

NATIONAL QUALITY FORUM

Measure Evaluation 4.1 January 2010

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The sub-criteria and most of the footnotes from the evaluation criteria are provided in Word comments and will appear if your cursor is over the highlighted area (or in the margin if your Word program is set to show revisions in balloons). Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized): Complete all **yellow highlighted** areas of the form. Evaluate the extent to which each sub-criterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: *If there is no TAP or workgroup, the SC also evaluates the sub-criteria (yellow highlighted areas).*

Steering Committee: Complete all **pink** highlighted areas of the form. Review the workgroup/TAP assessment of the sub-criterion, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met

C = Completely (unquestionably demonstrated to meet the criterion)

P = Partially (demonstrated to partially meet the criterion)

M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)

N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)

NA = Not applicable (only an option for a few sub-criteria as indicated)

(for NQF staff use) NQF Review #: OT3-038-10 NQF Project: Patient Outcomes Measures: Child Health and Mental Health (Phase III)	
MEASURE DESCRIPTIVE INFORMATION	
De.1 Measure Title: Children Who Receive Effective Care Coordination of Healthcare Services When Needed	
De.2 Brief description of measure: This is a two-part measure used to assess both care coordination services and communication among providers when needed.	
1.1-2 Type of Measure: outcome	
De.3 If included in a composite or paired with another measure, please identify composite or paired measure	
De.4 National Priority Partners Priority Area: care coordination	
De.5 IOM Quality Domain: patient-centered	
De.6 Consumer Care Need: Staying Healthy	

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	NQF Staff
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. <i>Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.</i>	A Y <input type="checkbox"/> N <input type="checkbox"/>
A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes	
A.2 Indicate if Proprietary Measure (as defined in measure steward agreement):	
A.3 Measure Steward Agreement: agreement signed and submitted	

A.4 Measure Steward Agreement attached: 2-2-2010 NQF Agreement Form for new measures-634006397869947652.pdf	
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	B Y <input type="checkbox"/> N <input type="checkbox"/>
C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ► Purpose: public reporting, quality improvement 0,0,0,	C Y <input type="checkbox"/> N <input type="checkbox"/>
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. D.1 Testing: Yes, fully developed and tested D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures? Yes	D Y <input type="checkbox"/> N <input type="checkbox"/>
(for NQF staff use) Have all conditions for consideration been met? Staff Notes to Steward (<i>if submission returned</i>):	Met Y <input type="checkbox"/> N <input type="checkbox"/>
Staff Notes to Reviewers (<i>issues or questions regarding any criteria</i>):	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. <i>Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.</i> (evaluation criteria) 1a. High Impact	Eval Ratin g
(for NQF staff use) Specific NPP goal:	
1a.1 Demonstrated High Impact Aspect of Healthcare: patient/societal consequences of poor quality 1a.2 1a.3 Summary of Evidence of High Impact: Care coordination is a critical component in a child having a medical home, which has been recognized as an objective by the U.S. Department of Health and Human Services' Healthy people 2010. Additionally, medical home is one of the 18 national performance measures established for the state Title V programs it administers. The care coordination component emphasizes a physician's role in improving the access to health care specialists as well as ensuring quality care to patients. This is essential for children with special health care needs, who require additional therapies or services, in which care coordination would emphasize communication amongst doctors and would lead to a decrease in delayed services. 1a.4 Citations for Evidence of High Impact: American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee. The medical home. Pediatrics. 2002, reaffirmed 2008; 110:184-187. U.S. Department of Health and Human Services. Healthy People 2010. Conference Edition. Washington, DC.	1a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>

