National Quality Forum

Comments on National Voluntary Consensus Standards for Child Health Outcomes Phase III, 2010

Comments reviewed and discussed by the Mental Health Steering Committee on September 16, 2010.

Member Council/ Public	Organization Contact	Topic	Comment	Response
P	Anne Sheetz, Massachusetts Department of Public Health	General	I am very concerned that the "unrecognized health care delivery system", i.e., the school nurse, is not included as a member of the committee. Furthermore the school health program as a key care delivery site for health services, (not for primary health care--but for nursing services---) is not considered in the indicators. In Massachusetts, the school nurses have approximately 10.6 million encounters with students annually--they are the safety net to ensure that the students are linked to primary care and health insurance, are provided with chronic disease management--and the portals of entry into the health and mental health care delivery systems. They have access to ALL children in the schools---and have a high degree of trust by both students and parents as demonstrated by our client satisfactions studies. I have forwarded the FY 09 annual statistics on 430,000 students in a separate e-mail. There are tremendous opportunities to improve care through better communication systems (with parent consent) between the providers and schools. Another concern is the lack of focus on prevention--and area that has major implications for the future of the health care delivery system, e.g., obesity epidemic.	The Steering Committee discussions frequently included school-based healthcare and healthcare interactions with schools. The recommended measures are not specific to certain providers and include any provider that cares for children including school nurses. Unfortunately, NQF did not receive any nominations for school nurses to serve on the Steering Committee. NQF is reaching out to school nurses for our new child health quality measures project.
P	Martha Bergren, National Association of School Nurses	General	The Committee did not recommended outcomes for dental care, although they recognize need. Dental care outcomes should be included in the future.	Dental care measures will be included in the recommendations for measure development. The new child health quality measures project will review many prevention measures, including dental measures.
M/Consumer Council	Debra Ness, National Partnership for Women & Families	General	The National Partnership for Women & Families appreciates the opportunity to comment on the children's health outcome measures that are currently in the NQF pipeline and we thank NQF for taking on this important work. Children's health has not received the same attention within the quality measurement enterprise as have other populations, but it has been the subject of renewed focus thanks to the quality improvement and measurement language in the Children's Health Insurance Program Reauthorization Act (CHIPRA). We are particularly pleased to see measures of care coordination and patient experience included in this set. While we do support many of the measures that have been recommended for endorsement, we also wish to express our concern with the lack of genuine outcome measures for children's health. Many of the measures that have been recommended are public health measures. We do not argue the importance of these types of measures, but at the same time, consumers want to know about experience and outcomes of care that can help them make decisions for their own children. We suggest that the section of the report on recommendations for research include language on the need for additional children's outcome measures to fill this large gap in the portfolio.	Thank you for your comments. Additional recommendations for measure development will be included in the revised draft. The new child health quality measures project will review the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) core measure set as well as many other child health measures.
M/Purchaser	Christine Chen,	General	The Pacific Business Group on Health (PBGH) appreciates the opportunity to	Thank you for your comments. Additional

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Council	Pacific Business Group on Health		comment on the recommended children's health outcome measures. We applaud NQF for its work to include more measures of child outcomes in its portfolio of measures,. We support many of the recommended measures and are particularly pleased that measures of care coordination and patient experience are included in the set of proposed measures. We are disappointed that the recommended set of measures contains very few provider-level measures of child outcomes. Instead the focus is on public health (i.e., population-level) measures, which are also important but do not help consumers better select their providers of care or advance accountability. To address this concern, the "additional recommendations" should be expanded to require that NQF clearly articulate how it will fill the many remaining gaps in its portfolio of provider-level child outcome measures. We are very encouraged that the steering committee recommends that data on the proposed measures be able to be stratified by race, ethnicity, and socioeconomic status. When data are stratified by these considerations they can be used to identify and address disparities in care.	recommendations for measure development will be included in the revised draft. NQF is beginning a second child health project, the child health quality measures project.
M/Consumer Council	Maureen Corry, Childbirth Connection	General	Childbirth Connection appreciates the opportunity to comment on the children's health outcome measures and thanks the NQF for calling much needed attention to this underemphasized area of measure development and endorsement. We support many of the proposed measures and are happy to see measures of patient experience and care coordination included. We are especially pleased to see the Healthy Term Newborn measure (OT3-031-10) that assesses optimal outcomes of pregnancy and childbirth in healthy term newborns. We note that the main focus of these proposed child health measures is on public health (population-level measures)and express our concern that there are too few provider-level measures of child outcomes. More children's health outcome measures are critically important to consumers for use in selecting providers and fostering quality improvement. We encourage the Steering Committee to include strong Research Recommendations in their final report that call for more provider-level child outcome measures to fill in this gap.	Thank you for your comments. Additional recommendations for measure development will be included in the revised draft. NQF will be expanding our portfolio of child and maternal health measures with the new child health quality measures project and the upcoming perinatal measures project (Spring 2011).
M/Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	General	The American Nurses Association (ANA) offers the following child health quality-relate topics for further consideration for measure development: •Visits to dental health professional •Tooth brushing and toothpaste use •Caries/caries prevention •Use of carbonated drinks by children •BMI, healthy weight, nutrition status •Immunizations for vaccine preventable diseases •Quality of life •Substance use and misuse •Accidental injury oMotor vehicle oOther	Thank you for your comments. Additional recommendations for measure development will be included in the revised draft. The new child health quality measures project will review measures in many of the suggested topic areas.

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			•Child Behavior Checklist •School achievement •Graduation rates Finally, ANA concurs that child health quality is an important, though under-emphasized, area of measure development and endorsement and therefore appreciates NQF targeting measures that could be used in public reporting of inpatient safety (e.g., pediatric catheter associated blood stream infection rates) among others.	
M/Health Professional Council	Andrea Kline, National Association of Pediatric Nurse Practitioners (NAPNAP)	General	May want to consider a measure on pediatric diabetes ketoacidosis admission rates in Type I diabetics. These can be costly and often preventable admissions with optimal ambulatory care management and access to providers. Page 47, measure description uses the term "pediatrician or physician" - yet the terms specialist, provider, or "doctor or nurse" is utilized. I do find it unfortunate that although the title is "Child Health and Mental Health", the majority of mental health issues were deemed beyond the scope or covered by other programs.	Additional recommendations for measure development will be added. Different developers use a variety of terminology for providers. At this point, NQF uses the language provided by the Measure Developer. In Phase 3 of the patient outcomes there are two separate projects - one for child health and one for mental health. Very few outcome measures of mental health for children were submitted. Most of the measures were process measures rather than outcome measures which is the focus of the project. The new child health quality measures project will review several measures related to children's mental health.
P	Martha Bergren, National Association of School Nurses	General	The National Association of School Nurses is encouraged that there are several criteria that will capture the quality and intensity of school nursing services. NASN looks forward to the development of additional indicators that are sensitive to school nursing and community nursing care. We applaud the effort to develop and implement child health outcome measures that promote health and well-being across all spectrums of care. Consideration of child health outcome measures that are focused on the ultimate outcome of healthful transition from childhood to adulthood creates meaningful data to assess will allow for a broader picture of the overall health of the public. Measures that look at care provided outside of the acute setting, such as schools, will allow for a better perspective of all children, not just those with acute conditions or those who are frequently hospitalized. Additionally, the Scope of Patient Outcomes demonstrates an intent to measure health promotion rather than simply treatment of illness. NASN is encouraged to see the measures that are related to schools and see potential for data collection in schools. A significant amount of health care occurs by school nurses in schools every day, where children spend 6 or more hours per day. Schools are an ideal setting for public health measures as school nurses are practicing public health where the children are.	Thank you for your comments.
M/Health Professional Council	Nancy H. Nielsen, MD, PhD, American Medical Association	General	The American Medical Association (AMA) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) National Voluntary Consensus Standards for Patient Outcomes: Child Health (Phase III): A Consensus Report. The AMA supports the NQF's efforts to advance the development of measures for children and adolescents, particularly those that	See responses to individual measures.

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			focus on outcomes. We believe that outcome measures are important for improving the quality of care and we appreciate NQF's continued focus on such measures. The AMA continues to have reservations about the endorsement of outcome measures that we believe inappropriately focus on individual clinician accountability.	
M/Purchaser Council	Gaye Fortner, HC21	General	I appreciate the opportunity to comment on the children's health outcome measures that are currently in the NQF pipeline and thank NQF for taking on this important work. Children's health not received the same attention within the quality measurement enterprise as have other populations, but it has been the subject of renewed focus thanks to the quality improvement and measurement language in the Children's Health Insurance Program Reauthorization Act (CHIPRA).	See responses to individual measures.
M/QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement®	General	The Physician Consortium for Performance Improvement(R) (PCPI) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) National Voluntary Consensus Standards for Patient Outcomes: Child Health (Phase III): A Consensus Report. The PCPI supports the NQF's efforts to advance the development of measures for children and adolescents, particularly those that focus on outcomes. We believe that outcome measures are important for improving the quality of care and we appreciate NQF's continued focus on such measures. The PCPI continues to have reservations about the endorsement of outcome measures that we believe inappropriately focus on individual clinician accountability. Additionally, we have a concern that a PCPI measure not recommended for endorsement, OT3-048-10 (Plan of Care for Inadequate Hemodialysis), was inappropriately characterized in the draft commenting report – we request its reconsideration. Please see our measure specific comments in their respective sections.	See responses to individual measures.
M/Consumer Council	Debra Ness, National Partnership for Women & Families	General	Finally, we agree with the steering committee's recommendation that data on these measures should be stratified by race, ethnicity, and socioeconomic status. Children, unfortunately, experience significant disparities in care and outcomes just as adults do. It therefore is critical that information be made available to identify where those disparities are occurring in the realm of children's health care delivery so that they can be addressed and eventually eradicated.	Thank you for your comments.
M/Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	General	The American Nurses Association (ANA) concurs that to ensure quality of care across the continuum of a child's experience, it is necessary to develop and implement child health outcome measures that promote health and well-being across all spectrums of care and influence. ANA applauds NQF for recognizing the gap in the area of outcomes measures for the promotion of healthy behaviors; in areas outside of tertiary care; and of the need to capture "influences and cost information on children's well being outside of traditional healthcare, such as in the community, schools, and the environment".	Thank you for your comments.

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			NQF's decision to focus on child function, health-related quality of life, patient and caregiver experience with care, and promotion of healthy behaviors are laudable. Consideration of child health outcome measures that are focused on the outcome of a healthy transition from childhood to adulthood creates a broader picture of the overall health of the public. Measures that look at care provided outside of the acute setting, such as schools, provides a better perspective of all children, not just those with acute conditions or those who are frequently hospitalized. Additionally, the scope of the project calls for measurement of both health promotion outcomes as well as treatment of illness.	
M/Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	General	The National Association of School Nurses (NASN), an Organizational Affiliate of the American Nurses Association (ANA), advocates electronic student health records for data collection in schools. A significant amount of health care occurs by school nurses in schools every day, where 98% of the nation's children spend 6 or more hours per day. Schools are essential to the public health mission; school nurses practice public health…where the children are. NASN would welcome the opportunity to work with NQF to identify mechanisms for collecting data at the school level. Given sufficient funding and support, school health data sets can be a powerful method for the collection of the data of interest to the quality enterprise. Collaboration with NASN has an added potential for increasing the validity of the measures.	NQF welcomes additional discussions regarding school based data.
P	Robert J. Wells, M.D., The University of Texas MD Anderson Cancer Center	General	There are a number of measures included in this project that clearly cannot be used to evaluate a specialty care facility such as our institution or, in some cases, any pediatric treatment facility. Many seem to be area, population or geographic comparisons that will be difficult to measure and are not applicable to individual hospitals and health care providers. In addition, many are impractical. For example, while school attendance may be an indicator of quality of care, reliable access to school attendance records is needed. Similarly, hospitals usually are not held responsible for the "safety" of the surrounding community or schools or for that matter the overall infant mortality of their community. Additional work is needed to identify practical measures that fill the gap at the individual practice, hospital or health care provider level.	Population health is one of the six goals of the National Priorities Partnership (NPP). Measures are needed at the population level as well as at the provider level. Providers should look to their community-level measures to understand their own community and what contributions are being made by their services. The population measures are generated from a standardized national survey of parents. The Committee agrees that additional measures are needed for children. The recommendations for measure development should provide guidance to measure developers. The new child health quality measures project will review the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) core measure set as well as many other child health measures.
M/Purchaser Council	David Knowlton, New Jersey Health Care Quality Institute	General	Regarding OT3-045-10: Measure of medical home for children and adolescents and OT3-038-10: (a) Children who did not receive care coordination services when needed. Children who are identified with developmental delays before age 3 have much different outcomes than those identified after. This is especially true for children on the Autism Spectrum. We recommend that a measure of medical home for children include screening as early as 12 to 18 months. We also recommend a special review of low birth weight	Thank you for your comments. Additional recommendations for measure development will be included in the revised draft.

