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 #:** 1400 **NQF Project:** Child Health Quality Measures 2010

MEASURE DESCRIPTIVE INFORMATION

De.1 **Measure Title:** Environmental Tobacco Assessment and Counseling

De.2 **Brief description of measure***:* The percentage of children who had an environmental tobacco assessment and counseling and proper follow-up performed. We are combining three measures into one form because measure features and evidence are the same or similar.
Measure 1: Environmental Tobacco Assessment or Counseling By 6 months of age
Measure 2: Environmental Tobacco Assessment or Counseling By 2 years of age
Measure 3: Environmental Tobacco Assessment or Counseling By 6 years of age

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 appears in the composite Comprehensive Well Care by Age 6 Months Comprehensive Well Care by Age 2 Years and Comprehensive Well Care by Age 6 Years.

De.4 **National Priority Partners Priority Area:** Patient and family engagement, Population health
De.5 **IOM Quality Domain**: Effectiveness, Patient-centered, Timeliness
De.6 **Consumer Care Need:** Staying healthy

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

A.3 Measure Steward Agreement: Agreement will be signed and submitted prior to or at the time of measure submission **A.4 Measure Steward Agreement attached:**	
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	**B** Y☐ N☐
C. The intended use of the measure includes both public reporting and quality improvement. ►**Purpose:** Public reporting, Internal quality improvement Accountability	**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, Leading cause of morbidity/mortality, Severity of illness, Patient/societal consequences of poor quality **1a.2** **1a.3 Summary of Evidence of High Impact:** Tobacco exposure has been linked to a variety of ailments in children, including asthma, bronchitis, pneumonia and middle-ear infections. In the U.S., approximately 38 percent of children between 2 months and 5 years of age are exposed to environmental tobacco smoke in the home (Gergen, 1998). Even if a parent smokes outside the home, children could still face a high level of environmental tobacco exposure. In addition to health consequences, there are health care expenditure implications. One study on the pediatric disease attributable to parental smoking found that tobacco-related morbidity in children results in annual direct medical expenditures of $4.6 billion and loss of life costs of $8.2 billion. **1a.4 Citations for Evidence of High Impact:** Weitzman M, Byrd RS, Aligne CA, Moss M. The effects of tobacco exposure on children´s behavioral and cognitive functioning: implications for clinical and public	**1a** C☐ P☐ M☐ N☐

health policy and future research. Neurotoxicol Teratol. 2002 May-Jun;24(3):397-406.

NIPO. Continuous research smoking habits in the Netherlands 2000-IV. Amsterdam: Defacto, 2000.

Gergen PJ, Fowler JA, Maurer KR, et al. The burden of environmental tobacco smoke exposure on the respiratory health of children 2 months through 5 years of age in the United States: Third National Health and Nutrition Examination Survey, 1988 to 1994. Pediatrics 1998;101:e8.

Research for International Tobacco Control. At What Cost? The Economic Impact of Tobacco Use on National Health Systems, societies and individuals: A Summary of Method and Findings. 2003. RITC Monograph Series No. 1:51: http://books.google.com/books?id=Z3C8NzjCTVgC&pg=PA51&lpg=PA51&dq=financial+impact+of+tobacco+exposure+to+children&source=bl&ots=a58XfftlZc&sig=H-6sJUBFI8IYEx_DiBedl2dxOtw&hl=en&ei=m3phTMaUEcOB8gaC_5WACg&sa=X&oi=book_result&ct=result&resnum=7&ved=0CD4Q6AEwBg#v=onepage&q&f=false. Accessed August 27, 2010.

1b. Opportunity for Improvement

1b.1 **Benefits (improvements in quality) envisioned by use of this measure:** Healthcare providers who care for children, especially pediatricians, are in a unique position to assist with tobacco control. This measure requires that health care providers counsel parents and caregivers on the dangers of environmental tobacco exposure in children, which can be an important opportunity to improve care.

1b.2 **Summary of data demonstrating performance gap (variation or overall poor performance) across providers:**
Environmental tobacco smoke (ETS) exposure is still a leading health concern in the United States. Despite efforts to educate and counsel on the adverse health effects, 70 percent of smokers with children smoke inside their homes. Currently, between 35 and 80 percent of U.S. children are affected by ETS (Downs, Zhu, Anand, Biondich, Carroll, 2008).

Despite support from professional organizations and federal government groups, many pediatricians and family physicians do not routinely engage in intensive efforts to reduce children's environmental tobacco smoke exposure (Klerman, 2004). Physicians have reported a number of barriers to providing counseling on environmental tobacco smoke which could include: negative parental expectations, lack of time, lack of skills or confidence, and perceptions of professional norms (Victor, Brewster , Ferrence, Ashley, Cohen, Selby, 2010).

1b.3 **Citations for data on performance gap:**
Lorraine V. Klerman, Protecting children: Reducing their environmental tobacco smoke exposure. Nicotine & Tobacco Research Volume 6, Supplement 2 (April 2004) S239–S252.

Stead LF, Bergson G, Lancaster T. Physician advice for smoking cessation. Cochrane Database of Systematic Reviews 2008, Issue 2. Art. No.: CD000165. DOI: 10.1002/14651858.CD000165.pub3.

Downs SM, Zhu V, Anand V, Biondich PG, Carroll AE. The CHICA Smoking Cessation System. AMIA Annu Symp Proc. 2008; 2008: 166–170.

Can Fam Physician. J. Charles Victor MSc, Joan M. Brewster PhD , Roberta Ferrence PhD , Mary Jane Ashley MD, Joanna E. Cohen PhD, Peter Selby MB BS. Tobacco-related medical education and physician interventions with parents who smoke. Vol. 56, No. 2, February 2010, pp.157 – 163.

1b.4 **Summary of Data on disparities by population group:**
The use of cigarettes is most prevalent among adults living below the poverty line and who have not completed high school, resulting in environmental tobacco smoke disproportionately affecting children living in low-income households (Committee on Environmental Health, 2009). In addition, more asthma cases and high levels of ETS exposure are being reported in African American, inner-city children (Fagnano, Conn, Halterman, 2008).

1b.5 **Citations for data on Disparities:**

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Flores G, Olson L, Tomany S. Does Disadvantage Start at Home? Racial and Ethnic Disparities in Early Childhood Home Routines, Safety, and Educational Practices/Resources. Abstr AcademyHealth Meet. 2004; 21

Tobacco Use: A Pediatric Disease. PEDIATRICS Vol. 124 No. 5 November 2009, pp. 1474-1487 (doi:10.1542/peds.2009-2114).

Fagnano M, BA, MPH, Conn KM, MPH, Halterman JS, MD, MPH. Environmental Tobacco Smoke and Behaviors of Inner-City Children With Asthma. Ambul Pediatr. 2008; 8(5): 288–293.

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*)**:** ETS exposure is directly responsible for numerous health conditions, especially in children, as they are still in their growth development stage of life. Studies suggest that infants exposed to secondhand smoke are more likely to die from sudden infant death syndrome (O'Keefe, 2009). Children exposed to secondhand smoke are more susceptible to respiratory ailments and other infections. Morbidity among children with asthma due to ETS is on the rise (Halterman et al, 2008). Evidence shows ETS exposure increases the prevalence of asthma, increases the severity of asthma and worsens asthma control in children who already have the disease (Dae Jin Song, 2010).

ETS can have far-reaching adverse effects. Children of parents who smoke are more apt to model their parents' behavior. Teenagers who experiment with tobacco are more prone to becoming addicted to tobacco (O'Keefe, 2009). Tobacco smoke can remain on one's lungs for decades, contributing to emphysema and chronic obstructive pulmonary disease's rise as one of the leading causes of death (Lovasi, 2010).

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

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*)**:**
Providing simple advice to parents on the health benefits of quitting smoking has helped some parents to quit. More intensive efforts and counseling results in slightly higher rates of quitting (Stead, Bergson, Lancaster, 2008). Counseling parents on the dangers of smoking and warning them about the many health complications a child could develop as a result of environmental tobacco smoke exposure is an important way pediatricians and other health care professionals aid in the fight against tobacco use, the most preventable cause of death in our society.

