

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 #: OT3-044-10		NQF Project: Patient Outcomes Measures: Child Health and Mental Health (Phase III)	
MEASURE DESCRIPTIVE INFORMATION			
De.1 Measure Title: Children Who Have Inadequate Insurance Coverage For Optimal Health			
De.2 Brief description of measure: The measure is designed to ascertain whether or not current insurance program coverage is adequate for the child's health needs--whether the out of pocket expenses are reasonable; whether the child is limited or not in choice of doctors; and whether the benefits meet child's healthcare needs.			
1.1-2 Type of Measure: outcome			
De.3 If included in a composite or paired with another measure, please identify composite or paired measure			
De.4 National Priority Partners Priority Area: population health			
De.5 IOM Quality Domain: equity			
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
<p>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></p> <p>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</p> <p>A.2 Indicate if Proprietary Measure (as defined in measure steward agreement):</p> <p>A.3 Measure Steward Agreement: agreement signed and submitted</p> <p>A.4 Measure Steward Agreement attached: 2-2-2010 NQF Agreement Form for new measures-634006403542880095.pdf</p>	<p>A</p> <p>Y <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>

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 (if submission returned):	Met Y <input type="checkbox"/> N <input type="checkbox"/>
Staff Notes to Reviewers (issues or questions regarding any criteria):	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. <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: Nationally, over 23% of children who have health insurance currently have inadequate insurance coverage to meet their health needs. 1a.4 Citations for Evidence of High Impact: Mental Health in the United States: Health Care and Well Being of Children With Chronic Emotional, Behavioral, or Developmental Problems—United States, 2001 CD Bethell, D Read, SJ Blumberg Differentiating subgroups of children with special health care needs by health status and complexity of health care needs. Bramlett MD, Read D, Bethell C, Blumberg SJ. Progress in Ensuring Adequate Health Insurance for Children With Special Health Care Needs Lynda E. Honberg, MHSAA, Michael D. Kogan, PhDa, Deborah Allen, ScDb, Bonnie B. Strickland, PhDa, Paul W. Newacheck, DrPHc The future of health insurance for children with special health care needs. Newacheck PW, Houtrow AJ, Romm DL, Kuhlthau KA, Bloom SR, Van Cleave JM, Perrin JM.	1a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>

<p>1b. Opportunity for Improvement</p> <p>1b.1 Benefits (improvements in quality) envisioned by use of this measure: This measure has been used to identify areas of care such as mental health which are severely impacted by insurance that does not cover specialist services. The adequacy of insurance measure also can identify children who are insured but lack the benefits and coverage to be provided with adequate health care. Therefore, rather than seeing insurance as insured or uninsured, it describes the level of coverage provided to an insured child.</p> <p>1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers: Children who have inadequate current insurance coverage ranges across states from 16% of currently insured children in Hawaii to 31% of currently insured children in Minnesota.</p> <p>There is also a performance gap among privately versus publicly insured children. Nationally, 18.6% of current publicly insured children do not have adequate coverage; 25.8% of current privately insured children do not have adequate coverage.</p> <p>1b.3 Citations for data on performance gap: Mental Health in the United States: Health Care and Well Being of Children With Chronic Emotional, Behavioral, or Developmental Problems—United States, 2001 CD Bethell, D Read, SJ Blumberg</p> <p>Differentiating subgroups of children with special health care needs by health status and complexity of health care needs. Bramlett MD, Read D, Bethell C, Blumberg SJ.</p> <p>Progress in Ensuring Adequate Health Insurance for Children With Special Health Care Needs Lynda E. Honberg, MHSAA, Michael D. Kogan, PhDa, Deborah Allen, ScDb, Bonnie B. Strickland, PhDa, Paul W. Newacheck, DrPHc</p> <p>The future of health insurance for children with special health care needs. Newacheck PW, Houtrow AJ, Romm DL, Kuhlthau KA, Bloom SR, Van Cleave JM, Perrin JM.</p> <p>1b.4 Summary of Data on disparities by population group: Nationally, 29.1% of children with special health care needs have current insurance coverage that is inadequate. 22.1% of children who have not been identified with special needs have inadequate coverage.</p> <p>1b.5 Citations for data on Disparities: Mental Health in the United States: Health Care and Well Being of Children With Chronic Emotional, Behavioral, or Developmental Problems—United States, 2001 CD Bethell, D Read, SJ Blumberg</p> <p>Differentiating subgroups of children with special health care needs by health status and complexity of health care needs. Bramlett MD, Read D, Bethell C, Blumberg SJ.</p> <p>Progress in Ensuring Adequate Health Insurance for Children With Special Health Care Needs Lynda E. Honberg, MHSAA, Michael D. Kogan, PhDa, Deborah Allen, ScDb, Bonnie B. Strickland, PhDa, Paul W. Newacheck, DrPHc</p> <p>The future of health insurance for children with special health care needs. Newacheck PW, Houtrow AJ, Romm DL, Kuhlthau KA, Bloom SR, Van Cleave JM, Perrin JM.</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.1 Relationship to Outcomes (For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population): Having health insurance</p>	<p>1c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/></p>

