals, state samples were designed to obtain a minimum of 1,700 completed interviews. The number of children to be selected in each National Immunization Survey (NIS) estimation area was determined by allocating the total of 1,700 children in the state to each National Immunization Survey (NIS) estimation area within the state in proportion to the total estimated number of households with children in the NIS estimation area. Given this allocation, the number of households that needed to be screened in each NIS estimation area was calculated using the expected proportion of households with children under 18 years of age in the area. Then, the number of telephone numbers that needed to be called was computed using the expected working residential number rate, adjusted for expected nonresponse.

A total of 91,642 interviews were completed from April 2007 to July 2008 for the 2007 National Survey of Children´s Health. A random-digit-dialed sample of households with children less than 18 years of age was selected from each of the 50 states and the District of Columbia. One child was randomly selected from all children in each identified household to be the subject of the survey. The respondent was a parent or guardian who knew about the child's health and health care.

2a.24 Data Source (*Check the source(s) for which the measure is specified and tested***)**

2a.25 Data source/data collection instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.***):**
2007 National Survey of Children´s Health

2a.26-28 Data source/data collection instrument reference web page URL or attachment: URL
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slaits/nsch07/1a_Survey_Instrument_English/NSCH_Questionnaire_052109.pdf

2a.29-31 Data dictionary/code table web page URL or attachment: URL
http://nschdata.org/Viewdocument.aspx?item=519

2a.32-35 Level of Measurement/Analysis *(Check the level(s) for which the measure is specified and tested)*
Population : National, Population : Regional/network, Population : states

2a.36-37 Care Settings (*Check the setting(s) for which the measure is specified and tested***)**
Other

2a.38-41 Clinical Services (*Healthcare services being measured, check all that apply*) Other Patient Experience	
TESTING/ANALYSIS	
2b. Reliability testing **2b.1 Data/sample** (*description of data/sample and size*)**:** **2b.2 Analytic Method** (*type of reliability & rationale, method for testing*)**:** Cognitive testing was conducted to test reliability and interpretability of questions across population. **2b.3 Testing Results** (*reliability statistics, assessment of adequacy in the context of norms for the test conducted*)**:** The Maternal and Child Health Bureau leads the development of the NSCH and NS-CSHCN survey and indicators, in collaboration with the National Center for Health Statistics (NCHS) and a national technical expert panel. The expert panel includes representatives from other federal agencies, state Title V leaders, family organizations, and child health researchers, and experts in all fields related to the surveys (adolescent health, family and neighborhoods, early childhood and development etc.). Previously validated questions and scales are used when available. Extensive literature reviewing and expert reviewing of items is conducted for all aspects of the survey. Respondents' cognitive understanding of the survey questions is assessed during the pretest phase and revisions made as required. All final data components are verified by NCHS and DRC/CAHMI staff prior to public release. Face validity is conducted in comparing results with prior years of the survey and/or results from other implementations of items. No specific reliability results are available for this measure. Please contact the CAHMI if quantitative measures are needed.	**2b** C☐ P☐ M☐ N☐
2c. Validity testing **2c.1 Data/sample** (*description of data/sample and size*)**:** **2c.2 Analytic Method** (*type of validity & rationale, method for testing*)**:** Cognitive testing was conducted with parents of children ages 0-17 years (interviews conducted over the phone with residential households). **2c.3 Testing Results** (*statistical results, assessment of adequacy in the context of norms for the test conducted*)**:** Please see the references section for peer-reviewed articles which have used these items. Peer-reviewed papers generally undertake their own validity testing in order to meet strict peer review standards. See also Reliability Testing Results above.	**2c** C☐ P☐ M☐ N☐
2d. Exclusions Justified **2d.1 Summary of Evidence supporting exclusion(s):** **2d.2 Citations for Evidence:** **2d.3 Data/sample** (*description of data/sample and size*)**:** **2d.4 Analytic Method** (*type analysis & rationale*)**:** **2d.5 Testing Results** (*e.g., frequency, variability, sensitivity analyses*)**:**	**2d** C☐ P☐ M☐ N☐ **NA** ☐
2e. Risk Adjustment for Outcomes/ Resource Use Measures **2e.1 Data/sample** (*description of data/sample and size*)**:**	**2e** C☐ P☐

2e.2 Analytic Method *(type of risk adjustment, analysis, & rationale)*: **2e.3 Testing Results** *(risk model performance metrics)*: **2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:**	M ☐ N ☐ NA ☐
2f. Identification of Meaningful Differences in Performance **2f.1 Data/sample from Testing or Current Use** *(description of data/sample and size)*: **2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance** *(type of analysis & rationale)*: **2f.3 Provide Measure Scores from Testing or Current Use** *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*:	**2f** C ☐ P ☐ M ☐ N ☐
2g. Comparability of Multiple Data Sources/Methods **2g.1 Data/sample** *(description of data/sample and size)*: **2g.2 Analytic Method** *(type of analysis & rationale)*: **2g.3 Testing Results** *(e.g., correlation statistics, comparison of rankings)*:	**2g** C ☐ P ☐ M ☐ N ☐ NA ☐
2h. Disparities in Care **2h.1 If measure is stratified, provide stratified results** *(scores by stratified categories/cohorts)*: **2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:**	**2h** C ☐ P ☐ M ☐ N ☐ NA ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Scientific Acceptability of Measure Properties*?	**2**
Steering Committee: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties*, met? **Rationale:**	**2** C ☐ P ☐ M ☐ N ☐
3. USABILITY	
Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)	**Eval Rating**
3a. Meaningful, Understandable, and Useful Information **3a.1 Current Use:** In use **3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large)** *(If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years)*: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and	**3a** C ☐ P ☐ M ☐ N ☐

Child Health Bureau. The Health and Well-Being of Children: A Portrait of States and the Nation 2007. Chartbook based on data from the 2007 National Survey of Children's Health. http://mchb.hrsa.gov/nsch07/index.html.

3a.3 If used in other programs/initiatives (*If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years***):**
The Data Resource Center websites have been accessed more than 18 million times since 2006. Thousands of state and national researchers, MCH providers and analysts use the data to report valid children's health data.
Healthy People 2010 uses items from the national surveys, and several more are slated to be added into Healthy People 2020.

Testing of Interpretability (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*)
3a.4 Data/sample (*description of data/sample and size*)**:** Focus groups were held with numerous stakeholder groups—family advocates, clinicians, Title V leaders, researchers—to obtain feedback on report formats. The Child and Adolescent Health Measurement Initiative led the focus groups and developed reports in accordance with a general consumer information framework. Additional focus groups were held when preparing data and reports for display on the Data Resource Center website. The Data Resource Center executive committee also reviewed report formats for interpretability and applicability.

3a.5 Methods (*e.g., focus group, survey, QI project*)**:**
Focus groups

3a.6 Results (*qualitative and/or quantitative results and conclusions*)**:**

3b/3c. Relation to other NQF-endorsed measures **3b.1 NQF # and Title of similar or related measures:**	
(for NQF staff use) **Notes on similar/related endorsed or submitted measures:**	
3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source or different topic but same target population): **3b.2 Are the measure specifications harmonized? If not, why?**	**3b** C☐ P☐ M☐ N☐ **NA** ☐
3c. Distinctive or Additive Value **3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** **5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality:**	**3c** C☐ P☐ M☐ N☐ **NA** ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Usability?*	**3**
Steering Committee: Overall, to what extent was the criterion, *Usability*, met? **Rationale:**	**3** C☐ P☐ M☐ N☐
4. FEASIBILITY	

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable

	Eval Rating
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)	
4a. Data Generated as a Byproduct of Care Processes **4a.1-2 How are the data elements that are needed to compute measure scores generated?** Survey	**4a** C ☐ P ☐ M ☐ N ☐
4b. Electronic Sources **4b.1 Are all the data elements available electronically?** (*elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims*) Yes **4b.2 If not, specify the near-term path to achieve electronic capture by most providers.**	**4b** C ☐ P ☐ M ☐ N ☐
4c. Exclusions **4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?** No **4c.2 If yes, provide justification.**	**4c** C ☐ P ☐ M ☐ N ☐ NA ☐
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences **4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.**	**4d** C ☐ P ☐ M ☐ N ☐
4e. Data Collection Strategy/Implementation **4e.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:** Items are well understood and easy to implement. Items yield very low levels of missing values, don't know or refused answers. **4e.2 Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*)**:** Item is public domain and there is no cost associated with its use. **4e.3 Evidence for costs:** **4e.4 Business case documentation:**	**4e** C ☐ P ☐ M ☐ N ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Feasibility?*	**4**
Steering Committee: Overall, to what extent was the criterion, *Feasibility*, met? **Rationale:**	**4** C ☐ P ☐ M ☐ N ☐
RECOMMENDATION	
(for NQF staff use) **Check if measure is untested and only eligible for time-limited endorsement.**	Time-limited

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable

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<tr><td colspan="2">Steering Committee: Do you recommend for endorsement?
Comments:</td><td>Y☐
N☐
A☐</td></tr>
</table>

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner)
Co.1 <u>Organization</u>
Maternal and Child Health Bureau, Health Resources & Services Administration, Parklawn Building Room 18-05, 5600 Fishers Lane, Rockville, Maryland, 20857

Co.2 <u>Point of Contact</u>
Christina, Bethell, Ph.D., MPH, MBA, bethellc@ohsu.edu, 503-494-1892-

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Measure Developer If different from Measure Steward
Co.3 <u>Organization</u>
See Ad.1 below, -, -, -, Maryland, -

Co.4 <u>Point of Contact</u>
Christina, Bethell, Ph.D., MPH, MBA, bethellc@ohsu.edu, 503-494-1892-

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Co.5 Submitter If different from Measure Steward POC
Christina, Bethell, Ph.D., MPH, MBA, bethellc@ohsu.edu, 503-494-1892-, Maternal and Child Health Bureau, Health Resources & Services Administration

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Co.6 Additional organizations that sponsored/participated in measure development
See Ad.1 below

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development
Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
The Maternal and Child Health Bureau convenes a Technical Expert Panel (TEP) comprised of more than a dozen members. Members include other federal agencies, health services researchers, survey methodology experts, consumer organizations and clinical health experts on children´s health. The TEP consults in the identification and/or development of items for MCHB to consider for inclusion in the National Survey of Children's Health, including making recommendations for the scoring and reporting of measures resulting from the national survey. Members of the committee are drawn from the public and private sector, including members from national universities and national parenting and family groups, the Child and Adolescent Health Measurement Initiative (through the MCHB-sponsored Data Resource Center for Child and Adolescent Health) as well as members from the National Center for Health Statistics, the Centers for Disease Control and Prevention and other federal agencies. There is a range of activity performed by different members of the TEP depending on which measure is being developed, areas of expertise etc. The TEP process usually consists of 1 or 2 in person meetings, 6 or more conference calls, and numerous email exchanges. Subcommittees are formed based on areas of expertise. Because this is a collaborative activity, there is not a single developer of this measure.

Ad.2 If adapted, provide name of original measure:
Ad.3-5 If adapted, provide original specifications URL or attachment

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Measure Developer/Steward Updates and Ongoing Maintenance
Ad.6 Year the measure was first released: 2007
Ad.7 Month and Year of most recent revision: 01, 2007
Ad.8 What is your frequency for review/update of this measure? Updated every 4 years when a new NSCH is developed
Ad.9 When is the next scheduled review/update for this measure? 01, 2011

Ad.10 Copyright statement/disclaimers:

Ad.11 -13 Additional Information web page URL or attachment: Attachment NSCH TEP 2007-634384067948075734.doc

Date of Submission (*MM*/*DD*/*YY*)**:** 04/14/2011

NATIONAL QUALITY FORUM

Measure Evaluation 4.1
December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized)**:** Complete all <mark>yellow highlighted</mark> areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: *If there is no TAP or workgroup, the SC also evaluates the subcriteria (<mark>yellow</mark> highlighted areas).*

Steering Committee: Complete all <mark>pink</mark> highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) **NQF Review #:** 1332　　　**NQF Project:** Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 Measure Title: Children Who Receive Preventive Medical Visits
De.2 Brief description of measure*:* Assesses how many medical preventive visits in a 12 month period, such as a physical exam or well-child check-up (does not include visits related to specific illnesses)
1.1-2 Type of Measure: Outcome **De.3 If included in a composite or paired with another measure, please identify composite or paired measure**
De.4 National Priority Partners Priority Area: Population health **De.5 IOM Quality Domain:** Effectiveness **De.6 Consumer Care Need:** Staying healthy

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	**NQF Staff**
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.* **A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)?** Yes **A.2 Indicate if Proprietary Measure** (*as defined in measure steward agreement*): Proprietary measure **A.3 Measure Steward Agreement:** Government entity and in the public domain - no agreement necessary **A.4 Measure Steward Agreement attached:**	**A** Y☐ N☐
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	**B** Y☐ N☐

C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ►**Purpose:**	**C** Y ☐ N ☐
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. **D.1 Testing:** Yes, fully developed and tested **D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?** Yes	**D** Y ☐ N ☐
(for NQF staff use**) Have all conditions for consideration been met?** **Staff Notes to Steward** (*if submission returned*)**:**	**Met** Y ☐ N ☐
Staff Notes to Reviewers (*issues or questions regarding any criteria*)**:**	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. *Measures must be judged to be important to measure and report* in order to be evaluated against the remaining criteria. (evaluation criteria) **1a. High Impact**	**Eval Rating**
(for NQF staff use) Specific NPP goal:	
1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers **1a.2** **1a.3 Summary of Evidence of High Impact:** Having preventive medical visits is important for maintaining the overall health status of children, and has been recognized by the U.S. Department of Health and Humans Services´ Healthy People 2020 (AH HP2020-4). **1a.4 Citations for Evidence of High Impact:** Betz CL, Baer MT, Poulsen M, et al. Secondary analysis of primary and preventive services accessed and perceived service barriers by children with developmental disabilities and their families. Issues Compr Pediatr Nurs. 2004;27(2):83-106. Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website. Flores G, Tomany-Korman SC. The language spoken at home and disparities in medical and dental health, access to care, and use of services in US children. Pediatrics. 2008;121(6):e1703-14. Kogan MD, Newacheck PW, Honberg L, Strickland B. Association between underinsurance and access to care among children with special health care needs in the United States. Pediatrics. 2005;116(5):1162-1169. Ngui EM, Flores G. Unmet needs for specialty, dental, mental, and allied health care among children with special health care needs: are there racial/ethnic disparities? J Health Care Poor Underserved. 2007;18(4):931-949. U.S. Department of Health and Human Services. Healthy People 2020.	**1a** C ☐ P ☐ M ☐ N ☐

http://www.healthypeople.gov/HP2020/.

Van Cleave J, Davis MM. Preventive care utilization among children with and without special health care needs: associations with unmet need. Ambul Pediatr. 2008;8(5):305-311.

Yu SM, Huang ZJ, Kogan MD. State-level health care access and use among children in US immigrant families. Am J Public Health. 2008;98(11):1996-2003.

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Health care providers, public health professionals and population-based health analysts can all benefit from knowing whether or not children are receiving preventive medical care. This measure provides the benefit of comparing children across populations or demographic groups as to where preventive care is not being received.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
Nationally, 88.5% of children age 0-17 years had a preventive medical visit in the past 12 months. There is a wide range in the proportion of children receiving preventive medical care, with state values ranging from 76.7% in Idaho to 97.7% in Rhode Island.

1b.3 Citations for data on performance gap:
Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website.

1b.4 Summary of Data on disparities by population group:
The proportion of children receiving routine preventive medical care varies by age. 96.0% of 0-5 year olds, 85.5% of 6-11 and 84.2% of 12-17 year olds had a preventive medical visit in the previous 12 months. Publicly insured children are the most likely to have routine preventive medical visits (91.4%), followed by privately insured (89.5%) and uninsured children (72.6%).

1b.5 Citations for data on Disparities:
Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website.

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1c. Outcome or Evidence to Support Measure Focus

1c.1 Relationship to Outcomes (*For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population***):** Outcomes are relevant to the target population for purposes of quality improvement. Measurement and receipt of routine preventive care can only be strenghtened with expansion of evidence-based indicators.

1c.2-3. Type of Evidence: Other Population Based Research

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome***):**
Children age 0-5 years with preventive medical visit are over twice as likely to receive developmental screening (19.8% vs 9.2%).

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom***):**

1c.6 Method for rating evidence:

1c.7 Summary of Controversy/Contradictory Evidence:

1c.8 Citations for Evidence (*other than guidelines***):**

1c.9 Quote the Specific guideline recommendation (*including guideline number and/or page number***):**

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1c.10 Clinical Practice Guideline Citation:
1c.11 National Guideline Clearinghouse or other URL:

1c.12 Rating of strength of recommendation (*also provide narrative description of the rating and by whom***):**

1c.13 Method for rating strength of recommendation (*If different from USPSTF system, also describe rating and how it relates to USPSTF***):**

1c.14 Rationale for using this guideline over others:

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Importance to Measure and Report*?	**1**
Steering Committee: Was the threshold criterion, *Importance to Measure and Report*, met? **Rationale:**	**1** Y☐ N☐

2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)	**Eval Rating**

2a. MEASURE SPECIFICATIONS

S.1 Do you have a web page where current detailed measure specifications can be obtained?
S.2 If yes, provide web page URL:

2a. Precisely Specified

2a.1 Numerator Statement (*Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome***):**
Percentage of children with one or more preventive medical visits in the past 12 months.

2a.2 Numerator Time Window (*The time period in which cases are eligible for inclusion in the numerator***):**
Encounter or point in time.

2a.3 Numerator Details (*All information required to collect/calculate the numerator, including all codes, logic, and definitions***):**
For a child to be included in the numerator of having preventive medical visit:
-Child saw doctor, nurse or other health care provider for preventive medical care such as a physical exam or well-child checkup during the past 12 months (K4Q20)

2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured***):**
Children age 0-17 years

2a.5 Target population gender: Female, Male
2a.6 Target population age range: Children age 0-17 years

2a.7 Denominator Time Window (*The time period in which cases are eligible for inclusion in the denominator***):**
Denominator window is a fixed point in time anchored to within the past 12 months.

2a.8 Denominator Details (*All information required to collect/calculate the denominator - the target

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*population being measured - including all codes, logic, and definitions***):**
Children age 0-17 years

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population***):** Excluded from denominator if child does not fall in target population age range of 0-17 years.

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions***):**
If child is older than 17 years of age, excluded from denominator.

2a.11 Stratification Details/Variables (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions***):**
No stratification is required.

When the Preventive Medical Visits measure was administered in its most recent form, in the 2007 National Survey of Children´s Health, the survey included a number of child demographic variables that allow for stratification of the findings by possible vulnerability:
• Age
• Gender
• Geographic location- State, HRSA Region, National level Rural Urban Commuter Areas (RUCA)
• Race/ethnicity
• Health insurance- type, consistency
• Primary household language
• Household income
• Special Health Care Needs- status and type

2a.12-13 Risk Adjustment Type: No risk adjustment necessary

2a.14 Risk Adjustment Methodology/Variables (*List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method***):**

2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score: Rate/proportion
2a.20 Interpretation of Score: Better quality = Higher score
2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**
To receive numerator of child having preventive medical visits:
-Child saw doctor, nurse or other helath care provider (K4Q20=1 or more times during past 12 months).

2a.22 Describe the method for discriminating performance *(e.g., significance testing)***:**

2a.23 Sampling (Survey) Methodology *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)*:
Best guideline to follow is the survey methodology used in the 2007 National Survey of Children´s Health.

