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** #: OT3-045-10 **NQF Project:** Patient Outcomes Measures: Child Health and Mental Health (Phase III)
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Measure of Medical Home for Children and Adolescents
De.2 **Brief description of measure**: This composite measure assesses whether or not children and adolescents (age 0-17 years) receive health care within a medical home according to the survey respondent (almost always the child’s parent). The medical home measure is based on six of the seven components of care first proposed by the American Academy of Pediatrics (AAP)—health care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. (Note: "accessible" is the one component of medical home that is not directly addressed in this composite measure. This will be explained in a later section) The AAP policy statement emphasizes that a medical home is “not a building, house, or hospital, but rather an approach to providing continuous and comprehensive primary pediatric care from infancy through young adulthood, with availability 24 hours a day, 7 days a week, from a pediatrician or physician whom families trust,” and this composite measure of medical home is designed to assess the receipt of quality health care using the AAP's recommended care guidelines.
1.1-2 **Type of Measure:** patient experience 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:** patient and family engagement De.5 **IOM Quality Domain**: patient-centered De.6 **Consumer Care Need:** Staying Healthy

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	**NQF Staff**

A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.* A.1 **Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)?** Yes A.2 **Indicate if Proprietary Measure** (*as defined in measure steward agreement*): A.3 **Measure Steward Agreement:** agreement signed and submitted A.4 **Measure Steward Agreement attached:** 2-2-2010 NQF Agreement Form for new measures-634006392895448239.pdf	**A** **Y**☐ **N**☐
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	**B** **Y**☐ **N**☐
C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ▶**Purpose:** public reporting, quality improvement 0,0,0,	**C** **Y**☐ **N**☐
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. D.1**Testing:** Yes, fully developed and tested D.2 **Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?** Yes	**D** **Y**☐ **N**☐
(for NQF staff use**) Have all conditions for consideration been met?** **Staff Notes to Steward** (*if submission returned*)**:**	**Met** **Y**☐ **N**☐
Staff Notes to Reviewers (*issues or questions regarding any criteria*)**:**	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. *Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.* (evaluation criteria) **1a. High Impact**	Eval Rating
(for NQF staff use) Specific NPP goal:	
1a.1 **Demonstrated High Impact Aspect of Healthcare:** patient/societal consequences of poor quality 1a.2 1a.3 **Summary of Evidence of High Impact:** National initiatives such as the U.S. Department of Health and Human Services' Healthy People 2010 have recently begun prioritizing the need to increase children's access to health care delivered under the medical home model, especially among children with special health care needs (Measuring Medical Home for Children and Youth). Yet making medical home a top children's health priority hasn't always existed; having the public acknowledge the importance of establishing medical homes for children has been challenging. Since the AAP first outlined the medical home concept in 1992, many divergent interpretations have emerged. Many physicians have encountered difficulties with inadequate reimbursement for the care they provide to children within a medical home, even though care provided	**1a** **C**☐ **P**☐ **M**☐ **N**☐

within a medical home is found to be less costly and more effective than care provided in emergency departments, and other urgent-care facilities (American Academy of Pediatrics). The medical home model helps physicians improve the effectiveness and efficiency of health care for all children.
The composite measure of medical home helps create a standardized assessment of whether children have access to an ongoing source of health care within a medical home and are receiving the high-quality care and services they need by using the AAP’s multi-dimensional definition of medical home (Measuring Medical Home for Children and Youth). This composite of medical home questions is one of the few sets to measure medical home among children and youth (another source is the CAHPS Health Plan Survey Child Questionnaire, which was also developed by the CAHMI and is considered an earlier version of this medical home measure). Due to feasibility and methodological constraints, the AAP’s entire list of 37 desirable characteristics of a medical home is not included in this composite measure. The numerator details describe how these questions map onto the components of AAP’s larger definition of medical home.

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. 2000.

U.S. Department of Health and Human Services. Healthy People 2020. http://www.healthypeople.gov/HP2020/.

National Priorities Partnership. Convened by the National Quality Forum. http://www.nationalprioritiespartnership.org/.

National Committee for Quality Assurance. http://www.ncqa.org/.

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.

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

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.

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/.