<p>coverage is not enough. The coverage must be adequate to meet children's healthcare needs. Having adequate coverage is important for all children, but particularly so for those living with illness or identified as having special health care needs. Without adequate coverage, missed services and treatment can delay or inhibit receipt of needed health care.</p> <p>1c.2-3. Type of Evidence: other (specify) Population based research</p> <p>1c.4 Summary of Evidence (as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome): Children whose current insurance is inadequate are less likely to be in excellent or very good health compared with those who have adequate insurance (82% vs. 87%).</p> <p>1c.5 Rating of strength/quality of evidence (also provide narrative description of the rating and by whom):</p> <p>1c.6 Method for rating evidence:</p> <p>1c.7 Summary of Controversy/Contradictory Evidence:</p> <p>1c.8 Citations for Evidence (other than guidelines):</p> <p>1c.9 Quote the Specific guideline recommendation (including guideline number and/or page number):</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 (also provide narrative description of the rating and by whom):</p> <p>1c.13 Method for rating strength of recommendation (If different from USPSTF system, also describe rating and how it relates to USPSTF):</p> <p>1c.14 Rationale for using this guideline over others:</p>	<p>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 Ratin g</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*):

Percentage of children whose current health insurance coverage is adequate for meeting child's healthcare needs

Adequate insurance is defined by these criteria: child currently has health insurance coverage AND benefits usually or always meet child's needs AND usually or always allow child to see needed providers AND either no out-of-pocket expenses or out-of pocket expenses are usually or always reasonable.

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

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

For a child to be included in the numerator of having adequate insurance coverage, criteria from the following five questions must be met:

- Child has current health insurance coverage (K3Q01)
- Insurance allows the child to see needed health care providers (K3Q22)
- Insurance coverage is sufficient to meet the child's needs (K3Q20)
- If the family pays some health care costs out of pocket (K3Q21A), these costs are reasonable (K3Q21B)

For a child to be included in the numerator of having inadequate insurance coverage, criteria from the following five questions must be met:

- Child has current health insurance coverage (K3Q01)
- Insurance coverage is not sufficient to meet the child's needs (K3Q20)
- Insurance does not allow the child to see needed health care providers (K3Q22)
- If the family pays some health care costs out of pocket (K3Q21A), these costs are not reasonable (K3Q21B)

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

Children age 0-17 years with current health insurance

2a.5 Target population gender: Female, Male

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

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

Denominator window is a fixed point in time anchored to "current". Coverage by insurance must be current as of interview time point.

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

Children age 0-17 years with current health insurance.

"Current health insurance" is defined as any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicaid.

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population*): Excluded from denominator if child does not fall in target population age range of 0-17 years and/or does not have current health insurance

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

If child is older than 17 years of age, excluded from denominator.

If child does not have current health insurance (any kind of health care coverage, including health

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insurance, prepaid plans such as HMOs, or government plans such as Medicaid), excluded from denominator.

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

No stratification is required.

When the inadequate insurance coverage for optimal health of child measure was administered in its most recent form, in the 2007 NSCH, the survey included a number of child demographic variables that allow for stratification of the findings by possible vulnerability:

- Age
- Gender
- Geographic location- State, HRSA Region, National level Rural Urban Commuter Areas (RUCA)
- Race/ethnicity
- Health insurance- type, consistency
- Primary household language
- Household income
- Special Health Care Needs- status and type

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

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

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

2a.18-19 Type of Score: rate/proportion

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

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

To receive numerator of child having adequate insurance:

- Current insurance coverage (K3Q01= Yes).
- Current insurance offers benefits or covers services that meet the child's needs (K3Q20 = Usually or K3Q20 = Always).
- Current insurance allows the child to see needed health care providers (K3Q22= Usually or K3Q22= Always).
- Family has no costs or premiums that are not covered by insurance (K3Q21A= No).
- If the family pays some health care costs out of pocket (K3Q21A= Yes), these costs are reasonable (K3Q21B= Usually or K3Q21B= Always).

To receive numerator of child having inadequate insurance:

- Current insurance coverage (K3Q01= Yes).
- Current insurance does not offer benefits or cover services that meet the child's needs (K3Q20 = Never or K3Q20 = Sometimes).
- Current insurance does not allow the child to see needed health care providers (K3Q22= Never or K3Q22= Sometimes).
- Family pays some health care costs out of pocket (K3Q21A= Yes), and these costs are not reasonable (K3Q21B= Never or K3Q21B= Sometimes).

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

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

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

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

To achieve these goals, state samples were designed to obtain a minimum of 1,700 completed interviews.

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

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

2a.24 Data Source (*Check the source(s) for which the measure is specified and tested*)
 Survey: Patient

2a.25 Data source/data collection instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*):
 2007 National Survey of Children's Health

2a.26-28 Data source/data collection instrument reference web page URL or attachment: URL
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slaits/nsch07/1a_Survey_Instrument_English/NSCH_Questionnaire_052109.pdf

2a.29-31 Data dictionary/code table web page URL or attachment: URL
<http://nschdata.org/Viewdocument.aspx?item=519>

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

TESTING/ANALYSIS

2b. Reliability testing

2b.1 Data/sample (*description of data/sample and size*): Qualitative testing of the entire 2007 National Survey of Children's Health was conducted by the National Center for Health Statistics. They conducted cognitive interviews with the 2007 NSCH Computer-Assisted Telephone Interview (CATI) to make sure the entire survey instrument was functioning properly. N=640 interviews were completed over 3 days in December 2006. The questionnaire was then revised and finalized based on feedback from participants in these interviews.