The goal of the NSCH sample design was to generate samples representative of populations of children within each state. An additional goal of the NSCH was to obtain state-specific sample sizes that were sufficiently large to permit reasonably precise estimates of the health characteristics of children in each state.

To achieve these goals, state samples were designed to obtain a minimum of 1,700 completed interviews. The number of children to be selected in each National Immunization Survey (NIS) estimation area was determined by allocating the total of 1,700 children in the state to each National Immunization Survey (NIS) estimation area within the state in proportion to the total estimated number of households with children in the NIS estimation area. Given this allocation, the number of households that needed to be screened in each NIS estimation area was calculated using the expected proportion of households with children under 18 years of age in the area. Then, the number of telephone numbers that needed to be called was computed using the expected working residential number rate, adjusted for expected nonresponse.

A total of 91,642 interviews were completed from April 2007 to July 2008 for the 2007 National Survey of

Children´s Health. A random-digit-dialed sample of households with children less than 18 years of age was selected from each of the 50 states and the District of Columbia. One child was randomly selected from all children in each identified household to be the subject of the survey. The respondent was a parent or guardian who knew about the child's health and health care.

2a.24 Data Source (*Check the source(s) for which the measure is specified and tested***)**

2a.25 Data source/data collection instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.***):**
2007 National Survey of Children´s Health

2a.26-28 Data source/data collection instrument reference web page URL or attachment: URL
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slaits/nsch07/1a_Survey_Instrument_English/NSCH_Questionnaire_052109.pdf

2a.29-31 Data dictionary/code table web page URL or attachment: URL
http://nschdata.org/Viewdocument.aspx?item=519

2a.32-35 Level of Measurement/Analysis (*Check the level(s) for which the measure is specified and tested*)
Population : National, Population : Regional/network, Population : states

2a.36-37 Care Settings (*Check the setting(s) for which the measure is specified and tested***)**
Other

2a.38-41 Clinical Services (*Healthcare services being measured, check all that apply*)
Other   Patient Experience

TESTING/ANALYSIS

2b. Reliability testing

2b.1 Data/sample (*description of data/sample and size*): Qualitative testing of the entire 2007 National Survey of Children´s Health was conducted by the National Center for Health Statistics. They conducted cognitive interviews with the 2007 NSCH Computer-Assisted Telephone Interview (CATI) to make sure the entire survey instrument was functioning properly. N=640 interviews were completed over 3 days in December 2006. The questionnaire was then revised and finalized based on feedback from participants in these interviews.

2b.2 Analytic Method (*type of reliability & rationale, method for testing*):
Cognitive testing was conducted to test reliability and interpretability of questions across population.

2b.3 Testing Results (*reliability statistics, assessment of adequacy in the context of norms for the test conducted*):
The Maternal and Child Health Bureau leads the development of the NSCH and NS-CSHCN survey and indicators, in collaboration with the National Center for Health Statistics (NCHS) and a national technical expert panel. The expert panel includes representatives from other federal agencies, state Title V leaders, family organizations, and child health researchers, and experts in all fields related to the surveys (adolescent health, family and neighborhoods, early childhood and development etc.). Previously validated questions and scales are used when available. Extensive literature reviewing and expert reviewing of items is conducted for all aspects of the survey. Respondents' cognitive understanding of the survey questions is assessed during the pretest phase and revisions made as required. All final data components are verified by NCHS and DRC/CAHMI staff prior to public release. Face validity is conducted in comparing results with prior years of the survey and/or results from other implementations of items. No specific reliability results are available for this measure. Please contact the CAHMI if quantitative measures are needed.

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2c. Validity testing

2c.1 Data/sample (*description of data/sample and size*): 640 interviews were completed over 3 days in December 2006

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2c.2 Analytic Method *(type of validity & rationale, method for testing)*: Cognitive testing was conducted with parents of children ages 0-17 years (interviews conducted over the phone with residential households). **2c.3 Testing Results** *(statistical results, assessment of adequacy in the context of norms for the test conducted)*: Please see the references section for peer-reviewed articles which have used these items. Peer-reviewed papers generally undertake their own validity testing in order to meet strict peer review standards. See also Reliability Testing Results above.	
2d. Exclusions Justified **2d.1 Summary of Evidence supporting exclusion(s):** **2d.2 Citations for Evidence:** **2d.3 Data/sample** *(description of data/sample and size)*: **2d.4 Analytic Method** *(type analysis & rationale)*: **2d.5 Testing Results** *(e.g., frequency, variability, sensitivity analyses)*:	**2d** C☐ P☐ M☐ N☐ NA ☐
2e. Risk Adjustment for Outcomes/ Resource Use Measures **2e.1 Data/sample** *(description of data/sample and size)*: **2e.2 Analytic Method** *(type of risk adjustment, analysis, & rationale)*: **2e.3 Testing Results** *(risk model performance metrics)*: **2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:**	**2e** C☐ P☐ M☐ N☐ NA ☐
2f. Identification of Meaningful Differences in Performance **2f.1 Data/sample from Testing or Current Use** *(description of data/sample and size)*: **2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance** *(type of analysis & rationale)*: **2f.3 Provide Measure Scores from Testing or Current Use** *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*:	**2f** C☐ P☐ M☐ N☐
2g. Comparability of Multiple Data Sources/Methods **2g.1 Data/sample** *(description of data/sample and size)*: **2g.2 Analytic Method** *(type of analysis & rationale)*: **2g.3 Testing Results** *(e.g., correlation statistics, comparison of rankings)*:	**2g** C☐ P☐ M☐ N☐ NA ☐

2h. Disparities in Care **2h.1 If measure is stratified, provide stratified results** *(scores by stratified categories/cohorts)*: **2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:**	**2h** C ☐ P ☐ M ☐ N ☐ NA ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Scientific Acceptability of Measure Properties*?	**2**
Steering Committee: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties*, met? **Rationale:**	*2* C ☐ P ☐ M ☐ N ☐
3. USABILITY	
Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)	**Eval Rating**
3a. Meaningful, Understandable, and Useful Information **3a.1 Current Use:** In use **3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large)** *(If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years)*: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The Health and Well-Being of Children: A Portrait of States and the Nation 2007. Chartbook based on data from the 2007 National Survey of Children's Health. http://mchb.hrsa.gov/nsch07/index.html. **3a.3 If used in other programs/initiatives (***If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years***):** The Data Resource Center websites have been accessed more than 18 million times since 2006. Thousands of state and national researchers, MCH providers and analysts use the data to report valid children's health data. Healthy People 2010 uses items from the national surveys, and several more are slated to be added into Healthy People 2020. **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **3a.4 Data/sample** *(description of data/sample and size)*: Focus groups were held with numerous stakeholder groups—family advocates, clinicians, Title V leaders, researchers—to obtain feedback on report formats. The Child and Adolescent Health Measurement Initiative led the focus groups and developed reports in accordance with a general consumer information framework. Additional focus groups were held when preparing data and reports for display on the Data Resource Center website. The Data Resource Center executive committee also reviewed report formats for interpretability and applicability. **3a.5 Methods** *(e.g., focus group, survey, QI project)*: Focus groups **3a.6 Results** *(qualitative and/or quantitative results and conclusions)*:	 **3a** C ☐ P ☐ M ☐ N ☐
3b/3c. Relation to other NQF-endorsed measures	

3b.1 NQF # and Title of similar or related measures:	3b
(for NQF staff use) **Notes on similar/related endorsed or submitted measures:**	
3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source <u>or</u> different topic but same target population): **3b.2 Are the measure specifications harmonized? If not, why?**	**3b** C☐ P☐ M☐ N☐ NA ☐
3c. Distinctive or Additive Value **3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** **5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality:**	**3c** C☐ P☐ M☐ N☐ NA ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Usability*?	**3**
Steering Committee: Overall, to what extent was the criterion, *Usability*, met? **Rationale:**	**3** C☐ P☐ M☐ N☐
4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)	**Eval Rating**
4a. Data Generated as a Byproduct of Care Processes **4a.1-2 How are the data elements that are needed to compute measure scores generated?** Survey	**4a** C☐ P☐ M☐ N☐
4b. Electronic Sources **4b.1 Are all the data elements available electronically?** (*elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims*) Yes **4b.2 If not, specify the near-term path to achieve electronic capture by most providers.**	**4b** C☐ P☐ M☐ N☐
4c. Exclusions **4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?** No **4c.2 If yes, provide justification.**	**4c** C☐ P☐ M☐ N☐ NA ☐
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences **4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.**	**4d** C☐ P☐ M☐ N☐

4e. Data Collection Strategy/Implementation **4e.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:** Items are well understood and easy to implement. Items yield very low levels of missing values, don't know or refused answers. **4e.2 Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*)**:** Item is public domain and there is no cost associated with its use. **4e.3 Evidence for costs:** **4e.4 Business case documentation:**	**4e** C☐ P☐ M☐ N☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Feasibility?*	**4**
Steering Committee: Overall, to what extent was the criterion, *Feasibility*, met? **Rationale:**	**4** C☐ P☐ M☐ N☐
RECOMMENDATION	
(for NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.	Time-limited ☐
Steering Committee: Do you recommend for endorsement? **Comments:**	Y☐ N☐ A☐
CONTACT INFORMATION	
Co.1 Measure Steward (Intellectual Property Owner) **Co.1 <u>Organization</u>** Maternal and Child Health Bureau, Health Resources & Services Administration, Parklawn Building Room 18-05, 5600 Fishers Lane, Rockville, Maryland, 20857 **Co.2 <u>Point of Contact</u>** Christina, Bethell, Ph.D., MPH, MBA, bethellc@ohsu.edu, 503-494-1892-	
Measure Developer If different from Measure Steward **Co.3 <u>Organization</u>** See Ad.1 below, -, -, -, Maryland, - **Co.4 <u>Point of Contact</u>** Christina, Bethell, Ph.D., MPH, MBA, bethellc@ohsu.edu, 503-494-1892-	
Co.5 Submitter If different from Measure Steward POC Christina, Bethell, Ph.D., MPH, MBA, bethellc@ohsu.edu, 503-494-1892-, Maternal and Child Health Bureau, Health Resources & Services Administration	
Co.6 Additional organizations that sponsored/participated in measure development See Ad.1 below	
ADDITIONAL INFORMATION	

Workgroup/Expert Panel involved in measure development
Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

The Maternal and Child Health Bureau convenes a Technical Expert Panel (TEP) comprised of more than a dozen members. Members include other federal agencies, health services researchers, survey methodology experts, consumer organizations and clinical health experts on children´s health. The TEP consults in the identification and/or development of items for MCHB to consider for inclusion in the National Survey of Children's Health, including making recommendations for the scoring and reporting of measures resulting from the national survey.
 Members of the committee are drawn from the public and private sector, including members from national universities and national parenting and family groups, the Child and Adolescent Health Measurement Initiative (through the MCHB-sponsored Data Resource Center for Child and Adolescent Health) as well as members from the National Center for Health Statistics, the Centers for Disease Control and Prevention and other federal agencies. There is a range of activity performed by different members of the TEP depending on which measure is being developed, areas of expertise etc. The TEP process usually consists of 1 or 2 in person meetings, 6 or more conference calls, and numerous email exchanges. Subcommittees are formed based on areas of expertise. Because this is a collaborative activity, there is not a single developer of this measure.

Ad.2 If adapted, provide name of original measure:
Ad.3-5 If adapted, provide original specifications URL or attachment

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.6 Year the measure was first released: 2007
Ad.7 Month and Year of most recent revision: 04, 2007
Ad.8 What is your frequency for review/update of this measure? Updated every 4 years when a new National Survey of Children´s Health is developed
Ad.9 When is the next scheduled review/update for this measure? 01, 2011

Ad.10 Copyright statement/disclaimers:

Ad.11 -13 Additional Information web page URL or attachment: Attachment NSCH TEP 2007-634384047497007348.doc

Date of Submission (*MM/DD/YY*): 04/14/2011

NATIONAL QUALITY FORUM

Measure Evaluation 4.1
December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized)**:** Complete all <mark>yellow highlighted</mark> areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: *If there is no TAP or workgroup, the SC also evaluates the subcriteria (<mark>yellow</mark> highlighted areas).*

Steering Committee: Complete all <mark>pink</mark> highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) **NQF Review #:** 1333	**NQF Project:** Child Health Quality Measures 2010

MEASURE DESCRIPTIVE INFORMATION
De.1 Measure Title: Children Who Receive Family-Centered Care
De.2 Brief description of measure*:* A composite measure designed to assess the family-centeredness of care delivery along several dimensions: whether doctor 1) partners with family in care, 2) listens to patient/parent carefully, 3) spends enough time with child, 4)is sensitive to family values/customs, 5) provides needed information, 6)whether family is able to access interpreter help, if needed.
1.1-2 Type of Measure: Process   **De.3 If included in a composite or paired with another measure, please identify composite or paired measure**   This measure is one component in the multi-dimensional measure "Children and adolescents with a medical home" which is currently in the NQF voting period
De.4 National Priority Partners Priority Area: Patient and family engagement   **De.5 IOM Quality Domain:** Patient-centered   **De.6 Consumer Care Need:** Staying healthy

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	**NQF Staff**
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.* **A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)?** Yes **A.2 Indicate if Proprietary Measure** (*as defined in measure steward agreement*)**:** Proprietary measure **A.3 Measure Steward Agreement:** Government entity and in the public domain - no agreement necessary **A.4 Measure Steward Agreement attached:**	A Y ☐ N ☐

B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	**B** Y☐ N☐
C. The intended use of the measure includes both public reporting and quality improvement. ►**Purpose:**	**C** Y☐ N☐
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. **D.1 Testing:** Yes, fully developed and tested **D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?** Yes	**D** Y☐ N☐
(for NQF staff use**) Have all conditions for consideration been met?** **Staff Notes to Steward** (*if submission returned*)**:**	**Met** Y☐ N☐
Staff Notes to Reviewers (*issues or questions regarding any criteria*)**:**	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. *Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.* (evaluation criteria) **1a. High Impact**	**Eval Rating**
(for NQF staff use) **Specific NPP goal**:	
1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers **1a.2** **1a.3 Summary of Evidence of High Impact:** Family centered care (FCC) is a critical component in a child having a medical home, which has been recognized as an objective by the U.S. Department of Health and Human Services' Healthy people 2010. Additionally, medical home is one of the 18 national performance measures established for the state Title V programs it administers. Family centered care recognizes that the family is a child´s main source of care and support and that the family´s needs and perspectives are important to clinical decision making, which is associated with improved health outcomes for children. **1a.4 Citations for Evidence of High Impact:** American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee. The medical home. Pediatrics. 2002, reaffirmed 2008; 110:184-187. Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website. www.nschdata.org U.S. Department of Health and Human Services. Healthy People 2010. Conference Edition. Washington, DC. 2000.	**1a** C☐ P☐ M☐ N☐

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable

U.S. Department of Health and Human Services. Healthy People 2020.
http://www.healthypeople.gov/HP2020/.

National Priorities Partnership. Convened by the National Quality Forum.
http://www.nationalprioritiespartnership.org/.

National Committee for Quality Assurance. http://www.ncqa.org/.

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Health care providers, public health professionals and population-based health analysts can all benefit from knowing whether or not children are receiving quality care. The measure of family centered care allows the benefit of comparing care quality across populations or demographic groups.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
Nationally, only 67.4% of children age 0-17 who saw a medical provider in the past 12 months received family centered care.

1b.3 Citations for data on performance gap:
1. Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website. www.nschdata.org

2. Coker TR, Rodriguez MA, Flores G. Family-Centered Care for US Children With Special Health Care Needs: Who Gets it and Why? Pediatrics. 2010.

3. Duke NN, Scal PB. Adult Care Transitioning for Adolescents with Special Health Care Needs: A Pivotal Role for Family Centered Care. Matern Child Health J. 2009.

4. Flores G, Olson L, Tomany-Korman SC. Racial and ethnic disparities in early childhood health and health care. Pediatrics. 2005;115(2):e183-93.

5. Strickland BB, Singh GK, Kogan MD, Mann MY, van Dyck PC, Newacheck PW. Access to the medical home: new findings from the 2005-2006 National Survey of Children with Special Health Care Needs. Pediatrics. 2009;123(6):e996-1004.

6. Toomey SL, Homer CJ, Finkelstein JA. Comparing medical homes for children with ADHD and asthma. Acad Pediatr. 2010;10(1):56-63.

1b.4 Summary of Data on disparities by population group:
35.1% of children living in Spanish speaking households have FCC care, compared to 63.3% of Hispanic children living in English speaking households and 72.0% of non-Hispanic children.
Children living in a lower income household (0-99% FPL; 50.1%) are less likely to receive FCC than children living in a higher income household(400% FPL or more; 78.3%).
Uninsured children are the least likely to receive FCC (45.2%), followed by publicly insured children (57.0%) and privately insured children (75.2%).
?   Latino children with parents interviewed in Spanish were almost half as likely as white children to receive adequate explanations and have the physician spend enough time with them. Blacks and Latinos interviewed in Spanish were significantly more likely than whites to say the doctor treated them with respect (always or usually).

1b.5 Citations for data on Disparities:
1. Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website. www.nschdata.org

2. Coker TR, Rodriguez MA, Flores G. Family-Centered Care for US Children With Special Health Care Needs: Who Gets it and Why? Pediatrics. 2010.

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3. Duke NN, Scal PB. Adult Care Transitioning for Adolescents with Special Health Care Needs: A Pivotal Role for Family Centered Care. Matern Child Health J. 2009.

4. Flores G, Olson L, Tomany-Korman SC. Racial and ethnic disparities in early childhood health and health care. Pediatrics. 2005;115(2):e183-93.

5. Strickland BB, Singh GK, Kogan MD, Mann MY, van Dyck PC, Newacheck PW. Access to the medical home: new findings from the 2005-2006 National Survey of Children with Special Health Care Needs. Pediatrics. 2009;123(6):e996-1004.

6. Toomey SL, Homer CJ, Finkelstein JA. Comparing medical homes for children with ADHD and asthma. Acad Pediatr. 2010;10(1):56-63.

7. Guerrero, AD, Chen, J, Inkelas, M, Rodriguez, HP, & Ortega, AN. (2010). Racial and ethnic disparities in pediatric experiences of family-centered care. Medical Care, 48(4),388-93.

1c. Outcome or Evidence to Support Measure Focus

1c.1 Relationship to Outcomes (*For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population*):

1c.2-3. Type of Evidence: Other Population Based Research

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*):
Children receiving FCC are more likely to be rated in very good or excellent health compared to those not receiveing FCC (89.3% vs. 75.6%).

Outcomes are relevant to the target population for purposes of quality improvement. Measurement and receipt of high quality care can only be strenghtened with expansion of evidence based quality indicators. All items included in the measure are report of patient experience with healthcare services. Family centered care is actionable by healthcare settings and personnel.