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			babies and the measuring of their developmental milestones such as with the Bailey tests or other recognized exam beginning at 6 months. Importance When developmental delay and Autism Spectrum diagnosis's are missed or delayed, the child does not get the benefits of valuable therapeutic interventions including those on Medicaid who would have access under EPSDT. Scientific Acceptability The American Academy of Neurology (AAN) and Child Neurology Society (CNS) issued guidelines on screening and diagnosis for autism. They state that, "developmental surveillance should be performed at all well-child visits from infancy through school-age." As well as that, "further developmental evaluation is required whenever a child fails to meet any of the following milestones: babbling by 12 months; gesturing by 12 months…" (http://www.aan.com/globals/axon/assets/2605.pdf) Another study finds that, "the symptoms of autism begin to emerge between 6 and 12 months of age." (Journa	
	David Knowlton, New Jersey Health Care Quality Institute	General	(Journal of the American Academy of Child & Adolescent Psychiatry (University of California – Davis – Health System (2010, February 19). http://www.sciencedaily.com/releases/2010/02/100216091009.htm Additional findings of the above study include, "These results suggest that closer monitoring of high-risk infants is warranted so that, if needed, interventions can begin as early as possible. These results also tell us that it is very important to screen for autism multiple times during the first years of life, since the emergence of symptoms can be so gradual it may be hard to detect in a single visit." Usability The intended audiences for this measure are Pediatricians and other specialized childhood healthcare providers. We also submit that it is more beneficial for purchasers and policy-makers to advocate for thorough developmental disability screening in newborns and children to assist in early interventions that enhance cost-effective treatments and reduce the risk of duplicative testing and unnecessary diagnostic and therapeutic interventions. Feasibility	

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			The additional resources a medical home provide reduce the burden on primary pediatric health care providers as there is increased access to specialized services and care coordination through a medical home. Specifically, medical records are easily accessible and usable (orderly, legible, and easy to access) for providers a family may be referred to. Since ancillary providers such as audiologist and physical	
M/Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	Not Recommended	The American Nurses Association (ANA) appreciates the myriad of issues identified by the Steering Committee related to measure OT3-049-10: Primary caries prevention intervention as part of well/ill child care as offered by primary care medical providers as developed by the University of Minnesota. Nevertheless, as noted by the Steering Committee, the issue of dental health is key to overall health and development of a measure to capture it should be encouraged.	Thank you for your comments. Recommendations for development of dental care measures will be added to the report. The new child health quality measures project will review dental measures.
M/Health Professional Council	Kathryn Schubert, American Society of Pediatric Nephrology	Not Recommended	The ASPN was disappointed that the steering committee did not recommend endorsement of measure OT3-048-10, which was previously endorsed by the AQA in 2008 and has been included for use by the Centers for Medicare and Medicaid Services' Physician Quality Reporting Initiative. The ASPN supports the AMA-PCPI's previous comments and response to the NQF's request for a review prior to the report. To that end: 1. The measure included a definition of the plan of care. This definition covers all of the strategies that a physician might use to adjust dialysis for a patient whose dialysis is found to not be adequate. Several of these items may be adjusted simultaneously in order to achieve a better result. At the present time, there is not evidence available that each strategy in and of itself can account for improving the adequacy of dialysis; and 2. Although the measure itself addresses a small patient population, there is a demonstrated gap in care that this measure could potentially impact, and we do believe that this measure is necessary to achieving our shared goal to quality care. With that said, the ASPN remains committed to ensuring quality of care in the vulnerable population it serves. We also understand that the NQF has opened a call for measures for end-stage renal disease and chronic kidney disease. We are disappointed that this measure cannot be resubmitted for this purpose given its relevance. We look forward to NQF's consideration of future similar measures.	The Committee reviewed these comments on September 16, 2010 and noted their concerns on lack of age/weight adjustments and lack of specificity of the plan of care. The Committee suggested that this measure also be evaluated by the Steering Committee for NQF's end-stage renal disease (ESRD) project that is just beginning.
M/Health Professional Council	Robert Blaser, Renal Physicians Association	Not Recommended	RPA shares the American Society for Pediatric Nephrology's disappointment that the steering committee did not recommend endorsement of measure OT3-048-10. The measure was previously endorsed by the AQA in 2008 and has been included for use by the CMS' PQRI. RPA supports the AMA-PCPI and ASPN's previous comments and response to the NQF's request for a review prior to the report: "1. The measure included a definition of the plan of care. This definition covers all of the strategies that a physician might use to adjust dialysis for a patient whose dialysis is found to not be adequate. Several of these items may be adjusted simultaneously in order to achieve a better result. At the present time, there is not evidence available that each strategy in and of itself can account for improving the adequacy of dialysis; and 2. Although the	The Committee reviewed these comments on September 16, 2010 and noted their concerns on lack of age/weight adjustments and lack of specificity of the plan of care. The Committee suggested that this measure also be evaluated by the Steering Committee for NQF's end-stage renal disease (ESRD) project that is just beginning.

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			measure itself addresses a small patient population, there is a demonstrated gap in care that this measure could potentially impact, and we do believe that this measure is necessary to achieving our shared goal to quality care." RPA also understands that the NQF has opened a call for measures for ESRD and CKD, however we are disappointed that this measure cannot be resubmitted for this purpose given its relevance. RPA looks forward to NQF's consideration of future similar measures. As the national representative for physicians engaged in the study and management of patients with renal disease, RPA remains committed to ensuring quality patient care.	
M/QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement®	Not Recommended	*OT3-048-10 (Plan of Care for Inadequate Hemodialysis) – Request for Reconsideration Given that the adult PCPI version of measure OT3-048-10 (Plan of Care for Inadequate Hemodialysis) initially received time-limited endorsement (NQF measure #0323), has been tested and has now received full endorsement per the July 14, 2010 CSAC meeting, we would like to respectfully request that the Steering Committee for this project reconsider their recommendation and move this pediatric measure forward for time-limited endorsement. Previous comments submitted by the American Society for Pediatric Nephrology and PCPI on July 1, 2010 clarified the issues noted in the minutes from the original Patient Outcome Measures – Child Health steering committee meeting. We are happy to resubmit our full comment, if necessary. While it is understood that this measure is relevant to only a small number of children, this is a particularly fragile segment of the pediatric population with a complex disease, and closing the gap in care demonstrated for the adequacy of hemodialysis could have a significant positive impact on this population. We appreciate the opportunity to comment on this report.	The Committee reviewed these comments on September 16, 2010 and noted their concerns on lack of age/weight adjustments and lack of specificity of the plan of care. The Committee suggested that this measure also be evaluated by the Steering Committee for NQF's end-stage renal disease (ESRD) project that is just beginning.
P	Nathan Selden, OHSU	OT3-027-10	The language in the document is inconsistent in specifying primary ventriculo-peritoneal shunt placement only. Subsequent surgeries (revisions, reimplantations, etc) and placement in other distal cavities (ventriculopleural, ventriculoatrial) are so diverse in indication and population of kids and what problems and extra challenges they have, would be totally confounded. Must be clear throughout, including in the operative code based data collection criteria.	Measure Developer response: We agree with this comment and will further explore the ability to measure primary shunt placement operations only. Although subsequent surgeries have diverse indications, purists may argue that these surgeries should be included for measurement with attention given to the minimization of shunt malfunction, especially as some children experience multiple shunt malfunctions over time.
P	Nathan Selden, OHSU	OT3-027-10	Risk stratification should be included (rather than excluded as in draft). As a simple way of avoiding risk stratification, they exclude less than 30 days old (but the risk of higher complication rate extends throughout infancy) and myelomeningocele patients, but both of those are important to study. Also, premie-IVH is very very high risk, probably higher than myelomeningocele at first shunt implant (esp since they exclude less than 30 days old, rather than 30 days past term birth).	Measure Developer response: We agree with the comment and will explore risk adjustment methods that include infants less than 30 days, myelomeningocele, and preemie-IVH patients.
M/Health	Rachel Groman,	OT3-027-10	The AANS requests that the definition of this measure be modified to read,	Measure Developer response: We agree and will

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Professional Council	American Association of Neurological Surgeons (AANS)		"shunt malfunction requiring operative intervention or shunt infection occurring within 30 days of discharge following initial placement." We object to inferences to "shunt misplacement" since physical location of the catheters, particularly the ventricular catheter, does not correlate with malfunction and the need for further intervention. We also believe the inclusion criteria should include all pts <18yrs with stratification for premature infants, spina bifida, infection, and all other etiologies Finally, there should be separate outcome reports/benchmarks for malfunction and infection.	modify the measure definition as suggested, remove inferences to shunt "misplacement" from the measure specifications, and revise the inclusion criteria. We believe that reporting separate outcomes for malfunction and infection is important. We will pursue further testing to inform how these two outcomes should be best measured and reported.
M/Health Professional Council	Nancy H. Nielsen, MD, PhD, American Medical Association	OT3-027-10	While this measure addresses am important area of pediatric care, we cannot support it as an accountability measure at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians (including the efforts of other health care professionals) that could affect the care of those patients who would be impacted by this measure. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the outcome is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, these types of measures are best represented at "higher" levels of measurement/analysis. Reporting of these outcomes at higher levels of analysis does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that NQF, in consultation with the measure developer, replace "Can be measured at all levels" with "non-clinician" levels for the Level of Measurement/Analysis for proposed measures OT3-027-10, OT3-028-10, OT3-029-10 and OT3-047-10. We recommend removing "Clinician" as a Level of Measurement/Analysis for proposed measures OT3-031-10 and OT3-043-10. We appreciate the opportunity to comment on this report.	Measure Developer response: We agree that this measure is probably best suited for hospital/departmental accountability rather than clinician-level accountability and will consider amending the measure for "non-clinician" levels. NQF staff note: Measure Developers have been asked to change the submission form to reflect the appropriate level of analysis.
M/QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement®	OT3-027-10	While this measure addresses an important area of pediatric care, we cannot support it as an accountability measure at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians (including the efforts of other health care professionals) that could affect the care of those patients who would be impacted by this measure. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the outcome is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, these types of measures are best represented at "higher" levels of	Measure Developer response: We agree that this measure is probably best suited for hospital/departmental accountability rather than clinician-level accountability and will consider amending the measure for "non-clinician" levels. NQF staff note: Measure Developers have been asked to change the submission form to reflect the appropriate level of analysis.

