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 yellow highlighted 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 (yellow highlighted areas).*

Steering Committee: Complete all pink 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 #:** 1340 **NQF Project:** Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care
De.2 **Brief description of measure***:* Whether children with special health care needs (CSHCN) ages 12-17 have doctors who usually/always encourage increasing responsibility for self-care AND (when needed) have discussed transitioning to adult health care, changing health care needs, and how to maintain insurance coverage
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:** Patient-centered De.6 **Consumer Care Need:** Living with illness

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:** 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 both public reporting and quality improvement. ►**Purpose:** Public reporting, Internal quality improvement	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:** Patient/societal consequences of poor quality 1a.2 1a.3 **Summary of Evidence of High Impact:** According to the MCHB, all youth with special health care needs should receive the services necessary to make appropriate transitions to adult health care, work and independence. Youth with Special Health Care Needs (YSHCN) who transition without specific transition services are more likely to have poor outcomes compared to their peers, including insurance inconsistency, higher rates of hospitalization and advanced care, and not achieving adult social roles. Two-thirds of CSHCN experience at least one adverse transition events: (1) do not have a usual source of care, (2) unmet need for health care, (3) delay in care the last 6 months, (4) uninsured or inconsistency in insurance coverage. Therefore, this is a critical issue to address through Transition to Adulthood Services to help CSHCN successfully transfer into young adulthood. 1a.4 **Citations for Evidence of High Impact:** Child and Adolescent Health Measurement Initiative. 2005/06 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. www.cshcndata.org	1a C☐ P☐ M☐ N☐

Salkever D. Activity status, life satisfaction and perceived productivity for young adults with developmental disabilities. Journal of Rehabilitation. 2000;66(3):4-13.

Van Naarden Braun K, Yeargin-Allsop M, Lollar D. A multidimensional approach to the transition of children with developmental disabilities into young adulthood: The acquisition of adult social roles. Disability and Rehabilitation 2006; 28(15): 915-926.

Lotstein DS, Inkelas M, Hays RD, Halfon N, Brook R. Access to care for youth with special health care needs in the transition to adulthood. Journal of Adolescent Health. 2008, 43(1):23-9.

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 are receiving quality care. The measure is comprised of three components: discussion about change in health care needs, discussion of continuity of insurance coverage, and discussion about self-care responsibility. The measure of transition services 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 41.2% of CSHCN age 12-17 years received guidance on transition to adult health care services.

1b.3 **Citations for data on performance gap:**
Child and Adolescent Health Measurement Initiative. 2005/06 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. www.cshcndata.org

1b.4 **Summary of Data on disparities by population group:**
Children living in a lower income household (0-199% FPL; 29.6%) are less likely to receive Transition to Adulthood Services than children living in a higher income household (400% FPL or more; 53.7%).

Uninsured children are the least likely to receive Transition to Adulthood Services (18.2%), followed by publicly insured children (27.5%) and privately insured children (49.1%).

Children whose condition is controlled by Prescription Medication only are more likely to receive transition services (49.9%), followed by Prescription Medication and Elevated Service Use (42.0%), Elevated Service Use only (31.6%), and Functional Limitations (29.9%).

Children with a strong parent-provider partnership were over 5 times more likely to receive transition services compared to those without (OR: 5.07).

1b.5 **Citations for data on Disparities:**
Child and Adolescent Health Measurement Initiative. 2005/06 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. www.cshcndata.org

Knapp CA, Madden VL, Marcu MI. Factors that Affect Parent Perceptions of Provider-Family Partnership for Children with Special Health Care Needs. Maternal & Child Health Journal, 2010, 14:742-750.

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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*): The Transition to Adulthood Services measure evaluates the involvement of health care provider in preparing CSHCN in making informed decisions. By initiating discussion about youth´s change in health care needs, insurance status, and responsibility for self-care, the health care provider providing the youth with important information to make a successful transition.

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

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1c.4 **Summary of Evidence** (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*)**:**
CSHCN who have a usual source of care were more likely to receive transition to adulthood services, including counseling on future health needs (47.4 vs. 33.6%) and self-care responsibility (79.3 vs. 64.4%).

Children who received Family-Centered Care were more likely to discuss future health needs with their health care provider (56.3 vs. 39.6%) and self-care responsibility (91.2 vs. 70.3%).

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

Duke, N. & Scal, P. Adult Care Transitioning for Adolescents with Special Health Care Needs: A Pivotal Role for Family Centered Care. Maternal & Child Health Journal, 2010.