<p>2000.</p> <p>U.S. Department of Health and Human Services. Healthy People 2020. http://www.healthypeople.gov/HP2020/.</p> <p>National Priorities Partnership. Convened by the National Quality Forum. http://www.nationalprioritiespartnership.org/.</p> <p>National Committee for Quality Assurance. http://www.ncqa.org/.</p> <p>Bethell, CD, Read, D. Strategy for assessing access to a medical home for CSHCN: Report to the federal Maternal and Child Health Bureau. The Child and Adolescent Health Measurement Initiative; 2002. Contract #01-MCHB-69A. Email cahmi@ohsu.edu to obtain the document.</p> <p>Homer CJ, Klatka K, Romm D, Kuhlthau K, Bloom S, Newacheck P, Van Cleave J, Perrin JM. A review of the evidence for medical home for children with special health care needs. Pediatrics. 2008; 122: e933-937. http://www.ncbi.nlm.nih.gov/pubmed/18829788</p> <p>U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The Health and Well-Being of Children: A Portrait of States and the Nation 2007. Chartbook based on data from the 2007 National Survey of Children’s Health. http://mchb.hrsa.gov/nsch07/index.html.</p> <p>U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The 2005/2006 National Survey of Children with Special Health Care Needs Chartbook. Information at http://mchb.hrsa.gov/cshcn05/.</p>	
<p>1b. Opportunity for Improvement</p> <p>1b.1 Benefits (improvements in quality) envisioned by use of this measure: Health care providers, public health professionals and population-based health analysts can all benefit from knowing whether or not children are receiving quality care. The measure of care coordination adds a benefit of comparing children across populations or demographic groups as to where quality care is not being delivered (e.g. those children who are not receiving adequate care coordination).</p> <p>1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers: Overall poor quality for the aspects of performance measured Only 68.7% of children age 0-17 who had two or more health related services (during the past 12 months) in the nation are receiving care coordination.</p> <p>1b.3 Citations for data on performance gap: Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. www.nschdata.org</p> <p>1b.4 Summary of Data on disparities by population group: Children with a lower household income (0-99% FPL; 59.9%) are less likely to receive effective care coordination, compared to children who live in a higher income household (400% FPL or more; 74.4%). Additionally, children with special health care needs are also less likely to receive the care coordination they need when compared with children generally (59% vs. 74%).</p> <p>1b.5 Citations for data on Disparities: Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. www.nschdata.org</p>	<p>1b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>1c. Outcome or Evidence to Support Measure Focus</p>	<p>1c C <input type="checkbox"/></p>

<p>1c.1 Relationship to Outcomes (<i>For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population</i>):</p> <p>1c.2-3. Type of Evidence: other (specify) Survey</p> <p>1c.4 Summary of Evidence (<i>as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome</i>): Outcomes are relevant to the target population for purposes of quality improvement. Measurement and receipt of high quality care can only be strengthened with expansion of evidence based quality indicators.</p> <p>All item included in the measure are report of patient experience with healthcare services. Care coordination is actionable by healthcare settings and personnel.</p> <p>1c.5 Rating of strength/quality of evidence (<i>also provide narrative description of the rating and by whom</i>):</p> <p>1c.6 Method for rating evidence:</p> <p>1c.7 Summary of Controversy/Contradictory Evidence:</p> <p>1c.8 Citations for Evidence (<i>other than guidelines</i>):</p> <p>1c.9 Quote the Specific guideline recommendation (<i>including guideline number and/or page number</i>):</p> <p>1c.10 Clinical Practice Guideline Citation: 1c.11 National Guideline Clearinghouse or other URL:</p> <p>1c.12 Rating of strength of recommendation (<i>also provide narrative description of the rating and by whom</i>):</p> <p>1c.13 Method for rating strength of recommendation (<i>If different from USPSTF system, also describe rating and how it relates to USPSTF</i>):</p> <p>1c.14 Rationale for using this guideline over others:</p>	<p>P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Importance to Measure and Report</i>?</p>	<p>1</p>
<p>Steering Committee: Was the threshold criterion, <i>Importance to Measure and Report</i>, met? Rationale:</p>	<p>1 Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p style="text-align: center;">2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES</p>	
<p>Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)</p>	<p>Eval Rating</p>
<p style="text-align: center;">2a. MEASURE SPECIFICATIONS</p>	
<p>S.1 Do you have a web page where current detailed measure specifications can be obtained? S.2 If yes, provide web page URL:</p> <p>2a. Precisely Specified</p>	<p>2a- specs C <input type="checkbox"/> P <input type="checkbox"/></p>

2a.1 Numerator Statement (*Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome*):

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N

(a) Children who needed care coordination help but did NOT receive all that they needed. (b) Children who needed care coordination communication but were NOT satisfied with what they received.

2a.2 Numerator Time Window (*The time period in which cases are eligible for inclusion in the numerator*):
Encounter or point in time.