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			measurement/analysis. Reporting of these outcomes at high levels of analysis does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that NQF, in consultation with the measure developer, replace "Can be measured at all levels" with "non-clinician" levels for the Level of Measurement/Analysis for proposed measures OT3-027-10, OT3-028-10, OT3-029-10 and OT3-046-10. We recommend removing "Clinician" as a Level of Measurement/Analysis for proposed measures OT3-031-10 and OT3-043-10.	
M/Provider Organization Council	Renee Demski, Johns Hopkins Medicine	OT3-027-10	The concern is that some children may have a loculated ventricle which may require a return to the OR for a revision or new catheter placement shortly after the initial shunt. This may be perceived as a malfunction which it is not.	Measure Developer response: The development of loculated ventricle post-shunt insertion is an interesting clinical situation that warrants further attention. Some may argue that any situation that significantly impedes cerebrospinal fluid leak (CSF) diversion should be considered a malfunction. We will explore this situation further (e.g., to determine its prevalence, correlation with per-operative care, etc.) to determine how to best account for it when measuring shunt malfunction.
M/Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	OT3-027-10	This condition has extremely low prevalence which makes it tenuous for accountability.	Measure Developer response: Hydrocephalus is a clinical condition with low prevalence compared with other pediatric chronic conditions (e.g., asthma). However, significant variation in shunt malfunction is reported among hospitals. We suggest a 3-year rolling average of shunt malfunction rates to help stabilize the variance (e.g., 95% confidence intervals or standard deviation) so that hospitals have more "stable" data to interpret and act upon.
M/Health Professional Council	Andrea Kline, National Association of Pediatric Nurse Practitioners (NAPNAP)	OT3-027-10	Appropriate Numerator and Denominator Good accessibility of data	Thank you for your comment.
M/Health Professional Council	Nancy H. Nielsen, MD, PhD, American Medical Association	OT3-028-10	While this measure addresses am important area of pediatric care, we cannot support it as an accountability measure at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians (including the efforts of other health care professionals) that could affect the care of those patients who would be impacted by this measure. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the outcome is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, these types of measures are best represented at "higher" levels of	Measure Developer response: I think this is appropriate and agree with this recommendation for metric reporting. NQF staff note: Measure Developers have been asked to change the submission form to reflect the appropriate level of analysis.

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			measurement/analysis. Reporting of these outcomes at higher levels of analysis does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that NQF, in consultation with the measure developer, replace "Can be measured at all levels" with "non-clinician" levels for the Level of Measurement/Analysis for proposed measures OT3-027-10, OT3-028-10, OT3-029-10 and OT3-047-10. We recommend removing "Clinician" as a Level of Measurement/Analysis for proposed measures OT3-031-10 and OT3-043-10. We appreciate the opportunity to comment on this report.	
M/QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement®	OT3-028-10	While this measure addresses an important area of pediatric care, we cannot support it as an accountability measure at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians (including the efforts of other health care professionals) that could affect the care of those patients who would be impacted by this measure. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the outcome is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, these types of measures are best represented at "higher" levels of measurement/analysis. Reporting of these outcomes at high levels of analysis does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that NQF, in consultation with the measure developer, replace "Can be measured at all levels" with "non-clinician" levels for the Level of Measurement/Analysis for proposed measures OT3-027-10, OT3-028-10, OT3-029-10 and OT3-046-10. We recommend removing "Clinician" as a Level of Measurement/Analysis for proposed measures OT3-031-10 and OT3-043-10.	Measure Developer response: I think this is appropriate and agree with this recommendation for metric reporting. NQF staff note: Measure Developers have been asked to change the submission form to reflect the appropriate level of analysis. NQF staff note: Measure Developers have been asked to change the submission form to reflect the appropriate level of analysis.
M/Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	OT3-028-10	This condition has extremely low prevalence which makes it tenuous for accountability.	The Steering Committee considered the low prevalence during the deliberations.
M/Health Professional Council	Andrea Kline, National Association of Pediatric Nurse Practitioners (NAPNAP)	OT3-028-10	Appropriate Numerator and Denominator Good accessibility of data	Thank you for your comment.
M/Health	Nancy H. Nielsen,	OT3-029-10	While this measure addresses am important area of pediatric care, we cannot	Measure Developer response: I think this is

Member Council/ Public	Organization Contact	Topic	Comment	Response
Professional Council	MD, PhD, American Medical Association		support it as an accountability measure at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians (including the efforts of other health care professionals) that could affect the care of those patients who would be impacted by this measure. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the outcome is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, these types of measures are best represented at "higher" levels of measurement/analysis. Reporting of these outcomes at higher levels of analysis does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that NQF, in consultation with the measure developer, replace "Can be measured at all levels" with "non-clinician" levels for the Level of Measurement/Analysis for proposed measures OT3-027-10, OT3-028-10, OT3-029-10 and OT3-047-10. We recommend removing "Clinician" as a Level of Measurement/Analysis for proposed measures OT3-031-10 and OT3-043-10. We appreciate the opportunity to comment on this report.	appropriate and agree with this recommendation for metric reporting. NQF staff note: Measure Developers have been asked to change the submission form to reflect the appropriate level of analysis.
M/QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement®	OT3-029-10	While this measure addresses an important area of pediatric care, we cannot support it as an accountability measure at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians (including the efforts of other health care professionals) that could affect the care of those patients who would be impacted by this measure. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the outcome is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, these types of measures are best represented at "higher" levels of measurement/analysis. Reporting of these outcomes at high levels of analysis does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that NQF, in consultation with the measure developer, replace "Can be measured at all levels" with "non-clinician" levels for the Level of Measurement/Analysis for proposed measures OT3-027-10, OT3-028-10, OT3-029-10 and OT3-046-10. We recommend removing "Clinician" as a Level of Measurement/Analysis for proposed measures OT3-031-10 and OT3-043-10.	Measure Developer response: I think this is appropriate and agree with this recommendation for metric reporting. NQF staff note: Measure Developers have been asked to change the submission form to reflect the appropriate level of analysis.
M/Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on	OT3-029-10	This condition has extremely low prevalence which makes it tenuous for accountability.	The Committee considered the low prevalence during its deliberations.

Member Council/ Public	Organization Contact	Topic	Comment	Response
	Quality and Practice, American Academy of Family Physicians			
M/Health Professional Council	Andrea Kline, National Association of Pediatric Nurse Practitioners (NAPNAP)	OT3-029-10	Appropriate numerator and denominator Well defined adverse events	Thank you for your comment.
P	Martha Bergren, National Association of School Nurses	OT3-031-10	School nurses play a major role in accessing prenatal services for pregnant teens and providing case management for them during the school day.	Thank you for your comments.
M/Health Professional Council	Nancy H. Nielsen, MD, PhD, American Medical Association	OT3-031-10	While this measure addresses am important area of pediatric care, we cannot support it as an accountability measure at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians (including the efforts of other health care professionals) that could affect the care of those patients who would be impacted by this measure. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the outcome is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, these types of measures are best represented at "higher" levels of measurement/analysis. Reporting of these outcomes at higher levels of analysis does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that NQF, in consultation with the measure developer, replace "Can be measured at all levels" with "non-clinician" levels for the Level of Measurement/Analysis for proposed measures OT3-027-10, OT3-028-10, OT3-029-10 and OT3-047-10. We recommend removing "Clinician" as a Level of Measurement/Analysis for proposed measures OT3-031-10 and OT3-043-10. We appreciate the opportunity to comment on this report.	Measure Developer response: We agree with this reviewer as it is difficult to attribute this outcome to a single provider (OB or Peds) but rather was directed towards the entire system of care within the hospital (or larger). NQF staff note: Measure Developers have been asked to change the submission form to reflect the appropriate level of analysis.
M/Purchaser Council	Gaye Fortner, HC21	OT3-031-10	This hospital-level measure provides information on the percentage of all term singleton live births without any significant complications during birth or post partum, arising from the management of the birth process itself. I support this measure as a complement to the already-endorsed NQF measure (from the perinatal care project) that reports the percentage of all singleton low-risk first births delivered by c-section. During the debate over the c-section measure, the perinatal care steering committee discussed the importance of having a companion measure that would help researchers better understand the relationship between c-section delivery and healthy newborn delivery. By endorsing – and subsequently implementing – this measure, stakeholders would be able to pair the c-section rate and health newborn rate, by hospital, thereby permitting easier comparisons of differences among outcomes and facilitating	Measure Developer response: Thank you for the comment. We also believe that the pairing of this measure with the low-risk Cesarean measure is an excellent approach.

Member Council/ Public	Organization Contact	Topic	Comment	Response
			further investigation.	
M/QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement®	OT3-031-10	While this measure addresses an important area of pediatric care, we cannot support it as an accountability measure at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians (including the efforts of other health care professionals) that could affect the care of those patients who would be impacted by this measure. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the outcome is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, these types of measures are best represented at "higher" levels of measurement/analysis. Reporting of these outcomes at high levels of analysis does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that NQF, in consultation with the measure developer, replace "Can be measured at all levels" with "non-clinician" levels for the Level of Measurement/Analysis for proposed measures OT3-027-10, OT3-028-10, OT3-029-10 and OT3-046-10. We recommend removing "Clinician" as a Level of Measurement/Analysis for proposed measures OT3-031-10 and OT3-043-10.	Measure Developer response: We agree with this reviewer as it is difficult to attribute this outcome to a single provider (OB or Peds) but rather was directed towards the entire system of care within the hospital (or larger). NQF staff note: Measure Developers have been asked to change the submission form to reflect the appropriate level of analysis.
M/Consumer Council	Debra Ness, National Partnership for Women & Families	OT3-031-10	This hospital-level measure provides information on the percentage of all term singleton live births without any significant complications during birth or post partum, arising from the management of the birth process itself. We support this measure as a complement to the already-endorsed NQF measure (from the perinatal care project) that reports the percentage of all singleton low-risk first births delivered by c-section. During the debate over the c-section measure, the perinatal care steering committee discussed the importance of having a companion measure that would help researchers better understand the relationship between c-section delivery and healthy newborn delivery. Endorsement of this measure would enable stakeholders to pair the c-section rate and health newborn rate, by hospital, thereby permitting easier comparisons of differences among outcomes and facilitating further investigation. We strongly support its endorsement.	Measure Developer response: Thank you for the comment. We also believe that the pairing of this measure with the low-risk Cesarean measure is an excellent approach.
M/Purchaser Council	Christine Chen, Pacific Business Group on Health	OT3-031-10	We strongly support this measure as a complement to the already-endorsed NQF measure (from the perinatal care project) that reports the percentage of all singleton low-risk first births delivered by c-section. When considered together, the measures will promote better understanding of the relationship between c-section delivery and healthy newborn delivery.	Measure Developer response: Thank you for the comment. We also believe that the pairing of this measure with the low-risk Cesarean measure is an excellent approach.
M/Consumer Council	Maureen Corry, Childbirth Connection	OT3-031-10	This hospital measure assesses optimal outcomes of pregnancy and childbirth in health term newborns that do not have signs of complications during birth or nursery care. With more than 4.2 million births per year in the U.S. and a cesarean section rate of close to 33%, this measure is especially important to consumers who wish to assess the number of term singleton births without any significant complications arising from the management of care during labor and	Measure Developer response: Thank you for the comment. We also believe that the pairing of this measure with the low-risk Cesarean measure is an excellent approach.