Among the many health complications that are directly contributable to tobacco use include: asthma in children, worsened and increased severity of asthma, emphysema, chronic obstructive pulmonary disease, numerous respiratory ailments and infections, and cancer. It is important for pediatricians and other primary health care professionals to counsel patients and families on these risks and to encourage them to make the extra efforts to quit smoking and ban smoking in homes.

Children are at very high risk of developing health complications through environmental tobacco smoking exposure because their bodies are still developing. Through initial ETS education and counseling, physicians can prevent further exposure and could make a difference in the health of a child and their family.

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

1c.6 Method for rating evidence: Expert Consensus

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

1c.8 Citations for Evidence (*other than guidelines***):** Michigan Quality Improvement Consortium. Routine preventive services for infants and children (birth-24 months). May 2007
Michigan Quality Improvement Consortium. Routine preventive services for infants and children (ages 2-18). May 2007
Stead LF, Bergson G, Lancaster T. Physician advice for smoking cessation. Cochrane Database of Systematic

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Reviews 2008, Issue 2. Art. No.: CD000165. DOI: 10.1002/14651858.CD000165.pub3.

Dae Jin Song. (2010) Environmental tobacco smoke and childhood asthma. Korean Journal of Pediatrics 53:2, 121.

Columbia University´s Mailman School of Public Health (2009, December 29). Exposure to tobacco smoke in childhood home associated with early emphysema in adulthood. ScienceDaily. Retrieved August 24, 2010, from http://www.sciencedaily.com/releases/2009/12/091228114732.htm.

Jill S. Halterman, MD, MPH; Belinda Borrelli, PhD; Paul Tremblay, RN; Kelly M. Conn, MPH; Maria Fagnano, BA; Guillermo Montes, PhD; Telva Hernandez, BA. Screening for Environmental Tobacco Smoke Exposure among Inner City Children with Asthma. Pediatrics. 2008 December; 122(6): 1277–1283.

Lori O'Keefe. (2009) Snuffing out tobacco use: AAP statements guide pediatricians. AAP News Vol. 30 No. 11 November 2009, p. 8.

1c.9 Quote the Specific guideline recommendation (*including guideline number and/or page number***):**
U.S. Preventive Services Task Force (2009)
The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.
Grade: A recommendation.

ICSI (2007)
ICSI recommends that health care providers counsel patients on education topics that include cigarette smoking.
Grade: Level III

Michigan Quality Improvement Consortium (2007)
The Consortium recommends that parents of children age one month to six years be counseled about various topics, including tobacco smoke.
Grade: Level B evidence

1c.10 Clinical Practice Guideline Citation: U.S. Preventive Services Task Force. Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults and Pregnant Women. Ann Intern Med 2009;150:551-55

Institute for Clinical Systems Improvement. Preventive Services for Children and Adolescents Thirteenth Edition. October 2007

Michigan Quality Improvement Consortium. Routine preventive services for infants and children (birth-24 months). May 2007

Michigan Quality Improvement Consortium. Routine preventive services for infants and children (ages 2-18). May 2007

1c.11 National Guideline Clearinghouse or other URL:
http://www.guideline.gov/syntheses/synthesis.aspx?id=16422&search=environmental+tobacco+assessment+and+counseling

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

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

1c.14 Rationale for using this guideline over others:
The USPSTF is an independent group of experts in clinical preventive services who base recommendations on

a comprehensive evidence review. There is fairly consistent guideline support for these measures.	
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***):** "Numerator 1: Children who had documentation in the medical record of an environmental tobacco assessment or counseling by age 6 months Numerator 2: Children who had documentation in the medical record of an environmental tobacco assessment or counseling by age 2 years Numerator 3: Children who had documentation in the medical record of an environmental tobacco assessment or counseling by age 6 years" **2a.2 Numerator Time Window (***The time period in which cases are eligible for inclusion in the numerator***):** 2 years **2a.3 Numerator Details (***All information required to collect/calculate the numerator, including all codes, logic, and definitions***):** Documentation must include a note indicating at least one of the following. • A screening question result indicating whether the child is exposed to secondhand smoke or environmental tobacco • A note indicating at least one of the following. - Engagement in discussion of the harms of environmental tobacco (e.g., dangers of secondhand smoke) - Checklist indicating environmental tobacco or quitting smoking was addressed - Counseling on environmental tobacco or referral for quitting smoking - Member or patient received educational materials on the harms of environmental tobacco or quitting smoking - Anticipatory guidance on environmental tobacco or quitting smoking	
2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured***):** Denominator 1: Children who turned 6 months of age between January 1 of the measurement year and December 31 of the measurement year and who had documentation of a face-to-face visit between the clinician and the child that predates the child's birthday by at least 12 months. Denominator 2: Children who turned 2 years of age between January 1 of the measurement year and December 31 of the measurement year and who had documentation of a face-to-face visit between the clinician and the child that predates the child's birthday by at least 12 months. Denominator 3: Children who turned 6 years of age between January 1 of the measurement year and December 31 of the measurement year and who had documentation of a face-to-face visit between the clinician and the child that predates the child's birthday by at least 12 months. **2a.5 Target population gender:** Female, Male	**2a-specs** **C☐** **P☐** **M☐** **N☐**

2a.6 Target population age range: Measure 1: 0-6 months, Measure 2: 6 months-2 years, Measure 3: 2 years-6 years

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

2a.8 Denominator Details (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions***):**
See above; chart review only

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

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

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

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

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

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

2a.18-19 Type of Score: Rate/proportion
2a.20 Interpretation of Score: Better quality = Higher score
2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**
Step 1: Determine the denominator
Children who turned the requisite age in the measurement year, AND
Who had a visit within the past 12 months of the child´s birthday
Step 2: Determine the numerator
Children who had documentation in the medical record of the screening or service during the measurement year or the year previous to the measurement year.

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

2a.23 Sampling (Survey) Methodology *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)*:
For this physician-level measure, we anticipate the entire population will be used in the denominator. If a sample is used, a random sample is ideal. NCQA's work has indicated that a sample size of 30-50 patients would be necessary for a typical practice size of 2000 patients.

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

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.***):**
Medical Record

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

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

2a.32-35 Level of Measurement/Analysis (*Check the level(s) for which the measure is specified and tested*)
Clinicians: Individual, Clinicians: Group, Population: national, Population: regional/network

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

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

TESTING/ANALYSIS

2b. Reliability testing

2b.1 Data/sample *(description of data/sample and size)*: NCQA received data from 19 physician practices who submitted 10 records per measure (total 190 records per measure)

2b.2 Analytic Method *(type of reliability & rationale, method for testing)*:
We did not conduct reliability testing for this measure.

2b.3 Testing Results *(reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
We did not conduct reliability testing for this measure.

2b C☐ P☐ M☐ N☐

2c. Validity testing

2c.1 Data/sample *(description of data/sample and size)*: NCQA received data from 19 physician practices who submitted 10 records per measure (total 190 records per measure)

2c.2 Analytic Method *(type of validity & rationale, method for testing)*:
NCQA tested the measure for face validity using a panel of stakeholders with specific expertise in measurement and child health care. This panel included representatives from key stakeholder groups, including pediatricians, family physicians, health plans, state Medicaid agencies and researchers. Experts reviewed the results of the field test and assessed whether the results were consistent with expectations, whether the measure represented quality care, and whether we were measuring the most important aspect of care in this area. This measure was deemed valid by the expert panel. In addition, this measure does not utilize administrative data sources; data recorded in the chart is considered the gold standard.