1b. Opportunity for Improvement

1b.1 **Benefits (improvements in quality) envisioned by use of this measure:** Health care providers, public health professionals and population-based health analysts can all benefit from knowing whether or not children are receiving quality care.
Because it is a multidimensional measure, there are benefits from the overall composite and the individual components. The overall measure can used be used to describe the quality of health care receipt among children in the population. In the process of creating the overall measure, individual measures are also created, so there is an added benefit of being able to compare children across populations or demographic groups as to where quality care is not being delivered (e.g. children are not receiving family-centered care, or lack care coordination).

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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 57.5% of children age 0-17 in the nation are receiving care within a medical home.

- Variation in quality for the performance measured

The rate varies across states from 45% in Nevada to 69% in New Hampshire.

- This measure provides reliable and valid information for baseline assessments and to guide quality improvement

Data was also collected in the 2003 NSCH. Data will likely be collected again in 2011. Improvements can be tracked and improvement plans made based on collected data.

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

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. 2000.

U.S. Department of Health and Human Services. Healthy People 2020. http://www.healthypeople.gov/HP2020/.

National Priorities Partnership. Convened by the National Quality Forum. http://www.nationalprioritiespartnership.org/.

National Committee for Quality Assurance. http://www.ncqa.org/.

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.

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

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.

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/.

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

The following groups are much less likely to have a medical home: non-white, poor, publicly insured children.

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

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

1c. Outcome or Evidence to Support Measure Focus	**1c** **C☐**

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

2a.1 Numerator Statement (*Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome***):**
The Measure of Medical Home for Children Adolescents measures whether or not a child or adolescent is receiving care within a medical home--that is, care that meets all of the following criteria--child has a regular doctor or nurse AND has a usual place for well and sick care AND receives care that is family-centered AND has no problems getting referrals when needed AND receives effective care coordination when needed.

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N☐

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 target numerator of receiving care within a medical home, the following numerator criteria must be met:
• Child has at least 1 healthcare provider considered as personal doctor or nurse (K4Q04)
• Child has usual source(s) for both sick and well-child care (K4Q01, K4Q02)
• If child used at least 1 of 5 different services in the past 12 months—preventive medical care, preventive dental care, mental health treatment or counseling, saw a specialist, or needed to see a specialist (K4Q20, K4Q21, K4Q22, K4Q23, K4Q25):
  o Received family-centered, compassionate, culturally effective care from ALL child's doctors and other health care providers (K5Q40, K5Q41, K5Q42, K5Q43, K5Q44, K5Q45, K5Q46)
  o If child needed referral(s), no problems getting referral(s) (K5Q10, K5Q11)
  o If child needed care coordination (used at least 2 of 5 different services in the past 12 months from above), no problems getting effective care coordination (K5Q20, K5Q21, K5Q22, K5Q30, K5Q31, K5Q32)

2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured***):**
Main denominator: Children age 0-17 years in the U.S. (this measure has only been officially tested on children in the United States and has not been tested for potential cultural differences among other countries).

Domain-Specific denominators:
• Established relationship with a specific provider:
  o Children age 0-17 years in the U.S.
• Family-centered/Compassionate:
  o Children age 0-17 years in the U.S. who received at least 1 service from a doctor or other health care provider in the past 12 months
• Comprehensive:
  o Children age 0-17 years in the U.S.
• Coordinated:
  o K5Q31, K5Q32 : Children age 0-17 years in the U.S. who received at least 1 service from a doctor or other health care provider in the past 12 months
  o K5Q20, K5Q21, K5Q22, and K5Q30: Children age 0-17 years in the U.S. who received 2 or more services from a doctor or other health care provider in the past 12 months
• Culturally effective:
  o K5Q42: Children age 0-17 years in the U.S. who received at least 1 service from a doctor or other health care provider in the past 12 months
  o K5Q45 and K5Q46: Children age 0-17 years in the U.S. who speak a primary household language other than English or unknown

2a.5 Target population gender: Female, Male
2a.6 Target population age range: Children and adolescents 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. Several items are anchored in fixed period windows of time. Most are anchored 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***):**
Geographically defined— the sampling frame used on this measure (from the most recently tested 2007 National Survey of Children's Health) is a geographically representative sample at both the national and state levels. Other denominator sampling frames are possible, such as sub-state geographic regions or health plans.

- Children age 0 to 17 years in the U.S.

o More specific denominators such as use of services-related skips are addressed in the Denominator Details field above.

2a.9 **Denominator Exclusions (***Brief text description of exclusions from the target population***):** The minimum denominator exclusions are: if the child is not between the ages of 0 and 17 years, if the child does not have at least 1 healthcare provider considered to be a personal doctor or nurse, or if the child does not have a usual source for both sick and well-child care, or if the child has not used any health-related services in the past 12 months. More specific denominator exclusions are explained in 2a.4. and 2a.10.