2a.3 Numerator Details (*All information required to collect/calculate the numerator, including all codes, logic, and definitions*):

For a child to be included in numerator part (a) of needing care coordination help but NOT receiving all that they needed:

- Child used at least two types of four different health care services in the past 12 months (preventive medical visit, preventive dental visit, mental health treatment or counseling, and/or medical health care specialist; K4Q20, K4Q21, K4Q22, K4Q24) AND
- Parent reports that they have felt that they could have help arranging or coordinating child's care among the different health care providers or services (K5Q21=Yes) AND
- Parent reports that they did not get as much help as they wanted with arranging or coordinating child's care (K5Q22=Never or Sometimes)

For a child to be included in numerator part (b) of needing care coordination communication but the parent NOT feeling satisfied with what they received:

- Child received treatment from a mental health professional or health care specialist in the past 12 months (K4Q22, K4Q24) AND
- Parent was not satisfied with the communication among providers (K5Q30= Somewhat satisfied, somewhat dissatisfied, or very dissatisfied) OR
- Doctors needed to communicate with child's school, early intervention program, special education program, etc (K5Q31=Yes) AND Parent was not satisfied with the communication between doctors and schools (K5Q32= Somewhat satisfied, somewhat dissatisfied, or very dissatisfied).

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

- (a) All children 0-17 years of age who needed care coordination in the past 12 months (children who visited at least two types of the following services in the past 12 months: preventive healthcare visit, preventive dental care visit, medical healthcare specialist, and/or mental health professional)
- (b) Children 0-17 years of age whose optimal care requires coordination communication among providers [e.g. those children who received mental health or specialist treatment in the past 12 months or whose care required coordination with school(s)].

2a.5 Target population gender: Female, Male

2a.6 Target population age range: Children age 0-17 years

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

Encounter or point in time data collection. This item is anchored in fixed period windows of time, to "the last 12 months or since the child was born" (for children younger than 12 months old).

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

- (a) All children 0-17 years of age who:
 - Visited at least two types of the following services in the past 12 months (preventive healthcare visit, preventive dental care visit, medical healthcare specialist, and/or mental health professional)

-Needed care coordination in the past 12 months (Either K5Q20=Yes OR K5Q20=No and K5Q21=Yes)

(b) All children 0-17 years who:

- Received treatment from a mental health professional or health care specialist in the past 12 months (K4Q22, K4Q24) OR
- Had doctors who needed to communicate with child's school, early intervention program, special education program, etc (K5Q31=Yes)

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population*):

(a) Excluded from denominator if child does not fall in target population age range of 0-17 years and/or did not receive two or more services which might require coordinating and/or parent did not report needing care coordination among services.

(b) Excluded from denominator if child does not fall in target population age range of 0-17 years and/or did not receive mental health or specialist treatment in the past 12 months and/or did not need child's providers to communicate with child's school.

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

If child is older than 17 years of age, excluded from denominator. (a) If parent does not report the child using two or more healthcare services, questions legitimately skipped. If parent does not report needing help arranging or coordinating care among services for their child, child excluded from denominator (b) If child's care did not require coordination with more than one provider, or providers and his/her school, no communication was needed and questions legitimately skipped and excluded from denominator.

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

No stratification is required.

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

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

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

2a.18-19 Type of Score: weighted score/composite/scale

2a.20 Interpretation of Score: better quality = higher score

2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps*):

To receive numerator of child receiving care coordination when needed:

-Parent reports someone helping to arrange or coordinate child's care among the different doctors and services (K5Q20=1)

-Either parent reports that they have not felt that they could have used extra help arranging or coordinating child's care among the different health care providers or services (K5Q21=0)

-Or parent reports that they have felt that they could have used extra help arranging or coordinating child's care among the different health care providers or services (K5Q21=1) AND Parent reports that they got as much help as they wanted with arranging or coordinating child's care usually (K5Q22=3)

Parent reports satisfaction with communication among doctors when needed (K5Q30=satisfied)

Parent report satisfaction with communication between doctors and others involved (e.g. school) when needed (K5Q31=yes and K5Q32=satisfied)

2a.22 Describe the method for discriminating performance (*e.g., significance testing*):

2a.23 Sampling (Survey) Methodology *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):*

Best guideline to follow is the survey methodology used in the 2007 National Survey of Children's Health.