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom*):

1c.6 Method for rating evidence:

1c.7 Summary of Controversy/Contradictory Evidence:

1c.8 Citations for Evidence (*other than guidelines*):

1c.9 Quote the Specific guideline recommendation (*including guideline number and/or page number*):

1c.10 Clinical Practice Guideline Citation:
1c.11 National Guideline Clearinghouse or other URL:

1c.12 Rating of strength of recommendation (*also provide narrative description of the rating and by whom*):

1c.13 Method for rating strength of recommendation (*If different from USPSTF system, also describe rating and how it relates to USPSTF*):

1c.14 Rationale for using this guideline over others:

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TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Importance to Measure and Report*?	**1**
Steering Committee: Was the threshold criterion, *Importance to Measure and Report*, met? **Rationale:**	**1** Y ☐ N ☐
2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES	
Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. ([evaluation criteria](#))	**Eval Rating**
2a. MEASURE SPECIFICATIONS	

S.1 Do you have a web page where current detailed measure specifications can be obtained?
S.2 If yes, provide web page URL:

2a. Precisely Specified

2a.1 Numerator Statement (*Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome***):**
Percentage of children receiving Family-Centered Care (FCC)

2a.2 Numerator Time Window (*The time period in which cases are eligible for inclusion in the numerator***):**
Encounter or point in time.

2a.3 Numerator Details (*All information required to collect/calculate the numerator, including all codes, logic, and definitions***):**
For a child to be included in the numerator of having family-centered care, criteria from the following six questions must be met:
-Parent reported that doctor usually or always spent enough time with child (K5Q40)
-Parent reported that doctor usually or always listened carefully (K5Q41)
-Parent reported that doctor usually or always provided care that is sensitive to the family's values and customs (K5Q42)
-Parent reported that doctor usually or always provided specific needed information (K5Q43)
-Parent reported that doctor usually or always helped the family feel like a partner in the child's care (K5Q44)
-Parent reported that doctor usually or always provided interpreter services for parents when needed (K5Q45 AND K5Q46)

2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured***):**
Children age 0-17 years with visit to a health care provider in last 12 months

2a.5 Target population gender: Female, Male
2a.6 Target population age range: Children age 0-17 years

2a.7 Denominator Time Window (*The time period in which cases are eligible for inclusion in the denominator***):**
Denominator window is a fixed point in time

2a.8 Denominator Details (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions***):**
Children age 0-17 years with visit to a health care provider in last 12 months

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population***): Excluded from denominator if child does not fall in target population age range of 0-17 years**

Excluded from denominator if child did not see any health care provider in the past 12 months— preventive medical care, preventive dental care, mental health treatment or counseling, saw a specialist, or needed to

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see a specialist (K4Q20, K4Q21, K4Q22, K4Q23, K4Q25)

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions***):**
If child is older than 17 years of age, excluded from denominator.
If child has not seen any health care provider in the past 12 months— preventive medical care, preventive dental care, mental health treatment or counseling, saw a specialist, or needed to see a specialist (K4Q20, K4Q21, K4Q22, K4Q23, K4Q25)

2a.11 Stratification Details/Variables (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions***):**
No stratification is required.

When the Family-Centered Care measure was administered in its most recent form, in the 2007 National Survey of Children´s Health, the survey included a number of child demographic variables that allow for stratification of the findings by possible vulnerability:
• Age
• Gender
• Geographic location- State, HRSA Region, National level Rural Urban Commuter Areas (RUCA)
• Race/ethnicity
• Health insurance- type, consistency
• Primary household language
• Household income
• Special Health Care Needs- status and type

2a.12-13 Risk Adjustment Type: No risk adjustment necessary

2a.14 Risk Adjustment Methodology/Variables (*List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method***):**

2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score: Rate/proportion
2a.20 Interpretation of Score: Better quality = Higher score
2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**
To receive numerator of child having adequate insurance:
-Parent reported that doctor usually or always spent enough time with child (K5Q40)
-Parent reported that doctor usually or always listened carefully (K5Q41)
-Parent reported that doctor usually or always provided care that is sensitive to the family's values and customs (K5Q42)
-Parent reported that doctor usually or always provided specific needed information (K5Q43)
-Parent reported that doctor usually or always helped the family feel like a partner in the child's care (K5Q44)
-Parent reported that doctor usually or always provided interpreter services for parents whose primary language is not English (K5Q45 AND K5Q46)

2a.22 Describe the method for discriminating performance (*e.g., significance testing*)**:**

2a.23 Sampling (Survey) Methodology *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)*:
Best guideline to follow is the survey methodology used in the 2007 National Survey of Children´s Health.

The goal of the NSCH sample design was to generate samples representative of populations of children within each state. An additional goal of the NSCH was to obtain state-specific sample sizes that were sufficiently large to permit reasonably precise estimates of the health characteristics of children in each state.

To achieve these goals, state samples were designed to obtain a minimum of 1,700 completed interviews. The number of children to be selected in each National Immunization Survey (NIS) estimation area was determined by allocating the total of 1,700 children in the state to each National Immunization Survey (NIS)

estimation area within the state in proportion to the total estimated number of households with children in the NIS estimation area. Given this allocation, the number of households that needed to be screened in each NIS estimation area was calculated using the expected proportion of households with children under 18 years of age in the area. Then, the number of telephone numbers that needed to be called was computed using the expected working residential number rate, adjusted for expected nonresponse.

A total of 91,642 interviews were completed from April 2007 to July 2008 for the 2007 National Survey of Children´s Health. A random-digit-dialed sample of households with children less than 18 years of age was selected from each of the 50 states and the District of Columbia. One child was randomly selected from all children in each identified household to be the subject of the survey. The respondent was a parent or guardian who knew about the child's health and health care.

2a.24 Data Source (*Check the source(s) for which the measure is specified and tested*)

2a.25 Data source/data collection instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*):
2007 National Survey of Children´s Health; 2005/06 National Survey of Children with Special Health Care Needs

2a.26-28 Data source/data collection instrument reference web page URL or attachment: URL
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slaits/nsch07/1a_Survey_Instrument_English/NSCH_Questionnaire_052109.pdf

2a.29-31 Data dictionary/code table web page URL or attachment: URL
http://nschdata.org/Viewdocument.aspx?item=519

2a.32-35 Level of Measurement/Analysis (*Check the level(s) for which the measure is specified and tested*)
Population : National, Population : Regional/network, Population : states

2a.36-37 Care Settings (*Check the setting(s) for which the measure is specified and tested*)
Other

2a.38-41 Clinical Services (*Healthcare services being measured, check all that apply*)
Other   Patient Experience

TESTING/ANALYSIS

2b. Reliability testing

2b.1 Data/sample (*description of data/sample and size*): Qualitative testing of the entire 2007 National Survey of Children´s Health was conducted by the National Center for Health Statistics. They conducted cognitive interviews with the 2007 NSCH Computer-Assisted Telephone Interview (CATI) to make sure the entire survey instrument was functioning properly. N=640 interviews were completed over 3 days in December 2006. The questionnaire was then revised and finalized based on feedback from participants in these interviews.

2b.2 Analytic Method (*type of reliability & rationale, method for testing*):
Cognitive testing was conducted to test reliability and interpretability of questions across population.

2b.3 Testing Results (*reliability statistics, assessment of adequacy in the context of norms for the test conducted*):
The Maternal and Child Health Bureau leads the development of the NSCH and NS-CSHCN survey and indicators, in collaboration with the National Center for Health Statistics (NCHS) and a national technical expert panel. The expert panel includes representatives from other federal agencies, state Title V leaders, family organizations, and child health researchers, and experts in all fields related to the surveys (adolescent health, family and neighborhoods, early childhood and development etc.). Previously validated questions and scales are used when available. Extensive literature reviewing and expert reviewing of items is conducted for all aspects of the survey. Respondents' cognitive understanding of the survey questions is assessed during the

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pretest phase and revisions made as required. All final data components are verified by NCHS and DRC/CAHMI staff prior to public release. Face validity is conducted in comparing results with prior years of the survey and/or results from other implementations of items. No specific reliability results are available for this measure. Please contact the CAHMI if quantitative measures are needed.	
2c. Validity testing **2c.1 Data/sample** *(description of data/sample and size)*: 640 interviews were completed over 3 days in December 2006 **2c.2 Analytic Method** *(type of validity & rationale, method for testing)*: Cognitive testing was conducted with parents of children ages 0-17 years (interviews conducted over the phone with residential households). **2c.3 Testing Results** *(statistical results, assessment of adequacy in the context of norms for the test conducted)*: Please see the references section for peer-reviewed articles which have used these items. Peer-reviewed papers generally undertake their own validity testing in order to meet strict peer review standards. See also Reliability Testing Results above.	**2c** C☐ P☐ M☐ N☐
2d. Exclusions Justified **2d.1 Summary of Evidence supporting exclusion(s)**: **2d.2 Citations for Evidence**: **2d.3 Data/sample** *(description of data/sample and size)*: **2d.4 Analytic Method** *(type analysis & rationale)*: **2d.5 Testing Results** *(e.g., frequency, variability, sensitivity analyses)*:	**2d** C☐ P☐ M☐ N☐ NA ☐
2e. Risk Adjustment for Outcomes/ Resource Use Measures **2e.1 Data/sample** *(description of data/sample and size)*: **2e.2 Analytic Method** *(type of risk adjustment, analysis, & rationale)*: **2e.3 Testing Results** *(risk model performance metrics)*: **2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:**	**2e** C☐ P☐ M☐ N☐ NA ☐
2f. Identification of Meaningful Differences in Performance **2f.1 Data/sample from Testing or Current Use** *(description of data/sample and size)*: **2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance** *(type of analysis & rationale)*: **2f.3 Provide Measure Scores from Testing or Current Use** *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*:	**2f** C☐ P☐ M☐ N☐

2g. Comparability of Multiple Data Sources/Methods **2g.1 Data/sample** (*description of data/sample and size*)**:** **2g.2 Analytic Method** (*type of analysis & rationale*)**:** **2g.3 Testing Results** (*e.g., correlation statistics, comparison of rankings*)**:**	**2g** C☐ P☐ M☐ N☐ NA ☐
2h. Disparities in Care **2h.1 If measure is stratified, provide stratified results** (*scores by stratified categories/cohorts*)**:** **2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:**	**2h** C☐ P☐ M☐ N☐ NA ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Scientific Acceptability of Measure Properties?*	**2**
Steering Committee: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties*, **met?** **Rationale:**	*2* C☐ P☐ M☐ N☐
3. USABILITY	
Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)	**Eval Rating**
3a. Meaningful, Understandable, and Useful Information **3a.1 Current Use:** In use **3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large)** (*If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years*)**:** U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The Health and Well-Being of Children: A Portrait of States and the Nation 2007. Chartbook based on data from the 2007 National Survey of Children's Health. http://mchb.hrsa.gov/nsch07/index.html. **3a.3 If used in other programs/initiatives (***If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years***):** The Data Resource Center websites have been accessed more than 18 million times since 2006. Thousands of state and national researchers, MCH providers and analysts use the data to report valid children's health data. Healthy People 2010 uses items from the national surveys, and several more are slated to be added into Healthy People 2020. **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **3a.4 Data/sample** (*description of data/sample and size*)**:** Focus groups were held with numerous stakeholder groups—family advocates, clinicians, Title V leaders, researchers—to obtain feedback on report formats. The Child and Adolescent Health Measurement Initiative led the focus groups and developed reports in accordance with a general consumer information framework. Additional focus groups were held when preparing data and reports for display on the Data Resource Center website. The Data Resource Center	**3a** C☐ P☐ M☐ N☐

executive committee also reviewed report formats for interpretability and applicability. **3a.5 Methods** *(e.g., focus group, survey, QI project)***:** Focus groups **3a.6 Results** *(qualitative and/or quantitative results and conclusions)***:**	
3b/3c. Relation to other NQF-endorsed measures **3b.1 NQF # and Title of similar or related measures:**	
(for NQF staff use) **Notes on similar/related endorsed or submitted measures:**	
3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source or different topic but same target population): **3b.2 Are the measure specifications harmonized? If not, why?**	**3b** C☐ P☐ M☐ N☐ NA ☐
3c. Distinctive or Additive Value **3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** **5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality:**	**3c** C☐ P☐ M☐ N☐ NA ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Usability?*	**3**
Steering Committee: Overall, to what extent was the criterion, *Usability*, met? **Rationale:**	**3** C☐ P☐ M☐ N☐
4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)	**Eval Ratin g**
4a. Data Generated as a Byproduct of Care Processes **4a.1-2 How are the data elements that are needed to compute measure scores generated?** Survey	**4a** C☐ P☐ M☐ N☐
4b. Electronic Sources **4b.1 Are all the data elements available electronically?** *(elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims)* Yes **4b.2 If not, specify the near-term path to achieve electronic capture by most providers.**	**4b** C☐ P☐ M☐ N☐
4c. Exclusions **4c.1 Do the specified exclusions require additional data sources beyond what is required for the**	**4c** C☐ P☐

numerator and denominator specifications? No **4c.2 If yes, provide justification.**	M ☐ N ☐ NA ☐
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences **4d.1** Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.	**4d** C ☐ P ☐ M ☐ N ☐
4e. Data Collection Strategy/Implementation **4e.1** Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: Items are well understood and easy to implement. Items yield very low levels of missing values, don't know or refused answers. **4e.2 Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*): Item is public domain and there is no cost associated with its use. **4e.3 Evidence for costs:** **4e.4 Business case documentation:**	**4e** C ☐ P ☐ M ☐ N ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Feasibility?*	**4**
Steering Committee: Overall, to what extent was the criterion, *Feasibility*, met? **Rationale:**	**4** C ☐ P ☐ M ☐ N ☐
RECOMMENDATION	
(for NQF staff use) **Check if measure is untested and only eligible for time-limited endorsement.**	Time-limited ☐
Steering Committee: Do you recommend for endorsement? **Comments:**	Y ☐ N ☐ A ☐
CONTACT INFORMATION	
Co.1 Measure Steward (Intellectual Property Owner) **Co.1** <u>Organization</u> Maternal and Child Health Bureau, Health Resources & Services Administration, Parklawn Building Room 18-05, 5600 Fishers Lane, 707 SW Gaines Street, Rockville, Maryland, 20857 **Co.2** <u>Point of Contact</u> Christina, Bethell, Ph.D., MPH, MBA, bethellc@ohsu.edu, 503-494-1892-	
Measure Developer If different from Measure Steward **Co.3** <u>Organization</u> See Ad.1 below, -, -, -, Maryland, - **Co.4** <u>Point of Contact</u>	

Christina, Bethell, Ph.D., MPH, MBA, bethellc@ohsu.edu, 503-494-1892-

Co.5 Submitter If different from Measure Steward POC
Christina, Bethell, Ph.D., MPH, MBA, bethellc@ohsu.edu, 503-494-1892-, Maternal and Child Health Bureau, Health Resources & Services Administration

Co.6 Additional organizations that sponsored/participated in measure development
See Ad.1 below

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development
Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
The Maternal and Child Health Bureau convenes a Technical Expert Panel (TEP) comprised of more than a dozen members. Members include other federal agencies, health services researchers, survey methodology experts, consumer organizations and clinical health experts on children´s health. The TEP consults in the identification and/or development of items for MCHB to consider for inclusion in the National Survey of Children's Health, including making recommendations for the scoring and reporting of measures resulting from the national survey. Members of the committee are drawn from the public and private sector, including members from national universities and national parenting and family groups, the Child and Adolescent Health Measurement Initiative (through the MCHB-sponsored Data Resource Center for Child and Adolescent Health) as well as members from the National Center for Health Statistics, the Centers for Disease Control and Prevention and other federal agencies. There is a range of activity performed by different members of the TEP depending on which measure is being developed, areas of expertise etc. The TEP process usually consists of 1 or 2 in person meetings, 6 or more conference calls, and numerous email exchanges. Subcommittees are formed based on areas of expertise. Because this is a collaborative activity, there is not a single developer of this measure.

Ad.2 If adapted, provide name of original measure:
Ad.3-5 If adapted, provide original specifications URL or attachment

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.6 Year the measure was first released: 2007
Ad.7 Month and Year of most recent revision: 04, 2007
Ad.8 What is your frequency for review/update of this measure? Updated every 4 years when a new National Survey of Children´s Health is developed
Ad.9 When is the next scheduled review/update for this measure? 01, 2011

Ad.10 Copyright statement/disclaimers:

Ad.11 -13 Additional Information web page URL or attachment: Attachment NSCH TEP 2007-634384065354465385.doc

Date of Submission (*MM/DD/YY*)**:** 04/14/2011

NATIONAL QUALITY FORUM

Measure Evaluation 4.1
December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized)**:** Complete all <mark>yellow highlighted</mark> areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: *If there is no TAP or workgroup, the SC also evaluates the subcriteria (<mark>yellow</mark> highlighted areas).*

Steering Committee: Complete all <mark>pink</mark> highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) **NQF Review #:** 1337 **NQF Project:** Child Health Quality Measures 2010	
MEASURE DESCRIPTIVE INFORMATION	

De.1 Measure Title: Children With Inconsistent Health Insurance Coverage in the Past 12 Months

**De.2 Brief description of measure*:* Measures whether children are uninsured at the time of the survey or if currently insured children experienced periods of no insurance during past 12 months

1.1-2 Type of Measure: Process
De.3 If included in a composite or paired with another measure, please identify composite or paired measure

De.4 National Priority Partners Priority Area: Population health
De.5 IOM Quality Domain: Effectiveness
De.6 Consumer Care Need: Staying healthy

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	**NQF Staff**
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.* **A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)?** Yes **A.2 Indicate if Proprietary Measure** (*as defined in measure steward agreement*): Proprietary measure **A.3 Measure Steward Agreement:** Government entity and in the public domain - no agreement necessary **A.4 Measure Steward Agreement attached:**	**A** Y ☐ N ☐
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	**B** Y ☐ N ☐

C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ►**Purpose:**	**C** Y☐ N☐
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. **D.1 Testing:** Yes, fully developed and tested **D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?** Yes	**D** Y☐ N☐
(for NQF staff use**) Have all conditions for consideration been met?** **Staff Notes to Steward** (*if submission returned*)**:**	**Met** Y☐ N☐
Staff Notes to Reviewers (*issues or questions regarding any criteria*)**:**	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. *Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.* (evaluation criteria) **1a. High Impact**	**Eval Rating**
(for NQF staff use) Specific NPP goal:	
1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, Leading cause of morbidity/mortality, Patient/societal consequences of poor quality **1a.2** **1a.3 Summary of Evidence of High Impact:** Nationally, 15.1% of children did not have consistent health insurance coverage in the previous 12 months. Children with inconsistent health insurance coverage are more likely to have no usual source of care, fewer preventive medical visits, and unmet medical or prescription needs than children who are consistently insured. Inconsistent insurance can have serious consequences for children with ongoing conditions since they may experience periods in which their care is not covered. It is also potentially harmful for children without current conditions but for whom identification of emerging conditions is impacted by lack of coverage. **1a.4 Citations for Evidence of High Impact:** Cassedy A, Fairbrother G, Newacheck PW. (2008). The impact of insurance instability on children´s access, utilization, and satisfaction with health care. Ambulatory Pediatrics, 8(5), 321-8. Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website. Derigne L, Porterfield S, Metz S. The influence of health insurance on parent´s reports of children´s unmet mental health needs. Matern Child Health J. 2009;13(2):176-186. Honberg L, McPherson M, Strickland B, Gage JC, Newacheck PW. Assuring adequate health insurance: results of the National Survey of Children with Special Health Care Needs. Pediatrics. 2005;115(5):1233-1239.	**1a** C☐ P☐ M☐ N☐

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable

Halterman JS, Montes G, Shone LP, Szilagyi PG. (2008). The impact of health insurance gaps on access to care among children with asthma in the United States. Ambulatory Pediatrics. 8(1):43-9.

Olson LM, Tang SF, Newacheck PW. (2005). Children in the United States with discontinuous health insurance coverage. New England Journal of Medicine., 28;353(4):382-91.