2a.10 **Denominator Exclusion Details (***All information required to collect exclusions to the denominator, including all codes, logic, and definitions***):**
See 2a.4. for full description of the denominators for each component of the medical home composite measure. A case is EXCLUDED from the denominator of having a medical home if:

- Child is not between 0-17 years
- Child does not have at least 1 healthcare provider considered as personal doctor or nurse (K4Q04)OR
- Child does not have usual source(s) for both sick and well-child care (K4Q01, K4Q02) OR
- Child has not seen any health care provider in the past 12 months—preventive medical care, preventive dental care, mental health treatment or counseling, saw a specialist, or needed to see a specialist (K4Q20, K4Q21, K4Q22, K4Q23, K4Q25)

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 medical home measure was administered most recently in the 2007 National Survey of Children's Health, the survey included a number of child demographic variables that allow for stratification of the findings by vulnerable groups or groups with known health care disparities such as:
- Age
- Gender
- Geographic location- State, HRSA Region, National level Rural Urban Commuter Areas (RUCA)
- Race/ethnicity
- Health insurance- status, type, consistency, adequacy
- 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: 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***):**
For a child to be included in the target numerator of receiving care within a medical home, the following threshold criteria must be met:
• Child has at least 1 healthcare provider considered as personal doctor or nurse (K4Q04=Yes, 1 person OR K4Q04=Yes, more than 1 person) AND
• Child has usual source(s) for both sick and well-child care (K4Q01= YES or K4Q01=More than 1 place; K4Q02=any place EXCEPT hospital emergency room or location out of the USA) AND
• If child used at least 1 of 5 different services in the past 12 months—preventive medical care (K4Q20=1 or more), preventive dental care (K4Q21= 1 or more), mental health treatment or counseling (K4Q22=Yes), saw a specialist (K4Q24=Yes), or needed to see a specialist (K4Q25=Yes):
o Child received family-centered, compassionate, culturally effective care from ALL child's doctors and other health care providers (K5Q40, K5Q41, K5Q42, K5Q43, K5Q44, K5Q45, K5Q46= Usually or Always) AND
o If child needed referral(s) (K5Q10=Yes), no problems getting referral(s) (K5Q11=Not a problem) AND
o If child needed care coordination (used at least 2 of 5 different services in the past 12 months from above), no problems getting effective care coordination (K5Q20=Yes; IF K5Q21=Yes, K5Q22=Usually; K5Q30=Very satisfied; IF K5Q31=Yes, K5Q32=Very 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)*:
The following is a brief rendering of 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 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; http://www.cdc.gov/nchs/data/slaits/NSCSHCNIIEnglishQuest.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: 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 Clinical experience

TESTING/ANALYSIS

2b. Reliability testing

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

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

2b.3 **Testing Results** *(reliability statistics, assessment of adequacy in the context of norms for the test conducted)***:**
The Maternal and Child Health Bureau leads the development of the NSCH and NS-CSHCN survey and indicators, in collaboration with the National Center for Health Statistics (NCHS) and a national technical expert panel. The expert panel includes representatives from other federal agencies, state Title V leaders, family organizations, and child health researchers, and experts in all fields related to the surveys (adolescent health, family and neighborhoods, early childhood and development etc.). Previously validated questions and scales are used when available. Extensive literature reviewing and expert reviewing of items is conducted for all aspects of the survey. Respondents' cognitive understanding of the survey questions is assessed during the pretest phase and revisions made as required. All final data components are verified by NCHS and DRC/CAHMI staff prior to public release. Face validity is conducted in comparing results with prior years of the survey and/or results from other implementations of items. No specific reliability results are available for this measure. Please contact the CAHMI if quantitative measures are needed.

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2c. Validity testing

2c.1 **Data/sample** *(description of data/sample and size)***:** 640 interviews were completed over 3 days in December 2006

2c.2 **Analytic Method** *(type of validity & rationale, method for testing)***:**
Cognitive testing was conducted with parents of children ages 0-17 years (interviews conducted over the phone with residential households).

2c.3 **Testing Results** *(statistical results, assessment of adequacy in the context of norms for the test conducted)***:**
- Interviewers reported that K5Q20 was very long and difficult for parents to understand. Question shortened in final version.
- Interviewers reported that parents asked for original K5Q31 question to be repeated, suggesting that the question is difficult for parents to understand or answer. Question was revised to include age skip patterns so the parent wasn't given too many options.