Member Council/ Public	Organization Contact	Topic	Comment	Response
			childbirth. We support this measure as a complement to the existing NQF perinatal measure that reports the percentage of all singleton low-risk first births delivered by cesarean section. Endorsement of this measure will enable consumers and other stakeholders to pair the c-section rate and the healthy newborn rate by hospital thereby permitting comparisons of differences among outcomes,and facilitating further investigation. We strongly support its endorsement.	
M/Health Professional Council	Andrea Kline, National Association of Pediatric Nurse Practitioners (NAPNAP)	OT3-031-10	Concern that some of the outcomes such as hypoxic ischemic encephalopathy (HIE), severe asphyxia, and need for gastrostomy tube placement may not be known at the time of data collection as these may take months or longer to be truly realized.	Measure Developer response: While it is true that some of the included diagnoses may in some cases not be apparent for many months, in our reviews almost always they will have had other included diagnoses earlier and at the very least a prolonged length of stay (LOS).
P	Anne Sheetz, Massachusetts Department of Public Health	OT3-032-10	Again, there is a disconnect with the role of the school nurse. School nurses track attendance and work very hard to reduce it by providing case management, services and care coordination in the schools. In MA the return to class rate after seeing the school nurse is now an education quality indicator through the Department of Elementary and Secondary Education. It currently stands at 91-92% for registered school nurses. This is markedly reduced for LPN's and for health assistants. A quality indicator should be that every school with 250-500 students should have a fulltime BSN or MSN prepared school nurse; larger schools should have an additional 0.1 FTE for each additional 50 students.	The Steering Committee agreed that the role of the school nurse is very important to child health and notes the wide variation in availability of school nurses across the country. Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the health care quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.
P	Martha Bergren, National Association of School Nurses	OT3-032-10	This measured outcome is extremely important and has far-reaching implications, not only for health, but for the education, quality of life, and potential productivity of children as they become adults. However, the data should be captured at the provider level. Asking parents to recall missed school days over a one year period will not result in accurate data. The providers who could most likely give the most valid and accurate data are school nurses. For example, parents may not consider a toothache to be an illness, and it is often a reason for missed school days.	Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the health care quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of

Member Council/ Public	Organization Contact	Topic	Comment	Response
				information of the health and well-being of the nation's children.
M/Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	OT3-032-10	The American Nurses Association (ANA) respectfully offers the following specific comments on behalf of the National Association of School Nurses (NASN), an Organizational Affiliate of ANA: •OT3-032-10: Number of school days children miss due to illness ~ The number of school days missed has far-reaching implications, not only for health, but for the education, quality of life, and productivity of children as they become adults. Absenteeism is a major predictor of school dropout. However, the data should be captured at the provider level. Asking parents to recall missed school days over a one year period will not result in accurate data. The providers who could most likely give the most valid and accurate data are school nurses.	Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the health care quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.
M/Health Professional Council	Andrea Kline, National Association of Pediatric Nurse Practitioners (NAPNAP)	OT3-032-10	Appropriate numerator and denominator Concern about relying on parental report of missed school days	Measure Developer response: Parental report of children's health is valid and reliable. Information in medical records on topics assessed in the National Survey of Children's Health (NSCH) (e.g., functioning, missed school, etc.)—information in medical charts, electronic medical records (EMRs)—is very often parent-reported information (though not using standardized provider administered questions, whereas the NSCH items are standardized across all children so variations can be trusted). Numerous studies have shown that parental report of symptoms, family history, previous medical history, and allergies to medication is often more accurate than either nurses or physicians. 1. Porter SC, Forbes P, Manzi S, et al., Kalish LA. Patients providing the answers: narrowing the gap in data quality for emergency care. Qual Saf Health Care,. 2010 May 27.[Epub ahead of print]. [Epub ahead of print] PubMed PMID: 20511242. 2. Bourgeois FT, Porter SC, Valim C, et al.,Jackson T, Cook EF, Mandl KD. The value of patient self-report for disease surveillance. J Am Med Inform Assoc,. 2007; Nov-Dec;14(6):765-771. Epub 2007 Aug 21. PubMed PMID: 17712092; PubMed Central

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				PMCID: PMC2213481. 3. Porter SC, Kohane IS, Goldmann DA. Parents as partners in obtaining the medication history,. J Am Med Inform Assoc,. ;2005 May-Jun;12(3):299-305. Epub 2005 Jan 31. PubMed PMID: 15684127; PubMed Central PMCID: PMC1090461. 4. Porter SC. Patients as experts: a collaborative performance support system. Proc AMIA Symp,. 2001:548-552. PubMed PMID: 11825247; PubMed Central PMCID:PMC2243331. 5. Porter SC, Silvia MT, Fleisher GR, et al.,Kohane IS, Homer CJ, Mandl KD. Parents as direct contributors to the medical record: validation of their electronic input,. Ann Emerg Med,. 2000 Apr;35(4):346-352. PubMed PMID: 10736120. 6. Porter SC, Mandl KD. Data quality and the electronic medical record: a role for direct parental data entry,. Proc AMIA Symp,. 1999:354-358. PubMed PMID:10566380; PubMed Central PMCID: PMC2232794.
P	Anne Sheetz, Massachusetts Department of Public Health	OT3-036-10	This is clearly an issue for schools, especially in the area of behavioral/mental health. A recommendation is that the schools have access to a mental/behavioral health expert within an hour of calling; the expert can advise on referral, behavior management. We are studying 911 calls in MA schools and preliminary data indicate that 24% are for behavioral/mental health issues---a questionable use of high cost health care dollars. This indicates a need for prevention, increased education on behavioral management in the schools, and a system to touch base with fragile students daily. The PCPs should be in the loop in terms of mental/behavioral health care--and as in all hospitalizations, there should be a re-entry plan for the schools.	The recommendation will be included in the report. Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the health care quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.
P	Martha Bergren, National Association of School Nurses	OT3-036-10	It is important that all providers of health care are considered, including dentists and ophthalmologists and/or optometrists. When a child is fortunate to have been assessed and deemed in need of a referral for a physical or mental health problem, there is often not a health care provider available in the geographic are to see the child in a timely manner, having a negative effect on the outcome. This is particularly true in the mental health	Measure Developer response: Parental report of children's health is valid and reliable. Information in medical records on topics assessed in the National Survey of Children's Health (NSCH) (e.g., functioning, missed school, etc.)—information in medical charts, electronic medical records (EMRs)—is very often parent-reported

Member Council/ Public	Organization Contact	Topic	Comment	Response
			arena, where children often wait months for an appointment, their insurance does not cover the care. Parent report to obtain this data may prove ineffective. Using a parent report assumes that parents believe referral is necessary. Often parents do not follow up with referrals when needed. i.e. vision screen failure at school, asthma (parents treat at home), hearing screen failure at school, etc.	information (though not using standardized provider administered questions, whereas the NSCH items are standardized across all children so variations can be trusted). Numerous studies have shown that parental report of symptoms, family history, previous medical history, and allergies to medication is often more accurate than either nurses or physicians. 1. Porter SC, Forbes P, Manzi S, et al., Patients providing the answers: narrowing the gap in data quality for emergency care. *Qual Saf Health Care*, 2010 May 27.[Epub ahead of print]. 2. Bourgeois FT, Porter SC, Valim C, et al.,The value of patient self-report for disease surveillance. *J Am Med Inform Assoc*, 2007;14(6):765-771. 3. Porter SC, Kohane IS, Goldmann DA. Parents as partners in obtaining the medication history, *J Am Med Inform Assoc*,;12(3):299-305. 4. Porter SC. Patients as experts: a collaborative performance support system. *Proc AMIA Symp*, 2001:548-552. 5. Porter SC, Silvia MT, Fleisher GR, et al., Parents as direct contributors to the medical record: validation of their electronic input, *Ann Emerg Med*, 2000;35(4):346-352. 6. Porter SC, Mandl KD. Data quality and the electronic medical record: a role for direct parental data entry, *Proc AMIA Symp*, 1999:354-358.
M/Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	OT3-036-10	This measure is somewhat subjective.	Measure Developer response: Parental report of children's health is valid and reliable. Information in medical records on topics assessed in the National Survey of Children's Health (NSCH) (e.g., functioning, missed school, etc.)—information in medical charts, electronic medical records (EMRs)—is very often parent-reported information (though not using standardized provider administered questions, whereas the NSCH items are standardized across all children so variations can be trusted). Numerous studies have shown that parental report of symptoms, family history, previous medical history, and

Member Council/ Public	Organization Contact	Topic	Comment	Response
				allergies to medication is often more accurate than either nurses or physicians. 1. Porter SC, Forbes P, Manzi S, et al., Patients providing the answers: narrowing the gap in data quality for emergency care. *Qual Saf Health Care*, 2010 May 27.[Epub ahead of print]. 2. Bourgeois FT, Porter SC, Valim C, et al.,The value of patient self-report for disease surveillance. *J Am Med Inform Assoc*, 2007;14(6):765-771. 3. Porter SC, Kohane IS, Goldmann DA. Parents as partners in obtaining the medication history, *J Am Med Inform Assoc*,;12(3):299-305. 4. Porter SC. Patients as experts: a collaborative performance support system. *Proc AMIA Symp*, 2001:548-552. 5. Porter SC, Silvia MT, Fleisher GR, et al., Parents as direct contributors to the medical record: validation of their electronic input, *Ann Emerg Med*, 2000;35(4):346-352. 6. Porter SC, Mandl KD. Data quality and the electronic medical record: a role for direct parental data entry, *Proc AMIA Symp*, 1999:354-358.
M/Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	OT3-036-10	The American Nurses Association (ANA) respectfully offers the following specific comments on behalf of the National Association of School Nurses (NASN), an Organizational Affiliate of ANA: •OT3-036-10: Children who have problems obtaining referrals when needed ~ It is important that all providers of health care are considered, including psychologists and psychiatrists, dentists and ophthalmologists and/or optometrists. When a child is fortunate to have been assessed and deemed in need of a referral for a physical or mental health problem, there is often not a health care provider available in the geographic are to see the child in a timely manner, having a negative effect on the outcome. This is particularly true in the mental health arena, where children often wait months for an appointment, their insurance does not cover the care. However, using parent report to obtain this data may prove ineffective. Using a parent report assumes that parents believe referral is necessary. Quite often parents do not follow up with referrals when needed. i.e. vision screen failure at	Measure Developer response: Parental report of children's health is valid and reliable. Information in medical records on topics assessed in the National Survey of Children's Health (NSCH) (e.g., functioning, missed school, etc.)—information in medical charts, electronic medical records (EMRs)—is very often parent-reported information (though not using standardized provider administered questions, whereas the NSCH items are standardized across all children so variations can be trusted). Numerous studies have shown that parental report of symptoms, family history, previous medical history, and allergies to medication is often more accurate than either nurses or physicians. 1. Porter SC, Forbes P, Manzi S, et al., Patients

Member Council/ Public	Organization Contact	Topic	Comment	Response
			school, asthma (parents treat at home), hearing screen failure at school, etc.	providing the answers: narrowing the gap in data quality for emergency care. *Qual Saf Health Care*, 2010 May 27.[Epub ahead of print]. 2. Bourgeois FT, Porter SC, Valim C, et al.,The value of patient self-report for disease surveillance. *J Am Med Inform Assoc*, 2007;14(6):765-771. 3. Porter SC, Kohane IS, Goldmann DA. Parents as partners in obtaining the medication history, *J Am Med Inform Assoc*,;12(3):299-305. 4. Porter SC. Patients as experts: a collaborative performance support system. *Proc AMIA Symp*, 2001:548-552. 5. Porter SC, Silvia MT, Fleisher GR, et al., Parents as direct contributors to the medical record: validation of their electronic input, *Ann Emerg Med*, 2000;35(4):346-352. 6. Porter SC, Mandl KD. Data quality and the electronic medical record: a role for direct parental data entry, *Proc AMIA Symp*, 1999:354-358.
M/Health Professional Council	Andrea Kline, National Association of Pediatric Nurse Practitioners (NAPNAP)	OT3-036-10	Concern that may be difficult to determine whether or not referral requested was or was not indicated for the child.	Measure Developer response: Parental report of children's health is valid and reliable. Information in medical records on topics assessed in the National Survey of Children's Health (NSCH) (e.g., functioning, missed school, etc.)—information in medical charts, electronic medical records (EMRs)—is very often parent-reported information (though not using standardized provider administered questions, whereas the NSCH items are standardized across all children so variations can be trusted). Numerous studies have shown that parental report of symptoms, family history, previous medical history, and allergies to medication is often more accurate than either nurses or physicians. 1. Porter SC, Forbes P, Manzi S, et al., Patients providing the answers: narrowing the gap in data quality for emergency care. *Qual Saf Health Care*, 2010 May 27.[Epub ahead of print]. 2. Bourgeois FT, Porter SC, Valim C, et al.,The

