



## Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

### Brief Measure Information

**NQF #:** 0107

**Corresponding Measures:**

**De.2. Measure Title:** Management of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents

**Co.1.1. Measure Steward:** Institute for Clinical Systems Improvement

**De.3. Brief Description of Measure:** Percentage of patients, aged 6-18 years old, treated with psychostimulant medication for the diagnosis of attention deficit hyperactivity disorder (ADHD) whose medical record contains documentation of follow-up visits at least twice a year that include height, weight, a discussion of medication, a discussion of school progress and a care plan.

**1b.1. Developer Rationale:** Ensure appropriate follow up is done for ADHD child and adolescent patients who are prescribed a psychostimulant medication.

**S.4. Numerator Statement:** Number of patients, aged 6-18 years, diagnosed with ADHD and prescribed psychostimulant medication whose medical record contains documentation of at least two follow-up visits within a year medication was prescribed and the following components were discussed at each of the visits: height, weight, a discussion of medication, a discussion of school progress and a care plan.

Documented is defined as any evidence in the medical record that at least 2 follow-up visits occur in the 12 months since psychostimulant medication prescription date. Each follow-up visit for ADHD includes documentation of the following twice a year: height, weight, a discussion of medication, a discussion of school progress, and a care plan discussion.

**S.7. Denominator Statement:** Number of patients, aged 6-18 years, diagnosed with ADHD and prescribed a psychostimulant medication in the past 12 months. For this measure, count medication initiation date as the start of a 12-month period.

**S.10. Denominator Exclusions:** None.

**De.1. Measure Type:** Process

**S.23. Data Source:** Other, Paper Medical Records

**S.26. Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Integrated Delivery System

**IF Endorsement Maintenance – Original Endorsement Date:** Aug 10, 2009 **Most Recent Endorsement Date:** Aug 10, 2009

**IF this measure is included in a composite, NQF Composite#/title:**

**IF this measure is paired/grouped, NQF#/title:**

**De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?** All of the components need to be discussed during follow up to be counted in the measure.

### 1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

**1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form**

[0107Importance-635392164860155642.docx](#)

**1b. Performance Gap**

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

**1b.1. Briefly explain the rationale for this measure** (e.g., the benefits or improvements in quality envisioned by use of this measure) [Ensure appropriate follow up is done for ADHD child and adolescent patients who are prescribed a psychostimulant medication.](#)

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.** (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use. [Studies have shown interventions are effective in improving adherence to guidelines. No studies found that directly linked physician guideline adherence to improve outcomes for children.](#)

**1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**

[N/A](#)

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.** (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

[N/A](#)

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.**

[N/A](#)

**1c. High Priority** (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

**1c.1. Demonstrated high priority aspect of healthcare**

[Affects large numbers, Patient/societal consequences of poor quality](#)

**1c.2. If Other:**

**1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.**

List citations in 1c.4.

[Attention deficit hyperactivity disorder \(ADHD\) may have an impact on child's/adolescent's experience within school, family, play or work. It is a chronic condition that may be variably expressed depending on the child's environment, as well as on the specific demands placed upon the child within that environment. According to the Centers for Disease Control and Prevention, as of 2006, 4.5 million children 5-17 years of age have ever been diagnosed with ADHD. The national prevalence of ADHD among school-aged children ranges from 3%-7%. The annual rate of increase of ADHD diagnosis on average was 3%. As of 2003, 2.5 million children ages 4-17 years or 56% of those with a diagnosis were receiving medication treatment for the disorder. Using a prevalence rate of 5%, the annual societal cost of ADHD is estimated to be between \\$36 and \\$52 billion in 2005 dollars. Additionally, children who have attention problems represent a very diverse, heterogeneous population and exhibit a broad range of symptom severity and a wide](#)

range of associated diagnoses. Children with ADHD are at risk for the coexistence of depression, anxiety disorders, conduct disorders and substance abuse. The prevalence of these conditions ranges from 15 to 30 percent. Up to 50% of children with ADHD may show evidence of an expressive language problem. Over 50% of children with ADHD are likely to have communication/interaction problems that manifest themselves as social skills deficits.