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

2c C☐ P☐ M☐ N☐

2d. Exclusions Justified

2d.1 Summary of Evidence supporting exclusion(s):
No exclusions

2d.2 Citations for Evidence:
NA

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

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

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

2d C☐ P☐ M☐ N☐ NA☐

2e. Risk Adjustment for Outcomes/ Resource Use Measures

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

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

2e C☐ P☐ M☐ N☐

NA **2e.3 Testing Results** *(risk model performance metrics)*: NA **2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:** The measure assesses prevention and wellness in a general population; risk adjustment is not indicated.	**NA** ☐
2f. Identification of Meaningful Differences in Performance **2f.1 Data/sample from Testing or Current Use** *(description of data/sample and size)*: NCQA received data from 19 physician practices who submitted 10 records per measure (total 190 records per measure) **2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance** *(type of analysis & rationale)*: Comparison of means and percentiles; analysis of variance against established benchmarks; if sample size is >400, we would use an analysis of variance **2f.3 Provide Measure Scores from Testing or Current Use** *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*: Measure 1: Environmental Tobacco Assessment and Counseling by Age 6 Mo Elig Population: 180 Documentation that the physician asked or counseled on ETS: 77.7 Measure 2: Environmental Tobacco Assessment and Counseling by Age 2 years Elig Population: 180 Documentation that the physician asked or counseled on ETS: 77.7 Measure 1: Environmental Tobacco Assessment and Counseling by Age 6 years Elig Population: 180 Documentation that the physician asked or counseled on ETS: 61.1	**2f** C☐ P☐ M☐ N☐
2g. Comparability of Multiple Data Sources/Methods **2g.1 Data/sample** *(description of data/sample and size)*: NCQA received data from 19 physician practices who submitted 10 records per measure (total 190 records per measure) **2g.2 Analytic Method** *(type of analysis & rationale)*: This measure is chart review only; no other sources were identified by the expert panel; this measure does not utilize administrative data **2g.3 Testing Results** *(e.g., correlation statistics, comparison of rankings)*: NA	**2g** C☐ P☐ M☐ N☐ **NA** ☐
2h. Disparities in Care **2h.1 If measure is stratified, provide stratified results** *(scores by stratified categories/cohorts)*: The measure is not stratified to detect disparities. **2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:** NA	**2h** C☐ P☐ M☐ N☐ **NA** ☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Scientific Acceptability of Measure Properties?*	**2**
Steering Committee: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties*, met? **Rationale:**	**2** C☐ P☐ M☐ N☐
3. USABILITY	

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)	Eval Rating
3a. Meaningful, Understandable, and Useful Information **3a.1 Current Use:** Not in use but testing completed **3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large)** (*If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years*)**:** This measure is not currently publicly reported. NCQA is exploring the feasibility of adding this measure and its related measures into a physician-level program and/or the HEDIS® measurement set as appropriate. **3a.3 If used in other programs/initiatives (***If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years***):** This measure is not currently used in QI. NCQA is exploring the feasibility of adding this measure and its related measures into a physician-level program and/or the HEDIS® measurement set as appropriate. NCQA anticipates that after we release these measures, they will become widely used, as all our measures do. **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)***:** NA **3a.5 Methods** *(e.g., focus group, survey, QI project)***:** NCQA vetted the measures with its expert panel. In addition, throughout the development process, NCQA vetted the measure concepts and specifications with other stakeholder groups, including the National Association of State Medicaid Directors, NCQA's Health Plan Advisory Council, NCQA's Committee on Performance Measurement, and the American Academy of Pediatrician's Quality Improvement Innovation Network. After field testing, NCQA also conducted a debrief call with field test participants. In the form of a group interview, NCQA systematically sought feedback on whether the measures were understandable, feasible, important, and had face validity. **3a.6 Results** *(qualitative and/or quantitative results and conclusions)***:** NCQA received feedback that the measure is understandable, feasible, important and valid.	**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**	**3c** **C☐** **P☐** **M☐** **N☐** **NA**

same target population), Describe why it is a more valid or efficient way to measure quality: NA	☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Usability?*	**3**
Steering Committee: Overall, to what extent was the criterion, *Usability*, met? **Rationale:**	**3** **C☐** **P☐** **M☐** **N☐**
4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)	Eval Rating
4a. Data Generated as a Byproduct of Care Processes **4a.1-2 How are the data elements that are needed to compute measure scores generated?** Data generated as byproduct of care processes during care delivery (Data are generated and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition), Coding/abstraction performed by someone other than person obtaining original information (E.g., DRG, ICD-9 codes on claims, chart abstraction for quality measure or registry)	**4a** **C☐** **P☐** **M☐** **N☐**
4b. Electronic Sources **4b.1 Are all the data elements available electronically?** (*elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims*) No **4b.2 If not, specify the near-term path to achieve electronic capture by most providers.** NCQA plans to eventually adapt this measure for use in electronic health records.	**4b** **C☐** **P☐** **M☐** **N☐**
4c. Exclusions **4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?** No **4c.2 If yes, provide justification.**	**4c** **C☐** **P☐** **M☐** **N☐** **NA** ☐
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences **4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.** During the measure development process the Child Health MAP and measure development team worked with NCQA's certified auditors and audit department to ensure that the measure specifications were clear and auditable. The denominator, numerator and optional exclusions are concisely specified and align with our audit standards.	**4d** **C☐** **P☐** **M☐** **N☐**
4e. Data Collection Strategy/Implementation **4e.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:** Based on field test results, we have specified the measure to assess whether screening was documented and whether use of a standardized tool was documented. Our field test results showed that these data elements are available in the medical record. In addition, our field test participants noted that many were able to program these requirements into their electronic health record systems, and several implemented point-of-service physician reminders for this measure.	**4e** **C☐** **P☐** **M☐** **N☐**

4e.2 Costs to implement the measure (*costs of data collection, fees associated with proprietary measures*): Collecting measures from medical charts is time-consuming and can be burdensome. Adapting this measure in electronic health records may relieve some of this burden. **4e.3 Evidence for costs:** Based on field test participant feedback and other stakeholder input **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** NCQA, 1100 13th St, NW, Suite 1000, Washington, District Of Columbia, 20005 **Co.2 Point of Contact** Sepheen, Byron, MHS, byron@ncqa.org, 202-955-3573-	
Measure Developer If different from Measure Steward **Co.3 Organization** NCQA, 1100 13th St, NW, Suite 1000, Washington, District Of Columbia, 20005 **Co.4 Point of Contact** Sepheen, Byron, MHS, byron@ncqa.org, 202-955-3573-	
Co.5 Submitter If different from Measure Steward POC Sepheen, Byron, MHS, byron@ncqa.org, 202-955-3573-, NCQA	
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.** Child Health Measurement Advisory Panel: Jeanne Alicandro Barbara Dailey Denise Dougherty, PhD Ted Ganiats, MD Foster Gesten, MD Nikki Highsmith, MPA	

Charlie Homer, MD, MPH Jeff Kamil, MD Elizabeth Siteman Mary McIntyre, MD, MPH Virginia Moyer, MD, MPH, FAAP Lee Partridge Xavier Sevilla, MD, FAAP Michael Siegal Jessie Sullivan
Ad.2 If adapted, provide name of original measure: NA **Ad.3-5 If adapted, provide original specifications URL or attachment**
Measure Developer/Steward Updates and Ongoing Maintenance **Ad.6 Year the measure was first released:** **Ad.7 Month and Year of most recent revision:** **Ad.8 What is your frequency for review/update of this measure?** **Ad.9 When is the next scheduled review/update for this measure?**
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 #:** 1338 **NQF Project:** Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Children with Special Health Care Needs (CSHCN) who are Screened Early and Continuously for Emerging Conditions
De.2 **Brief description of measure:** Children with Special Health Care Needs (CSHCN) receiving both preventive medical and dental care during the 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**: Timeliness De.6 **Consumer Care Need:** Staying healthy

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	NQF Staff
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.* A.1 **Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)?** Yes A.2 **Indicate if Proprietary Measure** (*as defined in measure steward agreement*)**:** Proprietary measure 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:** No, testing will be completed within 12 months 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:** 1a.4 **Citations for Evidence of High Impact:** Child and Adolescent Health Measurement Initiative. 2005/06 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. www.cshcndata.org	**1a** C☐ P☐ M☐ N☐
1b. Opportunity for Improvement 1b.1 **Benefits (improvements in quality) envisioned by use of this measure:** Children with special health care needs still require preventive care. Preventive and well-care visits allow for further assessment and early identification of emerging conditions. 1b.2 **Summary of data demonstrating performance gap (variation or overall poor performance) across providers:** 1b.3 **Citations for data on performance gap:**	**1b** C☐ P☐ M☐ N☐

1b.4 Summary of Data on disparities by population group: **1b.5 Citations for data on Disparities:**	
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:** **1c.4 Summary of Evidence** (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*)**:** **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, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)	Eval Rating
2a. MEASURE SPECIFICATIONS	

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

2a. Precisely Specified

2a.1 Numerator Statement (*Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome*):
Percentage of children who are screened early and continuously for emerging conditions

2a.2 Numerator Time Window (*The time period in which cases are eligible for inclusion in the numerator*):
Questions are anchored to previous 12 months

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 being screened early and continuously for emerging conditions, criteria from the following must be met:
-Child received some or all preventive medical care
-Child received some or all preventive dental care

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

2a.5 Target population gender: Female, Male
2a.6 Target population age range: Children with Special Health Care Needs 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 with special health care needs (CSHCN) 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 and/or does not have special health care needs.