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				value of patient self-report for disease surveillance. *J Am Med Inform Assoc*, 2007;14(6):765-771. 3. Porter SC, Kohane IS, Goldmann DA. Parents as partners in obtaining the medication history, *J Am Med Inform Assoc*,;12(3):299-305. 4. Porter SC. Patients as experts: a collaborative performance support system. *Proc AMIA Symp*, 2001:548-552. 5. Porter SC, Silvia MT, Fleisher GR, et al., Parents as direct contributors to the medical record: validation of their electronic input, *Ann Emerg Med*, 2000;35(4):346-352. 6. Porter SC, Mandl KD. Data quality and the electronic medical record: a role for direct parental data entry, *Proc AMIA Symp*, 1999:354-358.
P	Anne Sheetz, Massachusetts Department of Public Health	OT3-038-10 (a)	Care coordination is a time-consuming issue--and, again, much falls on the schools as the parents have access to the school nurse on a daily basis if desired. We all need to "think outside the box" and develop electronic communication systems that inform the PCP if the child goes to the ER--and the treatment plan---or if the child is hospitalized for a specialty issues, e.g., behavioral health---and then ALWAYS consider the school nurse as she will often be the health professional to implement the plan..... This will require parental permission---and confidentiality protections, but it can be done.... We find that in planning for children with life threatening allergies in the school, parents are involved as are the providers.	Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the health care quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.
P	Martha Bergren, National Association of School Nurses	OT3-038-10 (a)	Lack of continuity of care between primary provider, and schools is a major detriment to safe and appropriate care for students. There is often little or no communication between the provider and the school nurse. In instances where students are seen in the ER or for urgent issues by the primary provider, communication is most often through the parent, if at all. It is imperative that schools be included in receiving the communication about the care of the child during the school day, but the communication should be with the school nurse who can interpret and clarify limits on physical activity, diet restrictions, plan of care, medications prescribed, etc. The school nurse should be considered an integral component of health care continuum.	Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the health care quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of

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Member Council/ Public	Organization Contact	Topic	Comment	Response
				information of the health and well-being of the nation's children.
M/Purchaser Council	Christine Chen, Pacific Business Group on Health	OT3-038-10 (a)	This (part a and part b) vitally capture the patient's perspective of whether all needed care coordination services were provided and whether effective communication among the patient's care team occurred.	Thank you for your comments.
M/Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	OT3-038-10 (a)	The American Nurses Association (ANA) respectfully offers the following specific comments on behalf of the National Association of School Nurses (NASN), an Organizational Affiliate of ANA: •OT3-038-10: (a) Children who did not receive care coordination services when needed ~ Lack of continuity of care between primary providers and schools is a major detriment to safe and appropriate care for students. There is often little or no communication between the provider and the school nurse. In instances where students are seen in the Emergency Room, free standing urgent care clinics, or by the primary provider, communication is most often through the parent, if at all. It is imperative that schools be included in receiving the communication about the care of the child during the school day, but the communication should be with the school nurse who can interpret and clarify limits on physical activity, diet restrictions, plan of care, medications prescribed, etc. The school nurse should be considered an integral component of health care continuum. Conversely, primary care providers should be able to access the assessments and interventions that take place at school to integrate into the plan of care.	Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the health care quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.
M/Health Professional Council	Andrea Kline, National Association of Pediatric Nurse Practitioners (NAPNAP)	OT3-038-10 (a)	Recommend changing language to be consistent with "health care provider" throughout (see numerator)	Measure Developer response: Language in the item is "doctors and other services," which is intended to encompass other health care providers. The idea of changing the wording in future versions of the National Survey of Children's Health (NSCH) can be reviewed by the NSCH Technical Expert Panel and tested in field testing conducted prior to data collection.
P	Anne Sheetz, Massachusetts Department of Public Health	OT3-038-10 (b)	Again, speaking from the school's point of view, it is imperative that we develop systems of communication--electronic or otherwise--to ensure close communication with the school. If the school nurse does not know that a child was just been diagnosed with Type 1 diabetes, or has no appropriate orders--and cannot reach the physician if there are objective indicators that the plan must be adjusted---then the child is unsafe in the school setting. And, the physician needs ongoing feedback regarding glucose levels, use of prn orders, to manage the child--real time is important--not just an appointment every several weeks or months. Again, hand held computers, other communication devices might be useful.	Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the healthcare quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.
P	Martha Bergren,	OT3-038-10 (b)	Lack of continuity of care between primary provider, and schools is a major	Measure Developer response: We appreciate the

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	National Association of School Nurses		detriment to safe and appropriate care for students. There is often little or no communication between the provider and the school nurse. In instances where students are seen in the ER or for urgent issues by the primary provider, communication is most often through the parent, if at all. It is imperative that schools be included in receiving the communication about the care of the child during the school day, but the communication should be with the school nurse who can interpret and clarify limits on physical activity, diet restrictions, plan of care, medications prescribed, etc. The school nurse should be considered an integral component of health care continuum.	role of school nurses and other nurse professionals in the healthcare quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.
M/Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	OT3-038-10 (b)	This measure is someewhat subjective.	Measure Developer response: Parental report of children's health is valid and reliable. Information in medical records on topics assessed in the National Survey of Children's Health (NSCH) (e.g., functioning, missed school, etc.)—information in medical charts, electronic medical records (EMRs)—are very often parent-reported information (though not using standardized provider administered questions, whereas the NSCH items are standardized across all children so variations can be trusted). Numerous studies have shown that parental report of symptoms, family history, previous medical history, and allergies to medication is often more accurate than either nurses or physicians. 1. Porter SC, Forbes P, Manzi S, et al., Patients providing the answers: narrowing the gap in data quality for emergency care. *Qual Saf Health Care*, 2010 May 27.[Epub ahead of print]. 2. Bourgeois FT, Porter SC, Valim C, et al.,The value of patient self-report for disease surveillance. *J Am Med Inform Assoc*, 2007;14(6):765-771. 3. Porter SC, Kohane IS, Goldmann DA. Parents as partners in obtaining the medication history, *J Am Med Inform Assoc*,;12(3):299-305. 4. Porter SC. Patients as experts: a collaborative performance support system. *Proc AMIA Symp*, 2001:548-552.

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				5. Porter SC, Silvia MT, Fleisher GR, et al., Parents as direct contributors to the medical record: validation of their electronic input, *Ann Emerg Med*, 2000;35(4):346-352. 6. Porter SC, Mandl KD. Data quality and the electronic medical record: a role for direct parental data entry, *Proc AMIA Symp*, 1999:354-358.
M/Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	OT3-038-10 (b)	The American Nurses Association (ANA) respectfully offers the following specific comments on behalf of the National Association of School Nurses (NASN), an Organizational Affiliate of ANA: •OT3-038-10: (b) Children who did not receive satisfactory communication when needed ~ School nurses have an integral, yet often unrecognized, role in the management of children with chronic health conditions. It is essential to capture school nurse care coordination in this outcome measure. School nurse case management of asthma and diabetes and result in fewer emergency room visits and hospitalizations, improved ability of the child to manage their own care and the greater likelihood of having rescue medications at school and improved quality of life.	Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the healthcare quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.
M/Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	OT3-039-10	This measure is somewhat subjective.	Measure Developer response: Parental report of children's health is valid and reliable. Information in medical records on topics assessed in the National Survey of Children's Health (NSCH) (e.g., functioning, missed school, etc.)—information in medical charts, electronic medical records (EMRs)—is very often parent-reported information (though not using standardized provider administered questions, whereas the NSCH items are standardized across all children so variations can be trusted). Numerous studies have shown that parental report of symptoms, family history, previous medical history, and allergies to medication is often more accurate than either nurses or physicians. 1. Porter SC, Forbes P, Manzi S, et al., Patients providing the answers: narrowing the gap in data quality for emergency care. *Qual Saf Health Care*, 2010 May 27.[Epub ahead of print]. 2. Bourgeois FT, Porter SC, Valim C, et al.,The value of patient self-report for disease

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				surveillance. *J Am Med Inform Assoc*, 2007;14(6):765-771. 3. Porter SC, Kohane IS, Goldmann DA. Parents as partners in obtaining the medication history, *J Am Med Inform Assoc*,;12(3):299-305. 4. Porter SC. Patients as experts: a collaborative performance support system. *Proc AMIA Symp*, 2001:548-552. 5. Porter SC, Silvia MT, Fleisher GR, et al., Parents as direct contributors to the medical record: validation of their electronic input, *Ann Emerg Med*, 2000;35(4):346-352. 6. Porter SC, Mandl KD. Data quality and the electronic medical record: a role for direct parental data entry, *Proc AMIA Symp*, 1999:354-358.
P	Anne Sheetz, Massachusetts Department of Public Health	OT3-041-10	Again, school safety and bullying prevention/intervention are within the school's purview---and the school nurse is the person in whom students confide as she is "safe" and does not give grades--and peers do not question a visit to the school nurse whereas they may to the guidance counselor. Health education, a strong (and implemented) school policy against bullying, a school emergency plan and the tracking of intentional injuries in the health office are tools for addressing school climate. Community providers need to be knowledgeable about these areas in their local schools in order to address them in their practice.	The Committee discussed bullying as a safety concern. Measure Developer response: We agree that there are other elements of concern in school safety. The purpose of this population-based measure is to assess how parental feelings about school safety correlate with other children's health issues. Proximity of emergency services, disaster plans etc. would not be reliably captured in a population-based, parent-report survey.
P	Martha Bergren, National Association of School Nurses	OT3-041-10	Safety must be clearly defined and include school health services and who is providing those services. Safety extends beyond violence. Elements to consider are the physical facility of the school, teacher to student and nurse to student ratios, security practices, proximity of emergency services to the school, disaster plan, playground equipment and supervision.	Measure Developer response: We agree that there are other elements of concern in school safety. The purpose of this population-based measure is to assess how parental feelings about school safety correlate with other children's health issues. Proximity of emergency services, disaster plans etc. would not be reliably captured in a population-based, parent-report survey.
M/Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	OT3-041-10	This measure is somewhat subjective.	Measure Developer response: Parental report of children's health is valid and reliable. Information in medical records on topics assessed in the National Survey of Children Health (NSCH) (e.g., functioning, missed school, etc.)—information in medical charts, electronic medical records (EMRs)—is very often parent-reported information (though not using standardized provider administered questions, whereas the NSCH items are standardized across all children so variations can be trusted). Numerous studies

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				have shown that parental report of symptoms, family history, previous medical history, and allergies to medication is often more accurate than either nurses or physicians. 1. Porter SC, Forbes P, Manzi S, et al., Patients providing the answers: narrowing the gap in data quality for emergency care. *Qual Saf Health Care*, 2010 May 27.[Epub ahead of print]. 2. Bourgeois FT, Porter SC, Valim C, et al.,The value of patient self-report for disease surveillance. *J Am Med Inform Assoc*, 2007;14(6):765-771. 3. Porter SC, Kohane IS, Goldmann DA. Parents as partners in obtaining the medication history, *J Am Med Inform Assoc*,;12(3):299-305. 4. Porter SC. Patients as experts: a collaborative performance support system. *Proc AMIA Symp*, 2001:548-552. 5. Porter SC, Silvia MT, Fleisher GR, et al., Parents as direct contributors to the medical record: validation of their electronic input, *Ann Emerg Med*, 2000;35(4):346-352. 6. Porter SC, Mandl KD. Data quality and the electronic medical record: a role for direct parental data entry, *Proc AMIA Symp*, 1999:354-358.
M/Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	OT3-041-10	The American Nurses Association (ANA) respectfully offers the following specific comments on behalf of the National Association of School Nurses (NASN), an Organizational Affiliate of ANA: •OT3-041-10: Children who attend schools perceived as safe ~ Safety must be clearly defined. Safety extends beyond bullying, violence and school climate. The goal is to "measure what makes a difference". That should include "access to health care in school", access to a school nurse. Does the mother feel the child is safe at school? Other elements to consider are the physical facility of the school, teacher to student and nurse to student ratios, security practices, proximity of emergency services to the school, disaster plan, playground equipment and supervision, crossing guards for assistance to students walking to school, the existence and condition of sidewalks, street lighting, speed control on streets around schools, bicycle lanes, and the presence of school resource officers.	Measure Developer response: We agree that there are other elements of concern in school safety. The purpose of this population-based measure is to assess how parental feelings about school safety correlate with other children's health issues. Proximity of emergency services, disaster plans, etc. would not be reliably captured in a population-based, parent-report survey.
P	Kelly Kelleher, Nationwide	OT3-043-10	The PSC addresses the most common chronic conditions in childhood-behavioral and emotional morbidities. In our experience across many primary	Measure Developer response: We agree.