**1c.4. Citations for data demonstrating high priority provided in 1a.3**

1. CDC National Center for Birth Defects and Developmental Disabilities. Available at: <http://www.cdc.gov/ncbddd/adhd/data.html>. Accessed 8/20/09.
2. Biederman J, Faraone SV, Lapey K. Comorbidity of diagnosis in attention deficit hyperactivity disorder. *Child Adolesc Psychiatr Clin North Am* 1992; 1:335-60.
3. Faraone SV, Biederman J, Wozniak J, et al. Is comorbidity with ADHD a marker for juvenile-onset mania? *J Am Acad Child Adolesc Psychiatry* 1997; 36:1046-54.
4. Geller B, Zimmerman B, Williams M, et al. DSM-IV mania symptoms in a prepubertal and early adolescent bipolar disorder phenotype compared to attention deficit hyperactive and normal controls. *J of Child Adol Psychopharmacology* 2002; 12:11-24.
5. Giedd JN. Bipolar disorder and attention deficit hyperactivity disorder in children and adolescents. *J Clin Psychiatry* 2000; 61:31-34.
6. Jensen VK, Larrieu JA, Mack KK. Differential diagnosis between attention deficit hyperactivity disorder and pervasive developmental disorder-not otherwise specified. *Clin Pediatr* 1997; 36:555-61.
7. Spitzer RL, ed. In *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Washington DC: American Psychiatric Press, 1994; 63-65.
8. Werry JS, Elkind GS, Reeves JC. Attention deficit, conduct, oppositional, and anxiety disorders in children: III. laboratory differences. *J Abnorm Child Psychol* 1987; 15:409-28
9. Wozniak J, Biederman J, Kiely K, et al. Mania-like symptoms suggestive of childhood-onset bipolar disorder in clinically referred children. *J Am Acad Child Adolesc Psychiatry* 1995;34:867-76

**1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)**

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

**De.5. Subject/Topic Area** (check all the areas that apply):

Behavioral Health, Behavioral Health : Attention Deficit Hyperactivity Disorder (ADHD)

**De.6. Non-Condition Specific** (check all the areas that apply):

**S.1. Measure-specific Web Page** (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

[https://www.icsi.org/\\_asset/j0bww5/ADHDAimsMeas.pdf](https://www.icsi.org/_asset/j0bww5/ADHDAimsMeas.pdf)

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment: 0107Importance-635392164830360597.docx

**S.2b. Data Dictionary, Code Table, or Value Sets** (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment: 0107Importance-635392164840032287.docx

**S.3. For endorsement maintenance**, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

Age range has changed from 5-18 to 6-18 years old. The 6-18 years of age aligns with AAP guideline.

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Number of patients, aged 6-18 years, diagnosed with ADHD and prescribed psychostimulant medication whose medical record contains documentation of at least two follow-up visits within a year medication was prescribed and the following components were discussed at each of the visits: height, weight, a discussion of medication, a discussion of school progress and a care plan.

Documented is defined as any evidence in the medical record that at least 2 follow-up visits occur in the 12 months since psychostimulant medication prescription date. Each follow-up visit for ADHD includes documentation of the following twice a year: height, weight, a discussion of medication, a discussion of school progress, and a care plan discussion.

**S.5. Time Period for Data** (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

The numerator includes all patients with either a new or an existing ADHD diagnosis and a prescription for psychostimulant medication. Count medication prescription date as the start of a 12-month period.

**S.6. Numerator Details** (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

The numerator includes all patients with either a new or an existing ADHD diagnosis and a prescription for psychostimulant medication. Count medication prescription date as the start of a 12-month period.

Documented is defined as any evidence in the medical record that at least 2 follow-up visits occur in the 12 months since psychostimulant medication prescription date. Each follow-up visit for ADHD includes documentation of the following twice a year: height, weight, a discussion of medication, a discussion of school progress, and a care plan discussion.

**S.7. Denominator Statement** (Brief, narrative description of the target population being measured)

Number of patients, aged 6-18 years, diagnosed with ADHD and prescribed a psychostimulant medication in the past 12 months. For this measure, count medication initiation date as the start of a 12-month period.

**S.8. Target Population Category** (Check all the populations for which the measure is specified and tested if any):

Children

**S.9. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

A look back is a 12-month period from the medication prescription date. ADHD diagnosis can be either new or existing. Once a patient is prescribed a psychostimulant medication, there should be at least two follow ups done in a year (12 months) from the psychostimulant medication prescription date.

It is recommended to review all medical records in EHR for patients included in the denominator or select a random sample of 10 records to be reviewed.

**S.10. Denominator Exclusions** (Brief narrative description of exclusions from the target population)

None.

**S.11. Denominator Exclusion Details** (All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

N/A

**S.12. Stratification Details/Variables** (All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)

N/A

**S.13. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

**S.14. Identify the statistical risk model method and variables** (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

N/A

**S.15. Detailed risk model specifications** (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

**S.15a. Detailed risk model specifications** (if not provided in excel or csv file at S.2b)

**S.16. Type of score:**

Rate/proportion

If other:

**S.17. Interpretation of Score** (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

**S.18. Calculation Algorithm/Measure Logic** (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

Identify records for all patients, aged 6-18 years, who either have a new or existing ADHD diagnosis. Then determine if a psychostimulant medication was prescribed. If a medication was prescribed, look back 12 months to determine if at least 2 follow up visits were done in 12 months since initiation of medication and at each follow up visit, there was a discussion about height, weight, medication, school progress and a care plan.

