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 #:** 1329 **NQF Project:** Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Children Who Have a Personal Doctor or Nurse
De.2 **Brief description of measure:** Whether child has one or more doctors, nurses or other healthcare providers who know the child well
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:** 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	**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:** 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:** Having a personal doctor or nurse that knows the child well and is familiar with his or her medical history is necessary for a child to receive effective preventive and acute medical care. It has been recognized as an initiative by the U.S. Department of Health and Human Services´ Healthy People 2020 (AHS HP2020-3: Increase the proportion of persons with a usual primary care provider). 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 U.S. Department of Health and Human Services. Healthy People 2020. http://www.healthypeople.gov/HP2020/.	**1a** C☐ P☐ M☐ N☐
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. Having the ability to recognize the what proportion of children have a personal doctor or nurse in various populations is essential to providing equitable and effective care to all	**1b** C☐ P☐ M☐ N☐

patients across sociodemographic backgrounds.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
Nationally, 92.2% of children age 0-17 have at least 1 personal doctor or nurse. There is a broad range in the prevalence of children who have a personal doctor or nurse, from 82.4% in Nevada to 97.3% 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 personal doctor or nurse (PDN) varies by race. 85.8% of Hispanic children, 88.8% of black, non-Hispanic children and 95.5% white, non-Hispanic children have a PDN. 80.7% of Hispanic children living in Spanish speaking households, and 91.2% of Hispanic children living in English speaking Hispanic HHs have a personal doctor or nurse.

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

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*)**:** Health care providers, public health professionals and population-based health analysts can all benefit from knowing whether or not children are receiving quality care. Having the ability to recognize what proportion of various populations have a personal doctor or nurse is essential to providing equitable and effective care to all patients across sociodemographic backgrounds.

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 who have a personal doctor or nurse are less likely to have one or more unmet needs for care (6.4% vs. 11.4%). Children who have a personal doctor or nurse are also more likely to be in very good or excellent overall health than children who do not have a PDN (85.4% vs. 72.4%).

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
C☐
P☐
M☐
N☐

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*): Children with one or more health professionals considered by parents to be their child´s personal doctor or nurse **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 target numerator of having a personal doctor or nurse, their parent must answer "yes" to the following question: A personal doctor or nurse is a health professional who knows your child well and is familiar with your child´s health history. Do you have one or more person(s) you think of as your child´s personal doctor or nurse? (K4Q04)	
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*): No defined time window for denominator--all parents of children 0-17 years are included in the denominator, and the question isn´t anchored to a specific 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*): All children age 0-17 years	**2a-specs** **C☐** **P☐** **M☐** **N☐**
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***):**

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 Personal Doctor or Nurse 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 = Higher score
2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**
In order for a child to be scored as having a personal doctor or nurse, their parent must report that child has at least one health professional who knows the child well and is familiar with the child´s health history (K4Q04=1).

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)*
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.*)**:**
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 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)***:** 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.

2b
C☐ P☐ M☐ N☐

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)***:**

2c
C☐ P☐ M☐ N☐

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**

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:**	**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:**	

(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**

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

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December 2009

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(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

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B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and	B

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	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:** 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	**1a** C☐ P☐ M☐ N☐

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.

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

1b
C☐
P☐
M☐
N☐

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.

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:

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, 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*)**:** 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	**2a-specs** **C☐** **P☐** **M☐** **N☐**

• 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***):**
-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)*
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.***):**
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 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.	**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** C☐ P☐ M☐ N☐ NA☐

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

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)***:**	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?	**3**

Rationale:	**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 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: 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:

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

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 #:** 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:** 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	**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:** 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: 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	**1a** C☐ P☐ M☐ N☐

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. 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:**

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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 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-specs** **C☐** **P☐** **M☐** **N☐**

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 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)*
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.***):**
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 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)***:** 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

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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.	**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 executive committee also reviewed report formats for interpretability and applicability.	**3a** C☐ P☐ M☐ N☐

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 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?**	**4c** C☐ P☐ M☐

No **4c.2 If yes, provide justification.**	**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** 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: 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:

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

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 #:** 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:** Agreement will be signed and submitted prior to or at the time of measure submission	A Y☐ N☐

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 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.1Testing:** 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	**1a** C☐ P☐ M☐ N☐

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/.