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	Children's Hospital		care practices, the PSC has a high degree of acceptability to practices and patients, is feasible in diverse settings and allows for monitoring of patient symptoms efficiently.	
P	Laurie Flynn, TeenScreen National Center for Mental Health Checkups at Columbia University	OT3-043-10	The Pediatric Symptom Checklist (PSC) is well-validated and widely used to screen youth for mental health disorders in primary care settings. Multiple state Medicaid programs endorse the use of the PSC to screen for developmental and mental health disorders, and the TeenScreen National Center has worked successfully with health plans, hospitals, community health centers, group practices and individual clinicians to introduce the use of the PSC as a regular component of care. Consistent administration of the PSC over time can be used to assess changes in functioning, and this measure would address a gap in current quality measures to assess pediatric mental health outcomes.	The Committee agreed and recommended the measure. Measure Developer response: We agree and think it is important to highlight the comment's report of the widespread use and acceptance of the pediatric symptom checklist (PSC) as a screen and its potential to fill the current gap in mental health measures that can assess outcomes.
P	Martha Bergren, National Association of School Nurses	OT3-043-10	This essential measure encourages early identification of potential psychosocial dysfunction and allows for early intervention. School nurses could and should be included in mental health assessments.	Measure Developer response: We agree.
M/Health Professional Council	Nancy H. Nielsen, MD, PhD, American Medical Association	OT3-043-10	While this measure addresses am important area of pediatric care, we cannot support it as an accountability measure at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians (including the efforts of other health care professionals) that could affect the care of those patients who would be impacted by this measure. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the outcome is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, these types of measures are best represented at "higher" levels of measurement/analysis. Reporting of these outcomes at higher levels of analysis does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that NQF, in consultation with the measure developer, replace "Can be measured at all levels" with "non-clinician" levels for the Level of Measurement/Analysis for proposed measures OT3-027-10, OT3-028-10, OT3-029-10 and OT3-047-10. We recommend removing "Clinician" as a Level of Measurement/Analysis for proposed measures OT3-031-10 and OT3-043-10. We appreciate the opportunity to comment on this report.	Measure Developer response: This comment points out the differences in **"Level of measurement/analysis"** that NQF may specify in its recommendations in section 2a.32.35, noting that the pediatric symptom checklist (PSC) may be more appropriately specified at the "group," "program," "regional," or "national" level than at the "individual" clinician level. As the comment notes, such a distinction would not take away the value of the outcome for individual clinicians. We agree with the comment to the extent that we would not want to hold the individual clinician accountable for improving a specific child's pediatric symptom checklist (PSC) score as this might be beyond their control because of the nature of the mental illness or because it was secondary to family factors. However we would feel it appropriate to hold the clinician accountable as a process measure for completing the screening on an annual basis and then taking some action with those with positive screening scores, including tracking and critically reviewing treatment planning. We would expect many scores to improve, but agree that on an individual patient and physician level, direct accountability for improving every score is not appropriate. An analogy to the current use of body mass index (BMI) data on an individual clinician basis comes to mind: collecting the data on height and weight and recommending treatment for patients who are obese--but not holding clinicians responsible if the

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				obesity does not change--is now the standard of care and we argue that similar strategies should be employed for psychosocial problems. As we will argue later in response to comment #93 (Keller) it is only if we have the data on a standardized measure that we can begin to examine the impact that individual clinician action can have on psychosocial functioni+G12ng scores. The one large naturalistic longitudinal study we have suggests that pediatric symptom checklist (PSC) positive children who are referred by their pediatricians show significantly lower PSC scores the next year than do PSC positive children who are not referred. The large datasets have already been collected in pediatrics in Massachusetts and in schools in Chile should allow us to assess the impact of individual clinician factors in greater detail. NQF staff note: Measure Developers have been asked to change the submission form to reflect the appropriate level of analysis.
M/Purchaser Council	Gaye Fortner, HC21	OT3-043-10	This is an important quality measure. I support this measure.	Thank you for your comment.
M/QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement®	OT3-043-10	While this measure addresses an important area of pediatric care, we cannot support it as an accountability measure at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians (including the efforts of other health care professionals) that could affect the care of those patients who would be impacted by this measure. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the outcome is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, these types of measures are best represented at "higher" levels of measurement/analysis. Reporting of these outcomes at high levels of analysis does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that NQF, in consultation with the measure developer, replace "Can be measured at all levels" with "non-clinician" levels for the Level of Measurement/Analysis for proposed measures OT3-027-10, OT3-028-10, OT3-029-10 and OT3-046-10. We recommend removing "Clinician" as a Level of Measurement/Analysis for proposed measures OT3-031-10 and OT3-043-10.	See response to comment #66, Nancy Nielsen, American Medical Association (AMA)
M/Consumer Council	Debra Ness, National Partnership for Women & Families	OT3-043-10	This checklist consists of a group of 35 questions asked of the parent of a child between 4 and l6 years of age. While it was originally developed as a screening tool for psychosocial problems in children, it evolved into a “pre/post” measure	Measure Developer response: This comment highlights the usefulness of the pediatric symptom checklist (PSC) for both process and outcomes

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			and therefore meets the test of an outcomes measure for this project. In light of the known incidence of undetected psychosocial problems in children and adolescents, and the serious consequences if the problems remain unaddressed, this is an important quality measure. We are particularly pleased to note that it is also available in a "youth self-report" version, as parents often are not the best reporters of the emotional health of adolescents. We strongly support endorsement of this measure.	measurement. For process measurement, the PSC fulfills the Healthy People 2010 mandate (18-6) that primary care physicians screen for mental health problems and the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program mandate that all well children visits covered by Medicaid include screening for mental health problems. As the comment notes, used as a repeated measure over time, the PSC score becomes a pre/post indicator of outcome, with scores either improving, staying the same, or worsening longitudinally. When assessing older children, the use of the youth self report version of the PSC makes it possible to incorporate the youth's perspective.
M/Purchaser Council	Christine Chen, Pacific Business Group on Health	OT3-043-10	We applaud the steering committee for recommending this measure. The measure critically captures a child's change in psychosocial functioning, it also is also helpfully available in a "youth self-report" version, as parents frequently may not be the best reporters of the emotional health of adolescents. This measure will help to improve detection and treatment of psychosocial problems in children and adolescents, and ultimately enhance their quality of life.	Measure Developer response: We agree. We believe that the strongly positive tone of this and other comments by clinicians endorsing the value and feasibility of the pediatric symptom checklist (PSC) as a screening measure to improve detection and hopefully access to care as well point to one of the PSC's greatest strengths as an outcome measure: its widespread acceptability and use. Having already demonstrated buy in like this from providers we should be able to move to the next level of data collection and research in real world settings. The hope is that with NQF endorsement and the use of the PSC on even larger scales we should be able to address questions of the natural course of various symptoms and symptom clusters and begin to compare the effectiveness of various management approaches.
P	David Keller, HHS/ASPE	OT3-043-10	The Pediatric Symptom Checklist was developed and validated as a non-specific screening test for psychosocial problems in children. It is clearly justified as a screener; as a pediatrician in Massachusetts, it has been very useful in clinical practice. The justification provided with the report repeatedly conflates the validation as a screener with the occassional use by a few researchers as an outcome measure. These are two are separate questions, and much more work should be done before allowing the widespread use of this screener as an outcome measure. The Massachusetts Statewide data showing a decrease in the rate of positive screens over time should be looked at carefully before conclusions are drawn. Massachusetts allows the use of 9 screening tests and requires their use at all EPSDT visits. Over time, the majority of those screens will be conducted in children under the age of two, using something besides the PSC, which is not used in that age range. It is likely that the "early adopters" of	Measure Developer response: This comment underscores the usefulness of the pediatric symptom checklist (PSC) as a routine screener in pediatrics while also pointing out the more limited evidence base for its use as a traditional outcome measure. Although the evidence for the validity of the PSC as an outcome measure is limited it is not insubstantial. There have been five published studies of the use of the PSC over time and all of them have reported significant improvements in PSC scores for children who were referred and/or treated. One of these studies was an randomized controlled trial (RCT) showing improved PSC

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			the routine screening in the Medicaid system were the CHCs- as screening spreads to the wider population, it is possible that we are including some populations at lower risk in the screening. 2 versions of the PSC are used in Massachusetts- the PSC for parents in children under the age of 13 and the PSC-Y for teenagers. Care must be used in merging those two sources of data, as the adolescent self report is often quite different that the parent report on the same child.	scores after a school based mental health intervention and one involved a relatively large (N=1000+) naturalistic study in outpatient pediatrics and showed that PSC positive children who were referred by their pediatricians showed significantly larger improvements in functioning than did PSC positive patients who were not referred. Due to the relatively small number of studies, however, NQF may decide to provide only a time limited endorsement of the PSC as an outcome measure and/or recommend its use at the "Group" or higher level of analysis. This would provide the time needed to do the work suggested in the comment. With both national (Chile) and statewide (Massachusetts) data collections currently underway and/or completed over the past few years and some of these within the electronic data systems of large pediatric groups, it should be possible to model the use of the PSC as an outcome measure under real world conditions in relatively large samples. The fact that the rate of positive psychosocial screens in Massachusetts has declined--whether due to early adopter phenomena or to actually improved functioning--could not be investigated at all without the widespread use of a standardized measure like the PSC. With no other instrument proposed for identifying and tracking psychosocial outcomes in school aged children at this time, the alternative to the time limited endorsement of the PSC by NQF is to leave this very important area of child health out of the measurement equation, a decision which carries its own negative consequences. The comment about the difference between the parent and youth report versions of the PSC is well taken since the two forms will identify somewhat different groups of children as being at risk. This is usually resolved by administering only the PSC-Y or the parent PSC and then noting which version of the form will be the focus of attention.
	Maureen Corry, Childbirth Connection	OT3-043-10	We support this measure which comprises a group of 35 questions asked of the parent of a child between 4 and 16 years of age. It meets the test of an outcome measure for this project and is an important quality measure to detect the incidence of undetected psychosocial problems in children and adolescents.	Thank you for your comment.
M/Health Professional	Rita Munley Gallagher, PhD, RN,	OT3-043-10	The American Nurses Association (ANA) respectfully offers the following specific comments on behalf of the National Association of School Nurses	All providers may use the pediatric symptom checklist (PSC).