Smaldone A, Honig J, Byrne MW. Delayed and forgone care for children with special health care needs in New York State. Matern Child Health J. 2005;9(2):S75-86.

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: It is important to not only measure if a child is currently insured but also if they are consistently insured. Because gaps in health insurance are associated with delayed and/or less accessible medical care, health care providers, public health professionals and population-based health analysts can all benefit from knowing how many children lack consistent health insurance. This measure also allows for comparison across populations and demographic groups.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
There is a wide range in the percentage of children who have inconsistent health insurance, from 5.7% in Massachusetts to 26.2% in Texas.

1b.3 Citations for data on performance gap:
Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website.

1b.4 Summary of Data on disparities by population group:
The prevalence of children with inconsistent health insurance varies across race/ethnicity. Hispanic children are the most likely to have inconsistent health insurance (28.3%), followed by Black, non-Hispanic children (16.9%), and White, non-Hispanic children (10.4%).
Hispanic children living in Spanish-speaking households are more likely to have inconsistent health insurance than Hispanic children living in English-speaking households (37.4% vs. 18.4%).
Consistency of health insurance also varies by income. Children living at 200% FPL or lower are over four times more likely to have inconsistent health insurance than chidlren living at 400% FPL or above (24.3% vs. 5.6%).

1b.5 Citations for data on Disparities:
Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website.

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1c. Outcome or Evidence to Support Measure Focus

1c.1 Relationship to Outcomes (*For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population*): Children with consistent, private or public insurance coverage have low rates of unmet health care needs and good access to health care.

1c.2-3. Type of Evidence:

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*):
Children with consistent health insurance are more likely to have adequate health insurance than children with inconsistant coverate (77.3% vs 64.5%).
Children with consistent health insurance are also more likely to recieve preventive medical visits than children with inconsistent coverage (90.2% vs. 78.7%)and less likely to skip a grade in school (9.8% vs 15.0%).

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom***):**

1c
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1c.6 Method for rating evidence:

1c.7 Summary of Controversy/Contradictory Evidence:

1c.8 Citations for Evidence (*other than guidelines***):**

1c.9 Quote the Specific guideline recommendation (*including guideline number and/or page number***):**

1c.10 Clinical Practice Guideline Citation:
1c.11 National Guideline Clearinghouse or other URL:

1c.12 Rating of strength of recommendation (*also provide narrative description of the rating and by whom***):**

1c.13 Method for rating strength of recommendation (*If different from USPSTF system, also describe rating and how it relates to USPSTF***):**

1c.14 Rationale for using this guideline over others:

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Importance to Measure and Report*?	**1**
Steering Committee: Was the threshold criterion, *Importance to Measure and Report*, met? **Rationale:**	**1** **Y**☐ **N**☐
2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES	
Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)	**Eval Rating**
2a. MEASURE SPECIFICATIONS	

S.1 Do you have a web page where current detailed measure specifications can be obtained?
S.2 If yes, provide web page URL:

2a. Precisely Specified

2a.1 Numerator Statement (*Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome***):**
Percentage of children who are uninsured at the time of the survey or currently insured children who experienced periods of no insurance during past 12 months

2a.2 Numerator Time Window (*The time period in which cases are eligible for inclusion in the numerator***):**
Encounter or point in time

2a.3 Numerator Details (*All information required to collect/calculate the numerator, including all codes, logic, and definitions***):**
For a child to be included in the numerator of having inconsistent insurance coverage:
-Child is currently uninsured (K3Q01=no insurance), OR
-Child experienced periods of no insurance during past 12 months (K3Q03=yes, currently insured but had a point in previous 12 months with no insurance)

2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured***):**

The right column for section 2a contains: **2a-specs** with checkboxes **C**☐ **P**☐ **M**☐ **N**☐

Children age 0-17 years

2a.5 Target population gender: Female, Male
2a.6 Target population age range: Children age 0-17 years

2a.7 Denominator Time Window (*The time period in which cases are eligible for inclusion in the denominator***):**
Time window is a fixed period of time

2a.8 Denominator Details (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions***):**
Children age 0-17 years

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population***):** Excluded from denominator if child does not fall in target population age range of 0-17 years

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions***):**
If child is older than 17 years of age, excluded from denominator.

2a.11 Stratification Details/Variables (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions***):**
No stratification is required.

When the consistency of health insurance measure was administered in its most recent form, in the 2007 NSCH, the survey included a number of child demographic variables that allow for stratification of the findings by possible vulnerability:
• Age
• Gender
• Geographic location- State, HRSA Region, National level Rural Urban Commuter Areas (RUCA)
• Race/ethnicity
• Health insurance- type, consistency
• Primary household language
• Household income
• Special Health Care Needs- status and type

2a.12-13 Risk Adjustment Type: No risk adjustment necessary

2a.14 Risk Adjustment Methodology/Variables (*List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method***):**

2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score: Rate/proportion
2a.20 Interpretation of Score: Better quality = Lower score
2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**
If current insurance= yes, then follow with question about whether child was not covered in previous 12 months. If yes, then child is in numerator for "inconsistent insurance coverage." If current insurance = no, then child is in numerator for "inconsistent insurance coverage."

2a.22 Describe the method for discriminating performance (*e.g., significance testing*)**:**

2a.23 Sampling (Survey) Methodology *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)*:
Best guideline to follow is the survey methodology used in the 2007 National Survey of Children´s Health.

The goal of the NSCH sample design was to generate samples representative of populations of children within each state. An additional goal of the NSCH was to obtain state-specific sample sizes that were sufficiently large to permit reasonably precise estimates of the health characteristics of children in each state.

To achieve these goals, state samples were designed to obtain a minimum of 1,700 completed interviews. The number of children to be selected in each National Immunization Survey (NIS) estimation area was determined by allocating the total of 1,700 children in the state to each National Immunization Survey (NIS) estimation area within the state in proportion to the total estimated number of households with children in the NIS estimation area. Given this allocation, the number of households that needed to be screened in each NIS estimation area was calculated using the expected proportion of households with children under 18 years of age in the area. Then, the number of telephone numbers that needed to be called was computed using the expected working residential number rate, adjusted for expected nonresponse.

A total of 91,642 interviews were completed from April 2007 to July 2008 for the 2007 National Survey of Children´s Health. A random-digit-dialed sample of households with children less than 18 years of age was selected from each of the 50 states and the District of Columbia. One child was randomly selected from all children in each identified household to be the subject of the survey. The respondent was a parent or guardian who knew about the child's health and health care.

2a.24 Data Source (*Check the source(s) for which the measure is specified and tested*)

2a.25 Data source/data collection instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*)**:**
2007 National Survey of Children´s Health

2a.26-28 Data source/data collection instrument reference web page URL or attachment: URL
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slaits/nsch07/1a_Survey_Instrument_English/NSCH_Questionnaire_052109.pdf

2a.29-31 Data dictionary/code table web page URL or attachment: URL
http://nschdata.org/Viewdocument.aspx?item=519

2a.32-35 Level of Measurement/Analysis (*Check the level(s) for which the measure is specified and tested*)
Population : National, Population : Regional/network, Population : states

2a.36-37 Care Settings (*Check the setting(s) for which the measure is specified and tested*)
Other

2a.38-41 Clinical Services (*Healthcare services being measured, check all that apply*)
Other   patient experience

TESTING/ANALYSIS

2b. Reliability testing

2b.1 Data/sample (*description of data/sample and size*)**:** Qualitative testing of the entire 2007 National Survey of Children´s Health was conducted by the National Center for Health Statistics. They conducted cognitive interviews with the 2007 NSCH Computer-Assisted Telephone Interview (CATI) to make sure the entire survey instrument was functioning properly. N=640 interviews were completed over 3 days in December 2006. The questionnaire was then revised and finalized based on feedback from participants in these interviews.

2b.2 Analytic Method (*type of reliability & rationale, method for testing*)**:**
Cognitive testing was conducted to test reliability and interpretability of questions across population.

2b.3 Testing Results (*reliability statistics, assessment of adequacy in the context of norms for the test conducted*)**:**
The Maternal and Child Health Bureau leads the development of the NSCH and NS-CSHCN survey and indicators, in collaboration with the National Center for Health Statistics (NCHS) and a national technical expert panel. The expert panel includes representatives from other federal agencies, state Title V leaders, family organizations, and child health researchers, and experts in all fields related to the surveys (adolescent health, family and neighborhoods, early childhood and development etc.). Previously validated questions and

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scales are used when available. Extensive literature reviewing and expert reviewing of items is conducted for all aspects of the survey. Respondents' cognitive understanding of the survey questions is assessed during the pretest phase and revisions made as required. All final data components are verified by NCHS and DRC/CAHMI staff prior to public release. Face validity is conducted in comparing results with prior years of the survey and/or results from other implementations of items. No specific reliability results are available for this measure. Please contact the CAHMI if quantitative measures are needed.	

2c. Validity testing

2c.1 Data/sample *(description of data/sample and size)*: 640 interviews were completed over 3 days in December 2006

2c.2 Analytic Method *(type of validity & rationale, method for testing)*:
Cognitive testing was conducted with parents of children ages 0-17 years (interviews conducted over the phone with residential households).

2c.3 Testing Results *(statistical results, assessment of adequacy in the context of norms for the test conducted)*:
Please see the references section for peer-reviewed articles which have used these items. Peer-reviewed papers generally undertake their own validity testing in order to meet strict peer review standards. See also Reliability Testing Results above.

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2d. Exclusions Justified

2d.1 Summary of Evidence supporting exclusion(s):

2d.2 Citations for Evidence:

2d.3 Data/sample *(description of data/sample and size)*:

2d.4 Analytic Method *(type analysis & rationale)*:

2d.5 Testing Results *(e.g., frequency, variability, sensitivity analyses)*:

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NA
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2e. Risk Adjustment for Outcomes/ Resource Use Measures

2e.1 Data/sample *(description of data/sample and size)*:

2e.2 Analytic Method *(type of risk adjustment, analysis, & rationale)*:

2e.3 Testing Results *(risk model performance metrics)*:

2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:

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NA
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2f. Identification of Meaningful Differences in Performance

2f.1 Data/sample from Testing or Current Use *(description of data/sample and size)*:

2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance *(type of analysis & rationale)*:

2f.3 Provide Measure Scores from Testing or Current Use *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in*

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performance):	
2g. Comparability of Multiple Data Sources/Methods **2g.1 Data/sample** *(description of data/sample and size)*: **2g.2 Analytic Method** *(type of analysis & rationale)*: **2g.3 Testing Results** *(e.g., correlation statistics, comparison of rankings)*:	**2g** C ☐ P ☐ M ☐ N ☐ NA ☐
2h. Disparities in Care **2h.1 If measure is stratified, provide stratified results** *(scores by stratified categories/cohorts)*: **2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:**	**2h** C ☐ P ☐ M ☐ N ☐ NA ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Scientific Acceptability of Measure Properties?*	**2**
Steering Committee: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties*, met? **Rationale:**	*2* C ☐ P ☐ M ☐ N ☐
3. USABILITY	
Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. ([evaluation criteria](#))	Eval Ratin g
3a. Meaningful, Understandable, and Useful Information **3a.1 Current Use:** In use **3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large)** (*If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years*): U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The Health and Well-Being of Children: A Portrait of States and the Nation 2007. Chartbook based on data from the 2007 National Survey of Children's Health. http://mchb.hrsa.gov/nsch07/index.html **3a.3 If used in other programs/initiatives (***If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years***):** The Data Resource Center websites have been accessed more than 18 million times since 2006. Thousands of state and national researchers, MCH providers and analysts use the data to report valid children's health data. Healthy People 2010 uses items from the national surveys, and several more are slated to be added into Healthy People 2020. **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **3a.4 Data/sample** *(description of data/sample and size)*: Focus groups were held with numerous stakeholder groups—family advocates, clinicians, Title V leaders, researchers—to obtain feedback on report formats. The Child and Adolescent Health Measurement Initiative led the focus groups and developed reports in accordance with a general consumer information framework. Additional focus groups were held when	 **3a** C ☐ P ☐ M ☐ N ☐

preparing data and reports for display on the Data Resource Center website. The Data Resource Center executive committee also reviewed report formats for interpretability and applicability. **3a.5 Methods** *(e.g., focus group, survey, QI project)***:** Focus groups **3a.6 Results** *(qualitative and/or quantitative results and conclusions)***:**	
3b/3c. Relation to other NQF-endorsed measures **3b.1 NQF # and Title of similar or related measures:**	
(for NQF staff use) **Notes on similar/related** underlined endorsed **or submitted measures:**	
3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source or different topic but same target population): **3b.2 Are the measure specifications harmonized? If not, why?**	**3b** C☐ P☐ M☐ N☐ NA ☐
3c. Distinctive or Additive Value **3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** **5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality:**	**3c** C☐ P☐ M☐ N☐ NA ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Usability*?	**3**
Steering Committee: Overall, to what extent was the criterion, *Usability*, met? **Rationale:**	**3** C☐ P☐ M☐ N☐
4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)	**Eval Ratin g**
4a. Data Generated as a Byproduct of Care Processes **4a.1-2 How are the data elements that are needed to compute measure scores generated?** Survey	**4a** C☐ P☐ M☐ N☐
4b. Electronic Sources **4b.1 Are all the data elements available electronically?** *(elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims)* Yes **4b.2 If not, specify the near-term path to achieve electronic capture by most providers.**	**4b** C☐ P☐ M☐ N☐
4c. Exclusions	**4c** C☐

4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications? No **4c.2 If yes, provide justification.**	P ☐ M ☐ N ☐ NA ☐
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences **4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.**	**4d** C ☐ P ☐ M ☐ N ☐
4e. Data Collection Strategy/Implementation **4e.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:** Items are well understood and easy to implement. Items yield very low levels of missing values, don't know or refused answers. **4e.2 Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*)**:** Item is public domain and there is no cost associated with its use. **4e.3 Evidence for costs:** **4e.4 Business case documentation:**	**4e** C ☐ P ☐ M ☐ N ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Feasibility*?	**4**
Steering Committee: Overall, to what extent was the criterion, *Feasibility*, met? **Rationale:**	**4** C ☐ P ☐ M ☐ N ☐
RECOMMENDATION	
(for NQF staff use) **Check if measure is untested and only eligible for time-limited endorsement.**	Time-limited ☐
Steering Committee: Do you recommend for endorsement? **Comments:**	Y ☐ N ☐ A ☐
CONTACT INFORMATION	
Co.1 Measure Steward (Intellectual Property Owner) **Co.1 Organization** Maternal and Child Health Bureau, Health Resources & Services Administration, Parklawn Building Room 18-05, 5600 Fishers Lane, Rockville, Maryland, 20857 **Co.2 Point of Contact** Christina, Bethell, Ph.D., MPH, MBA, bethellc@ohsu.edu, 503-494-1892-	
Measure Developer If different from Measure Steward **Co.3 Organization** See Ad.1 below, -, -, -, Maryland, -	

Co.4 <u>Point of Contact</u> Christina, Bethell, Ph.D., MPH, MBA, bethellc@ohsu.edu, 503-494-1892-	

Co.5 Submitter If different from Measure Steward POC
Christina, Bethell, Ph.D., MPH, MBA, bethellc@ohsu.edu, 503-494-1892-, Maternal and Child Health Bureau, Health Resources & Services Administration

Co.6 Additional organizations that sponsored/participated in measure development
See Ad.1 below

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development
Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
The Maternal and Child Health Bureau convenes a Technical Expert Panel (TEP) comprised of more than a dozen members. Members include other federal agencies, health services researchers, survey methodology experts, consumer organizations and clinical health experts on children´s health. The TEP consults in the identification and/or development of items for MCHB to consider for inclusion in the National Survey of Children's Health, including making recommendations for the scoring and reporting of measures resulting from the national survey. Members of the committee are drawn from the public and private sector, including members from national universities and national parenting and family groups, the Child and Adolescent Health Measurement Initiative (through the MCHB-sponsored Data Resource Center for Child and Adolescent Health) as well as members from the National Center for Health Statistics, the Centers for Disease Control and Prevention and other federal agencies. There is a range of activity performed by different members of the TEP depending on which measure is being developed, areas of expertise etc. The TEP process usually consists of 1 or 2 in person meetings, 6 or more conference calls, and numerous email exchanges. Subcommittees are formed based on areas of expertise. Because this is a collaborative activity, there is not a single developer of this measure.

Ad.2 If adapted, provide name of original measure:
Ad.3-5 If adapted, provide original specifications URL or attachment

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.6 Year the measure was first released: 2003
Ad.7 Month and Year of most recent revision: 04, 2007
Ad.8 What is your frequency for review/update of this measure? Updated every 4 years when a new National Survey of Children´s Health is developed
Ad.9 When is the next scheduled review/update for this measure? 01, 2011

Ad.10 Copyright statement/disclaimers:

Ad.11 -13 Additional Information web page URL or attachment: Attachment NSCH TEP 2007-634384064111801182.doc

Date of Submission (*MM/DD/YY*): 04/14/2011

NATIONAL QUALITY FORUM

Measure Evaluation 4.1
December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized)**:** Complete all <mark>yellow highlighted</mark> areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: *If there is no TAP or workgroup, the SC also evaluates the subcriteria (<mark>yellow</mark> highlighted areas).*

Steering Committee: Complete all <mark>pink</mark> highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) **NQF Review #:** 1381   **NQF Project:** Child Health Quality Measures 2010

MEASURE DESCRIPTIVE INFORMATION
De.1 Measure Title: Asthma Emergency Department Visits
De.2 Brief description of measure*:* Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period.
1.1-2 Type of Measure: Outcome **De.3 If included in a composite or paired with another measure, please identify composite or paired measure** N/A
De.4 National Priority Partners Priority Area: Population health **De.5 IOM Quality Domain:** Effectiveness **De.6 Consumer Care Need:** Staying healthy

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	**NQF Staff**
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.* **A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)?** Yes **A.2 Indicate if Proprietary Measure** (*as defined in measure steward agreement*): **A.3 Measure Steward Agreement:** Government entity and in the public domain - no agreement necessary **A.4 Measure Steward Agreement attached:**	**A** **Y**☐ **N**☐
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least	**B** **Y**☐

every 3 years. Yes, information provided in contact section	N ☐
C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ►**Purpose:**	**C** Y ☐ N ☐
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. **D.1 Testing:** Yes, fully developed and tested **D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?** Yes	**D** Y ☐ N ☐
(for NQF staff use**) Have all conditions for consideration been met?** **Staff Notes to Steward** (*if submission returned*)**:**	**Met** Y ☐ N ☐
Staff Notes to Reviewers (*issues or questions regarding any criteria*)**:**	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. *Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.* (evaluation criteria) **1a. High Impact**	**Eval Rating**
(for NQF staff use) **Specific NPP goal**:	
1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers **1a.2** **1a.3 Summary of Evidence of High Impact:** 213,825 Medicaid eligibles/enrollees in the pilot area 21,780 identified as being "Asthmatic" based on the logic developed to identify persons at risk for possible targeted interventions. 1,296 recipients were enrolled in a chronic care management pilot called Q4U. **1a.4 Citations for Evidence of High Impact:** Alabama Asthma Coalition State Plan and Burden Document, Alabama Department of Public Health, April 2009 http://www.adph.org/steps/assets/ALAsthmaStatePlan2009.pdf It is estimated that by 2025 the number of people with asthma will grow by more than 100 million. See World Health Organization. Global surveillance,prevention and control of chronic respiratory diseases: a comprehensive approach, 2007. Asthma accounts for 217,000 emergency room visits and 10.5 million office visits a year. See Pitts SR, Niska RW, Xu J, Burt CW. National Hospital Ambulatory Medical Care Survey: 2006 emergency department summary. National health statistics reports; no. 7. Hyattsville, MD: National Center for Health Statistics. 2008.	**1a** C ☐ P ☐ M ☐ N ☐
1b. Opportunity for Improvement **1b.1 Benefits (improvements in quality) envisioned by use of this measure:** Allows for the identification of persons seen in the emergency room with a primary diagnosis (first diagnosis) of Asthma. By identifying these persons, their providers can be made aware of the visits, care managers/coordinators can work with them, potential for targeting for directed education and self-management education for	**1b** C ☐ P ☐ M ☐ N ☐

person/parent/caregiver. Also can be incorporated as a clinical ALERT for providers in an EHR to notify the provider that this patient has been seen in the ER for Asthma.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
Focused on variation for this from one county to the next although individual provider variation was reviewed it was not the specific focus of the pilot implemented. Overall performance was considered to be poor with the overall (combined counties) measure being higher than anticipated.