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

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

The CSHCN Screened Early and Continuously for Emerging Conditions measure is currently being administered in the 2009/10 National Survey of Children with Special Health Care Needs, which includes 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☐

• Type of Special Health Care Need

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

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

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

2a.18-19 Type of Score: Rate/proportion
2a.20 Interpretation of Score: Better quality = Higher score
2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**
Questions C4Q05_1, C4Q05_1a, C4Q05_1c, C4Q05_31, C4Q05_31a, C4Q05_31c all included in this measure.

To receive numerator of child having early and continuous screening for emerging conditions:
-Child received some or all preventive medical care (at least one preventive visit in past 12 months)
-Child received some or all preventive dental care (at least one preventive visit in 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)*:
Although the most recent version of the measure is currently in development and still undergoing data collection in the 2009/2010 NS-CSHCN, the best guideline to follow is the survey methodology used in the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), as the two surveys are overall very similar. 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.***):**
2009/2010 National Survey of Children with Special Health Care Needs

2a.26-28 Data source/data collection instrument reference web page URL or attachment: **2a.29-31 Data dictionary/code table web page URL or attachment:** **2a.32-35 Level of Measurement/Analysis** (*Check the level(s) for which the measure is specified and tested)* 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** C☐ P☐ M☐ N☐ NA☐

2d.4 Analytic Method *(type analysis & rationale)*: **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.1 Current Use:** Testing not yet completed **3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large)** (*If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years*)**:** U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The National Survey of Children with Special Health Care Needs Chartbook 2005-2006. Rockville, Maryland: U.S. Department of Health and Human Services, 2008. http://mchb.hrsa.gov/cshcn05/ **3a.3 If used in other programs/initiatives (***If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years***):** The Data Resource Center websites have been accessed more than 18 million times since 2006. Thousands of state and national researchers, MCH providers and analysts use the data to report valid children's health data. Healthy People 2010 uses items from the national surveys, and several more are slated to be added into Healthy People 2020. **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **3a.4 Data/sample** *(description of data/sample and size)***:** **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*) No 4b.2 **If not, specify the near-term path to achieve electronic capture by most providers.** No- measure still in development. The questionnaire with the measure specifications isn't available yet due to potential final changes from MCHB, but we will provide the electronic version of the questionnaire once it is finalized.	**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:** 4e.2 **Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*)**:** 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:** 2005
Ad.7 **Month and Year of most recent revision:** 01, 2009
Ad.8 **What is your frequency for review/update of this measure?** Updated every 4 years when a new NS-CSHCN is developed
Ad.9 **When is the next scheduled review/update for this measure?** 01, 2013

Ad.10 **Copyright statement/disclaimers:**

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

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

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 #:** 1345 **NQF Project:** Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Children with Special Health Care Needs (CSHCN) Screener
De.2 **Brief description of measure***:* The CSHCN Screener is a validated tool for identifying children who have ongoing health conditions. It is a non-condition specific screener which operationalizes the Maternal and Child Health Bureau definition of children with special health care needs. Specifically, children who currently experience one or more of five common health consequences: (1) need or use of prescription medications; (2) an above routine use of services; (3) need or use of specialized therapies or services; (4) need or use of mental health counseling (5) a functional limitation; due to a physical, mental, behavioral or other type of health condition lasting or expected to last at least 12 months are identified as having special health care needs.
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	A Y☐ N☐

measure submission A.4 **Measure Steward Agreement attached:**	
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	**B** Y☐ N☐
C. The intended use of the measure includes 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:** Children with special health care needs use a disproportionate amount of health care services and corresponding health care costs. Children who experience chronic conditions require extra health care services in order to ameliorate conditions and prevent emerging conditions. Identifying CSHCN is important for public policy. CHIPRA legislation will require that children´s quality health measures be reported by special health care needs status. The CSHCN Screener is a validated methods for identify CSHCN. The CSHCN Screener is in the National Measures Clearinghouse, has been used in five large national surveys (3 iterations of the NS-CSHCN and 2 iterations of the NSCH), and is included in CAHPS. 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 Bethell, C. D., Read, D., Neff, J., Blumberg, S. J., Stein, R., Sharp, V. and Newacheck, P. W. Comparison	**1a** C☐ P☐ M☐ N☐

of the Children with Special Health Care Needs Screener to the Questionnaire for Identifying Children with Chronic Conditions—revised. Ambulatory Pediatrics. 2002; 2 (1): 49–57. http://www.ncbi.nlm.nih.gov/pubmed/11888438
Bethell, C. D., Read, D., Stein, R. E. K., Blumberg, S. J., Wells, N. and Newacheck, P. W. Identifying children with special health needs: development and evaluation of a short screening instrument. Ambulatory Pediatrics. 2002; 2 (1): 38–48. http://www.ncbi.nlm.nih.gov/pubmed/11888437
van Dyck, P. C., Kogan, M. D., McPherson, M. G., Weissman, G.R. and Newacheck, P.W. Prevalence and characteristics of children with special health care needs. Archives of Pediatrics & Adolescents Medicine. 2004; 158: 884–890. http://www.ncbi.nlm.nih.gov/pubmed/15351754
Davidoff, A. J. Identifying children with special health care needs in the National Health Interview Survey: a new resource for policy analysis. Health Services Research. 2004; 39(1), 53– 71. http://www.ncbi.nlm.nih.gov/pubmed/14965077
Bethell, C., Read, D. and Blumberg, S.J. What is the prevalence of children with special health care needs? Toward an understanding of variations in findings and methods across three national surveys Maternal and Child Health Journal. 2008; 12:1–14. http://www.ncbi.nlm.nih.gov/pubmed/17566855
Read, D., Bethell, C., Blumberg, S.J., Abreu, M. and Molina, C. An evaluation of the linguistic and cultural validity of the Spanish language version of the Children with Special Health Care Needs Screener. Maternal and Child Health Journal. 2007; 11(6):568-85. http://www.ncbi.nlm.nih.gov/pubmed/17562154
Carle, A.C., Blumberg, S.J. and Poblenz, C. Internal psychometric properties of the Children with Special Health Care Needs Screener. Academic Pediatrics. 2010; Epub. http://www.ncbi.nlm.nih.gov/pubmed/20227936
Bramlett, M.D., Read, D., Bethell, C. and Blumberg, S.J. Differentiating subgroups of children with special health care needs by health status and complexity of health care needs. Maternal and Child Health Journal. 2009; 13:151-163. http://www.ncbi.nlm.nih.gov/pubmed/18386168

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Identifying children with special health care needs will be a requirement for ongoing measures of quality health care for children. Policy makers and public health officials benefit from looking at quality measures for CSHCN as distinct from the child population who do not experience chronic health conditions.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
Nationally, 12.8%-19.2% of children ages 0-17 years meet criteria having special health care needs according to National Surveys (NSCH, NS-CSHCN,MEPS) conducted between 2001 and 2007. The prevalence rates vary slightly due to survey year and sampling methods.

1b.3 Citations for data on performance gap:
Bethell, C.D., Read, D., and Blumberg, S.J. 2008. What is the Prevalence of Children with Special Health Care Needs? Toward an Understanding of Variations in Findings and Methods Across Three National Surveys Maternal Child Health Journal 12:1–14

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:
Children with special health care needs are less likely to receive care within a medical home – only 49.8% of CSHCN receive such coordinated and ongoing care, compared with 59.4% of children living without special needs.

Boys are more likely to have special health care needs than girls –22.2% versus 16.0%, respectively.

Children with special health care needs are more likely to be insured by public health insurance: public 23.6% and private 18.1%

More children with special health care needs live in families with income of below poverty level: 0-99% FPL 20.8%. 18.6%-18.9% of CSHCN live in families with above 100% FPL.