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

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peer review standards.	
2d. Exclusions Justified 2d.1 **Summary of Evidence supporting exclusion(s):** 2d.2 **Citations for Evidence:** 2d.3 **Data/sample** *(description of data/sample and size)*: 2d.4 **Analytic Method** *(type analysis & rationale)*: 2d.5 **Testing Results** *(e.g., frequency, variability, sensitivity analyses)*:	**2d** **C**☐ **P**☐ **M**☐ **N**☐ **NA**☐
2e. Risk Adjustment for Outcomes/ Resource Use Measures 2e.1 **Data/sample** *(description of data/sample and size)*: 2e.2 **Analytic Method** *(type of risk adjustment, analysis, & rationale)*: 2e.3 **Testing Results** *(risk model performance metrics)*: 2e.4 **If outcome or resource use measure is not risk adjusted, provide rationale:**	**2e** **C**☐ **P**☐ **M**☐ **N**☐ **NA**☐
2f. Identification of Meaningful Differences in Performance 2f.1 **Data/sample from Testing or Current Use** *(description of data/sample and size)*: 2f.2 **Methods to identify statistically significant and practically/meaningfully differences in performance** *(type of analysis & rationale)*: 2f.3 **Provide Measure Scores from Testing or Current Use** *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*:	**2f** **C**☐ **P**☐ **M**☐ **N**☐
2g. Comparability of Multiple Data Sources/Methods 2g.1 **Data/sample** *(description of data/sample and size)*: The same measure of medical home was implemented the 2005/2006 National Survey of Children with Special Health Care Needs. N=40,804 2g.2 **Analytic Method** *(type of analysis & rationale)*: 2g.3 **Testing Results** *(e.g., correlation statistics, comparison of rankings)*: For full details on the comparability of the medical home items in the 2007 NSCH and 2005/2006 NS-CSHCN, please reference: Child and Adolescent Health Measurement Initiative. Measuring Medical Home for Children and Youth: Methods and Findings from the National Survey of Children with Special Health Care Needs and the National Survey of Children's Health. Prepared for the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. May 2009. http://medicalhomedata.org/ViewDocument.aspx?item=436.	**2g** **C**☐ **P**☐ **M**☐ **N**☐ **NA**☐
2h. Disparities in Care	**2h**

2h.1 **If measure is stratified, provide stratified results** *(scores by stratified categories/cohorts)***:** 2h.2 **If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:**	**C**☐ **P**☐ **M**☐ **N**☐ **NA**☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria **for** *Scientific Acceptability of Measure Properties?*	**2**
Steering Committee: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties*, **met?** **Rationale:**	*2* **C**☐ **P**☐ **M**☐ **N**☐
3. USABILITY	
Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)	Eval Rating
3a. Meaningful, Understandable, and Useful Information 3a.1 **Current Use:** in use 3a.2 **Use in a public reporting initiative (disclosure of performance results to the public at large)** (*If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). <u>If not publicly reported</u>, state the plans to achieve public reporting within 3 years*)**:** U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The Health and Well-Being of Children: A Portrait of States and the Nation 2007. Chartbook based on data from the 2007 National Survey of Children's Health. http://mchb.hrsa.gov/nsch07/index.html. U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The 2006/2006 National Survey of Children with Special Health Care Needs Chartbook. Information at http://mchb.hrsa.gov/cshcn05/. 3a.3 **If used in other programs/initiatives (***If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). <u>If not used for QI</u>, state the plans to achieve use for QI within 3 years*)**:** U.S. Department of Health and Human Services. Healthy People 2010. Conference Edition. Washington, DC. 2000. U.S. Department of Health and Human Services. Healthy People 2020. http://www.healthypeople.gov/HP2020/. Medical Home measure being submitted to National Quality Measures Clearinghouse in 2010. **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) 3a.4 **Data/sample** *(description of data/sample and size)***:** Focus groups were held with numerous stakeholder groups—family advocates, clinicians, Title V leaders, researchers—to obtain feedback on report formats. The Child and Adolescent Health Measurement Initiative led the focus groups and developed reports in accordance with a general consumer information framework. Additional focus groups were held when preparing data and reports for display on the Data Resource Center website. The Data Resource Center executive committee also reviewed report formats for interpretability and applicability. 3a.5 **Methods** *(e.g., focus group, survey, QI project)***:** Focus groups	**3a** **C**☐ **P**☐ **M**☐ **N**☐