1b.3 Citations for data on performance gap:
http://www.medicaid.alabama.gov/Transformation/Pilot_Counties_Asthma_Measures.aspx
The county to county variation is noted at the above URL.

1b.4 Summary of Data on disparities by population group:
Not looked at for this pilot. The logic itself will allow review by race/ethnicity, geographic area (county, provider and gender).

1b.5 Citations for data on Disparities:
N/A

1c. Outcome or Evidence to Support Measure Focus

1c.1 Relationship to Outcomes (*For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population*)**:** A reduction in emergency room visits is related to improved quality of life and decreased morbidity and mortality. Self management education to improve utilization of appropriate medications, allow for the differentiation of controller from rescue medications, quality of life assessments, environmental assessment (triggers), focus on Asthma Action Plan, provider education oncurrent asthma guidelines are just some of the strategies used to improve asthma management to reduce emergency room visits for the Medicaid population in the pilot counties.

1c.2-3. Type of Evidence: Expert opinion, Other Evaluation being conducted by the University of Alabama School of Public Health has been ongoing and final evaluation is underway. Statistical analysis of results planned. Logic Model developed prior to start of pilot to look at short term and long term goals.

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*)**:**
See results for first year of pilot.
http://www.medicaid.alabama.gov/Transformation/Pilot_Counties_Asthma_Measures.aspx
External Evaluation underway the University of Alabama at Birminghma (UAB) School of Public Health which includes the results of QoL tools and surveys in addition to the claims measured captured above. This will be available later this year.

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom*)**:**
External Evaluator when available

1c.6 Method for rating evidence: n/a

1c.7 Summary of Controversy/Contradictory Evidence: n/a

1c.8 Citations for Evidence (*other than guidelines*)**:** n/a

1c.9 Quote the Specific guideline recommendation (*including guideline number and/or page number*)**:**
n/a

1c.10 Clinical Practice Guideline Citation: n/a
1c.11 National Guideline Clearinghouse or other URL: n/a

1c.12 Rating of strength of recommendation (*also provide narrative description of the rating and by*

1c
C☐
P☐
M☐
N☐

*whom***):** n/a **1c.13 Method for rating strength of recommendation** (*If different from <u>USPSTF system</u>, also describe rating and how it relates to USPSTF*)**:** n/a **1c.14 Rationale for using this guideline over others:** n/a	
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Importance to Measure and Report?*	**1**
Steering Committee: Was the threshold criterion, *Importance to Measure and Report*, met? Rationale:	**1** Y☐ N☐

2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (<u>evaluation criteria</u>)	**<u>Eval Rating</u>**

2a. MEASURE SPECIFICATIONS

S.1 Do you have a web page where current detailed measure specifications can be obtained? **S.2 If yes, provide web page URL:** **2a. Precisely Specified** **2a.1 Numerator Statement (***Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome***):** Measuring percentage of people with Asthma that have an emergency room visit during a 12 month measurement period.	
2a.2 Numerator Time Window (*The time period in which cases are eligible for inclusion in the numerator***):** The measurement period is a 12 consecutive month period. This can be calendar year, fiscal year or as otherwise determined. For the Together for Quality Pilot a baseline period was determined and then two 12 month periods were defined as measurement periods during the pilot. **2a.3 Numerator Details (***All information required to collect/calculate the numerator, including all codes, logic, and definitions***):** Emergency Department Visits Numerator is patients with = 1 asthma related ED visits as identified via ED visit codes (procedure codes 99281-99285) AND also has an asthma diagnosis code ICD-9-CM codes 493.00, 493.01, 493.02, 493.10,493.11, 493.12, 493.81, 493.82, 493.90, 493.91, and 493.92 as the primary diagnosis on the emergency room claim during the measurement period). Use table of denominator recipient IDs to pull all recipients that have received claims described above.	
2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured***):** Denominator is all patients age two through age 20, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with ICD-9-CM codes 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.81, 493.82, 493.90, 493.91,and 493.92 (excludes 493.20, 493.21 and 493.22)asprimary and secondary diagnoses with the dates of service"Begin Date through End Date" equal any consecutive 12 month period with paid dates from "Begin Date through End Date which includes 3 month tail". This is the measurement period. Total period of our pilot initiative was 24 months. We used Baseline Measurement period of March 1, 2006 through February 28, 2007 with paid dates through May 31, 2007 to provide a 3 month claims tail.	**2a-specs** C☐ P☐ M☐ N☐

A "Measurement period is any 12 consecutive months".

2a.5 Target population gender: Female, Male
2a.6 Target population age range: Any one greater than or equal to two through age 20.

2a.7 Denominator Time Window (*The time period in which cases are eligible for inclusion in the denominator***):**
"Measurement period" = A 12 Consecutive month period that can be defined as calendar year, fiscal year, or based on a specific pilot or initiative.

2a.8 Denominator Details (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions***):**
SQL for Asthma Denominator

```
(
SELECT
DSS.T_CA_ICN.ID_MEDICAID,
trunc(months_between(DSS.T_CA_ICN.DTE_FIRST_SVC,DSS.T_RE_BASE_DN.DTE_BIRTH)/12),
DSS.T_CA_RECIP_KEY.CDE_RECIP_COUNTY || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RECIP_COUNTY,
DSS.T_CA_RECIP_KEY.CDE_RACE || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RACE,
DSS.T_CA_RECIP_KEY.CDE_SEX || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_SEX
FROM
DSS.T_CA_ICN,
DSS.T_RE_BASE_DN,
DSS.T_CA_RECIP_KEY,
DSS.T_CA_AID_GROUP
WHERE
( DSS.T_CA_ICN.RECIP_KEY=DSS.T_CA_RECIP_KEY.RECIP_KEY )
AND ( DSS.T_RE_BASE_DN.SAK_RECIP(+)=DSS.T_CA_ICN.SAK_RECIP )
AND ( DSS.T_CA_AID_GROUP.SAK_AID_GROUP=DSS.T_CA_ICN.SAK_AID_GROUP )
AND (
(DSS.T_CA_ICN.CDE_DIAG_PRIM IN (´49300´, ´49301´, ´49302´, ´49310´, ´49311´, ´49312´, ´49381´,
´49382´, ´49390´, ´49391´, ´49392´)
OR DSS.T_CA_ICN.CDE_DIAG_2 IN (´49300´, ´49301´, ´49302´, ´49310´, ´49311´, ´49312´, ´49381´,
´49382´, ´49390´, ´49391´, ´49392´))
AND DSS.T_CA_ICN.DTE_FIRST_SVC BETWEEN ´03-01-2006 00:00:00´ AND ´02-28-2007 00:00:00´
AND DSS.T_CA_ICN.DTE_PTN BETWEEN ´03-01-2006 00:00:00´ AND ´05-31-2007 00:00:00´
AND trunc(months_between(DSS.T_CA_ICN.DTE_FIRST_SVC,DSS.T_RE_BASE_DN.DTE_BIRTH)/12) != 0
AND DSS.T_CA_ICN.CDE_DTL_STATUS != ´D´
AND DSS.T_CA_AID_GROUP.CDE_GROUP_D NOT IN (´D98´, ´D99´, ´D1 ´, ´D2 ´, ´D3 ´, ´D4 ´, ´D5 ´, ´D6 ´,
´D7 ´, ´D8 ´, ´D9 ´)
AND DSS.T_CA_ICN.CDE_CLM_TYPE IN (´I´, ´A´, ´C´, ´M´, ´O´, ´B´)
)
GROUP BY
DSS.T_CA_ICN.ID_MEDICAID,
trunc(months_between(DSS.T_CA_ICN.DTE_FIRST_SVC,DSS.T_RE_BASE_DN.DTE_BIRTH)/12),
DSS.T_CA_RECIP_KEY.CDE_RECIP_COUNTY || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RECIP_COUNTY,
DSS.T_CA_RECIP_KEY.CDE_RACE || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RACE,
DSS.T_CA_RECIP_KEY.CDE_SEX || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_SEX
HAVING
( count(DISTINCT DSS.T_CA_ICN.NUM_ICN) >= 1)
UNION
SELECT
DSS.T_CA_ICN.ID_MEDICAID,
trunc(months_between(DSS.T_CA_ICN.DTE_FIRST_SVC,DSS.T_RE_BASE_DN.DTE_BIRTH)/12),
DSS.T_CA_RECIP_KEY.CDE_RECIP_COUNTY || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RECIP_COUNTY,
DSS.T_CA_RECIP_KEY.CDE_RACE || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RACE,
DSS.T_CA_RECIP_KEY.CDE_SEX || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_SEX
FROM
```

```
DSS.T_CA_ICN,
DSS.T_RE_BASE_DN,
DSS.T_CA_RECIP_KEY,
DSS.T_CA_DRUG,
DSS.T_CA_AID_GROUP
WHERE
( DSS.T_CA_ICN.RECIP_KEY=DSS.T_CA_RECIP_KEY.RECIP_KEY )
AND ( DSS.T_CA_DRUG.SAK_CLAIM(+)=DSS.T_CA_ICN.SAK_CLAIM and
DSS.T_CA_DRUG.DTE_PTN(+)=DSS.T_CA_ICN.DTE_PTN )
AND ( DSS.T_RE_BASE_DN.SAK_RECIP(+)=DSS.T_CA_ICN.SAK_RECIP )
AND ( DSS.T_CA_AID_GROUP.SAK_AID_GROUP=DSS.T_CA_ICN.SAK_AID_GROUP )
AND (
DSS.T_CA_DRUG.NUM_DRUG_GCN_SEQ IN (05037, 04963, 04964, 04966, 04967, 04968, 05032, 05033, 05034,
05039, 05040, 16033, 22230, 28090,
41848, 41849, 48698, 48699, 49871, 51197, 51198, 54687, 57879, 58890)
AND DSS.T_CA_ICN.DTE_FIRST_SVC BETWEEN ´03-01-2006 00:00:00´ AND ´02-28-2007 00:00:00´
AND DSS.T_CA_ICN.DTE_PTN BETWEEN ´03-01-2006 00:00:00´ AND ´05-31-2007 00:00:00´
AND trunc(months_between(DSS.T_CA_ICN.DTE_FIRST_SVC,DSS.T_RE_BASE_DN.DTE_BIRTH)/12) != 0
AND DSS.T_CA_ICN.CDE_DTL_STATUS != ´D´
AND DSS.T_CA_AID_GROUP.CDE_GROUP_D NOT IN (´D98´, ´D99´, ´D1 ´, ´D2 ´, ´D3 ´, ´D4 ´, ´D5 ´, ´D6 ´,
´D7 ´, ´D8 ´, ´D9 ´)
AND DSS.T_CA_ICN.CDE_CLM_TYPE IN (´P´, ´Q´)
)
GROUP BY
DSS.T_CA_ICN.ID_MEDICAID,
trunc(months_between(DSS.T_CA_ICN.DTE_FIRST_SVC,DSS.T_RE_BASE_DN.DTE_BIRTH)/12),
DSS.T_CA_RECIP_KEY.CDE_RECIP_COUNTY || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RECIP_COUNTY,
DSS.T_CA_RECIP_KEY.CDE_RACE || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_RACE,
DSS.T_CA_RECIP_KEY.CDE_SEX || ´ - ´ || DSS.T_CA_RECIP_KEY.DSC_SEX
HAVING
(
count(DISTINCT DSS.T_CA_ICN.NUM_ICN) >= 2
)
)
Make a table of the recipient IDs retrieved from Asthma Denominator query.
```

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population***):** Excludes children less than age two or greater than age twenty.

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions***):**
Anyone under age two. Actually Query language states "Recipient Age FDOS - Calculated Between Age 2 and 20"

2a.11 Stratification Details/Variables (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions***):**
Recipient Gender & Description
Recipient Race Code & Description
Recipient County & Description

2a.12-13 Risk Adjustment Type: No risk adjustment necessary

2a.14 Risk Adjustment Methodology/Variables (*List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method***):**
N/A

2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score:
2a.20 Interpretation of Score: Better quality = Lower score

2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**
N/A-Measure results were simply reviewed in relationship to the established target goal.

2a.22 Describe the method for discriminating performance *(e.g., significance testing)***:**
Target goal for end of pilot determined by TFQ Clinical Workgroup
Measure used to determine AL Medicaid success in reducing ER utilization for the targeted population.

2a.23 Sampling (Survey) Methodology *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)*:
N/A

2a.24 Data Source (*Check the source(s) for which the measure is specified and tested)*
Electronic administrative data/claims

2a.25 Data source/data collection instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.***):**
It is Business Objects software with the Client side version known as DeskTop Intelligence or DI. It uses SQL structured business language and rules to allow for the development of queries of the administrative claims database. It is provided through our MMIS contract with HP Enterprises.

2a.26-28 Data source/data collection instrument reference web page URL or attachment: URL Not needed http://www.medicaid.alabama.gov/Transformation/Pilot_Counties_Asthma_Measures.aspx

2a.29-31 Data dictionary/code table web page URL or attachment: URL N/A
http://www.medicaid.alabama.gov/documents/Transformation-TFQ-Documents/Pilot%20Counties%20Asthma%20Measures/TFQ_Interim_Summary_Measure_Results_4-15-10.pdf

2a.32-35 Level of Measurement/Analysis (*Check the level(s) for which the measure is specified and tested)*
Population : Counties or cities

2a.36-37 Care Settings (*Check the setting(s) for which the measure is specified and tested)*
Ambulatory Care : Emergency Dept

2a.38-41 Clinical Services (*Healthcare services being measured, check all that apply*)
Clinicians: Physicians (MD/DO)

TESTING/ANALYSIS	

2b. Reliability testing

2b.1 Data/sample *(description of data/sample and size)*: Query has been run multiple times. By identifying the specific dates of service for the measurement period and attaching a "tail" for paid dates it prevents huge variability in the results.

2b.2 Analytic Method *(type of reliability & rationale, method for testing)*:
n/a

2b.3 Testing Results *(reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
n/a

2b
C☐
P☐
M☐
N☐

2c. Validity testing

2c.1 Data/sample *(description of data/sample and size)*: Face Validity-The "sample" was actually any persons identified in the numerator who were then referred for enrollment in chronic care management. There were no persons identified as being seen in the emergency room who had not presented to the emergency room during the timeframe noted.

2c.2 Analytic Method *(type of validity & rationale, method for testing)*:
N/A

2c
C☐
P☐
M☐
N☐

2c.3 Testing Results *(statistical results, assessment of adequacy in the context of norms for the test conducted)*: N/A	

2d. <mark>Exclusions Justified</mark>

2d.1 Summary of Evidence supporting exclusion(s):
Alabama Medicaid Agency (AMA) excluded those under age one in its original results. At the request of the Committee, the exclusion has been modififed to include anyone under age two. AMA´s original measures also included adults. Measure has been modified to create two separate measures; one for ages two through twenty and a second measure for those ages 21 through 64 excluding dual eligibles. Based on these modifications the following occurred:

Starting at Age 2 instead of one reduces the population Denominator by ~3,000.

Removing the use of the GSNs for identification of the population of Asthmatics using two or more short acting beta adrenergic agents reduces the Denominator by 9,142 (57,558 to 48,416).

The Numerator is 4,670 so the Measure Results With GSNs is 8.1% and the result Without GSNs is 9.6%. Therefore excluding the use of medications to identify the population results in an increase in the measure percentage.

By removing the use of the GSNs in the denominator methodology only those recipients with claims that have a diagnosis of Asthma are included in the DENOMINATOR.

2d.2 Citations for Evidence:
N/A

2d.3 Data/sample *(description of data/sample and size)*: n/A

2d.4 Analytic Method *(type analysis & rationale)*:
n/a

2d.5 Testing Results *(e.g., frequency, variability, sensitivity analyses)*:
n/a

2d
C☐
P☐
M☐
N☐
NA☐

2e. Risk Adjustment for Outcomes/ Resource Use Measures

2e.1 Data/sample *(description of data/sample and size)*: No risk adjustment since interested in ANY emergency room visit with Asthma as the primary diagnosis

2e.2 Analytic Method *(type of risk adjustment, analysis, & rationale)*:
n/a

2e.3 Testing Results *(risk model performance metrics)*:
n/a

2e.4 If outcome or resource use measure is not risk adjusted, provide rationale: n/a

2e
C☐
P☐
M☐
N☐
NA☐

2f. Identification of Meaningful Differences in Performance

2f.1 Data/sample from Testing or Current Use *(description of data/sample and size)*: Variation across counties and providers noted. Reduction in emergency room visits in pilot counties as a whole cut by about half at end of first year of pilot.