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Children who live in families with two biological or adoptive parents less likely to have special health care needs (16.3%), compared to the children live in families of two parent with at least one step-parent (23.2%) and single mother (25.9%).

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*)**:** 18.1% of CSHCN live in families where their conditions have caused financial problems for the family
Almost one quarter (24%) of CSHCN have health conditions which consistently and often greatly affect their daily activities
14.3% of CSHCN ages 5-17 years missed more than 11 days of school due to illness.
23.8-29.8% of CSHCN live in families where one or more members had to cut back or stop working due to children's condition (rates vary due to survey year question wording and ordering).
These adverse child and family-level impacts were concentrated among low income and uninsured CSHCN.

The level and complexity of special needs, as measured by how many of the 5 domains of the screener that children qualify on, also presents evidence for the impact on burden of consequences of chronic conditions. For instance, CSHCN who qualify on 4 of the 5 screener domains have families who are 5 times more likely to have to provide 11 or more hours of care per week and live in families that are 3 times as likely to have a family member who had to cut back and stop working to provide care for children. Half of the families had to decrease employment due to child's condition CSHCN with functional limitation group.

Use of health care for CSHCN compared to non-CSHCN:
Four times the number of hospitalizations (89 vs. 22 discharges per 1000)
Spent more than 7 times as many days in hospitals (370 vs. 49 days per 1000)
Although CSHCN account for less than 16% of the child population,
they accounted for more than half (52.5%) of children's hospital days
More than twice as many physician visits annually (4.35 vs. 1.75)
Seven times as many non-physician visits (2.17 vs. 0.30) on an annual basis
More than 5 times the number of prescribed medications per year (6.94 vs. 1.22)
Used substantially more home health provider days on an annual basis
(1.73 vs. 0.002); approximately 87% of home health care days were accounted for by CSHCN.

Along with increased use of services among CSHCN, there is a corresponding increased rate of unmet care and services among CSHCN are reported. According to the 2005/2006 National Survey of Children with Special Health Care Needs 16.1% of CSHCN have at least one unmet need for specific health care services and 21.1% of CSHCN needed a referral for specialist care and services but had difficulty getting it. 34.5% of CSHCN reported not receiving family-centered care.

Medical expenditure for CSHCN compared to non-CSHCN:
Total health care expenditures 3 times more ($2099 versus $628).
Hospital care expenses 4 times higher ($361 versus $96),
Physician services expenses more than double the amount ($406 versus $150),
Six times greater non-physician services expenses ($144 versus $24).
Average expenditures on prescribed medications 10 times higher ($340 versus $34) and home health expenses were much greater than those of other children.
Average expenditures for "other" medical services were about twice those for other children ($37 versus $16).

Families of CSHCN are 2 to 3 times more likely to have high out-of-pocket expenses (>$1000 per year, >5% of family income). Children in households with incomes less than 200% FPL spent about 164% more of their family's income on health care and those living in households with incomes between 200% and 400% of the FPL spent about 46% more than their counterparts in households with incomes at or above 400% of the FPL.

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Medical expenditures for CSHCN who qualify on 4 of the 5 screener domains are more than 5 times those of CSHCN who qualify on only one screening criterion.

Newacheck, P.W. and Kim, S.E.A (2005) National Profile of Health Care Utilization and Expenditures for Children With Special Health Care Needs. Archives Pediatrics Adolescents Medicine , 159:10-17

van Dyck, P. C., Kogan, M. D., McPherson, M. G., Weissman, G.R., Newacheck, P.W. (2004). Prevalence and characteristics of children with special health care needs. Archives Pediatrics Adolescents Medicine, 158, 884-890.

Bramlett, M.D., Read, D., Bethell, C., Blumberg, S.J. (2009) Differentiating Subgroups of Children with Special Health Care Needs by Health Status and Complexity of Health Care Needs. Matern Child Health J. 13:151-163

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*)**:**

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***):** Bethell, C. D., Read, D., Neff, J., Blumberg, S. J., Stein, R., Sharp, V. and Newacheck, P. W. Comparison of the Children with Special Health Care Needs Screener to the Questionnaire for Identifying Children with Chronic Conditions—revised. Ambulatory Pediatrics. 2002; 2 (1): 49–57. http://www.ncbi.nlm.nih.gov/pubmed/11888438
Bethell, C. D., Read, D., Stein, R. E. K., Blumberg, S. J., Wells, N. and Newacheck, P. W. Identifying children with special health needs: development and evaluation of a short screening instrument. Ambulatory Pediatrics. 2002; 2 (1): 38–48. http://www.ncbi.nlm.nih.gov/pubmed/11888437
van Dyck, P. C., Kogan, M. D., McPherson, M. G., Weissman, G.R. and Newacheck, P.W. Prevalence and characteristics of children with special health care needs. Archives of Pediatrics & Adolescents Medicine. 2004; 158: 884–890. http://www.ncbi.nlm.nih.gov/pubmed/15351754
Davidoff, A. J. Identifying children with special health care needs in the National Health Interview Survey: a new resource for policy analysis. Health Services Research. 2004; 39(1), 53– 71. http://www.ncbi.nlm.nih.gov/pubmed/14965077
Bethell, C., Read, D. and Blumberg, S.J. What is the prevalence of children with special health care needs? Toward an understanding of variations in findings and methods across three national surveys Maternal and Child Health Journal. 2008; 12:1–14. http://www.ncbi.nlm.nih.gov/pubmed/17566855
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Carle, A.C., Blumberg, S.J. and Poblenz, C. Internal psychometric properties of the Children with Special Health Care Needs Screener. Academic Pediatrics. 2010; Epub. http://www.ncbi.nlm.nih.gov/pubmed/20227936
Bramlett, M.D., Read, D., Bethell, C. and Blumberg, S.J. Differentiating subgroups of children with special health care needs by health status and complexity of health care needs. Maternal and Child Health Journal. 2009; 13:151-163. http://www.ncbi.nlm.nih.gov/pubmed/18386168

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***):** Children with an ongoing health condition or special health care need. **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***):** In order to meet the CSHCN Screener criteria for having a chronic condition or special health care need the following numerator inclusion criteria should be met: 1. Child experiences one of five different health consequences: -Use or need of prescription medication. -Above average use or need of medical, mental health or educational services. -Functional limitations compared with others of same age. -Use or need of specialized therapies (OT, PT, speech, etc.). -Treatment or counseling for emotional or developmental problems. 2. The above mentioned consequence results from a physical, developmental, behavioral, emotional or any other health condition lasting or expected to last for at least 12 months.	
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

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 CSHCN Screener 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
- Type of Special Health Care Need

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

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

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

2a.18-19 Type of Score: Weighted score/composite/scale
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*):
A filter item is asked for each of the following health consequences:
-Use or need of prescription medication.
-Above average use or need of medical, mental health or educational services.
-Functional limitations compared with others of same age.
-Use or need of specialized therapies (OT, PT, speech, etc.).
-Treatment or counseling for emotional or developmental problems.

If the answer to any of the five health consequences is YES, then two follow up questions are asked (one for the treatment or counseling item):
1) Is the health consequence due to any medical, behavioral or other health condition? (Note: this is not asked of the treamtent/counseling question since the language about emotional, behavioral or health condition is already included in that item)
2) If the answer to the above question is YES, then a final question is asked
about whether the condition has lasted or is expected to last for at least 12 months.

Final scoring: A child must meet all three criteria within one domain in order to be classified as having a special health care need. For example, a child would have a special health care need if the child uses prescription medication, for a health/medical/behavioral condition that has lasted/is expected to last at

least 12 months (YES on all three items).

Children can qualify as having a special health care need on more than one domain.

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** C☐

2b.1 Data/sample *(description of data/sample and size)*: The first pretest phase of the NS-CSHCN used two different batteries of questions to screen households to identify CSHCN: CSHCN Screener and Questionnaire for Identifying Children with Chronic Conditions-Revised Version (QuICCH-R). A total of 1,284 households with children from eight states were screened by telephone, resulting in the completion of 2,420 child-level screening interviews, 445 special-needs interviews between March 3 and May 30, 2000.