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

To achieve these goals, state samples were designed to obtain a minimum of 1,700 completed interviews. The number of children to be selected in each National Immunization Survey (NIS) estimation area was determined by allocating the total of 1,700 children in the state to each National Immunization Survey (NIS) estimation area within the state in proportion to the total estimated number of households with children in the NIS estimation area. Given this allocation, the number of households that needed to be screened in each NIS estimation area was calculated using the expected proportion of households with children under 18 years of age in the area. Then, the number of telephone numbers that needed to be called was computed using the expected working residential number rate, adjusted for expected nonresponse.

A total of 91,642 interviews were completed from April 2007 to July 2008 for the 2007 National Survey of Children's Health. A random-digit-dialed sample of households with children less than 18 years of age was selected from each of the 50 states and the District of Columbia. One child was randomly selected from all children in each identified household to be the subject of the survey. The respondent was a parent or guardian who knew about the child's health and health care.

- 2a.24 Data Source** (*Check the source(s) for which the measure is specified and tested*)
 Survey: Patient
- 2a.25 Data source/data collection instrument** (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*):
 2007 National Survey of Children's Health
- 2a.26-28 Data source/data collection instrument reference web page URL or attachment:** [URL ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slait/nsch07/1a_Survey_Instrument_English/NSCH_Questionnaire_052109.pdf](ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slait/nsch07/1a_Survey_Instrument_English/NSCH_Questionnaire_052109.pdf)
- 2a.29-31 Data dictionary/code table web page URL or attachment:** [URL http://nschdata.org/Viewdocument.aspx?item=519](http://nschdata.org/Viewdocument.aspx?item=519)
- 2a.32-35 Level of Measurement/Analysis** (*Check the level(s) for which the measure is specified and tested*)
 Population: states, Population: national, Population: regional/network
- 2a.36-37 Care Settings** (*Check the setting(s) for which the measure is specified and tested*)
 Other (specify) Survey was conducted over a telephone
- 2a.38-41 Clinical Services** (*Healthcare services being measured, check all that apply*)
 Other Patient experience

TESTING/ANALYSIS

- 2b. Reliability testing**
- 2b.1 Data/sample** (*description of data/sample and size*): Qualitative testing of the entire 2007 National Survey of Children's Health was conducted by the National Center for Health Statistics. They conducted cognitive interviews with the 2007 NSCH Computer-Assisted Telephone Interview (CATI) to make sure the entire survey instrument was functioning properly. N=640 interviews were completed over 3 days in December 2006. The questionnaire was then revised and finalized based on feedback from participants in these interviews.
- 2b.2 Analytic Method** (*type of reliability & rationale, method for testing*):
 Cognitive testing was conducted to test reliability and interpretability of questions across population.
- 2b.3 Testing Results** (*reliability statistics, assessment of adequacy in the context of norms for the test*)