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

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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.

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
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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 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-specs** **C☐** **P☐** **M☐** **N☐**

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 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)*
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.***):**
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 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)***:** 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)***:**

2b
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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.	
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**	**2f** C☐ P☐ M☐ N☐

(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)*:	
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.	**3a** C☐ P☐ M☐ N☐

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	
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*	**4b** C☐ P☐

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.**	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 **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:** 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:**

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

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 #:** 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:** 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	**B** Y☐

every 3 years. Yes, information provided in contact section	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:** 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. Inconsitent 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.	**1a** C☐ P☐ M☐ N☐

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.

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

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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.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 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***):**	**2a-specs** **C☐** **P☐** **M☐** **N☐**

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***):**
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)*
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.***):**
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 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)*: 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.

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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.	
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** C☐

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)*:	**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.	**3a C☐ P☐ M☐ N☐**

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	
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**

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.**	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 **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:** 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:**

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

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 #:** 1344 **NQF Project:** Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Children Who Have Problems Accessing Needed Specialist Care
De.2 **Brief description of measure:** Measures how many children needed to see a specialist but had problems receiving specialist care in the past 12 months
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:** 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	**B** Y☐

every 3 years. Yes, information provided in contact section	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:** Nationally, 23.5% of children who needed or received specialist care in the previous 12 months had a problem accessing that care. **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 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. Sices, L., Feudtner, C., McLaughlin, J., Drotar, D., & Williams, M. (2004). How do primary care physicians manage children with possible developmental delays? A national survey with an experimental design. Pediatrics, 113(2), 274-282. Thomas, KC, Ellis, AR, McLaurin, C, Daniels, J, & Morrissey, JP. (2007). Access to care for autism-related services.	**1a** C☐ P☐ M☐ N☐
1b. Opportunity for Improvement	**1b**

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. Having the ability to recognize the problems various populations have accessing needed specialist care is essential to providing equitable and effective care to all patients across sociodemographic backgrounds.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
There is a large range in the proportion of children who had problems accessing needed specialist care, from 15.5% in Nebraska to 31.7% in New Mexico.

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:
The proportion of children who had problems accessing needed specialist care varies by insurance status. 39.4% of uninsured children, 32.4% of publicly insured children, 18.0% of privately insured children who needed or received specialist care had problems doing so.
Children with special health care needs are more likely to have problems getting needed specialist care than non-CSHCN (27.0% vs. 21.2%).
Problems accessing needed specialist care also varies by income level. 37.5% of children living below 99% FPL, 29.7% of children living at 100-199% FPL, 21.3% of children living at 200-399% FPL, and 15.7% of children living at 400% FPL and above have problems getting needed specialist care.

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

C☐ P☐ 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 who require specialist care should have timely access to that 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*)**:**
All items included in the measure are report of patient experience with healthcare services.

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
C☐ P☐ M☐ N☐

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 children who had problems receiving specialist care 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; question is anchored to past 12 months **2a.3 Numerator Details** (*All information required to collect/calculate the numerator, including all codes, logic, and definitions*)**:** Parents of children who saw a specialist doctor (K4Q24) or who needed to see a specialist (K4Q25) during the past 12 months were asked how much of a problem it was to get specialist care (K4Q26). Problem is defined as those who answered big problem or small problem. Children with no problems obtaining specialist care were those for whom parent answered "no problem".	
2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured*)**:** Children age 0-17 years who needed specialist care **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*)**:** Encounter or point in time; question is anchored to past 12 months **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 who needed specialist care, defined as either seeing a specialist (K4Q24=Yes) or	**2a-specs** **C☐** **P☐** **M☐** **N☐**

needed to see a specialist (K4Q25=Yes)

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 and/or did not need specialist care

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 did not see or need to see a specialist (K4Q24 or K4Q25), 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 Problems Accessing Specialist 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 = Lower score
2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**
To receive numerator of child having problems accessing specialist care:
-Child had small problem accessing specialist care (K4Q26= Small Problem), OR
-Child had big problem accessing specialist care (K4Q26= Big Problem).