3a.6 **Results** *(qualitative and/or quantitative results and conclusions)***:** 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.	
3b/3c. Relation to other NQF-endorsed measures 3b.1 **NQF # and Title of similar or related measures:**	
(for NQF staff use) **Notes on similar/related** endorsed **or submitted measures:**	
3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source or different topic but same target population): 3b.2 **Are the measure specifications harmonized? If not, why?**	**3b** **C**☐ **P**☐ **M**☐ **N**☐ **NA**☐
3c. Distinctive or Additive Value 3c.1 **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** 5.1 **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:**	**3c** **C**☐ **P**☐ **M**☐ **N**☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria **for** *Usability?*	**3**
Steering Committee: Overall, to what extent was the criterion, *Usability*, **met?** **Rationale:**	**3** **C**☐ **P**☐ **M**☐ **N**☐
4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)	Eval Rating
4a. Data Generated as a Byproduct of Care Processes 4a.1-2 **How are the data elements that are needed to compute measure scores generated?** Survey,	**4a** **C**☐ **P**☐ **M**☐ **N**☐
4b. Electronic Sources 4b.1 **Are all the data elements available electronically?** (*elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims*) Yes 4b.2 **If not, specify the near-term path to achieve electronic capture by most providers.**	**4b** **C**☐ **P**☐ **M**☐ **N**☐
4c. Exclusions 4c.1 **Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?**	**4c** **C**☐ **P**☐ **M**☐

No 4c.2 **If yes, provide justification.**	**N**☐ **NA**☐
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences 4d.1 **Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.**	**4d** **C**☐ **P**☐ **M**☐ **N**☐
4e. Data Collection Strategy/Implementation 4e.1 **Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:** 4e.2 **Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*)**:** All items are public domain. Costs of implementing survey items will vary depending on sample size, population and sampling frame. 4e.3 **Evidence for costs:** 4e.4 **Business case documentation:**	**4e** **C**☐ **P**☐ **M**☐ **N**☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria **for** *Feasibility?*	**4**
Steering Committee: Overall, to what extent was the criterion, *Feasibility*, **met?** **Rationale:**	**4** **C**☐ **P**☐ **M**☐ **N**☐
RECOMMENDATION	
(for NQF staff use) **Check if measure is untested and only eligible for time-limited endorsement.**	**Time-limited** ☐
Steering Committee: Do you recommend for endorsement? **Comments:**	**Y**☐ **N**☐ **A**☐

CONTACT INFORMATION

Co.1 **Measure Steward (Intellectual Property Owner)**
Co.1 **Organization**
Child and Adolescent Health Measurement Initiative on behalf of the Maternal and Child Health Bureau | Oregon Health & Science University, 707 SW Gaines Street | Portland | Oregon | 97239

Co.2 **Point of Contact**
Christina | Bethell, Ph.D., MPH, MBA | bethellc@ohsu.edu | 503-494-1892

Measure Developer If different from Measure Steward
Co.3 **Organization**
Maternal and Child Health Bureau | Parklawn Building Room 18-05, 5600 Fishers Lane | Rockville | Maryland | 20857

Co.4 **Point of Contact**

Christina | Bethell, Ph.D., MPH, MBA | bethellc@ohsu.edu | 503-494-1892

Co.5 **Submitter If different from Measure Steward POC**
Christina | Bethell, Ph.D., MPH, MBA | bethellc@ohsu.edu | 503-494-1892- |Child and Adolescent Health Measurement Initiative on behalf of the Maternal and Child Health Bureau

Co.6 **Additional organizations that sponsored/participated in measure development**
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.**

Ad.2 **If adapted, provide name of original measure:**
Ad.3-5 **If adapted, provide original specifications URL or attachment**

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.6 **Year the measure was first released:** 2005
Ad.7 **Month and Year of most recent revision:** 2007-04
Ad.8 **What is your frequency for review/update of this measure?** Every 2 years when a new national survey is developed (either the NSCH or NS-CSHCN)
Ad.9 **When is the next scheduled review/update for this measure?** 2011-01

Ad.10 **Copyright statement/disclaimers:** CAHMI- The Child and Adolescent Health Measurement Initiative.

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

Date of Submission (*MM/DD/YY*)**:** 04/06/2010