Member Council/ Public	Organization Contact	Topic	Comment	Response
Council	American Nurses Association		(NASN), an Organizational Affiliate of ANA: •OT3-043-10: Pediatric Symptom Checklist (PSC) ~ The Pediatric Symptom Checklist encourages early identification of potential psychosocial dysfunction and allows early intervention. School nurses should be included in this assessment.	
M/Health Professional Council	Andrea Kline, National Association of Pediatric Nurse Practitioners (NAPNAP)	OT3-043-10	Innovative way to capture unidentified pediatric issues/problems	Thank you for your comment.
M/QMRI Council	Robert Plovnick, American Psychiatric Institute for Research and Education	OT3-043-10	The need for screening is clear, and the argument for a screening process measure involving the PSC may be strong. However, the application of a screening instrument as an outcome measure when it has not been rigorously validated as such is concerning. Evidence (or the lack of evidence) should be carefully considered before the instrument is endorsed in this capacity. Further, individual patient outcomes are likely to be dependent on the actions of multiple clinicians, patients and families, and system of care characteristics, not solely on the actions of individual clinicians. The endorsement of this measure at the individual clinician level of analysis should be reconsidered.	Measure Developer response: This comment acknowledges the usefulness of the pediatric symptom checklist (PSC) as a routine screener in pediatrics while also pointing out the more limited evidence base for its use as a traditional outcome measure. As noted above in response to comment #93, the evidence for the use of the PSC as an outcome measure is smaller but not insubstantial, with one randomized control trial (RCT), one large naturalistic study, and three other intervention studies. But it is because the evidence base is smaller that NQF may recommend only a time limited endorsement of the PSC as an outcome measure. With several papers in submission or preparation that further demonstrate positive findings, more of the data needed for this kind of evaluation should be available soon. As noted in the comments on the PSC by Laurie Flynn of the National Teen Screen project, the youth version of the PSC is already widely used as one of the measures for the U.S Preventive Services Task Force (USPSTF) recommendation for routine screening of adolescents for depression in pediatrics despite similar limitations in the evidence base for positive outcomes. Given the likely increasing adoption of the medical home model and the importance of psychosocial concerns in pediatric practice, having no instrument even provisionally approved seems counterproductive. The PSC with its focus on daily functioning rather than the complexities of psychiatric diagnoses (which, like other medical diagnoses do not directly communicate severity) is a place to start in what will likely be a decade long development process.
P	Anne Sheetz,	OT3-044-10	Schools are the safetynet and through such procedures as the registration of	Measure Developer response: We appreciate the

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	Massachusetts Department of Public Health		students, emergency cards from parents, etc. should identify and refer all children needing health insurance. Again this is why a fulltime nurse is needed in every school. Several years ago in MA we gave school nurses the authority to give presumptive eligibility for the Children's Medical Security primary care insurance plan (45 days coverage) to ill children being seen by the school nurses. During those 45 days the family was assessed to determine whether they met the health insurance criteria. This worked exceedingly well in finding the children---but it went $6 million over the budget and was discontinued.	role of school nurses and other nurse professionals in the health care quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.
P	Martha Bergren, National Association of School Nurses	OT3-044-10	School nurses assisting families in getting insurance coverage and in establishing medical homes and accessing services at that medical home. Accessing a medical home appropriately is a key to child health and that parents who access the medical home for their children are modeling good health behavior for their children.	Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the health care quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.
M/Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	OT3-044-10	This measure is somewhat subjective.	Measure Developer response: Parental report of children's health is valid and reliable. Information in medical records on topics assessed in the National Survey of Children's Health (NSCH) (e.g., functioning, missed school, etc.)—information in medical charts, electronic medical records (EMRs)—is very often parent-reported information (though not using standardized provider administered questions, whereas the NSCH items are standardized across all children so variations can be trusted). Numerous studies have shown that parental report of symptoms, family history, previous medical history, and allergies to medication is often more accurate than either nurses or physicians. 1. Porter SC, Forbes P, Manzi S, et al., Patients providing the answers: narrowing the gap in

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				data quality for emergency care. *Qual Saf Health Care*, 2010 May 27.[Epub ahead of print]. 2. Bourgeois FT, Porter SC, Valim C, et al.,The value of patient self-report for disease surveillance. *J Am Med Inform Assoc*, 2007;14(6):765-771. 3. Porter SC, Kohane IS, Goldmann DA. Parents as partners in obtaining the medication history, *J Am Med Inform Assoc*,;12(3):299-305. 4. Porter SC. Patients as experts: a collaborative performance support system. *Proc AMIA Symp*, 2001:548-552. 5. Porter SC, Silvia MT, Fleisher GR, et al., Parents as direct contributors to the medical record: validation of their electronic input, *Ann Emerg Med*, 2000;35(4):346-352. 6. Porter SC, Mandl KD. Data quality and the electronic medical record: a role for direct parental data entry, *Proc AMIA Symp*, 1999:354-358.
P	Anne Sheetz, Massachusetts Department of Public Health	OT3-045-10	Every child clearly needs a medical home--again a quality indicator is that all children are assessed for a medical home at the beginning of the school year and referred/linked if needed--this is within the school nurse's purview. School nurses know the medical resources within their communities.	Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the health care quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.
P	Martha Bergren, National Association of School Nurses	OT3-045-10	School nurses assisting families in getting insurance coverage and in establishing medical homes and accessing services at that medical home. Accessing a medical home appropriately is a key to child health and that parents who access the medical home for their children are modeling good health behavior for their children.	Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the health care quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives

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				and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.
M/Purchaser Council	Gaye Fortner, HC21	OT3-045-10	I believe this type of measure is directionally important and reflects the growing attention being paid to this model. However, the definition of "patient centered medical home" used by this survey does not match up with the definitions being used by the states, several of whom have already passed legislation or implemented regulations detailing a specific definition for use in its publicly funded programs. Other states actively incorporating this model are using the standards incorporated in the NCQA PCC-PCMH recognition tool. Thus, for most states, using this composite measure would not be a feasible method of identifying practice or clinics that qualify to participate in the state's PCMH incentive program. For these reasons, I do not support endorsement of this measure at this time.	The Steering Committee discussed this comment in detail and noted that this measure is a true outcome measure - the parent's perception of characteristics of the medical home - compared to the National Committee for Quality Assurance (NCQA) structural measure. The Committee also believes this measure is more relevant to pediatrics. Also, this is a population-based measure similar to others recommended in this report rather than a provider-level accountability measure. Measure Developer response: The National Committee for Quality Assurance (NCQA) Physician Practice Connections ® Patient-Centered Medical Home™ (PCC®-PCMH™) model of measuring medical home is an important measure of medical home currently being implemented by a variety of states. There are several concerns we have with the PCC®-PCMH™: 1) it is a structural measure of whether a practice/provider/plan offer something called a medical home; 2) There is no assessment built into the PCC®-PCMH™ which looks at the patient experience of a medical home. Therefore, you could potentially have a practice which has met all of the structural elements outlined in the PCC®-PCMH™ for a medical home, but where patients do not feel they are receiving high quality care.which is the goal of the medical home. The PCC®-PCMH™ offers the necessary prerequisites within which care should be delivered, but does not express patient experience; 3) The PCC®-PCMH™ medical home model was developed for adult care and does not fully account for pediatric and specialty care for children and their unique health experiences; 4) The medical home model offered through the National Survey of Children's Health (NSCH) is modeled after the American Academy of Pediatrics (AAP) definition of a medical home. It specifically operationalizes key components of care which meet the definition of

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				desirable criteria for a medical home for children; 5) We submitted extensive comments to National Committee for Quality Assurance (NCQA) during their recent public comment period about the lack of alignment between the PCC®-PCMH™ and children's health and the AAP definition of medical home. We believe the PCC®-PCMH™ model would be strengthened by adopting standardized patient-centered and patient-reported modules, which are specifically anchored to a definition of medical home like the AAP; 6) Population-based health measures are collected through random sampling which allow standardized comparison across and between states. The fact that states have adopted and modified NCQA standards means that states will not be able to compare data. Population-based health measures serve to enhance our understanding of children's health across a broad range of health issues.
M/Consumer Council	Debra Ness, National Partnership for Women & Families	OT3-045-10	This composite measure is a cluster of more than 20 questions drawn from the periodic National Survey of Children's Health conducted by the National Center for Health Statistics, and is meant to provide – at both the state and national levels – the percentage of parents who reported their child received care from a "medical home." The definition of medical home is based on the American Academy of Pediatrics recommended guidelines for care. It has not been revised to be consistent with the joint principles for a patient-centered medical home adopted by AAP, ACP, AOA, and AAFP in 2008. With the passage of the Affordable Care Act and its language on including the medical home as a payment reform pilot model, the national interest in adopting a medical home model as a means of moving to a more patient-centered health care system continues to grow. We do believe this type of measure is directionally important and reflects the growing attention being paid to this model.	The Steering Committee discussed this comment in detail and noted that this measure is a true outcome measure - the parent's perception of characteristics of the medical home - compared to the National Committee for Quality Assurance (NCQA) structural measure. The Committee also believes this measures is more relevant to pediatrics. Also, this is a population-based measure similar to others recommended in this report rather than a provider-level accountability measure. Measure developer response: The NCQA Physician Practice Connections ® Patient-Centered Medical Home™ (PCC®-PCMH™) model of measuring medical home is an important measure of medical home currently being implemented by a variety of states. There are several concerns we have with the PCC®-PCMH™: 1) it is a structural measure of whether a practice/provider/plan offer something called a medical home; 2) There is no assessment built into the PCC®-PCMH™ which looks at the patient experience of a medical home. Therefore, you could potentially have a practice which has met all of the structural elements outlined in the PCC®-PCMH™ for a medical home, but where patients do not feel they are receiving high quality

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M/Consumer Council	Debra Ness, National Partnership for Women & Families	OT3-045-10	However, the definition of "patient centered medical home" used by this survey does not match up with the definitions being used by the states, several of whom have already passed legislation or implemented regulations detailing a specific definition for use in its publicly funded programs. Other states actively incorporating this model are using the standards incorporated in the NCQA PCC-PCMH recognition tool. (A major revision of the NCQA standards is in process and will be published late this year.) We understand that these PCMH standards are more comprehensive than what is asked for in this survey; most existing PCMH criteria assume the practice or clinic will have some threshold level of electronic health information record-keeping and/or exchange capacity; the survey does not address these or many other important elements. Thus, for most states, using this composite measure would not be a feasible method of identifying practice or clinics that qualify to participate in the state's PCMH incentive program. For these reasons, we do not support endorsement of this	The Steering Committee discussed this comment in detail and noted that this measure is a true outcome measure - the parent's perception of characteristics of the medical home - compared to the National Committee for Quality Assurance (NCQA) structural measure. The Committee also believes this measure is more relevant to pediatrics. Also, this is a population-based measure similar to others recommended in this report rather than a provider-level accountability measure. Measure developer response: The NCQA Physician Practice Connections ® Patient-Centered Medical Home™ (PCC®-PCMH™) model of measuring medical home is an important

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			measure at this time.	measure of medical home currently being implemented by a variety of states. There are several concerns we have with the PCC®-PCMH™ : 1) it is a structural measure of whether a practice/provider/plan offer something called a medical home; 2) There is no assessment built into the PCC®-PCMH™ which looks at the patient experience of a medical home. Therefore, you could potentially have a practice which has met all of the structural elements outlined in the PCC®-PCMH™ for a medical home, but where patients do not feel they are receiving high quality care...which is the goal of the medical home. The PCC®-PCMH™ offers the necessary prerequisites within which care should be delivered, but does not express patient experience; 3) The PCC®-PCMH™ medical home model was developed for adult care and does not fully account for pediatric and specialty care for children and their unique health experiences; 4) The medical home model offered through the National Survey of Children's Health (NSCH) is modeled after the American Academy of Pediatrics (AAP) definition of a medical home. It specifically operationalizes key components of care which meet the definition of desirable criteria for a medical home for children; 5) We submitted extensive comments to NCQA during their recent public comment period about the lack of alignment between the PCC®-PCMH™ and children's health and the AAP definition of medical home. We believe the PCC-PCMH™ model would be strengthened by adopting standardized patient-centered and patient-reported modules, which are specifically anchored to a definition of medical home like the AAP; 6) Population-based health measures are collected through random sampling which allow standardized comparison across and between states. The fact that states have adopted and modified National Committee for Quality Assurance (NCQA) standards means that states will not be able to compare data. Population-based health measures serve to enhance our understanding of children's health across a broad range of health issues.
M/Purchaser	Christine Chen,	OT3-045-10	We do not support endorsement of this measure at this time. The measure is	The Steering Committee discussed this comment