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<p><i>conducted</i>):</p> <p>The Maternal and Child Health Bureau leads the development of the NSCH and NS-CSHCN survey and indicators, in collaboration with the National Center for Health Statistics (NCHS) and a national technical expert panel. The expert panel includes representatives from other federal agencies, state Title V leaders, family organizations, and child health researchers, and experts in all fields related to the surveys (adolescent health, family and neighborhoods, early childhood and development etc.). Previously validated questions and scales are used when available. Extensive literature reviewing and expert reviewing of items is conducted for all aspects of the survey. Respondents' cognitive understanding of the survey questions is assessed during the pretest phase and revisions made as required. All final data components are verified by NCHS and DRC/CAHMI staff prior to public release. Face validity is conducted in comparing results with prior years of the survey and/or results from other implementations of items. No specific reliability results are available for this measure. Please contact the CAHMI if quantitative measures are needed.</p>	
<p>2c. Validity testing</p> <p>2c.1 Data/sample (<i>description of data/sample and size</i>): 640 interviews were completed over 3 days in December 2006</p> <p>2c.2 Analytic Method (<i>type of validity & rationale, method for testing</i>): Cognitive testing was conducted with parents of children ages 0-17 years (interviews conducted over the phone with residential households).</p> <p>2c.3 Testing Results (<i>statistical results, assessment of adequacy in the context of norms for the test conducted</i>):</p> <p>The Maternal and Child Health Bureau leads the development of the NSCH and NS-CSHCN survey and indicators, in collaboration with the National Center for Health Statistics (NCHS) and a national technical expert panel. The expert panel includes representatives from other federal agencies, state Title V leaders, family organizations, and child health researchers, and experts in all fields related to the surveys (adolescent health, family and neighborhoods, early childhood and development etc.). Previously validated questions and scales are used when available. Extensive literature reviewing and expert reviewing of items is conducted for all aspects of the survey. Respondents' cognitive understanding of the survey questions is assessed during the pretest phase and revisions made as required. All final data components are verified by NCHS and DRC/CAHMI staff prior to public release. Face validity is conducted in comparing results with prior years of the survey and/or results from other implementations of items.</p> <p>Interviewers reported that this question was very long and difficult for some parents to understand. In addition, many parents cut the interviewer off after the initial question and were not interested in hearing the definition of "arrange or coordinate." As a result, K5Q20 was shortened to ask "Does anyone help you arrange or coordinate [child name]'s care among the different doctors or services that he/she uses?" with an optional follow-up question of "By 'arrange or coordinate,' I mean: Is there anyone who helps you make sure that [child name] gets all the health care and services he/she needs, that health care providers share information, and that these services fit together and are paid for in a way that works for you?"</p> <p>No specific reliability results are available for this measure. Please contact the CAHMI if quantitative measures are needed.</p> <p>Please see the references section for peer-reviewed articles which have used these items. Peer-reviewed papers generally undertake their own validity testing in order to meet strict peer review standards.</p>	<p>2c</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>2d. Exclusions Justified</p> <p>(a) Children 0-17 years old who did not receive two or more services which might require coordinating and/or parent did not report needing care coordination among services were excluded from the denominator because the measure is most useful when it reports on the percent of children who needed care coordination but did not receive all that they needed</p> <p>(b) Children 0-17 years old who did not receive mental health or specialist treatment in the past 12 months and/or did not need child's providers to communicate with child's school were excluded from the denominator because the measure is most useful when it reports on the percent of children who needed care coordination communication but were not satisfied with what they received</p> <p>2d.1 Summary of Evidence supporting exclusion(s):</p> <p>(a) Among children 0-17 years who needed care coordination, 27.2% did not receive the coordination they</p>	<p>2d</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>

<p>needed. Including the children who did not need a care coordination in the denominator would make the measure less useful for its intended purpose of ascertaining the perceived difficulty in obtaining care coordination for children when needed for optimum health.</p> <p>(b) Among children 0-17 years who used required services (saw a mental health professional or health care specialist in the past year, or needed communication with schools). 30.5% were not satisfied with the coordination communication. Including the children who did not need coordination communication in the denominator would make the measure less useful for its intended purpose of ascertaining the perceived difficulty in having providers communicate with each other and schools for children’s care coordination when needed for optimum health.</p> <p>2d.2 Citations for Evidence: Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. www.nschdata.org</p> <p>2d.3 Data/sample (<i>description of data/sample and size</i>):</p> <p>2d.4 Analytic Method (<i>type analysis & rationale</i>):</p> <p>2d.5 Testing Results (<i>e.g., frequency, variability, sensitivity analyses</i>):</p>	
<p>2e. Risk Adjustment for Outcomes/ Resource Use Measures</p> <p>2e.1 Data/sample (<i>description of data/sample and size</i>):</p> <p>2e.2 Analytic Method (<i>type of risk adjustment, analysis, & rationale</i>):</p> <p>2e.3 Testing Results (<i>risk model performance metrics</i>):</p> <p>2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:</p>	<p>2e C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>2f. Identification of Meaningful Differences in Performance</p> <p>2f.1 Data/sample from Testing or Current Use (<i>description of data/sample and size</i>):</p> <p>2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance (<i>type of analysis & rationale</i>):</p> <p>2f.3 Provide Measure Scores from Testing or Current Use (<i>description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance</i>):</p>	<p>2f C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2g. Comparability of Multiple Data Sources/Methods</p> <p>2g.1 Data/sample (<i>description of data/sample and size</i>): 2005/2006 National Survey of Children with Special Health Care Needs</p> <p>2g.2 Analytic Method (<i>type of analysis & rationale</i>):</p> <p>2g.3 Testing Results (<i>e.g., correlation statistics, comparison of rankings</i>):</p>	<p>2g C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>2h. Disparities in Care</p>	<p>2h C <input type="checkbox"/></p>