2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance *(type of analysis & rationale)*:
n/a

2f
C☐
P☐
M☐
N☐

2f.3 Provide Measure Scores from Testing or Current Use *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*: n/a	
2g. Comparability of Multiple Data Sources/Methods **2g.1 Data/sample** *(description of data/sample and size)*: Does not apply since source of data is Alabama Medicaid claims **2g.2 Analytic Method** *(type of analysis & rationale)*: n/a **2g.3 Testing Results** *(e.g., correlation statistics, comparison of rankings)*: n/a	**2g** C☐ P☐ M☐ N☐ NA☐
2h. Disparities in Care **2h.1 If measure is stratified, provide stratified results** *(scores by stratified categories/cohorts)*: Not stratified as part of this pilot. No disparities looked for at this time. **2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:** Have discussed this but will wait to do as part of CHIPRA Core Measure reporting.	**2h** C☐ P☐ M☐ N☐ NA☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Scientific Acceptability of Measure Properties?*	**2**
Steering Committee: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties*, **met?** **Rationale:**	*2* C☐ P☐ M☐ N☐
3. USABILITY	
Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)	**Eval Rating**
3a. Meaningful, Understandable, and Useful Information **3a.1 Current Use:** In use **3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large)** (*If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years*): http://www.medicaid.alabama.gov/Transformation/Pilot_Counties_Asthma_Measures.aspx **3a.3 If used in other programs/initiatives (**If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). *If not used for QI, state the plans to achieve use for QI within 3 years*): http://www.medicaid.alabama.gov/documents/Program-Pt1st/3-H_1c_Sample_Profiler_7-09.pdf Asthma ER measure is part of a Shared Savings program for our Patient 1st Program and individual provider performance is compared to that of their peer group. **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **3a.4 Data/sample** *(description of data/sample and size)*: n/a **3a.5 Methods** *(e.g., focus group, survey, QI project)*: Reviewed with a two separate groups; the TFQ Clinical Workgroup and the Patient 1st Advisory Council. The first group developed the measure and has reviewed the results. The second group approved its use as part of a Shared Savings methodology.	**3a** C☐ P☐ M☐ N☐

3a.6 Results *(qualitative and/or quantitative results and conclusions)*: Qualltative-Lower is best.	
3b/3c. Relation to other NQF-endorsed measures **3b.1 NQF # and Title of similar or related measures:** Unaware of any. Checked NQF endorsed list and could not find one related to Asthma and Emergency Room Visits.	
(for NQF staff use) **Notes on similar/related endorsed or submitted measures:**	
3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source or different topic but same target population): **3b.2 Are the measure specifications harmonized? If not, why?** n/a	**3b** C☐ P☐ M☐ N☐ NA☐
3c. Distinctive or Additive Value **3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** n/a **5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality:** n/a	**3c** C☐ P☐ M☐ N☐ NA☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Usability?*	**3**
Steering Committee: Overall, to what extent was the criterion, *Usability*, met? **Rationale:**	**3** C☐ P☐ M☐ N☐
4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)	**Eval Rating**
4a. Data Generated as a Byproduct of Care Processes **4a.1-2 How are the data elements that are needed to compute measure scores generated?** Coding/abstraction performed by someone other than person obtaining original information (E.g., DRG, ICD-9 codes on claims, chart abstraction for quality measure or registry)	**4a** C☐ P☐ M☐ N☐
4b. Electronic Sources **4b.1 Are all the data elements available electronically?** *(elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims)* Yes **4b.2 If not, specify the near-term path to achieve electronic capture by most providers.**	**4b** C☐ P☐ M☐ N☐
4c. Exclusions **4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?** No **4c.2 If yes, provide justification.**	**4c** C☐ P☐ M☐ N☐ NA☐

4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences **4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.** Potential to identify persons as being asthmatic due to provider error in coding. This is the same as for any claims data. Since the purpose of our use of this measure was to target persons who potentially could benefit from interventions we were not worried about including people without a confirmed diagnosis of asthma but were alright with potentially identifying others we could potentially keep out of the emergency room for respiratory problems.	**4d** C☐ P☐ M☐ N☐
4e. Data Collection Strategy/Implementation **4e.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:** Prior to assigning individuals identified in the numerator directly to a care coordinator would incorporate verification of the diagnosis with their primary care provider into the care coordination protocol before attempting enrollment. Limiting the identification of persons in the denominator to only those with the diagnosis would reduce the number of persons who indicated they did not have a diagnosis of asthma (13.1% of 1667 persons who were identified for care management but Never Enrolled) but would prevent the inclusion of persons who had asthma but were unaware of the diagnosis which was felt to be more relevant clinically. **4e.2 Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*): Currently working on an Asthma Return on Investment calculation using AHRQ Asthma ROI Calculator to evaluation the return on investment for the Asthma Chronic Care management program, Q4U. This is not the cost of implementing the measure but the cost of implementing a program to improve the measure! The costs to pull the data for the measure were minimal involving staff already doing this in our Statiscal Support Unit. **4e.3 Evidence for costs:** N/A **4e.4 Business case documentation:** None	**4e** C☐ P☐ M☐ N☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Feasibility?*	**4**
Steering Committee: Overall, to what extent was the criterion, *Feasibility*, met? **Rationale:**	**4** C☐ P☐ M☐ N☐
RECOMMENDATION	
(for NQF staff use) **Check if measure is untested and only eligible for time-limited endorsement.**	Time-limited ☐
Steering Committee: Do you recommend for endorsement? **Comments:**	Y☐ N☐ A☐
CONTACT INFORMATION	
Co.1 Measure Steward (Intellectual Property Owner) **Co.1 Organization** Alabama Medicaid Agency, 501 Dexter Avenue, PO Box 5624, Montgomery, Alabama, 36103-5624	

Co.2 <u>Point of Contact</u>
Mary, McIntyre, MD., MPH, mary.mcintyre@medicaid.alabama.gov, 334-242-5574-

Measure Developer If different from Measure Steward
Co.3 <u>Organization</u>
Alabama Medicaid Agency, 501 Dexter Avenue, PO Box 5624, Montgomery, Alabama, 36103-5624

Co.4 <u>Point of Contact</u>
Mary, McIntyre, MD., MPH, mary.mcintyre@medicaid.alabama.gov, 334-242-5574-

Co.5 Submitter If different from Measure Steward POC
Mary, McIntyre, MD., MPH, mary.mcintyre@medicaid.alabama.gov, 334-242-5574-, Alabama Medicaid Agency

Co.6 Additional organizations that sponsored/participated in measure development
http://www.medicaid.alabama.gov/documents/Transformation-TFQ-Documents/Charter/TFQ%20Clinical_Workgroup_Charter_V%207%2030%202009_revised%20(3).pdf

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development
Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
http://www.medicaid.alabama.gov/documents/Transformation-TFQ-Documents/Charter/TFQ%20Clinical_Workgroup_Charter_V%207%2030%202009_revised%20(3).pdf
List is available at this URL.
Group helped identify the codes, age group, etc. Included Domain Experts from University in the development. See meeting documents.

Ad.2 If adapted, provide name of original measure:
Ad.3-5 If adapted, provide original specifications URL or attachment

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.6 Year the measure was first released: 2008
Ad.7 Month and Year of most recent revision: 04, 2010
Ad.8 What is your frequency for review/update of this measure? Reviewed Yearly
Ad.9 When is the next scheduled review/update for this measure? 04, 2011

Ad.10 Copyright statement/disclaimers: State Government

Ad.11 -13 Additional Information web page URL or attachment:

Date of Submission (*MM/DD/YY*): 01/24/2011

NATIONAL QUALITY FORUM

Measure Evaluation 4.1
December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized)**:** Complete all <mark>yellow highlighted</mark> areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

<u>Note</u>: *If there is no TAP or workgroup, the SC also evaluates the subcriteria (<mark>yellow</mark> highlighted areas).*

Steering Committee: Complete all <mark>pink</mark> highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

<u>Evaluation ratings of the extent to which the criteria are met</u>
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) **NQF Review #:** 1392 **NQF Project:** Child Health Quality Measures 2010	
MEASURE DESCRIPTIVE INFORMATION	

De.1 Measure Title: Well-Child Visits in the First 15 Months of Life

De.2 Brief description of measure*:* The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported:
•No well-child visits
•One well-child visit
•Two well-child visits
•Three well-child visits
•Four well-child visits
•Five well-child visits
•Six or more well-child visits

1.1-2 Type of Measure: Use of services
De.3 If included in a composite or paired with another measure, please identify composite or paired measure
None

De.4 National Priority Partners Priority Area: Population health
De.5 IOM Quality Domain: Timeliness
De.6 Consumer Care Need: Staying healthy

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	**NQF Staff**
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.*	**A** Y☐ N☐

A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes **A.2 Indicate if Proprietary Measure** (*as defined in measure steward agreement*): Proprietary measure, Proprietary complex measure with fees **A.3 Measure Steward Agreement:** Agreement will be signed and submitted prior to or at the time of measure submission **A.4 Measure Steward Agreement attached:**	
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	**B** Y☐ N☐
C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ►**Purpose:**	**C** Y☐ N☐
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. **D.1 Testing:** Yes, fully developed and tested **D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?** Yes	**D** Y☐ N☐
(for NQF staff use**) Have all conditions for consideration been met?** **Staff Notes to Steward** (*if submission returned*):	**Met** Y☐ N☐
Staff Notes to Reviewers (*issues or questions regarding any criteria*):	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. *Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.* (evaluation criteria) **1a. High Impact**	**Eval Rating**
(for NQF staff use) **Specific NPP goal**:	
1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, Patient/societal consequences of poor quality **1a.2** **1a.3 Summary of Evidence of High Impact:** Well-care child visits currently serve as the focal point of contact for the delivery of preventive services for children (Nevin, 2002). Investing in preventive care can reduce morbidity and mortality. In addition, these preventive services can result in significant cost savings. An analysis of the cost-effectiveness of recommended preventive services demonstrated that for a relatively small net cost, most of preventive services produce valuable health benefits. Eighteen of the 25 preventive services evaluated cost $50,000 or less per quality-adjusted life year (QALY), and 10 of these cost less than $15,000 per QALY, all within the range of what is considered a favorable cost-effectiveness ratio.(Schor, 2007) **1a.4 Citations for Evidence of High Impact:** Nevin, Janice E., MD, MPH., and Witt, Deborah K., MD. "Well	**1a** C☐ P☐ M☐ N☐

child and preventive care" Prim Care Clin Office Pract 29 (2002): 543-555.

Edward L. Schor T, MD. The future pediatrician: promoting children's health and development. Partnership for prevention. Preventive Care: A national profile on use, disparities, and health Benefits. November 2007.

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: This measure encourages health care providers to champion well-care visits, which are an important opportunity for the provider to share information on health and safety issues, information on nutrition and physical fitness and information on how to manage emergencies and illness with the child's parents/guardian. Guidance may also be provided by the physician on issues such as behavioral problems, learning problems, emotional problems, family problems and socialization problems (Healthy Children: Investing in the Future).

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
NCQA's HEDIS measure has shown that performance among health plans is low. For well-child visits in their 15 months of life, the rate without visit was 5.68% in 2007; the rate for having 1 visit was 3.3%; the rate for having 3 visits was 6.2%; the rate for having 6 or more visits was 52.95. For well-child visits in their 3-6 years of life, the rate was 65.11% in general.

The quality of child health supervision varies greatly among physician practices. Among a Medicaid population, only approximately one-fifth of children received preventive and developmental services that met a basic threshold of quality for each aspect of care assessed. A national survey of parents found that over 94 percent of parents reported an unmet need for parenting guidance, education, or screening by pediatric clinicians in one or more content of care areas. In general, substantially less than one-half of children and adolescents receive developmental and psychosocial surveillance, disease screening, and anticipatory guidance.

1b.3 Citations for data on performance gap:
http://health.utah.gov/hda/reports/2008/hmo/quality/commercial/wellcare.php#1
Edward L. Schor, MD. Rethinking Well-Child Care

NCQA State of Health Care Quality Report. 2009

1b.4 Summary of Data on disparities by population group:
Variables such as the age and education level of an infant's parent or caregiver may affect the likelihood that the parent or caregiver schedules and keeps a well-care visit (Grossman, 1996).
Higher-need families, those with low incomes or low levels of maternal education, and those relying on Medicaid for their children's health care do not receive additional anticipatory guidance or longer well-child visits, and in fact sometimes receive less information and shorter visits. At-risk children have been found to be less likely to receive preventive and developmental services during well-child care visits, and low-income families are less likely to receive referrals to community resources that may be helpful to them.

1b.5 Citations for data on Disparities:
Grossman LK, Humbert AL, Powell M. Continuity of care between obstetrical and pediatric preventive care: Indicators of nonattendance at the first well-child appointment. Clinical Pediatrics. 11/96;563-569.

Edward L. Schor T, MD. The future pediatrician: promoting children's health and development. Partnership for prevention. Preventive Care: A national profile on use, disparities, and health Benefits. November 2007.

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1c. Outcome or Evidence to Support Measure Focus

1c.1 Relationship to Outcomes (*For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population*): Well-care visits are routine visits to the child's physician for the purpose of physical examinations, immunization updates, tracking growth and development, and finding problems before they become serious. They provide an opportunity for primary prevention practices (e.g. immunizations), secondary prevention practices (e.g. developmental

1c
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N☐

screenings), and anticipatory guidance. The benefits of primary and secondary prevention practices on health outcomes has been well established.

In general, the outcomes of well-child care include: the child´s physical health and development; emotional, social, and cognitive development; the family´s capacity and functioning. Although outcomes can focus on both the long and short term, it is important to remember that well-child care can affect the seemingly distant future for both child and family. For example, altering dietary habits in childhood or adolescence can help prevent heart attacks during middle age. Positive parenting can avoid adult depression and substance abuse.

1c.2-3. Type of Evidence: Evidence-based guideline, Expert opinion

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*)**:**
Along with immunizations, anticipatory guidance and health monitoring are the cornerstones of well-child care for both healthy children and children with special health care needs (CSHCN). The American Academy of Pediatrics (AAP) provides recommendations for pediatric health supervision visits through their Guidelines for Health Supervision III.(AAP, 2008) In addition, the Maternal and Child HealthBureau (MCHB) launched a major initiative to improve the quality of health promotion and preventive services for infants, children, and adolescents through the sponsorship of Bright Futures.(Green M, 2002) These recommendations call for periodic monitoring, screening, and guidance for all children. Furthermore, preventive care is an essential part of the AAP´s Medical Home policy statement.(AAP, 2002) Specifically, the AAP states that primary care services should include "growth and developmental assessments, appropriate screening, health care supervision, and patient and parent counseling about health, nutrition, and safety." (AAP, 2002) Many recent studies have focused on access to and use of preventive health care and anticipatory guidance for children in general, and well-child care can affect the seemingly distant future for both child and family.

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom***):**
Good

1c.6 Method for rating evidence: Expert consensus

1c.7 Summary of Controversy/Contradictory Evidence: None

1c.8 Citations for Evidence (*other than guidelines***):** Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.

Green M, Palfrey J, Clark E, Anastasi J, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 2nd ed., rev. Arlington, VA: Maternal and Child Health Bureau; 2002

Medical Home Initiatives for Children With Special Needs Project Advisory Committee. American Academy of Pediatrics. The medical home. Pediatrics. 2002;110 (pt 1):184 –186

1c.9 Quote the Specific guideline recommendation (*including guideline number and/or page number***):**
W15

American Academy of Pediatrics (2008), Bright Futures
The AAP recommends a total of eight well-care visits from the time the child is a newborn to the point he reaches 15 months old.

W34

American Academy of Pediatrics (2008), Bright Futures
The AAP recommends a total of four well-care visits for children ages three to six years of age.

1c.10 Clinical Practice Guideline Citation: Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines

for Health Supervision of Infants, Children, and Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.

1c.11 National Guideline Clearinghouse or other URL: Routine preventive services for infants and children (birth - 24 months). http://www.guideline.gov/content.aspx?id=15116&search=child+preventive+services

1c.12 Rating of strength of recommendation (*also provide narrative description of the rating and by whom***):**
Expert Consensus

1c.13 Method for rating strength of recommendation (*If different from USPSTF system, also describe rating and how it relates to USPSTF***):**
Expert consensus with evidence review

1c.14 Rationale for using this guideline over others:
NCQA convened a multistakeholder panel of experts to review evidence and guidelines for child health care. The Child Health Measurement Advisory Panel reviewed these guidelines together with the health importance and field test results of this measure. The MAP concluded that the health importance, evidence and feasibility supports this measure.

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Importance to Measure and Report?*	**1**
Steering Committee: Was the threshold criterion, *Importance to Measure and Report,* met? **Rationale:**	**1** Y☐ N☐

2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)	**Eval Rating**

2a. MEASURE SPECIFICATIONS

S.1 Do you have a web page where current detailed measure specifications can be obtained?
S.2 If yes, provide web page URL:

2a. Precisely Specified

2a.1 Numerator Statement (*Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome***):**
Had the following number of well-child visits with a PCP during their first 15 months of life.
• No well-child visits
• One well-child visit
• Two well-child visits
• Three well-child visits
• Four well-child visits
• Five well-child visits
• Six or more well-child visits

2a.2 Numerator Time Window (*The time period in which cases are eligible for inclusion in the numerator***):**
1 year

2a.3 Numerator Details (*All information required to collect/calculate the numerator, including all codes, logic, and definitions***):**
Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits with a PCP during their first 15 months of life.
The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. A child who had a claim/encounter with a code listed in Table W15-A is considered to have received a well-child visit.
Table W15-A: Codes to Identify Well-Child Visits

2a-specs
C☐
P☐
M☐
N☐

99381, 99382, 99391, 99392, 99432, 99461
V20.2, V20.3, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Medical record (non-Commercial plans only):
Documentation must include a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of all of the following.
• A health and developmental history (physical and mental)
• A physical exam
• Health education/anticipatory guidance
Do not include services rendered during an inpatient or ED visit.
Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.
Visits to school-based clinics with practitioners whom the organization would consider PCPs may be counted if documentation of a well-child exam is available. The PCP does not have to be assigned to the member.
The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured***):**
Healthl plan members who turned 15 months old during the measurement year

2a.5 Target population gender: Female, Male
2a.6 Target population age range: 0-15 months

2a.7 Denominator Time Window (*The time period in which cases are eligible for inclusion in the denominator***):**
1 year

2a.8 Denominator Details (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions***):**
Product lines   Commercial, Medicaid (report each product line separately).
Age   15 months old during the measurement year.
Continuous enrollment 31 days–15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth. Calculate the 15-month birthday as the child's first birthday plus 90 days. For example, a child born on January 9, 2009, and included in the rate of "six or more well-child visits" must have had six well-child visits by April 9, 2010.
Allowable gap   No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date   Day the child turns 15 months old.
Benefit Medical

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population***):** None

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions***):**
NA

2a.11 Stratification Details/Variables (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions***):**
Stratified by age (see above)

2a.12-13 Risk Adjustment Type: No risk adjustment necessary

2a.14 Risk Adjustment Methodology/Variables (*List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method***):**
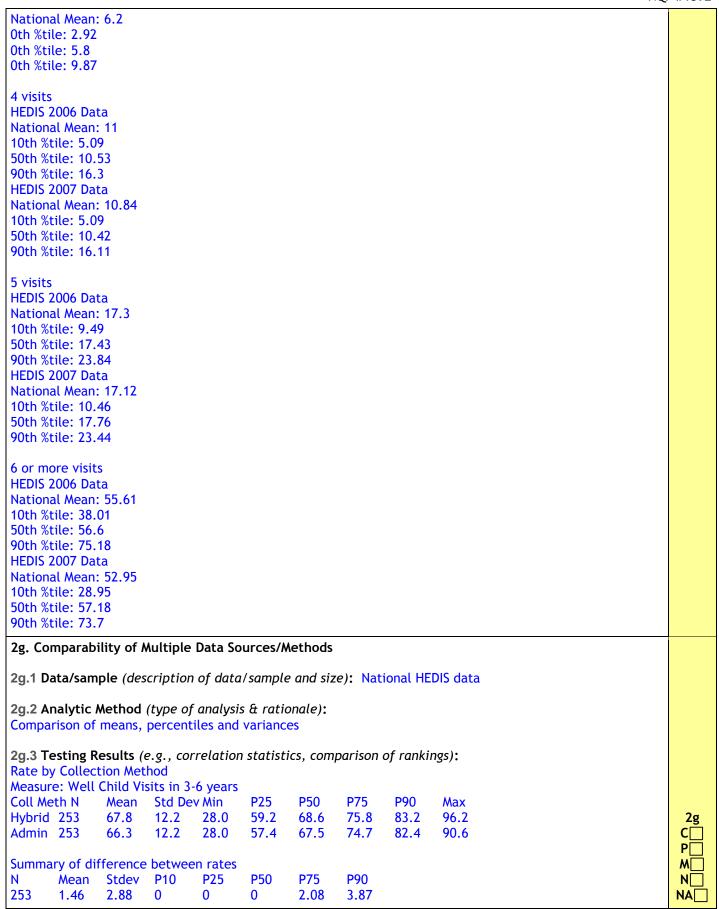NA

2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score: Rate/proportion
2a.20 Interpretation of Score: Better quality = Higher score
2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**
Step 1: Determine the eligible population (see denominator information)
Step 2: Determine the numerator
Children who had documentation of a well visit during the measurement year using the information above

2a.22 Describe the method for discriminating performance *(e.g., significance testing)***:**
Comparison of means and percentiles; analysis of variance against established benchmarks; if sample size is >400, we would use an analysis of variance.