**S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment** (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No diagram provided

**S.20. Sampling** (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Medical groups should identify all medical records in EHR for patients aged 6-18 years with either new or existing ADHD diagnosis and on psychostimulant medication. If sampling, all records of patients aged 6-18 years with either new or existing diagnosis of ADHD and on psychostimulant medication can be pulled into Excel or another tool to select a sample of 10 random patient records. If using Excel, random number generator function (RAND) can be used to select a random sample of medical records to review. To do this:

- o Sort medical records by a chart number, but could also use birth date and lastly patient name. Chart number is the most reliable method to ensure a random sample.
- o Insert a blank column on the leftmost side of the spreadsheet.
- o Label new column "RAND".
- o Place cursor in the first blank cell of new column "RAND" and type =RAND(). Then press ENTER.
- o Place your cursor back into the cell and resting over the corner to have the pointer change to a black cross, double click or drag the formula down.
- o Highlight the whole column and do "Edit, Copy, Paste Special = Values" to freeze the random number (otherwise it will keep changing with every click on your spreadsheet).
- o Sort your entire patient population by this new random number.
- o Select the first 10 records as your sample (minimum sample size of 10 charts is suggested, but groups may use a larger sample size depending on the size of ADHD child and adolescent population in the clinic).

**S.21. Survey/Patient-reported data** (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

**S.22. Missing data** (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

**S.23. Data Source** (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Other, Paper Medical Records

**S.24. Data Source or Collection Instrument** (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

N/A

**S.25. Data Source or Collection Instrument** (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

**S.26. Level of Analysis** (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual, Integrated Delivery System

**S.27. Care Setting** (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

**S.28. COMPOSITE Performance Measure** - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

**2a. Reliability** – See attached Measure Testing Submission Form

**2b. Validity** – See attached Measure Testing Submission Form

0107\_MeasureTesting\_MS5.0\_Data.doc



### 3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

#### 3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

##### 3a.1. Data Elements Generated as Byproduct of Care Processes.

Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry), Other

If other: Program measure components into EHR to be tracked and extracted electronically.

#### 3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

**3b.1. To what extent are the specified data elements available electronically in defined fields?** (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.**

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.**

Attachment:

#### 3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

**3c.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 and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.**

**IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.**

N/A

**3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).**

Not applicable.

### 4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

#### 4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

#### 4.1. Current and Planned Use

*NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.*

Planned	Current Use (for current use provide URL)
Public Reporting	
Quality Improvement (Internal to the specific organization)	
Use Unknown	

#### 4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

#### 4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

*We write measures and leave it up to our members to use it if they are working on a related project.*

#### 4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

*Not available*

#### 4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

#### 4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

#### 4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

#### 4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).



**4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.**

N/A

## 5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

### 5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

**5.1a. List of related or competing measures (selected from NQF-endorsed measures)**

**5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.**

### 5a. Harmonization

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

**5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**

**Are the measure specifications completely harmonized?**

**5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.**

### 5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

**OR**

Multiple measures are justified.

**5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):**

**Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)**

## Appendix

**A.1 Supplemental materials may be provided in an appendix.** All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

No appendix Attachment: <a href="#">0107Importance.docx</a>
<b>Contact Information</b>
<b>Co.1 Measure Steward (Intellectual Property Owner):</b> <a href="#">Institute for Clinical Systems Improvement</a> <b>Co.2 Point of Contact:</b> <a href="#">Senka, Hadzic, shadzic@icsi.org, 952-814-7065-</a> <b>Co.3 Measure Developer if different from Measure Steward:</b> <a href="#">Institute for Clinical Systems Improvement</a> <b>Co.4 Point of Contact:</b> <a href="#">Senka, Hadzic, shadzic@icsi.org, 952-814-7065-</a>
<b>Additional Information</b>
<b>Ad.1 Workgroup/Expert Panel involved in measure development</b> <b>Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.</b> <a href="#">ICSI ADHD Guideline Workgroup:</a> <a href="#">Leader: Colleen Dobie, Pediatrics, Allina Medical Clinic</a> <a href="#">Members:</a> <a href="#">Paul Spinner, Family Practice, CentraCare</a> <a href="#">W. Brooks Donald, Behavioral Pediatrician, HealthPartners Medical Group and Regions Hospital</a> <a href="#">Lynne Steiner, Family Practice, HealthPartners Medical Group and Regions Hospital</a> <a href="#">Taya Staples, Pharmacy, Marshfield Clinic</a> <a href="#">John Huxsahl, Psychiatry, Park Nicollet Health Services</a> <a href="#">Robert Karasov, Pediatrics, Park Nicollet Health Services</a> <a href="#">Carolyn Kippes, Behavioral Pediatrician, Park Nicollet Health Services</a> <a href="#">Anita Neumann, Patient/Family Representative</a> <a href="#">ICSI Staff: Cassie Myers</a>
<b>Measure Developer/Steward Updates and Ongoing Maintenance</b> <b>Ad.2 Year the measure was first released:</b> <a href="#">1997</a> <b>Ad.3 Month and Year of most recent revision:</b> <a href="#">03, 2012</a> <b>Ad.4 What is your frequency for review/update of this measure?</b> <a href="#">24 months</a> <b>Ad.5 When is the next scheduled review/update for this measure?</b> <a href="#">04</a>
<b>Ad.6 Copyright statement:</b> <a href="#">Copyright 2014 by Institute for Clinical Systems Improvement</a> <b>Ad.7 Disclaimers:</b>
<b>Ad.8 Additional Information/Comments:</b>