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.***):**
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: states, Population: counties or cities

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)***:** 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

2b
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(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.	
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*	**2f** C☐ P☐ M☐ N☐

quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in 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 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	**3a** C☐ P☐ M☐ N☐

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	
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 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: 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:

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

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 #:** 1348 **NQF Project:** Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Children Age 6-17 Years who Engage in Weekly Physical Activity
De.2 **Brief description of measure***:* Measures how many times per week child 6-17 years exercises vigorously (based on AAP and CDC recommendations)
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:** 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	**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:** 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:** Affects large numbers, Leading cause of morbidity/mortality, Patient/societal consequences of poor quality 1a.2 1a.3 **Summary of Evidence of High Impact:** Physical activity is closely associated with BMI status and the overall health of children and has been recognized as an objective by the U.S. Department of Health and Human Services' Healthy people 2020 (PAF HP2020-3: increase the proportion of adolescents who participate in daily school physical education). 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 U.S. Department of Health and Human Services. Healthy People 2020. http://www.healthypeople.gov/HP2020/.	**1a** C☐ P☐ M☐ N☐
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 know whether or not children are getting physical activity. Use of this measure allows for comparison accross populations and	**1b** C☐ P☐ M☐ N☐

demographic groups.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
Nationally, 64.3% of children age 6-17 years participate in at least 20 minutes of vigorous physical activity 4 or more times a week, with a broad range geographically. State range is 54.7% in the District of Columbia to 72.8% in Vermont and Minnesota.

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:
Urban children are more likely to be physically inactive than rural children (29.1% vs. 25.2%).
Immigrant Hispanic children are more likely to be physically inactive than US-born white children with US-born parents (22.5% vs. 9.5%).
Physical activity also varies by income level. Children living at 400% FPL or above are less likely to be physically inactive than children living at 99% FPL or lower (5.8% vs. 20.8%).

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

Liu J, Bennett KJ, Harun N, Probst JC. Urban-rural differences in overweight status and physical inactivity among US children aged 10-17 years. J Rural Health. 2008;24(4):407-415.

Liu J, Probst JC, Harun N, Bennett KJ, Torres ME. Acculturation, physical activity, and obesity among Hispanic adolescents. Ethn Health. 2009;14(5):509-525.

McKay CM, Bell-Ellison BA, Wallace K, Ferron JM. A multilevel study of the associations between economic and social context, stage of adolescence, and physical activity and body mass index. Pediatrics. 2007;119 Suppl 1:S84-91.

Rimmer JA, Rowland JL. Physical activity for youth with disabilities: a critical need in an underserved population. Dev Neurorehabil. 2008;11(2):141-148.

Singh GK, Kogan MD, Siahpush M, van Dyck PC. Prevalence and correlates of state and regional disparities in vigorous physical activity levels among US children and adolescents. J Phys Act Health. 2009;6(1):73-87.

Singh GK, Yu SM, Siahpush M, Kogan MD. High levels of physical inactivity and sedentary behaviors among US immigrant children and adolescents. Arch Pediatr Adolesc Med. 2008;162(8):756-763.

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*)**:** Physical activity is inversely associated with BMI status. Increasing physical activity levels in children can help decrease childhood overweight and obesity and lead to improved health outcomes.

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 who get at least 20 minutes of vigorous physical activity 4 or more times a week are more likely to be in very good or excellent overall health than children who get no days of vigorous physical activity (88.0% vs. 64.2%). Additionally, children who get at least 4 days of vigorous physical activity a week are less likely to be overweight or obese than children who get no days of vigorous physical activity a week (28.9% vs. 35.9%).