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:**

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, as specified, 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 youth with special health care needs who receive services needed for transition to adult health care services

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 receiving services needed to transition to adulthood, criteria from the following must be met:
-Child must qualify as having one or more special health care needs
-Doctors usually/always encourage increasing responsibility for self-care (C6Q08)
-If child's doctor only treats children, then doctor had conversation with child about eventually seeing other health care providers who treat adults (C6Q0A_B), if needed
-Doctor discussed changing health care needs as youth becomes adult (C6Q0A), if needed
-Doctor discussed insurance coverage as youth becomes adult (C6Q0A_E), if needed

2a.4 **Denominator Statement (***Brief, text description of the denominator - target population being measured***):**
Children with special health care needs (CSHCN) age 12-17 years

2a.5 **Target population gender:** Female, Male
2a.6 **Target population age range:** Children with Special Health Care Needs age 12-17 years

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

2a.8 **Denominator Details (***All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions***):**
Children with special health care needs (CSHCN) age 12-17 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 12-17 years and/or if child does not have one or more special health care needs (non-CSHCN).

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 is younger than 12 years, excluded from denominator.
CSHCN are defined by the standardized and validated CSHCN Screener. The screener is administered at the beginning of the survey and all remaining items in the survey are only asked regarding a child with special health care needs.

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 Transition to Adulthod measure was administered in its most recent form, in the 2005/06 National Survey of Children with Special Health Care Needs, the survey included a number of child demographic variables that allow for stratification of the findings by possible vulnerability:
- Age
- Gender

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- Geographic location- State, HRSA Region, National level Rural Urban Commuter Areas (RUCA)
- Race/ethnicity
- Health insurance- type, consistency
- Primary household language
- Household income
- Type of Special Health Care Need

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 receiving services needed to transition to adulthood, youth must meet all 4 criteria:
-If child's doctor only treats children (C6Q07=1), then doctor had conversation with child about eventually seeing other health care providers who treat adults (C6Q0A_B=0), or the discussion would not have been helpful (C6Q0A_C=0).
-Doctor discussed changing health care needs as youth becomes adult (C6Q0A=1), or the discussion would not have been helpful (C6Q0A_D=0)
-Doctor discussed insurance coverage as youth becomes adult (C6Q0A_E=1), or the discussion would not have been helpful (C6Q0A_F)
-Doctor usually or always encourage youth to engage in appropriate self-care, such as taking medications, understanding his/her diagnosis, or following medical advice (C6Q08=3 or 4)

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 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN). The NS-CSHCN first uses the sampling frame generated in the process of data collection for the National Immunization Survey (NIS). Once it is determined whether a child is present in the household and whether or not they are age eligible for the NIS, it is then determined whether the child may also be eligible for the NS-CSHCN.

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

To achieve these goals, state samples were designed to obtain a minimum of 750 completed interviews. The number of children to be selected in each NIS estimation area was determined by allocating the total of 750 CSHCN in the state to each 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 40,723 interviews were completed from April 2005 to February 2007 for the 2005/2006 National Survey of Children with Special Health Care Needs. 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. All children residing in the household under 18 years of age were screened for special health care needs using the validated CSHCN Screener. If more than one child in the household was identified with special needs, only one child with special health care needs was randomly selected 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)*
Survey: Patient

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.***):**
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
http://www.cdc.gov/nchs/data/slaits/NSCSHCNIIEnglishQuest.pdf

2a.29-31 Data dictionary/code table web page URL or attachment: URL
http://www.cshcndata.org/ViewDocument.aspx?item=260

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 Applies to any care setting in which child receives care. Can stratify by usual source of care.

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.

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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

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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 National Survey of Children with Special Health Care Needs Chartbook 2005-2006. Rockville, Maryland: U.S. Department of Health and Human Services, 2008. http://mchb.hrsa.gov/cshcn05/ 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:**	
(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 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*	4e C☐ P☐ M☐ N☐

measures): Item is public domain and there is no cost associated with its use. 4e.3 **Evidence for costs:** 4e.4 **Business case documentation:**	
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**
Child and Adolescent Health Measurement Initiative on behalf of the Maternal and Child Health Bureau, Oregon Health & Science University, 707 SW Gaines Street, Portland, Oregon, 97239

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**
Maternal and Child Health Bureau, Parklawn Building Room 18-05, 5600 Fishers Lane, Rockville, Maryland, 20857

Co.4 **Point of Contact**
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-, Child and Adolescent Health Measurement Initiative on behalf of the Maternal and Child Health Bureau

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

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 dozens of health services researchers, survey methodology experts, and clinical health experts on children´s health to develop items for the National Survey of Children´s Health. In addition, members of the National Center for Health Statistics are included in item construction and measure development. The TEP participates in all aspects of measure development.

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: 2005

Ad.7 Month and Year of most recent revision: 01, 2009

Ad.8 What is your frequency for review/update of this measure? Updated every 4 years when a new NS-CSHCN is developed

Ad.9 When is the next scheduled review/update for this measure? 01, 2013

Ad.10 Copyright statement/disclaimers:

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

Date of Submission (*MM/DD/YY*)**:** 08/30/2010