2a.23 Sampling (Survey) Methodology *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)*:
None for Commercial plans; for others, see above.

2a.24 Data Source (*Check the source(s) for which the measure is specified and tested***)**
Electronic administrative data/claims, Paper medical record/flow-sheet

2a.25 Data source/data collection instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.***):**
HEDIS

2a.26-28 Data source/data collection instrument reference web page URL or attachment:

2a.29-31 Data dictionary/code table web page URL or attachment:

2a.32-35 Level of Measurement/Analysis *(Check the level(s) for which the measure is specified and tested)*
Health Plan, Integrated Delivery System, Population : National, Population : Regional/network

2a.36-37 Care Settings (*Check the setting(s) for which the measure is specified and tested***)**
Ambulatory Care : Clinic, Ambulatory Care : Hospital Outpatient, Ambulatory Care : Office

2a.38-41 Clinical Services (*Healthcare services being measured, check all that apply***)**
Clinicians: PA/NP/Advanced Practice Nurse, Clinicians: Physicians (MD/DO)

TESTING/ANALYSIS

2b. Reliability testing

2b.1 Data/sample *(description of data/sample and size)*: The reliability metric for this measure was calculated separately for Commercial and Medicaid plans where applicable using 2010 data.

2b.2 Analytic Method *(type of reliability & rationale, method for testing)*:
Reliability was estimated by using the beta-binomial model. Beta-binomial is a better fit when estimating the reliability of simple pass/fail rate measures as is the case with most HEDIS® health plan measures. The beta-binomial model assumes the plan score is a binomial random variable conditional on the plan´s true value that comes from the beta distribution. The beta distribution is usually defined by two parameters, alpha and beta. Alpha and beta can be thought of as intermediate calculations to get to the needed variance estimates. The beta distribution can be symmetric, skewed or even U-shaped.

2b.3 Testing Results *(reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
Well-Child Visits in the First 15 Months of Life - zero visits Rate
Commercial: 0.9169
Medicaid: 0.9437
Well-Child Visits in the First 15 Months of Life - one visit Rate
Commercial: 0.9169
Medicaid: 0.8870

2b
C ☐
P ☐
M ☐
N ☐

Well-Child Visits in the First 15 Months of Life - two visits Rate
Commercial: 0.9169
Medicaid: 0.9035
Well-Child Visits in the First 15 Months of Life - three visits Rate
Commercial: 0.9169
Medicaid: 0.9256
Well-Child Visits in the First 15 Months of Life - four visits Rate
Commercial: 0.9169
Medicaid: 0.9482
Well-Child Visits in the First 15 Months of Life - five visits Rate
Commercial: 0.9169
Medicaid: 0.9435
Well-Child Visits in the First 15 Months of Life - Six or More visits Rate
Commercial: 0.9169
Medicaid: 0.9891

2c. Validity testing **2c.1 Data/sample** *(description of data/sample and size)*: expert panel and stakeholders **2c.2 Analytic Method** *(type of validity & rationale, method for testing)*: NCQA tested the measure for face validity using a panel of stakeholders with specific expertise in measurement and child health care. This panel included representatives from key stakeholder groups, including pediatricians, family physicians, health plans, state Medicaid agencies and researchers. Experts reviewed the results of the field test and assessed whether the results were consistent with expectations, whether the measure represented quality care, and whether we were measuring the most important aspect of care in this area. **2c.3 Testing Results** *(statistical results, assessment of adequacy in the context of norms for the test conducted)*: This measure was deemed valid by the expert panel.	**2c** C☐ P☐ M☐ N☐
2d. Exclusions Justified **2d.1 Summary of Evidence supporting exclusion(s):** No exclusions **2d.2 Citations for Evidence:** NA **2d.3 Data/sample** *(description of data/sample and size)*: NA **2d.4 Analytic Method** *(type analysis & rationale)*: NA **2d.5 Testing Results** *(e.g., frequency, variability, sensitivity analyses)*: NA	**2d** C☐ P☐ M☐ N☐ NA☐
2e. Risk Adjustment for Outcomes/ Resource Use Measures **2e.1 Data/sample** *(description of data/sample and size)*: NA **2e.2 Analytic Method** *(type of risk adjustment, analysis, & rationale)*: NA **2e.3 Testing Results** *(risk model performance metrics)*: NA **2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:** The measure assesses prevention and wellness in a general population; risk adjustment is not indicated.	**2e** C☐ P☐ M☐ N☐ NA☐

2f. Identification of Meaningful Differences in Performance

2f.1 Data/sample from Testing or Current Use *(description of data/sample and size)*: The measures are part of the Healthplan Effectiveness Data and Information Set (HEDIS).

2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance *(type of analysis & rationale)*:
Comparison of means and percentiles; analysis of variance against established benchmarks; if sample size is >400, we would use an analysis of variance

2f.3 Provide Measure Scores from Testing or Current Use *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*:
 Well-Child Visits - First 15 Months of Life

0 visits
HEDIS 2006 Data
National Mean: 3.79
10th %tile: 0.37
50th %tile: 1.43
90th %tile: 6.81
HEDIS 2007 Data
National Mean: 5.68
10th %tile: 0.57
50th %tile: 1.85
90th %tile: 7.79

1 visit
HEDIS 2006 Data
National Mean: 2.6
10th %tile: 0.25
50th %tile: 1.7
90th %tile: 5.11
HEDIS 2007 Data
National Mean: 3.3
10th %tile: 0.46
50th %tile: 1.85
90th %tile: 6.38

2 visits
HEDIS 2006 Data
National Mean: 3.6
10th %tile: 1.05
50th %tile: 3.22
90th %tile: 6.46
HEDIS 2007 Data
National Mean: 3.92
10th %tile: 1.23
50th %tile: 3.1
90th %tile: 7.54

3 visits
HEDIS 2006 Data
National Mean: 6.09
10th %tile: 2.68
50th %tile: 5.81
90th %tile: 9.51
HEDIS 2007 Data

2f
C☐
P☐
M☐
N☐

National Mean: 6.2
0th %tile: 2.92
0th %tile: 5.8
0th %tile: 9.87

4 visits
HEDIS 2006 Data
National Mean: 11
10th %tile: 5.09
50th %tile: 10.53
90th %tile: 16.3
HEDIS 2007 Data
National Mean: 10.84
10th %tile: 5.09
50th %tile: 10.42
90th %tile: 16.11

5 visits
HEDIS 2006 Data
National Mean: 17.3
10th %tile: 9.49
50th %tile: 17.43
90th %tile: 23.84
HEDIS 2007 Data
National Mean: 17.12
10th %tile: 10.46
50th %tile: 17.76
90th %tile: 23.44

6 or more visits
HEDIS 2006 Data
National Mean: 55.61
10th %tile: 38.01
50th %tile: 56.6
90th %tile: 75.18
HEDIS 2007 Data
National Mean: 52.95
10th %tile: 28.95
50th %tile: 57.18
90th %tile: 73.7

2g. Comparability of Multiple Data Sources/Methods

2g.1 Data/sample (*description of data/sample and size*): National HEDIS data

2g.2 Analytic Method (*type of analysis & rationale*):
Comparison of means, percentiles and variances

2g.3 Testing Results (*e.g., correlation statistics, comparison of rankings*):
Rate by Collection Method
Measure: Well Child Visits in 3-6 years

Coll Meth	N	Mean	Std Dev	Min	P25	P50	P75	P90	Max
Hybrid	253	67.8	12.2	28.0	59.2	68.6	75.8	83.2	96.2
Admin	253	66.3	12.2	28.0	57.4	67.5	74.7	82.4	90.6

Summary of difference between rates

N	Mean	Stdev	P10	P25	P50	P75	P90
253	1.46	2.88	0	0	0	2.08	3.87

2g
C ☐
P ☐
M ☐
N ☐
NA ☐

2h. Disparities in Care **2h.1 If measure is stratified, provide stratified results** (*scores by stratified categories/cohorts*)**:** The measure is not stratified to detect disparities. **2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:** NA	**2h** C ☐ P ☐ M ☐ N ☐ NA ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Scientific Acceptability of Measure Properties*?	**2**
Steering Committee: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties*, **met?** **Rationale:**	*2* C ☐ P ☐ M ☐ N ☐
3. USABILITY	
Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)	**Eval Rating**
3a. Meaningful, Understandable, and Useful Information **3a.1 Current Use:** In use **3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large)** (*If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years*)**:** This measure is used in public reporting. **3a.3 If used in other programs/initiatives (***If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years***):** This measure is a measure in the Healthcare Effectiveness Data and Information Set (HEDIS) **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **3a.4 Data/sample** (*description of data/sample and size*)**:** General public and other stakeholder groups (i.e. HEDIS users) **3a.5 Methods** (*e.g., focus group, survey, QI project*)**:** NCQA vetted the measures with its expert panel. In addition, throughout the development process, NCQA vetted the measure concepts and specifications with other stakeholder groups, including HEDIS users and NCQA's Committee on Performance Measurement. For the health plan measure, we released the measure for public comment and reviewed all results with the NCQA Committee on Performance Measurement (CPM). We also reviewed first-year results with the CPM. **3a.6 Results** (*qualitative and/or quantitative results and conclusions*)**:** NCQA received feedback that the measure is understandable, feasible, important and valid. Upon review of public comment results, the Committee on Performance Measurement approved the NCQA staff recommendation to add the measure to HEDIS. After reviewing first-year analysis results, the CPM approved the staff recommendation to publicly report the measure. The measure was deemed usable and feasible.	**3a** C ☐ P ☐ M ☐ N ☐
3b/3c. Relation to other NQF-endorsed measures **3b.1 NQF # and Title of similar or related measures:**	
(for NQF staff use) **Notes on similar/related endorsed or submitted measures:**	

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable

3b. Harmonization If this measure is related to measure(s) already [endorsed by NQF](#) (e.g., same topic, but different target population/setting/data source <u>or</u> different topic but same target population): **3b.2 Are the measure specifications harmonized? If not, why?**	**3b** C☐ P☐ M☐ N☐ NA☐
3c. Distinctive or Additive Value **3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** **5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality:** NA	**3c** C☐ P☐ M☐ N☐ NA☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Usability?*	**3**
Steering Committee: Overall, to what extent was the criterion, *Usability*, met? **Rationale:**	**3** C☐ P☐ M☐ N☐

4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. ([evaluation criteria](#))	**Eval Rating**
4a. Data Generated as a Byproduct of Care Processes **4a.1-2 How are the data elements that are needed to compute measure scores generated?** Data generated as byproduct of care processes during care delivery (Data are generated and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition), Coding/abstraction performed by someone other than person obtaining original information (E.g., DRG, ICD-9 codes on claims, chart abstraction for quality measure or registry)	**4a** C☐ P☐ M☐ N☐
4b. Electronic Sources **4b.1 Are all the data elements available electronically?** (*elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims*) No **4b.2 If not, specify the near-term path to achieve electronic capture by most providers.** NCQA may eventually adapt this measure for use in electronic health records.	**4b** C☐ P☐ M☐ N☐
4c. Exclusions **4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?** No **4c.2 If yes, provide justification.**	**4c** C☐ P☐ M☐ N☐ NA☐
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences **4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.** All measures that are used in NCQA programs are audited.	**4d** C☐ P☐ M☐ N☐
4e. Data Collection Strategy/Implementation	**4e**

4e.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: Based on data analysis over the years, we specified the measure to assess whether children received preventive care visits; we assess several age bands that focus on early childhood and then school-age children and up. HEDIS results show that these data elements are available in administrative data sources. **4e.2** Costs to implement the measure (*costs of data collection, fees associated with proprietary measures*): This measure appears in HEDIS and is subject to HEDIS costs. **4e.3** Evidence for costs: Based on user feedback **4e.4** Business case documentation:	C☐ P☐ M☐ N☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Feasibility*?	**4**
Steering Committee: Overall, to what extent was the criterion, *Feasibility*, met? **Rationale:**	**4** C☐ P☐ M☐ N☐
RECOMMENDATION	
(for NQF staff use) **Check if measure is untested and only eligible for time-limited endorsement.**	Time-limited ☐
Steering Committee: Do you recommend for endorsement? **Comments:**	Y☐ N☐ A☐
CONTACT INFORMATION	

Co.1 Measure Steward (Intellectual Property Owner)
Co.1 Organization
National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005

Co.2 Point of Contact
Sepheen, Byron, MHS, byron@ncqa.org, 202-955-3573-

Measure Developer If different from Measure Steward
Co.3 Organization
National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005

Co.4 Point of Contact
Sepheen, Byron, MHS, byron@ncqa.org, 202-955-3573-

Co.5 Submitter If different from Measure Steward POC
Sepheen, Byron, MHS, byron@ncqa.org, 202-955-3573-, National Committee for Quality Assurance

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Co.6 Additional organizations that sponsored/participated in measure development

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ADDITIONAL INFORMATION
Workgroup/Expert Panel involved in measure development

Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

Over the years, the following expert panel has contributed to many of the measures in the HEDIS set that apply to women and children.

David Archer, MD
Eastern Virginia Medical School
Grant P. Bagley, MD, JD
Arnold & Porter
Thomas J. Benedetti, MD
University of Washington Medical Center
Denis Dougherty
Agency for Healthcare Research and Quality (AHRQ)
Christopher B. Forrest, MD, PhD
The Children's Hospital of Philadelphia
Shirley Girouard, PhD, RN
Southern Connecticut State University
Bill Heuston, MD
Medical University of South Carolina
Mary Kay Holleran
Highmark Caring Foundation
Charles Homer MD, MPH
National Initiative for Children's Healthcare Quality
Marilyn C. Jones, MD
Children's Hospital
Milton Kotelchuck, PhD, MPH
Boston University School of Public Health   Mark Mandell, MD
Partners Community Health Care, Inc.
Dorothy Mann, PhD, MPH
Consultant
Robert H. Pantell, MD
University of California, San Francisco
Lee Partridge

Ad.2 If adapted, provide name of original measure: NA
Ad.3-5 If adapted, provide original specifications URL or attachment

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.6 Year the measure was first released: 1997
Ad.7 Month and Year of most recent revision: 07, 2010
Ad.8 What is your frequency for review/update of this measure? Annual
Ad.9 When is the next scheduled review/update for this measure? 07, 2011

Ad.10 Copyright statement/disclaimers: © 1997 by the National Committee for Quality Assurance
1100 13th Street, NW, Suite 1000
Washington, DC 20005

Ad.11 -13 Additional Information web page URL or attachment:

Date of Submission (*MM/DD/YY*): 01/24/2011

NATIONAL QUALITY FORUM

Measure Evaluation 4.1
December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized)**:** Complete all <mark>yellow highlighted</mark> areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: *If there is no TAP or workgroup, the SC also evaluates the subcriteria (*<mark>yellow</mark> *highlighted areas).*

Steering Committee: Complete all <mark>pink</mark> highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) **NQF Review #:** 1516 **NQF Project:** Child Health Quality Measures 2010	
MEASURE DESCRIPTIVE INFORMATION	

De.1 Measure Title: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

De.2 Brief description of measure*:* The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.

1.1-2 Type of Measure: Use of services
De.3 If included in a composite or paired with another measure, please identify composite or paired measure None

De.4 National Priority Partners Priority Area: Population health
De.5 IOM Quality Domain: Timeliness
De.6 Consumer Care Need: Staying healthy

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	**NQF Staff**
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.* **A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)?** Yes **A.2 Indicate if Proprietary Measure** (*as defined in measure steward agreement*)**:** Proprietary measure, Proprietary complex measure with fees **A.3 Measure Steward Agreement:** Agreement will be signed and submitted prior to or at the time of measure submission **A.4 Measure Steward Agreement attached:**	A Y☐ N☐

B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	**B** Y☐ N☐
C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ►**Purpose:**	**C** Y☐ N☐
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. **D.1 Testing:** Yes, fully developed and tested **D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?** Yes	**D** Y☐ N☐
(for NQF staff use**) Have all conditions for consideration been met?** **Staff Notes to Steward** (*if submission returned*)**:**	**Met** Y☐ N☐
Staff Notes to Reviewers (*issues or questions regarding any criteria*)**:**	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. *Measures must be judged to be important to measure and report* in order to be evaluated against the remaining criteria. (evaluation criteria) **1a. High Impact**	**Eval Rating**
(for NQF staff use) **Specific NPP goal**:	
1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, Patient/societal consequences of poor quality **1a.2** **1a.3 Summary of Evidence of High Impact:** Well-care child visits currently serve as the focal point of contact for the delivery of preventive services for children (Nevin, 2002). Investing in preventive care can reduce morbidity and mortality. In addition, these preventive services can result in significant cost savings. An analysis of the cost-effectiveness of recommended preventive services demonstrated that for a relatively small net cost, most of preventive services produce valuable health benefits. Eighteen of the 25 preventive services evaluated cost $50,000 or less per quality-adjusted life year (QALY), and 10 of these cost less than $15,000 per QALY, all within the range of what is considered a favorable cost-effectiveness ratio.(Schor, 2007) **1a.4 Citations for Evidence of High Impact:** Nevin, Janice E., MD, MPH., and Witt, Deborah K., MD. "Well child and preventive care" Prim Care Clin Office Pract 29 (2002): 543-555. Edward L. Schor T, MD. The future pediatrician: promoting children's health and development. Partnership for prevention. Preventive Care: A national profile on use, disparities, and health Benefits. November 2007.	**1a** C☐ P☐ M☐ N☐
1b. Opportunity for Improvement	**1b** C☐

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable

1b.1 Benefits (improvements in quality) envisioned by use of this measure: This measure encourages health care providers to champion well-care visits, which are an important opportunity for the provider to share information on health and safety issues, information on nutrition and physical fitness and information on how to manage emergencies and illness with the child's parents/guardian. Guidance may also be provided by the physician on issues such as behavioral problems, learning problems, emotional problems, family problems and socialization problems (Healthy Children: Investing in the Future).	P☐ M☐ N☐

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
NCQA's HEDIS measure has shown that performance among health plans is low. For well-child visits in their 15 months of life, the rate without visit was 5.68% in 2007; the rate for having 1 visit was 3.3%; the rate for having 3 visits was 6.2%; the rate for having 6 or more visits was 52.95. For well-child visits in their 3-6 years of life, the rate was 65.11% in general.

The quality of child health supervision varies greatly among physician practices. Among a Medicaid population, only approximately one-fifth of children received preventive and developmental services that met a basic threshold of quality for each aspect of care assessed. A national survey of parents found that over 94 percent of parents reported an unmet need for parenting guidance, education, or screening by pediatric clinicians in one or more content of care areas. In general, substantially less than one-half of children and adolescents receive developmental and psychosocial surveillance, disease screening, and anticipatory guidance.