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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***):** Number of days per week that child 6-17 years engages in vigorous physical activity 2a.2 **Numerator Time Window (***The time period in which cases are eligible for inclusion in the numerator***):** Encounter or point in time; question is anchored to past week 2a.3 **Numerator Details (***All information required to collect/calculate the numerator, including all codes, logic, and definitions***):** Number of days a week that child exercised, played a sport, or participated in a physical activity for at least 20 minutes that made [him/her] sweat and breathe hard -Child engaged in physical activity 0-7days (K7Q41=0 through 7)	**2a-specs** **C☐** **P☐** **M☐** **N☐**

2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured***):**
Children age 6-17 years

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

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 6-17 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 6-17 years.

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions***):**
If child is younger than 6 years of age, excluded from denominator.
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 Child Physical Activity 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***):**
Number of days a week that child exercised, played a sport, or participated in a physical activity for at least 20 minutes that made [him/her] sweat and breathe hard
-Child engaged in physical activity 0-7 days (K7Q41=0 through 7)

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)*
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.***):**
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 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)***:** 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*

2b
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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.	
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** C☐ P☐ M☐

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)*:	**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.	**3a** **C**☐ **P**☐ **M**☐ **N**☐

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	
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*	**4b** C☐ P☐

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.**	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 **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:** 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:**

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

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 #:** 1349 **NQF Project:** Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)
De.2 **Brief description of measure:** Age and gender specific calculation of BMI based on parent reported height and weight of child. The measure uses CDC BMI-for-age guidelines in attributing overweight status (85th percentile up to 94th percentile) and obesity status (95th percentile and above).
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**: Efficiency 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:** 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	B

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	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:** Affects large numbers, Patient/societal consequences of poor quality 1a.2 1a.3 **Summary of Evidence of High Impact:** Childhood overweight and obesity is closely related to adverse health outcomes and the prevalence of obesity is growing nationally. Childhood overweight and obesity has been recognized as an objective by the U.S. Department of Health and Human Services' Healthy People 2020 (NWS HP2020-5). Additionally, obesity prevalence increased by 10% for all U.S. children from 2003 to 2007. An estimated 10.58 million children age 10-17 years, were overweight or obese in 2007. Children who are overweight are more likely to have risk factors associated with cardiovascular disease and to be obese as adults. Children who are obesity are also at higher risk for developing chronic disease such as such as stroke; breast, colon, and kidney cancers; musculoskeletal disorders; and gall bladder disease. Obesity has also been linked to poorer school performance, depression, and social isolation. 1a.4 **Citations for Evidence of High Impact:** Bethell C, Simpson L, Stumbo S, Carle AC, Gombojav N. National, state, and local disparities in childhood obesity. Health Aff (Millwood). 2010;29(3):347-356. 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	**1a** C☐ P☐ M☐ N☐

Curtin C, Anderson SE, Must A, Bandini L. The prevalence of obesity in children with autism: a secondary data analysis using nationally representative data from the National Survey of Children´s Health. BMC Pediatr. 2010;10(1):11.

Daniels SR. Jacobson MS. McCrindle BW. Eckel RH. Sanner BM. (2009). American Heart Association childhood obesity research summit: Executive summary.

Liu J, Bennett KJ, Harun N, Probst JC. Urban-rural differences in overweight status and physical inactivity among US children aged 10-17 years. J Rural Health. 2008;24(4):407-415.

McKay CM, Bell-Ellison BA, Wallace K, Ferron JM. A multilevel study of the associations between economic and social context, stage of adolescence, and physical activity and body mass index. Pediatrics. 2007;119 Suppl 1:S84-91.

Singh GK, Kogan MD, Yu SM. Disparities in obesity and overweight prevalence among US immigrant children and adolescents by generational status. J Community Health. 2009;34(4):271-281.