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)*:
Prevalence of CSHCN identified by the Screener and QuICCH-R were similar with high (90%) agreement. However, QuICCH-R identified more children as having special health care needs than Screener including the children whose special health care need status was less certain. Based on the pretest results, the CSHCN Screener does not appear to miss or leave out children which specific types of medical, behavioral, or other health conditions. The Screener does not appear to fail to identify children with more serious diagnoses and conditions requiring extensive use of health care services.
Numerous additional documents and statistics are available for this validated measure.

P☐ M☐ N☐

2c. Validity testing

2c.1 Data/sample *(description of data/sample and size)*: The CSHCN Screener was tested in 17,985 samples of the second round of pretest of NS-CSHCN ("National Sample") and 3,894 samples of children enrolled in Medicaid managed care through the Temporary Aid to Needy Families ("Medicaid Managed Care Sample") and 1,550 samples of children receiving SSI benefits ("SSI sample") in Washington State. The Medicaid Managed care sample and SSI sample were drawn from the CAHPS survey samples.

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)*:
In summary, the CSHCN Screener identified numbers of children commensurate with other epidemiological studies of special health care needs. The screener did not systematically exclude categories of children according to the type and/or severity of their health conditions, and exhibited a high level of agreement with other methods.

Good internal psychometric properties of responses to the CSHCN Screener and minimal random measurement error of the Screener was identified on the study used data 2005-2006 NS_CSHCN (e.g., Cronbach's coefficient a level >.80).

A Spanish language version was validated through 2001 NS-CSHCN. Nineteen cognitive interviews were conducted resulting in 37 children screened for special health care needs. Eight interviews took place in Portland, OR; the rest were conducted in Boston, MA. All participating parents were the mothers of children screened during the interviews. Cognitive interviews with parents did not identify any linguistic or cultural deficiencies in the Spanish translation of the CSHCN Screener.

2c
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2d. Exclusions Justified

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

2d.2 Citations for Evidence:

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

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

2d
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.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.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: 01, 2009
Ad.8 What is your frequency for review/update of this measure? Updated every 2 years when a new NSCH or NS-CSHCN 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 #:** 1373 **NQF Project:** Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Children with Special Health Care Needs whose Parents Report Participating in Shared Decision-Making in Child´s Care
De.2 **Brief description of measure:** Measures whether parent is actively engaged as a partner by health care providers in CSHCN´s care
1.1-2 **Type of Measure:** Process De.3 **If included in a composite or paired with another measure, please identify composite or paired measure**
De.4 **National Priority Partners Priority Area:** Population health De.5 **IOM Quality Domain:** Patient-centered De.6 **Consumer Care Need:** Staying healthy

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	NQF Staff
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.* A.1 **Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)?** Yes A.2 **Indicate if Proprietary Measure** (*as defined in measure steward agreement*)**:** Proprietary measure A.3 **Measure Steward Agreement:** 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:** No, testing will be completed within 12 months 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:** 1a.4 **Citations for Evidence of High Impact:**	**1a** C☐ P☐ M☐ N☐
1b. Opportunity for Improvement 1b.1 **Benefits (improvements in quality) envisioned by use of this measure:** 1b.2 **Summary of data demonstrating performance gap (variation or overall poor performance) across providers:** 1b.3 **Citations for data on performance gap:** 1b.4 **Summary of Data on disparities by population group:**	**1b** C☐ P☐ M☐ N☐

1b.5 Citations for data on Disparities:	
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:** **1c.4 Summary of Evidence** (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*)**:** **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-specs** **C☐** **P☐**

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*)**:**
The percentage of children with special health care needs whose parents/guardians feel they are engaged as partners in making decisions about their child´s care

2a.2 Numerator Time Window (*The time period in which cases are eligible for inclusion in the numerator*)**:**
Encounter, point in time--anchored to prior 12 months

2a.3 Numerator Details (*All information required to collect/calculate the numerator, including all codes, logic, and definitions*)**:**
During the past 12 months, how often did doctors or other health care providers…
- Discuss with you the range of options to consider for his/her health care or treatment?
- Encourage you to ask questions or raise concerns?
- Make it easy for you to ask questions or raise concerns
- Consider and respect what health care and treatment choices you thought would work best for him/her

Never, Rarely, Sometimes, Usually or Always

2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured*)**:**
Denominator includes all children with special health care needs 0-17 years of age.

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, 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 0-17 years with special health care needs (CSHCN).

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population*)**:** Children age 0-17 years who are not identified as having special health care needs are excluded.

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions*)**:**
Children over 17 years are excluded from the denominator.
CSHCN are defined by the standardized and validated CSHCN Screener. The screener is administered at the beginning of the survey and all remaining items in the survey are only asked regarding a child with special health care needs.

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

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*)**:**
No stratification is required.

The Shared Decision Making measure is currently being administered in the 2009/10 National Survey of Children with Special Health Care Needs, which includes 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)

M☐
N☐

• Race/ethnicity • Health insurance- type, consistency • Primary household language • Household income • Type of Special Health Care Need **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)*:	
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.***):** 2009/2010 National Survey of Children with Special Health Care Needs **2a.26-28 Data source/data collection instrument reference web page URL or attachment:** **2a.29-31 Data dictionary/code table web page URL or attachment:** **2a.32-35 Level of Measurement/Analysis** (*Check the level(s) for which the measure is specified and tested)* 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)*: **2b.3 Testing Results** *(reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:	**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)*:	**2c** **C☐** **P☐** **M☐** **N☐**

2c.3 Testing Results *(statistical results, assessment of adequacy in the context of norms for the test conducted)*:	
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:** Testing not yet completed **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*)**:** **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***):** **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)***:** **3a.5 Methods** *(e.g., focus group, survey, QI project)***:** **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*) No **4b.2 If not, specify the near-term path to achieve electronic capture by most providers.** No- measure still in development. The questionnaire with the measure specifications isn't available yet due to potential final changes from MCHB, but we will provide the electronic version of the questionnaire once it is finalized.	**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.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:** **4e.2 Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*)**:** **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.

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: 2009
Ad.7 Month and Year of most recent revision: 01, 2010
Ad.8 What is your frequency for review/update of this measure? Updated every 4 years when a new NS-CSHCN is developed
Ad.9 When is the next scheduled review/update for this measure? 01, 2013

Ad.10 Copyright statement/disclaimers:

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

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

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 #:** 1346 **NQF Project:** Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Children Who Are Exposed To Secondhand Smoke Inside Home
De.2 **Brief description of measure***:* Determines the perentage of children who live with a smoker and if that smoker smokes inside the child´s house
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**: 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, Severity of illness 1a.2 1a.3 **Summary of Evidence of High Impact:** The U.S. Department of Health and Human Services´ Healthy People 2020 has prioritized the need to decrease nonsmokers´ exposure to second hand smoke (TU HP2020-11). 1a.4 **Citations for Evidence of High Impact:** 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:** The effects of exposure to secondhand smoke can be nearly as large as chronic smoking. Additionally, use of tobacco products by household members has an adverse impact on the health of the children. Reducing the proportion of children exposed to secondhand smoke will drastically improve their short and long term health outcomes. 1b.2 **Summary of data demonstrating performance gap (variation or overall poor performance) across providers:** Nationally, 7.6% of children age 0-17 years are exposed to second hand smoke inside their home.	**1b** C☐ P☐ M☐ N☐

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:
Exposure to secondhand smoke inside the home varies by socioeconomic status, race/ethnicity, geographic location and child´s age. Compared to children living at 400% FPL or greater, children living below 100% FPL, have 3.23 times the odds of exposure to secondhand smoke inside the come. Fifty percent of African American children and more than one-third of children from low-income families in smoking households were exposed to secondhand smoke inside the home.
Children living in rural locations are more likely to be exposed to secondhand smoke inside the home than children living in urban areas (12.4 vs. 6.5%).
2.6% of Hispanic children, 8.0% of white children and 13.6% of black children are exposed to secondhand smoke inside the home.
Prevalence of exposure to secondhand smoke inside the home increases as children get older. 4.8% of children age 0-5 years, 7.4% of children age 6-11 years and 10.4% of children age 12-17 years are exposed to secondhand smoke inside the home.

1b.5 Citations for data on Disparities:
Barnoya J, Glantz, SA. Cardiovascular effects of second hand smoke: Nearly as large as smoking. American Heart Association Special Report. 24 May, 2005.

Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website.

Lam TH. Leung GM. Ho LM. (2001). The effects of environmental tobacco smoke on health services utilization in the first eighteen months of life. Pediatrics, 107(6), 91-97.

Singh GK, Siahpush M, Kogan MD. Disparities in children´s exposure to environmental tobacco smoke in the United States, 2007. Pediatrics. 2010;126(1):4-13.

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*)**:** Reducing the proportion of children exposed to secondhand smoke will drastically improve their short and long term 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 exposed to secondhand smoke inside the home are less likely to be in very good or excellent overall health than children who live in a home where no one uses tobacco (78.9% vs. 85.5%).

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-specs** **C☐** **P☐** **M☐** **N☐**
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 live in a household with someone who smokes and smoking occurs inside home **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*)**:** Children who live in a household with someone who smokes (K9Q40=Yes) and smoking occurs inside home (K9Q41=Yes)	
2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured*)**:** Children age 0-17 years **2a.5 Target population gender:** Female, Male **2a.6 Target population age range:** Children age 0-17 years **2a.7 Denominator Time Window** (*The time period in which cases are eligible for inclusion in the denominator*)**:** Denominator window is a fixed point in time anchored to "current". **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 Exposure to Secondhand Smoke in Home 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 living in a household with someone who smokes and smoking occurs inside home:
-Child lives in household with someone who smokes (K9Q40= Yes) AND
-Smoking occurs within the child´s home (K9Q41=Yes)

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.

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 C☐ P☐ M☐

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.	**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.5 Methods** *(e.g., focus group, survey, QI project)*: Focus groups **3a.6 Results** *(qualitative and/or quantitative results and conclusions)*:	**3a** **C☐** **P☐** **M☐** **N☐**
3b/3c. Relation to other NQF-endorsed measures	

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

	N☐
4e. Data Collection Strategy/Implementation **4e.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:** Items are well understood and easy to implement. Items yield very low levels of missing values, don't know or refused answers. **4e.2 Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*)**:** Item is public domain and there is no cost associated with its use. Costs associated with administering surveys is not included here. **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

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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 #:** 1335 **NQF Project:** Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Children Who Have Dental Decay or Cavities
De.2 **Brief description of measure:** Assesses if children age 1-17 years have had tooth decay or cavities in the past 6 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:** Affects large numbers, Severity of illness 1a.2 1a.3 **Summary of Evidence of High Impact:** Dental cavities have been identified as the most common chronic disease for children. Nationally, 19.4% of children have dental decay or cavities. 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☐
1b. Opportunity for Improvement 1b.1 **Benefits (improvements in quality) envisioned by use of this measure:** Children who have dental decay or cavities are less likely to be in very good or excellent overall health than children without decay or cavities. Children with decay are also more likely to have other oral health problems such as toothaches, broken teeth, and bleeding gums. 1b.2 **Summary of data demonstrating performance gap (variation or overall poor performance) across providers:** There is a broad range in the proportion of children with dental decay or cavities. The range across states is 14.5% in Minnesota to 24.6% of children in Arizona.	**1b** C☐ P☐ M☐ N☐

1b.3 Citations for data on performance gap:
1. Edelstein BL, Chinn CH. Update on disparities in oral health and access to dental care for America´s children. Acad Pediatr. 2009;9(6):415-419.

2. Milgrom P, Zero DT, Tanzer JM. An examination of the advances in science and technology of prevention of tooth decay in young children since the Surgeon General´s Report on Oral Health. Acad Pediatr. 2009;9(6):404-409.

1b.4 Summary of Data on disparities by population group:
Children with a household income below 200% FPL are more likely to have dental decay or cavities than children living at 200% FPL or higher (25.2% vs 16%).
Hispanic children have the highest prevalence of dental decay or cavities at 28.1%, followed by black, non-Hispanic children at 20.2% and white children at 16.2%.

1b.5 Citations for data on Disparities:
1. Edelstein BL, Chinn CH. Update on disparities in oral health and access to dental care for America´s children. Acad Pediatr. 2009;9(6):415-419.

2. Milgrom P, Zero DT, Tanzer JM. An examination of the advances in science and technology of prevention of tooth decay in young children since the Surgeon General´s Report on Oral Health. Acad Pediatr. 2009;9(6):404-409.

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 with dental decay or cavities are less likely to be in very good or excellent health than children without denal decay or cavities (77% vs. 86%).

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***):** Whether child had cavities or decayed teeth in past 6 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 anchored to past 6 months **2a.3 Numerator Details (***All information required to collect/calculate the numerator, including all codes, logic, and definitions***):** If K2Q53=1, child had decayed teeth or cavities in last 6 months. If K2Q53=0, child did not have decayed teeth or cavities in last 6 months.	
2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured***):** Children and adolescents age 1-17 years **2a.5 Target population gender:** Female, Male **2a.6 Target population age range:** Children age 1-17 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. Assesses whether child had cavities or decayed teeth in the last 6 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 1-17 years of age	
2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population***):** Children are excluded from denominator if they do not fall in target population age range (1-17 years) **2a.10 Denominator Exclusion Details (***All information required to collect exclusions to the denominator, including all codes, logic, and definitions***):** Children are excluded from denominator if --child does not fall in target population age range (1-17 years). If child is less than one year old, skip questions	
2a.11 Stratification Details/Variables (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions***):**	**2a-specs** **C☐** **P☐** **M☐** **N☐**

No stratification is required.

When the Decay or Cavities 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 decayed teeth or cavities:
-Had decayed teeth or cavities(K2Q53= Yes).

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.

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

2c C☐ P☐ M☐ N☐

Reliability Testing Results above.	
2d. Exclusions Justified **2d.1 Summary of Evidence supporting exclusion(s):** **2d.2 Citations for Evidence:** **2d.3 Data/sample** *(description of data/sample and size)*: **2d.4 Analytic Method** *(type analysis & rationale)*: **2d.5 Testing Results** *(e.g., frequency, variability, sensitivity analyses)*:	**2d** C☐ P☐ M☐ N☐ NA☐
2e. Risk Adjustment for Outcomes/ Resource Use Measures **2e.1 Data/sample** *(description of data/sample and size)*: **2e.2 Analytic Method** *(type of risk adjustment, analysis, & rationale)*: **2e.3 Testing Results** *(risk model performance metrics)*: **2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:**	**2e** C☐ P☐ M☐ N☐ NA☐
2f. Identification of Meaningful Differences in Performance **2f.1 Data/sample from Testing or Current Use** *(description of data/sample and size)*: **2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance** *(type of analysis & rationale)*: **2f.3 Provide Measure Scores from Testing or Current Use** *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*:	**2f** C☐ P☐ M☐ N☐
2g. Comparability of Multiple Data Sources/Methods **2g.1 Data/sample** *(description of data/sample and size)*: **2g.2 Analytic Method** *(type of analysis & rationale)*: **2g.3 Testing Results** *(e.g., correlation statistics, comparison of rankings)*:	**2g** C☐ P☐ M☐ N☐ NA☐
2h. Disparities in Care **2h.1 If measure is stratified, provide stratified results** *(scores by stratified categories/cohorts)*: **2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:**	**2h** C☐ P☐ M☐ N☐ NA☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Scientific*	**2**

Acceptability of Measure Properties?	
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.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	**4e** C☐ P☐ M☐ N☐

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:**	
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 #:** 1334 **NQF Project:** Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Children Who Received Preventive Dental Care
De.2 **Brief description of measure:** Assesses how many preventive dental visits during the prevsiou 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:** 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 every 3 years. Yes, information provided in contact section	**B** Y☐ N☐

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

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. ***Measures must be judged to be important to measure and report*** *in order to be evaluated against the remaining criteria.* (evaluation criteria) **1a. High Impact**	Eval Rating
(for NQF staff use) Specific NPP goal:	
1a.1 **Demonstrated High Impact Aspect of Healthcare:** Affects large numbers 1a.2 1a.3 **Summary of Evidence of High Impact:** Preventive dental visits are important to oral health and have been recognized as an objective by The U.S. Department of Health and Human Services as an objective in Healthy People 2010 and Healthy People 2020 (OH HP2020-4 Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year). 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☐
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 dental care. This measure allows for comparison across populations and demographic groups. 1b.2 **Summary of data demonstrating performance gap (variation or overall poor performance) across providers:** Nationally, 78.4% of children had at least 1 preventive dental visit in the past 12 months. There is a broad range in the proportion of children who have routine preventive dental visits. The range across states is	**1b** C☐ P☐ M☐ N☐

68.5% of children in Florida to 86.9% of children in Hawaii.