1b.3 Citations for data on performance gap:
http://health.utah.gov/hda/reports/2008/hmo/quality/commercial/wellcare.php#1
Edward L. Schor, MD. Rethinking Well-Child Care

NCQA State of Health Care Quality Report. 2009

1b.4 Summary of Data on disparities by population group:
Variables such as the age and education level of an infant's parent or caregiver may affect the likelihood that the parent or caregiver schedules and keeps a well-care visit (Grossman, 1996).
Higher-need families, those with low incomes or low levels of maternal education, and those relying on Medicaid for their children's health care do not receive additional anticipatory guidance or longer well-child visits, and in fact sometimes receive less information and shorter visits. At-risk children have been found to be less likely to receive preventive and developmental services during well-child care visits, and low-income families are less likely to receive referrals to community resources that may be helpful to them.

1b.5 Citations for data on Disparities:
Grossman LK, Humbert AL, Powell M. Continuity of care between obstetrical and pediatric preventive care: Indicators of nonattendance at the first well-child appointment. Clinical Pediatrics. 11/96;563-569.

Edward L. Schor T, MD. The future pediatrician: promoting children's health and development. Partnership for prevention. Preventive Care: A national profile on use, disparities, and health Benefits. November 2007.

1c. Outcome or Evidence to Support Measure Focus **1c.1 Relationship to Outcomes (***For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population***):** Well-care visits are routine visits to the child's physician for the purpose of physical examinations, immunization updates, tracking growth and development, and finding problems before they become serious. They provide an opportunity for primary prevention practices (e.g. immunizations), secondary prevention practices (e.g. developmental screenings), and anticipatory guidance. The benefits of primary and secondary prevention practices on health outcomes has been well established. In general, the outcomes of well-child care include: the child´s physical health and development; emotional, social, and cognitive development; the family´s capacity and functioning. Although outcomes can focus on both the long and short term, it is important to remember that well-child care can affect the seemingly distant future for both child and family. For example, altering dietary habits in childhood or adolescence can help prevent heart attacks during middle age. Positive parenting can avoid adult	**1c** C☐ P☐ M☐ N☐

depression and substance abuse.

1c.2-3. Type of Evidence: Evidence-based guideline, Expert opinion

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*)**:**
Along with immunizations, anticipatory guidance and health monitoring are the cornerstones of well-child care for both healthy children and children with special health care needs (CSHCN). The American Academy of Pediatrics (AAP) provides recommendations for pediatric health supervision visits through their Guidelines for Health Supervision III.(AAP, 2008) In addition, the Maternal and Child HealthBureau (MCHB) launched a major initiative to improve the quality of health promotion and preventive services for infants, children, and adolescents through the sponsorship of Bright Futures.(Green M, 2002) These recommendations call for periodic monitoring, screening, and guidance for all children. Furthermore, preventive care is an essential part of the AAP´s Medical Home policy statement.(AAP, 2002) Specifically, the AAP states that primary care services should include "growth and developmental assessments, appropriate screening, health care supervision, and patient and parent counseling about health, nutrition, and safety." (AAP, 2002) Many recent studies have focused on access to and use of preventive health care and anticipatory guidance for children in general, and well-child care can affect the seemingly distant future for both child and family.

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom*)**:**
Good

1c.6 Method for rating evidence: Expert consensus

1c.7 Summary of Controversy/Contradictory Evidence: None

1c.8 Citations for Evidence (*other than guidelines*)**:** Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.

Green M, Palfrey J, Clark E, Anastasi J, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 2nd ed., rev. Arlington, VA: Maternal and Child Health Bureau; 2002

Medical Home Initiatives for Children With Special Needs Project Advisory Committee. American Academy of Pediatrics. The medical home. Pediatrics. 2002;110 (pt 1):184 –186

1c.9 Quote the Specific guideline recommendation (*including guideline number and/or page number*)**:**
W15

American Academy of Pediatrics (2008), Bright Futures
The AAP recommends a total of eight well-care visits from the time the child is a newborn to the point he reaches 15 months old.

W34

American Academy of Pediatrics (2008), Bright Futures
The AAP recommends a total of four well-care visits for children ages three to six years of age.

1c.10 Clinical Practice Guideline Citation: Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.
1c.11 National Guideline Clearinghouse or other URL: Routine preventive services for infants and children (birth - 24 months). http://www.guideline.gov/content.aspx?id=15116&search=child+preventive+services

1c.12 Rating of strength of recommendation (*also provide narrative description of the rating and by whom*)**:**
Expert Consensus

1c.13 Method for rating strength of recommendation (*If different from USPSTF system, also describe rating and how it relates to USPSTF*)**:**
Expert consensus with evidence review

1c.14 Rationale for using this guideline over others:
NCQA convened a multistakeholder panel of experts to review evidence and guidelines for child health care. The Child Health Measurement Advisory Panel reviewed these guidelines together with the health importance and field test results of this measure. The MAP concluded that the health importance, evidence and feasibility supports this measure.

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Importance to Measure and Report*?	**1**
Steering Committee: Was the threshold criterion, *Importance to Measure and Report*, met? **Rationale:**	**1** Y☐ N☐

2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)	**Eval Rating**

2a. MEASURE SPECIFICATIONS

S.1 Do you have a web page where current detailed measure specifications can be obtained?
S.2 If yes, provide web page URL:

2a. Precisely Specified

2a.1 Numerator Statement (*Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome***):**
Received one or more well-child visits with a PCP during the measurement year.

2a.2 Numerator Time Window (*The time period in which cases are eligible for inclusion in the numerator***):**
1 year

2a.3 Numerator Details (*All information required to collect/calculate the numerator, including all codes, logic, and definitions***):**
At least one well-child visit with a PCP during the measurement year.
The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. A child who had a claim/encounter with a code listed in Table W34-A is considered to have received a well-child visit.

Table W34-A: Codes to Identify Well-Child Visits
99382, 99383, 99392, 99393
V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Medical record (non-Commercial plans only) for both measures:
Documentation must include a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of all of the following.
• A health and developmental history (physical and mental)
• A physical exam
• Health education/anticipatory guidance
Do not include services rendered during an inpatient or ED visit.
Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.
Visits to school-based clinics with practitioners whom the organization would consider PCPs may be counted if documentation of a well-child exam is available. The PCP does not have to be assigned to the member.

2a-specs
C☐
P☐
M☐
N☐

The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured***):**
Product lines: Commercial, Medicaid (report each product line separately).
Ages: 3–6 years as of December 31 of the measurement year.
Continuous enrollment: The measurement year.
Allowable gap: No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date: December 31 of the measurement year.
Benefit: Medical

Medical Record (non-Commercial plans) for both measures:
A systematic sample drawn from the eligible population for the Medicaid product line. The organization may reduce its sample size using the current year's administrative rate or the prior year's audited rate.

2a.5 Target population gender: Female, Male
2a.6 Target population age range: 3-6 years

2a.7 Denominator Time Window (*The time period in which cases are eligible for inclusion in the denominator***):**
1 year

2a.8 Denominator Details (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions***):**
Product lines   Commercial, Medicaid (report each product line separately).
Age   3-6 years old during the measurement year.
Continuous enrollment The measurement year
Allowable gap   No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date   December 31 of the measurement year
Benefit Medical.
Event Diagnosis: None

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population***):** None

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions***):**
NA

2a.11 Stratification Details/Variables (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions***):**
None

2a.12-13 Risk Adjustment Type: No risk adjustment necessary

2a.14 Risk Adjustment Methodology/Variables (*List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method***):**
NA

2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score: Rate/proportion
2a.20 Interpretation of Score: Better quality = Higher score
2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**

2a.22 Describe the method for discriminating performance *(e.g., significance testing)*:
Comparison of means and percentiles; analysis of variance against established benchmarks; if sample size is >400, we would use an analysis of variance.

2a.23 Sampling (Survey) Methodology *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)*:
None for Commercial plans; for others, see above.

2a.24 Data Source *(Check the source(s) for which the measure is specified and tested)*
Electronic administrative data/claims, Paper medical record/flow-sheet

2a.25 Data source/data collection instrument *(Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.)*:
HEDIS

2a.26-28 Data source/data collection instrument reference web page URL or attachment:

2a.29-31 Data dictionary/code table web page URL or attachment:

2a.32-35 Level of Measurement/Analysis *(Check the level(s) for which the measure is specified and tested)*
Health Plan, Integrated Delivery System, Population : National, Population : Regional/network

2a.36-37 Care Settings *(Check the setting(s) for which the measure is specified and tested)*
Ambulatory Care : Clinic, Ambulatory Care : Hospital Outpatient, Ambulatory Care : Office

2a.38-41 Clinical Services *(Healthcare services being measured, check all that apply)*
Clinicians: PA/NP/Advanced Practice Nurse, Clinicians: Physicians (MD/DO)

TESTING/ANALYSIS	

2b. Reliability testing

2b.1 Data/sample *(description of data/sample and size)*: The reliability metric for each measure was calculated separately for Commercial and Medicaid plans where applicable using 2010 data.

2b.2 Analytic Method *(type of reliability & rationale, method for testing)*:
Reliability was estimated by using the beta-binomial model. Beta-binomial is a better fit when estimating the reliability of simple pass/fail rate measures as is the case with most HEDIS® health plan measures. The beta-binomial model assumes the plan score is a binomial random variable conditional on the plan´s true value that comes from the beta distribution. The beta distribution is usually defined by two parameters, alpha and beta. Alpha and beta can be thought of as intermediate calculations to get to the needed variance estimates. The beta distribution can be symmetric, skewed or even U-shaped.

Reliability used here is the ratio of signal to noise. The signal in this case is the proportion of the variability in measured performance that can be explained by real differences in performance.

2b.3 Testing Results *(reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
Commercial Reliability: 0.9984
Medicaid Reliability: 0.9907

A reliability of zero implies that all the variability in a measure is attributable to measurement error. A reliability of one implies that all the variability is attributable to real differences in performance. The higher the reliability score, the greater is the confidence with which one can distinguish the performance of one plan from another. A reliability score greater than or equal to 0.7 is considered very good.

2b
C ☐
P ☐
M ☐
N ☐

2c. Validity testing

2c.1 Data/sample *(description of data/sample and size)*: expert panel and stakeholders

2c
C ☐
P ☐

2c.2 Analytic Method *(type of validity & rationale, method for testing)*: NCQA tested the measure for face validity using a panel of stakeholders with specific expertise in measurement and child health care. This panel included representatives from key stakeholder groups, including pediatricians, family physicians, health plans, state Medicaid agencies and researchers. Experts reviewed the results of the field test and assessed whether the results were consistent with expectations, whether the measure represented quality care, and whether we were measuring the most important aspect of care in this area. **2c.3 Testing Results** *(statistical results, assessment of adequacy in the context of norms for the test conducted)*: This measure was deemed valid by the expert panel.	M☐ N☐
2d. Exclusions Justified **2d.1 Summary of Evidence supporting exclusion(s):** No exclusions **2d.2 Citations for Evidence:** NA **2d.3 Data/sample** *(description of data/sample and size)*: NA **2d.4 Analytic Method** *(type analysis & rationale)*: NA **2d.5 Testing Results** *(e.g., frequency, variability, sensitivity analyses)*: NA	**2d** C☐ P☐ M☐ N☐ NA☐
2e. Risk Adjustment for Outcomes/ Resource Use Measures **2e.1 Data/sample** *(description of data/sample and size)*: NA **2e.2 Analytic Method** *(type of risk adjustment, analysis, & rationale)*: NA **2e.3 Testing Results** *(risk model performance metrics)*: NA **2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:** The measure assesses prevention and wellness in a general population; risk adjustment is not indicated.	**2e** C☐ P☐ M☐ N☐ NA☐
2f. Identification of Meaningful Differences in Performance **2f.1 Data/sample from Testing or Current Use** *(description of data/sample and size)*: The measures are part of the Healthplan Effectiveness Data and Information Set (HEDIS). **2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance** *(type of analysis & rationale)*: Comparison of means and percentiles; analysis of variance against established benchmarks; if sample size is >400, we would use an analysis of variance **2f.3 Provide Measure Scores from Testing or Current Use** *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*: HEDIS 2006 Data National Mean: 66.81 10th %ile: 55.7 50th %ile: 67.59 90th %ile: 79.87	**2f** C☐ P☐ M☐ N☐

HEDIS 2006 Data National Mean: 65.11 10th %ile: 50.94 50th %ile: 67.92 90th %ile: 78.94	

2g. Comparability of Multiple Data Sources/Methods

2g.1 Data/sample *(description of data/sample and size)*: National HEDIS data

2g.2 Analytic Method *(type of analysis & rationale)*:
Comparison of means, percentiles and variances

2g.3 Testing Results *(e.g., correlation statistics, comparison of rankings)*:
Rate by Collection Method
Measure: Well Child Visits in 3-6 years

Coll Meth	N	Mean	Std Dev	Min	P25	P50	P75	P90	Max
Hybrid	253	67.8	12.2	28.0	59.2	68.6	75.8	83.2	96.2
Admin	253	66.3	12.2	28.0	57.4	67.5	74.7	82.4	90.6

Summary of difference between rates

N	Mean	Stdev	P10	P25	P50	P75	P90
253	1.46	2.88	0	0	0	2.08	3.87

2g
C☐
P☐
M☐
N☐
NA☐

2h. Disparities in Care

2h.1 If measure is stratified, provide stratified results *(scores by stratified categories/cohorts)*: The measure is not stratified to detect disparities.

2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:
NA

2h
C☐
P☐
M☐
N☐
NA☐

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Scientific Acceptability of Measure Properties*?

2

Steering Committee: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties*, met?
Rationale:

2
C☐
P☐
M☐
N☐

3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)

Eval Rating

3a. Meaningful, Understandable, and Useful Information

3a.1 Current Use: In use

3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large) *(If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years)*:
This measure is used in public reporting.

3a.3 If used in other programs/initiatives (*If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years***):**
This measure is a measure in the Healthcare Effectiveness Data and Information Set (HEDIS)

Testing of Interpretability   *(Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement)*

3a
C☐
P☐
M☐
N☐

3a.4 Data/sample *(description of data/sample and size)*: General public and other stakeholder groups (i.e. HEDIS users) **3a.5 Methods** *(e.g., focus group, survey, QI project)*: NCQA vetted the measures with its expert panel. In addition, throughout the development process, NCQA vetted the measure concepts and specifications with other stakeholder groups, including HEDIS users and NCQA's Committee on Performance Measurement. For the health plan measure, we released the measure for public comment and reviewed all results with the NCQA Committee on Performance Measurement (CPM). We also reviewed first-year results with the CPM. **3a.6 Results** *(qualitative and/or quantitative results and conclusions)*: NCQA received feedback that the measure is understandable, feasible, important and valid. Upon review of public comment results, the Committee on Performance Measurement approved the NCQA staff recommendation to add the measure to HEDIS. After reviewing first-year analysis results, the CPM approved the staff recommendation to publicly report the measure. The measure was deemed usable and feasible.	
3b/3c. Relation to other NQF-endorsed measures **3b.1 NQF # and Title of similar or related measures:**	
(for NQF staff use) **Notes on similar/related endorsed or submitted measures:**	
3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source <u>or</u> different topic but same target population): **3b.2 Are the measure specifications harmonized? If not, why?**	**3b** C☐ P☐ M☐ N☐ NA☐
3c. Distinctive or Additive Value **3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** **5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality:** NA	**3c** C☐ P☐ M☐ N☐ NA☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Usability?*	**3**
Steering Committee: Overall, to what extent was the criterion, *Usability*, met? **Rationale:**	**3** C☐ P☐ M☐ N☐
4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)	**Eval Rating**
4a. Data Generated as a Byproduct of Care Processes **4a.1-2 How are the data elements that are needed to compute measure scores generated?** Data generated as byproduct of care processes during care delivery (Data are generated and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition), Coding/abstraction performed by someone other than person obtaining original information (E.g., DRG, ICD-9 codes on claims, chart abstraction for quality measure or registry)	**4a** C☐ P☐ M☐ N☐

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable

4b. Electronic Sources **4b.1 Are all the data elements available electronically?** (*elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims*) No **4b.2 If not, specify the near-term path to achieve electronic capture by most providers.** NCQA may eventually adapt this measure for use in electronic health records.	**4b** C ☐ P ☐ M ☐ N ☐
4c. Exclusions **4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?** No **4c.2 If yes, provide justification.**	**4c** C ☐ P ☐ M ☐ N ☐ NA ☐
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences **4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.** All measures that are used in NCQA programs are audited.	**4d** C ☐ P ☐ M ☐ N ☐
4e. Data Collection Strategy/Implementation **4e.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:** Based on data analysis over the years, we specified the measure to assess whether children received preventive care visits; we assess several age bands that focus on early childhood and then school-age children and up. HEDIS results show that these data elements are available in administrative data sources. **4e.2 Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*): This measure appears in HEDIS and is subject to HEDIS costs. **4e.3 Evidence for costs:** Based on user feedback **4e.4 Business case documentation:**	**4e** C ☐ P ☐ M ☐ N ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Feasibility*?	**4**
Steering Committee: Overall, to what extent was the criterion, *Feasibility*, met? **Rationale:**	**4** C ☐ P ☐ M ☐ N ☐
RECOMMENDATION	
(for NQF staff use) **Check if measure is untested and only eligible for time-limited endorsement.**	Time-limited ☐
Steering Committee: Do you recommend for endorsement? **Comments:**	Y ☐ N ☐ A ☐
CONTACT INFORMATION	

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable

Co.1 Measure Steward (Intellectual Property Owner)
Co.1 <u>Organization</u>
National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005

Co.2 <u>Point of Contact</u>
Sepheen, Byron, MHS, byron@ncqa.org, 202-955-3573-

Measure Developer If different from Measure Steward
Co.3 <u>Organization</u>
National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005

Co.4 <u>Point of Contact</u>
Sepheen, Byron, MHS, byron@ncqa.org, 202-955-3573-

Co.5 Submitter If different from Measure Steward POC
Sepheen, Byron, MHS, byron@ncqa.org, 202-955-3573-, National Committee for Quality Assurance

Co.6 Additional organizations that sponsored/participated in measure development

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ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development
Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
Over the years, the following expert panel has contributed to many of the measures in the HEDIS set that apply to women and children.
David Archer, MD
Eastern Virginia Medical School
Grant P. Bagley, MD, JD
Arnold & Porter
Thomas J. Benedetti, MD
University of Washington Medical Center
Denis Dougherty
Agency for Healthcare Research and Quality (AHRQ)
Christopher B. Forrest, MD, PhD
The Children's Hospital of Philadelphia
Shirley Girouard, PhD, RN
Southern Connecticut State University
Bill Heuston, MD
Medical University of South Carolina
Mary Kay Holleran
Highmark Caring Foundation
Charles Homer MD, MPH
National Initiative for Children's Healthcare Quality
Marilyn C. Jones, MD
Children's Hospital
Milton Kotelchuck, PhD, MPH
Boston University School of Public Health   Mark Mandell, MD
Partners Community Health Care, Inc.
Dorothy Mann, PhD, MPH
Consultant
Robert H. Pantell, MD
University of California, San Francisco
Lee Partridge

Ad.2 If adapted, provide name of original measure: NA
Ad.3-5 If adapted, provide original specifications URL or attachment

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.6 Year the measure was first released: 1997
Ad.7 Month and Year of most recent revision: 07, 2010
Ad.8 What is your frequency for review/update of this measure? Annual
Ad.9 When is the next scheduled review/update for this measure? 07, 2011

Ad.10 Copyright statement/disclaimers: © 1997 by the National Committee for Quality Assurance
1100 13th Street, NW, Suite 1000
Washington, DC 20005

Ad.11 -13 Additional Information web page URL or attachment:

Date of Submission (*MM/DD/YY*)**:** 01/18/2011