Singh GK, Siahpush M, Kogan MD. Rising social inequalities in US childhood obesity, 2003-2007. Ann Epidemiol. 2010;20(1):40-52.

Strauss, RS, Pollack, HA. Social marginalization of overweight children. Arch Pediatr Adolesc Med. 2003;157:746-752.

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

Wieting JM. (2008). Cause and effect in childhood obesity: solutions for a national epidemic. Journal of the American Osteopathic Association. 108(10):545-52.

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Because BMI status has such a large impact on health, health care providers, public health professionals and population-based health analysts can all benefit from this measure. This measure also has the benefit of comparing children across populations or demographic groups as to who is most at risk for being overweight or obese.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
Nationally, 31.7% of children age 10-17 are overweight or obese.

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 prevalence of obesity is higher in children with autism than in children without autism (30.4% vs. 23.6%).
Children living in rural areas are more likely to be overweight than children living in urban areas (16.5% vs. 14.3%).
There are large disparities in childhood overweight and obesity within and among states, associated with socioeconomic status, school outcomes, neighborhoods, type of health insurance, and quality of care.
Children living in low-income and low-education households have 3.4-4.3 times higher odds of being obese than children from higher socioeconomic households.

1b.5 Citations for data on Disparities:
Bethell C, Simpson L, Stumbo S, Carle AC, Gombojav N. National, state, and local disparities in childhood obesity. Health Aff (Millwood). 2010;29(3):347-356.

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Curtin C, Anderson SE, Must A, Bandini L. The prevalence of obesity in children with autism: a secondary data analysis using nationally representative data from the National Survey of Children´s Health. BMC Pediatr. 2010;10(1):11.

Liu J, Bennett KJ, Harun N, Probst JC. Urban-rural differences in overweight status and physical inactivity among US children aged 10-17 years. J Rural Health. 2008;24(4):407-415.

Singh GK, Siahpush M, Kogan MD. Rising social inequalities in US childhood obesity, 2003-2007. Ann Epidemiol. 2010;20(1):40-52.

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*)**:** Measurement of childhood BMI status is important for identifying disparities and targeting prevention efforts in groups that are at high risk of being overweight or obese, leading to improved health outcomes.

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 who are obese are less likely to be in very good or excellent overall health than children who are a healthy weight for their age (69.9% vs. 87.4%).

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, 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 children who are underweight, normal weight, overweight or obese. **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*)**:** Body-Mass-Index (BMI) Status for children: -Underweight (<5th percentile) -Normal weight (5th to 84th percentile) -Overweight (85th to 94th percentile) -Obese (95th percentile or above)	
2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured*)**:** Children age 10-17 years **2a.5 Target population gender:** Female, Male **2a.6 Target population age range:** Children age 10-17 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 10-17 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 10-17 years **2a.10 Denominator Exclusion Details** (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions*)**:** If child is younger than 10 years of age, excluded from denominator. 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 Parent Report of BMI Status 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)	**2a-specs** **C**☐ **P**☐ **M**☐ **N**☐

- 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***):**

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)*
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.***):**
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 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)*: 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. In addition, a separate analyis showed that while parental report of height and weight is not perfect, it is highly correlated with clinical measures: Akinbami LJ, and Ogden CL. Childhood overweight prevalence in the United States: the impact of parent-reported height and weight. Obesity (Silver Spring). 2009;17(8): 1574-1580.	**2b** C☐ P☐ M☐ N☐
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** C☐ P☐

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)*:	**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:**	
(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-**	**3c** C☐

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:**	**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. Parental report of height and weight of children has been debated, but tends to align with clinical observed measures. Please see Akinbami LJ, and Ogden CL. Childhood overweight prevalence in the United States: the impact of parent-reported height and weight. Obesity (Silver Spring). 2009;17(8): 1574-1580.	**4e C☐ P☐ M☐ N☐**

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