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Council	Pacific Business Group on Health		based on the American Academy of Pediatrics' (AAP) definition of medical home and it has not been revised to be consistent with joint principles for a patient-centered medical home adopted by AAP, ACP, AOA, and AAFP in 2008 nor does it align with standards being used by states. For example, several states are using standards from NCQA's Physician Practice Connections Patient-Centered Medical Home (PPC-PCMH) recognition tool (which is undergoing major revisions for 2011 and will be published late this year). It is our understanding that the PPC-PCMH standards will be more comprehensive than those reflected in the recommended measure. We nonetheless appreciate the steering committee's recognition of the increasingly important role that medical homes will be playing in improving patient care.	in detail and noted that this measure is a true outcome measure - the parent's perception of characteristics of the medical home - compared to the National Committee for Quality Assurance (NCQA) structural measure. The Committee also believes this measure is more relevant to pediatrics. Also, this is a population-based measure similar to others recommended in this report rather than a provider-level accountability measure. Measure Developer response: The NCQA Physician Practice Connections ® Patient-Centered Medical Home™ (PCC®-PCMH™) model of measuring medical home is an important measure of medical home currently being implemented by a variety of states. There are several concerns we have with the PCC®-PCMH™: 1) it is a structural measure of whether a practice/provider/plan offer something called a medical home; 2) There is no assessment built into the PCC®-PCMH™ which looks at the patient experience of a medical home. Therefore, you could potentially have a practice which has met all of the structural elements outlined in the PCC®-PCMH™ for a medical home, but where patients do not feel they are receiving high quality care...which is the goal of the medical home. The PCC®-PCMH™ offers the necessary prerequisites within which care should be delivered, but does not express patient experience; 3) The PCC®-PCMH™ medical home model was developed for adult care and does not fully account for pediatric and specialty care for children and their unique health experiences; 4) The medical home model offered through the National Survey of Children's Health (NSCH) is modeled after the American Academy of Pediatrics (AAP) definition of a medical home. It specifically operationalizes key components of care which meet the definition of desirable criteria for a medical home for children; 5) We submitted extensive comments to NCQA during their recent public comment period about the lack of alignment between the PCC®-PCMH™ and children's health and the AAP definition of medical home. We believe the PCC®-PCMH™ model would be strengthened by adopting standardized patient-centered and patient-reported

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M/Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	OT3-045-10	This measure is subjective.	Measure Developer response: Parental report of children's health is valid and reliable. Information in medical records on topics assessed in the National Survey of Children's Health (NSCH) (e.g., functioning, missed school, etc.)—information in medical charts, electronic medical records (EMRs)—is very often parent-reported information (though not using standardized provider administered questions, whereas the NSCH items are standardized across all children so variations can be trusted). Numerous studies have shown that parental report of symptoms, family history, previous medical history, and allergies to medication is often more accurate than either nurses or physicians. 1. Porter SC, Forbes P, Manzi S, et al., Patients providing the answers: narrowing the gap in data quality for emergency care. *Qual Saf Health Care*, 2010 May 27.[Epub ahead of print]. 2. Bourgeois FT, Porter SC, Valim C, et al.,The value of patient self-report for disease surveillance. *J Am Med Inform Assoc*, 2007;14(6):765-771. 3. Porter SC, Kohane IS, Goldmann DA. Parents as partners in obtaining the medication history, *J Am Med Inform Assoc*,;12(3):299-305. 4. Porter SC. Patients as experts: a collaborative performance support system. *Proc AMIA Symp*, 2001:548-552. 5. Porter SC, Silvia MT, Fleisher GR, et al., Parents as direct contributors to the medical record: validation of their electronic input, *Ann Emerg Med*, 2000;35(4):346-352.

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				6. Porter SC, Mandl KD. Data quality and the electronic medical record: a role for direct parental data entry, *Proc AMIA Symp*, 1999:354-358.
	Maureen Corry, Childbirth Connection	OT3-045-10	This composite measure is a cluster of more than 20 questions taken from the periodic National Survey of Children's Health conducted by the NCHS. It is meant to provide at the national and state levels, the percentage of parents who reported that their child recieved care from a "medical home." We do not recommend endorsement of this measure at this time because it is not aligned with the joint principles for a patient-centered medical home adopted by AAP, ACP, AOA, amnd AAFP in 2008, and the definition of "patient-centered medical home" used does not match up with definitions being used by the states. In addition NCQA is now revising its standards for a patient-centered medical home for release at the end of 2010. These standards are likely to be more comprehensive than the standards currently asked for in this measure.	The Steering Committee discussed this comment in detail and noted that this measure is a true outcome measure - the parent's perception of characteristics of the medical home - compared to the National Committee for Quality Assurance (NCQA) structural measure. The Committee also believes this measure is more relevant to pediatrics. Also, this is a population-based measure similar to others recommended in this report rather than a provider-level accountability measure. Measure Developer response: The NCQA Physician Practice Connections ® Patient-Centered Medical Home™ (PCC®-PCMH™) model of measuring medical home is an important measure of medical home currently being implemented by a variety of states. There are several concerns we have with the PCC®-PCMH™: 1) it is a structural measure of whether a practice/provider/plan offers something called a medical home; 2) There is no assessment built into the PCC®-PCMH™ which looks at the patient experience of a medical home. Therefore, you could potentially have a practice which has met all of the structural elements outlined in the PCC®-PCMH™ for a medical home, but where patients do not feel they are receiving high quality care...which is the goal of the medical home. The PCC®-PCMH™ offers the necessary prerequisites within which care should be delivered, but does not express patient experience; 3) The PCC®-PCMH™ medical home model was developed for adult care and does not fully account for pediatric and specialty care for children and their unique health experiences; 4) The medical home model offered through the National Survey of Children's Health (NSCH) is modeled after the American Academy of Pediatrics (AAP) definition of a medical home. It specifically operationalizes key components of care which meet the definition of desirable criteria for a medical home for children; 5) We submitted extensive comments to NCQA during their recent public comment period about

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				the lack of alignment between the PCC®-PCMH™ and children's health and the AAP definition of medical home. We believe the PCC®-PCMH™ model would be strengthened by adopting standardized patient-centered and patient-reported modules, which are specifically anchored to a definition of medical home like the AAP; 6) Population-based health measures are collected through random sampling which allow standardized comparison across and between states. The fact that states have adopted and modified NCQA standards means that states will not be able to compare data. Population-based health measures serve to enhance our understanding of children's health across a broad range of health issues.
M/Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	OT3-045-10	The American Nurses Association (ANA) respectfully offers the following specific comments on behalf of the National Association of School Nurses (NASN), an Organizational Affiliate of ANA: •OT3-045-10: Measure of medical home for children and adolescents~ School nurses assist families in getting insurance coverage and in establishing medical homes and accessing services at that medical home. Schools in many states account for the highest number of referrals to SCHIP program. Accessing a medical home appropriately is key to child health.	Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the health care quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.
M/Health Professional Council	Andrea Kline, National Association of Pediatric Nurse Practitioners (NAPNAP)	OT3-045-10	Medical homes are directly by pediatric health care professionals inclusive of physicians and nurse practitioners; language should be adjusted to reflect this information. Also, families/patients should have access to their health care professional 24 hours/day, 7 days per week.	Measure Developer response: We appreciate the role of school nurses and other nurse professionals in the health care quality of children. The population based measures included in the National Survey of Children's Health (NSCH) are designed to assess a broad range of health indicators, many of which are not school based, nor are they clinic based. The range of measures covers a wide variety of areas of children's lives and parents are the most valid reporters of this information. Population based health measures, collected through random sampling at the national and state level, are an important source of information of the health and well-being of the nation's children.

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M/Health Professional Council	Nancy H. Nielsen, MD, PhD, American Medical Association	OT3-046-10	While this measure addresses am important area of pediatric care, we cannot support it as an accountability measure at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians (including the efforts of other health care professionals) that could affect the care of those patients who would be impacted by this measure. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the outcome is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, these types of measures are best represented at "higher" levels of measurement/analysis. Reporting of these outcomes at higher levels of analysis does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that NQF, in consultation with the measure developer, replace "Can be measured at all levels" with "non-clinician" levels for the Level of Measurement/Analysis for proposed measures OT3-027-10, OT3-028-10, OT3-029-10 and OT3-047-10. We recommend removing "Clinician" as a Level of Measurement/Analysis for proposed measures OT3-031-10 and OT3-043-10. We appreciate the opportunity to comment on this report.	Measure Developer response: I agree to replace "Can be measured at all levels" with "non-clinician" levels for the level of measurement/analysis
M/QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement®	OT3-046-10	While this measure addresses an important area of pediatric care, we cannot support it as an accountability measure at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians (including the efforts of other health care professionals) that could affect the care of those patients who would be impacted by this measure. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the outcome is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, these types of measures are best represented at "higher" levels of measurement/analysis. Reporting of these outcomes at high levels of analysis does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that NQF, in consultation with the measure developer, replace "Can be measured at all levels" with "non-clinician" levels for the Level of Measurement/Analysis for proposed measures OT3-027-10, OT3-028-10, OT3-029-10 and OT3-046-10. We recommend removing "Clinician" as a Level of Measurement/Analysis for proposed measures OT3-031-10 and OT3-043-10.	Measure Developer response I agree to replace "can be measured at all levels" with "non-clinician" levels for the level of measurement/analysis
M/Purchaser Council	Christine Chen, Pacific Business	OT3-046-10	Patients value information on patient experience. Patients believe that knowing how other patients have rated a provider's quality of care says a lot about the	The Steering Committee stressed the importance of harmonizing with other endorsed surveys.

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	Group on Health		quality of the provider. We are therefore supportive of making patient experience surveys available to assess care in the inpatient pediatric hospital setting, as HCAHPS currently excludes children. We also agree with the steering committee about the importance of harmonizing the survey with HCAHPS.	Measure Developer response: I agree and have been working to make the survey similar Hospital Care Quality Information from the Consumer Perspective (HCAHPS).
M/Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	OT3-055-10	The American Nurses Association (ANA) respectfully offers the following specific comments on behalf of the National Association of School Nurses (NASN), an Organizational Affiliate of ANA: •OT3-055-10: Gastroenteritis admission rate (pediatric) ~ There are many implications for health education of parents on hygiene practices that impact both gastroenteritis and other communicable diseases, and consequently, school absenteeism. School density, custodial services, school hand washing supplies and facilities will affect gastroenteritis admission rates for school aged children.	Thank you for your comment.
P	Anne Sheetz, Massachusetts Department of Public Health	OT3-057-10	Asthma is the greatest cause of absenteeism in the school setting. Yet the school offers the site where management and student/parent teaching can occur, thus preventing many asthma hospitalizations. We are looking at reducing asthma visits to the school health room in MA by teaching parents and children how to avoid triggers--with remarkable outcomes. In addition, more schools have nebulizers. We need to work with providers to share asthma management information from the school setting with the prescriber--as mentioned previously, the use of hand held computers to have the student report the symptoms on a daily basis might be one tool. The technology of school health software systems has advanced so far that information is easily downloaded and shared with parent permission. School nurses can track asthma symptoms, interventions, absenteeism, asthma action plans by provider, etc. Somehow we need to develop an integrated system where all providers are working together to better manage the child's condition. This includes visits to the ER--summaries should automatically go to the PCP.	Care coordination will be emphasized the in the report.
P	Martha Bergren, National Association of School Nurses	OT3-057-10	School nurses provide the case management that prevents many child asthma exacerbations and hospital admissions. Asthma is the leading cause of missed school days for students. Emergency Department visits for asthmatic episodes may be a more appropriate measure for quality of asthma control. This is linked to coordination of care and communication to parents and other providers, such as school nurse.	Thank you for your comment.
M/Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	OT3-057-10	The American Nurses Association (ANA) respectfully offers the following specific comments on behalf of the National Association of School Nurses (NASN), an Organizational Affiliate of ANA: •OT3-057-10: Asthma admission rate (pediatric) ~ School nurses provide the case management that prevents many child asthma exacerbations and hospital admissions. Asthma is the leading cause of missed school days for students. Emergency Department visits for asthmatic episodes may be a more appropriate measure for quality of asthma control than hospitalizations. This is linked to coordination of care and communication to parents and other providers, such as	Thank you for your comment.

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			school nurse.	
M/Health Professional Council	Andrea Kline, National Association of Pediatric Nurse Practitioners (NAPNAP)	OT3-057-10	May be challenging to obtain accurate data in children 2-3 years of age as often these children have not yet been diagnosed with/carry the diagnosis of asthma (these children are often admitted with 'reactive airways disease, pneumonia, wheezing).	Measure developer response: The expert panel convened by Agency for Healthcare Research and Quality (AHRQ) to inform this measured discussed the issue of asthma diagnosis in young children and they concurred that young children may receive other diagnoses. We adopted their recommendation of 2 years and older.