THE NATIONAL QUALITY FORUM

CALL FOR MEASURES:

NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR PATIENT OUTCOMES: CHILD HEALTH

To achieve quality healthcare across the full continuum, there is a need for additional measures that specifically address various child health outcomes to which our nation's healthcare system contributes. Many outcome measures are inherently relevant because they reflect the reason consumers seek healthcare (e.g., to prevent disease, improve function, decrease pain, survive), as well as reflect the result healthcare providers are trying to achieve. To date, NQF has endorsed a few outcome measures across all ages, typically focused on mortality, readmission, and complications. However, a major gap remains for more patient-focused outcomes, such as patient or parent-reported health-related quality of life, functional status (e.g., ambulation) and productivity (e.g., days missed from school). These cross-cutting measures have the advantage of applicability across a wide range of patients across conditions and complement disease-specific outcomes. The outcomes measures should reflect – at least in part -- the care provided by the health care system in any or all settings, such as hospitals, skilled nursing facilities, home health, and ambulatory (including non-traditional sites such as school based health centers), as well as across patient-focused episodes.

To enlarge NQF's portfolio of outcome measures for children, NQF is soliciting outcome measures for child health (ages 0-21 years) applicable to any healthcare setting; applicable to any level of analysis (e.g., system, plan, practice, community); any or all settings of health care delivery; individual or composite measures; and use any data source(s). Measures that assess the entire population of a practice, plan, system or community are particularly desirable.

Candidate outcome measures may be cross-cutting or condition/disease specific including, but not limited to, measures of:

- child and family functioning, including maintenance and improvement in functioning and attaining optimal functioning (ex: school attendance and performance, physical fitness);
- symptom improvement or relief (ex: pain control; asthma control; reduced hyperactivity/impulsivity);
- growth and development (physical, cognitive, social, emotional), (ex: meeting age appropriate developmental milestones, transition to adulthood);
- patient or parent[1] reported outcomes using standardized health status or health-related quality of life assessments (physical, cognitive, emotional, social);
- intermediate clinical outcomes (ex: blood pressure; BMI percentile; HgbA1c);
- patient or parent/family experience with care (satisfaction, shared-decision making, capacity for self-management);
- behavioral change (ex: smoking cessation; medication adherence; seat belt use; reduced high-risk behavior);
- health care services utilization as a proxy for change in status (ex: unplanned admission or re-admission, ED visits);
- potentially preventable adverse social outcomes (e.g., incarceration)
- clinical morbidity from disease progression or intervention (ex: graft versus host; neurological impairment after heart surgery; chemotherapy side such as procedural pain);
- healthcare-acquired adverse event or complication (non-mortality);
- survival/mortality; and
- population health indicators, such as, suicide, sexually transmitted infections (STIs), rates of congenital HIV, rates of child abuse, infant mortality, etc. Consider, for example, the following populations:
  - populations with specific diseases (chronic conditions, disabilities, special needs);
  - disparities-sensitive populations (e.g., race, ethnicity, geographic); and

---

[1] The term "parent" includes parent surrogates and caregivers.

  - populations of children in which the health care sector shares responsibilities with others. These could include, for example, children in schools, children and youth in the juvenile justice system, and children in custody of child welfare agencies.

Any organization or individual may submit measures for consideration. To be included as part of the initial evaluation, candidate consensus standards must meet the following general criteria:

- be fully developed for use (e.g., research and testing have been completed);
- be open source or in the public domain[2]
- have an identified measure steward[3]
- be intended for both public reporting and quality improvement

To submit a measure, please complete the following:

- Online Measure Submission Form
  Clicking on this link will redirect you to the webpage for this project, from which you can access the online measure submission form.
- Measure Steward Agreement Form

Please note that no material will be accepted without fully executing the attached *Measure Steward Agreement Form.* All materials not meeting this requirement will be returned to the sender.

Materials must be submitted using the online measure submission form by 6:00 pm, ET on Tuesday, February 2, 2010. If you have any questions, please contact Nicole McElveen, MPH at 202.783.1300 or outcomes@qualityforum.org subject line, child health. Thank you for your assistance with this project!

---

[2] NQF requires any organization submitting a measure for endorsement to execute an intellectual property agreement that addresses disclosure of the measure's proprietary components, including but not limited to specifications, risk adjustment methodologies, data collection instrument, data collection or analysis software, and database access. For details, please see our Policy on Endorsement of Proprietary Measures

[3] NQF requires any measure considered for endorsement to have an identified responsible entity and process to maintain and update the measure on a schedule commensurate with clinical innovation, but at least every 3 years.