2b.2 Analytic Method (*type of reliability & rationale, method for testing*):
 Cognitive testing was conducted to test reliability and interpretability of questions across population.

2b.3 Testing Results (*reliability statistics, assessment of adequacy in the context of norms for the test conducted*):
 The Maternal and Child Health Bureau leads the development of the NSCH and NS-CSHCN survey and indicators, in collaboration with the National Center for Health Statistics (NCHS) and a national technical expert panel. The expert panel includes representatives from other federal agencies, state Title V leaders, family organizations, and child health researchers, and experts in all fields related to the surveys (adolescent health, family and neighborhoods, early childhood and development etc.). Previously validated

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<p>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>): K3Q21B was originally phrased as "Are the costs not covered by [child name]'s health insurance reasonable?" but several interviewers during the pretest noted that parents consistently had trouble figuring out how to answer this question. After asking the question, some interviewers immediately began explaining what the question meant (e.g. "The question is asking whether any out-of-pocket costs that you have to pay are unreasonable") and this was reported to help parents understand.</p> <p>The final version of K3Q21B was revised to ask "How often are these costs reasonable? Would you say: [never, sometimes, usually, always, or no out of pocket costs?]. A help screen was added in case parents seemed confused by the question.</p> <p>Face validity is conducted in comparing results with prior years of the survey and/or results from other implementations of items. 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 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2d. Exclusions Justified</p> <p>2d.1 Summary of Evidence supporting exclusion(s):</p> <p>2d.2 Citations for Evidence:</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>2d C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></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></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.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>2h C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> 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 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p style="text-align: center;">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> The Data Resource Center websites have been accessed more than 18 million times since 2006. Thousands of state and national researchers, MCH providers and analysts use the data to report valid children’s health</p>	<p>3a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>

<p>data.</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>): The Data Resource Center websites have been accessed more than 18 million times since 2006. Thousands of state and national researchers, MCH providers and analysts use the data to report valid children’s health data.</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.2 Are the measure specifications harmonized? If not, why?</p>	<p>3b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>3c. Distinctive or Additive Value</p> <p>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>
4. FEASIBILITY	
<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</p> <p>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"/></p>

	N <input type="checkbox"/>
<p>4b. Electronic Sources</p> <p>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</p> <p>4b.2 If not, specify the near-term path to achieve electronic capture by most providers.</p>	<p>4b</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>4c. Exclusions</p> <p>4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications? No</p> <p>4c.2 If yes, provide justification.</p>	<p>4c</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>4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences</p> <p>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</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>4e. Data Collection Strategy/Implementation</p> <p>4e.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: Items are well understood and easy to implement. Items yield very low levels of missing values, don't know or refused answers.</p> <p>4e.2 Costs to implement the measure (<i>costs of data collection, fees associated with proprietary measures</i>): All items are public domain. Costs of implementing survey items will vary depending on sample size, population and sampling frame.</p> <p>4e.3 Evidence for costs:</p> <p>4e.4 Business case documentation:</p>	<p>4e</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>
TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Feasibility</i>?	4
<p>Steering Committee: Overall, to what extent was the criterion, <i>Feasibility</i>, met? Rationale:</p>	<p>4</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>
RECOMMENDATION	
(for NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.	<p>Time-limited</p> <p><input type="checkbox"/></p>
<p>Steering Committee: Do you recommend for endorsement? Comments:</p>	<p>Y <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>A <input type="checkbox"/></p>

CONTACT INFORMATION
<p>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</p> <p>Co.2 Point of Contact Christina Bethell, Ph.D., MPH, MBA bethellc@ohsu.edu 503-494-1892</p>
<p>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</p> <p>Co.4 Point of Contact Christina Bethell, Ph.D., MPH, MBA bethellc@ohsu.edu 503-494-1892</p>
<p>Co.5 Submitter If different from Measure Steward POC Christina Bethell, Ph.D., MPH, MBA bethellc@ohsu.edu 503-494-1892- Child and Adolescent Health Measurement Initiative on behalf of the Maternal and Child Health Bureau</p>
<p>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.</p>
ADDITIONAL INFORMATION
<p>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>
<p>Ad.2 If adapted, provide name of original measure: Ad.3-5 If adapted, provide original specifications URL or attachment</p>
<p>Measure Developer/Steward Updates and Ongoing Maintenance Ad.6 Year the measure was first released: 2007 Ad.7 Month and Year of most recent revision: 2007-04 Ad.8 What is your frequency for review/update of this measure? Updated every 4 years when a new National Survey of Children's Health is developed Ad.9 When is the next scheduled review/update for this measure? 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 (MM/DD/YY): 04/06/2010</p>