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. Dietrich T, Culler C, Garcia RI, Henshaw MM. Racial and ethnic disparities in children´s oral health: the National Survey of Children´s Health. J Am Dent Assoc. 2008;139(11):1507-1517.

3. Edelstein BL, Chinn CH. Update on disparities in oral health and access to dental care for America´s children. Acad Pediatr. 2009;9(6):415-419.

4. 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.

5. Kenney MK. Oral health care in CSHCN: state Medicaid policy considerations. Pediatrics. 2009;124 Suppl 4:S384-91.

6. Kenney MK, Kogan MD, Crall JJ. Parental perceptions of dental/oral health among children with and without special health care needs. Ambul Pediatr. 2008;8(5):312-320.

7. Liu J, Probst JC, Martin AB, Wang JY, Salinas CF. Disparities in dental insurance coverage and dental care among US children: the National Survey of Children´s Health. Pediatrics. 2007;119 Suppl 1:S12-21.

8. Milgrom P, Zero DT, Tanzer JM. An examination of the advances in science and technology of prevention of tooth decay in young children since the Surgeon General´s Report on Oral Health. Acad Pediatr. 2009;9(6):404-409.

9. Mouradian WE, Slayton RL, Maas WR, et al. Progress in children´s oral health since the Surgeon General´s Report on Oral Health. Acad Pediatr. 2009;9(6):374-379.

1b.4 Summary of Data on disparities by population group:

Uninsured children are the least likely to receive preventive dental visits (58.5%), followed by publicly insured children (76.2%) and privately insured children (82.4%).
Only 53.5% of 1 to 5-year-old children have preventive dental visits, while at least 87.8% of children age 6 years and older have preventive dental visits.

1b.5 Citations for data on Disparities:

1. Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children´s Health, Data Resource Center for Child and Adolescent Health website. www.nschdata.org

2. Dietrich T, Culler C, Garcia RI, Henshaw MM. Racial and ethnic disparities in children´s oral health: the National Survey of Children´s Health. J Am Dent Assoc. 2008;139(11):1507-1517.

3. Edelstein BL, Chinn CH. Update on disparities in oral health and access to dental care for America´s children. Acad Pediatr. 2009;9(6):415-419.

4. 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.

5. Kenney MK. Oral health care in CSHCN: state Medicaid policy considerations. Pediatrics. 2009;124 Suppl 4:S384-91.

6. Kenney MK, Kogan MD, Crall JJ. Parental perceptions of dental/oral health among children with and without special health care needs. Ambul Pediatr. 2008;8(5):312-320.

7. Liu J, Probst JC, Martin AB, Wang JY, Salinas CF. Disparities in dental insurance coverage and dental care among US children: the National Survey of Children´s Health. Pediatrics. 2007;119 Suppl 1:S12-21.

8. Milgrom P, Zero DT, Tanzer JM. An examination of the advances in science and technology of prevention of tooth decay in young children since the Surgeon General´s Report on Oral Health. Acad Pediatr. 2009;9(6):404-409.

9. Mouradian WE, Slayton RL, Maas WR, et al. Progress in children´s oral health since the Surgeon General´s Report on Oral Health. Acad Pediatr. 2009;9(6):374-379.

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*)**:** Increasing preventive dental care among children will have a positive impact on overall oral health and potentially reduce the need and burden of acute oral health care. It will also help to identify emerging oral conditions and alleviate future unmet need for 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*)**:**
Children who had at least one preventive dental visit in the previous 12 months were less likely to report having unmet needs for dental care (38.4% vs. 50.4%).

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:

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

Eval

the quality of care when implemented. (evaluation criteria)	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 one or more preventive dental 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; anchored to past 12 months **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, they must have seen a dentsit for preventive dental care at least once in the past 12 months.	
2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured*)**:** Children age 1-17 years **2a.5 Target population gender:** Female, Male **2a.6 Target population age range:** Children age 1-17 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 1-17 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 1-17 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. If child is younger than 1 year 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 Dental 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-specs** **C**☐ **P**☐ **M**☐ **N**☐

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 dental visit:
-Must have at 1 or more visits to the dentist for preventive care (K4Q21=1 or more).

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.	**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.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? **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 #:** 1347 **NQF Project:** Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Children Who Needed and Received Mental Health Services
De.2 **Brief description of measure:** Assesses if children age 2-17 years old who have an emotional, developmental or behavioral problem requiring treatment or counseling actually received services from a mental health professional 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:** Getting better

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:** Patient/societal consequences of poor quality 1a.2 1a.3 **Summary of Evidence of High Impact:** National initiatives such as the U.S. Department of Health and Human Services' Healthy People 2010 have recently begun prioritizing the need to increase the proportion of children with mental disorders that receive mental health care (Objective 18-7). 1a.4 **Citations for Evidence of High Impact:** U.S. Department of Health and Human Services. Healthy People 2010. Conference Edition. Washington, DC. 2000.	**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 unmet mental health needs of various populations 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:** Nationally, only 60.0% of U.S. children age 2-17 years who need mental health care receive it.	**1b** C☐ P☐ M☐ N☐

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 range of receiving needed mental health care varies across race, with Hispanic children least likely to receive needed care (50.6%) and Multi-racial children most likely to receive needed care (73.8%). Among Hispanic children, children with Spanish as the primary household language are significantly less likely to receive needed mental health care (33.5%) compared to Hispanic children whose primary household language is English (66.2%).
More black female CSHCN have unment mental health care needs (41%) than white female CSHCN(16%) or Hispanic female CSHCN (13%).

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

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.

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 have an ongoing mental, emotional or behavioral condition need immediate access to high quality mental 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*)**:**
All items included in the measure are report of patient experience with healthcare services. Healthcare providers who identify patients with an ongoing mental, emotional or behavioral condition may refer their patients to a mental health specialist.

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*

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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-specs** **C☐** **P☐** **M☐** **N☐**
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 age 2-17 who needed and received mental health care during the previous 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*)**:** -Children who have any kind of current emotional, developmental, or behavioral problem that requires treatment or counseling (K2Q22=YES) AND -Children who received treatment or counseling from a mental health professional during the past 12 months (K4Q22=YES).	
2a.4 **Denominator Statement** (*Brief, text description of the denominator - target population being measured*)**:** Children age 2-17 years who have emotional, developmental, or behavioral problems for which they need treatment or counseling 2a.5 **Target population gender:** Female, Male 2a.6 **Target population age range:** Children age 2-17 years 2a.7 **Denominator Time Window** (*The time period in which cases are eligible for inclusion in the denominator*)**:** Denominator window is a fixed point in time anchored to within the past 12 months. 2a.8 **Denominator Details** (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions*)**:** Children age 2-17 years who have emotional, developmental, or behavioral problems for which they need treatment or counseling (K2Q22).	
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 2-17 years and/or did not have emotional, developmental, or behavioral problems for which they need treatment or counseling.	

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 2 years of age, excluded from denominator.
If child is older than 17 years of age, excluded from denominator.
If child did does not have emotional, developmental, or behavioral problems for which they need treatment or counseling (K2Q22=No), 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 Received Needed Mental Health 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
- Type of Special Health Care Needs

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

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

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

2a.18-19 Type of Score: Rate/proportion
2a.20 Interpretation of Score: Better quality = Higher score
2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**
To receive numerator of child receiving needed mental health care:
-Child has emotional, developmental, or behavioral problems for which they need treatment or counseling (K2Q22=Yes), AND
-Child received care from a mental health professional (K4Q22=Yes).

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.

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2c. Validity testing

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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.	**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** **C☐ P☐ M☐ N☐ NA☐**

2g.3 **Testing Results** *(e.g., correlation statistics, comparison of rankings)*:	
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-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**	**4d** C☐ P☐

describe how these potential problems could be audited. If audited, provide results.	**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