<p>2h.1 If measure is stratified, provide stratified results (<i>scores by stratified categories/cohorts</i>):</p> <p>2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:</p>	<p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Scientific Acceptability of Measure Properties</i>?</p>	<p>2</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Scientific Acceptability of Measure Properties</i>, met? Rationale:</p>	<p>2</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>3. USABILITY</p>	
<p>Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)</p>	<p>Eval Ratin g</p>
<p>3a. Meaningful, Understandable, and Useful Information</p>	
<p>3a.1 Current Use: in use</p> <p>3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large) (<i>If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years</i>): U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The Health and Well-Being of Children: A Portrait of States and the Nation 2007. Chartbook based on data from the 2007 National Survey of Children’s Health.</p> <p>3a.3 If used in other programs/initiatives (<i>If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years</i>):</p> <p>Testing of Interpretability (<i>Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement</i>)</p> <p>3a.4 Data/sample (<i>description of data/sample and size</i>): Focus groups were held with numerous stakeholder groups—family advocates, clinicians, Title V leaders, researchers—to obtain feedback on report formats. The Child and Adolescent Health Measurement Initiative led the focus groups and developed reports in accordance with a general consumer information framework. Additional focus groups were held when preparing data and reports for display on the Data Resource Center website. The Data Resource Center executive committee also reviewed report formats for interpretability and applicability.</p> <p>3a.5 Methods (<i>e.g., focus group, survey, QI project</i>): Focus groups</p> <p>3a.6 Results (<i>qualitative and/or quantitative results and conclusions</i>):</p>	<p>3a</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>3b/3c. Relation to other NQF-endorsed measures</p>	
<p>3b.1 NQF # and Title of similar or related measures:</p>	
<p>(for NQF staff use) Notes on similar/related endorsed or submitted measures:</p>	
<p>3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source <u>or</u> different topic but same target population):</p>	<p>3b</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p>

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

collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:	N <input type="checkbox"/>
4e.2 Costs to implement the measure (<i>costs of data collection, fees associated with proprietary measures</i>):	
4e.3 Evidence for costs:	
4e.4 Business case documentation:	
TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Feasibility</i> ?	4
Steering Committee: Overall, to what extent was the criterion, <i>Feasibility</i> , met? Rationale:	4 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
RECOMMENDATION	
(for NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.	Time-limited <input type="checkbox"/>
Steering Committee: Do you recommend for endorsement? Comments:	Y <input type="checkbox"/> N <input type="checkbox"/> A <input type="checkbox"/>
CONTACT INFORMATION	
Co.1 Measure Steward (Intellectual Property Owner) Co.1 Organization Child and Adolescent Health Measurement Initiative on behalf of the Maternal and Child Health Bureau Oregon Health & Science University, 707 SW Gaines Street Portland Oregon 97239	
Co.2 Point of Contact Christina Bethell, Ph.D., MPH, MBA bethellc@ohsu.edu 503-494-1892	
Measure Developer If different from Measure Steward Co.3 Organization Maternal and Child Health Bureau Parklawn Building Room 18-05, 5600 Fishers Lane Rockville Maryland 20857	
Co.4 Point of Contact Christina Bethell, Ph.D., MPH, MBA bethellc@ohsu.edu 503-494-1892	
Co.5 Submitter If different from Measure Steward POC Christina Bethell, Ph.D., MPH, MBA bethellc@ohsu.edu 503-494-1892- Maternal and Child Health Bureau	
Co.6 Additional organizations that sponsored/participated in measure development The Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Dept of Health & Human Services. The National Center of Health Statistics, Centers for Disease Control and Prevention.	
ADDITIONAL INFORMATION	
Workgroup/Expert Panel involved in measure development Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.	

<p>Ad.2 If adapted, provide name of original measure:</p> <p>Ad.3-5 If adapted, provide original specifications URL or attachment</p>
<p>Measure Developer/Steward Updates and Ongoing Maintenance</p> <p>Ad.6 Year the measure was first released: 2007</p> <p>Ad.7 Month and Year of most recent revision: 2007-04</p> <p>Ad.8 What is your frequency for review/update of this measure?</p> <p>Ad.9 When is the next scheduled review/update for this measure? 2011-01</p>
<p>Ad.10 Copyright statement/disclaimers: CAHMI- The Child and Adolescent Health Measurement Initiative.</p>
<p>Ad.11 -13 Additional Information web page URL or attachment:</p>
<p>Date of Submission (<i>MM/DD/YY</i>): 04/06/2010</p>