



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
<p>NQF #: 0720</p> <p>Corresponding Measures:</p> <p>De.2. Measure Title: Children Who Live in Communities Perceived as Safe</p> <p>Co.1.1. Measure Steward: The Child and Adolescent Health Measurement Initiative</p> <p>De.3. Brief Description of Measure: This measure ascertains the parents' perceived safety of child's community or neighborhood.</p> <p>1b.1. Developer Rationale: Parental perception of neighborhood safety is important to assess. Neighborhood safety and characteristics have been shown to correlate with several important health indicators. Perception of safety has particular relevance to whether or not children are allowed to play outside and engage in other out-of-door activities.</p>
<p>S.4. Numerator Statement: Children whose parents report their neighborhood or community is usually/always safe for children</p> <p>S.7. Denominator Statement: Children age 0-17 years</p> <p>S.10. Denominator Exclusions: Excluded from denominator if child does not fall in target population age range of 0-17 years.</p>
<p>De.1. Measure Type: Outcome</p> <p>S.23. Data Source: Instrument-Based Data</p> <p>S.26. Level of Analysis: Other, Population : Regional and State</p>
<p>IF Endorsement Maintenance – Original Endorsement Date: Jan 17, 2011 Most Recent Endorsement Date: Jan 17, 2011</p>
<p>IF this measure is included in a composite, NQF Composite#/title:</p> <p>IF this measure is paired/grouped, NQF#/title:</p> <p>De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?</p>

1. Evidence, Performance Gap, Priority – Importance to Measure and Report
<p>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.</p>
<p>1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form 0720_Evidence_MSF5.0_Data.doc</p>
<p>1b. Performance Gap</p> <p>Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:</p> <ul style="list-style-type: none"> considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or disparities in care across population groups. <p>1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure) Parental perception of neighborhood safety is important to assess. Neighborhood safety and characteristics have been shown to correlate with several important health indicators. Perception of safety has particular relevance to whether or not children are</p>

allowed to play outside and engage in other out-of-door activities.

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.*

In 2011/12, children who live in communities that are usually or always perceived as safe ranges across states from 72.6% in D.C. to 94.7% in Idaho.

In 2007, children who live in communities that are usually or always perceived as safe ranges across states from 66.5% in D.C. to 95.2% in Vermont.

In 2003, children who live in communities that are usually or always perceived as safe ranges across states from 61.2% in D.C. to 94.5% in Vermont.

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.

1. BeLue R, Francis LA, Rollins B, Colaco B. One size does not fit all: identifying risk profiles for overweight in adolescent population subsets. *J Adolesc Health*. 2009;45(5):517-524.
2. Bethell C, Simpson L, Stumbo S, Carle AC, Gombojav N. National, state, and local disparities in childhood obesity. *Health Aff (Millwood)*. 2010;29(3):347-356.
3. Howie LD, Lukacs SL, Pastor PN, Reuben CA, Mendola P. Participation in activities outside of school hours in relation to problem behavior and social skills in middle childhood. *J Sch Health*. 2010;80(3):119-125.
4. Larson K, Russ SA, Crall JJ, Halfon N. Influence of multiple social risks on children's health. *Pediatrics*. 2008;121(2):337-344.
5. Lutfiyya MN, Garcia R, Dankwa CM, Young T, Lipsky MS. Overweight and obese prevalence rates in African American and Hispanic children: an analysis of data from the 2003-2004 National Survey of Children's Health. *J Am Board Fam Med*. 2008;21(3):191-199.
6. Singh GK, Kogan MD, Siahpush M, van Dyck PC. Independent and joint effects of socioeconomic, behavioral, and neighborhood characteristics on physical inactivity and activity levels among US children and adolescents. *J Community Health*. 2008;33(4):206-216.
7. Singh GK, Kogan MD, van Dyck PC. A multilevel analysis of state and regional disparities in childhood and adolescent obesity in the United States. *J Community Health*. 2008;33(2):90-102.
8. Singh GK, Siahpush M, Kogan MD. Neighborhood socioeconomic conditions, built environments, and childhood obesity. *Health Aff (Millwood)*. 2010;29(3):503-512.
9. Smaldone A, Honig JC, Byrne MW. Sleepless in America: inadequate sleep and relationships to health and well-being of our nation's children. *Pediatrics*. 2007;119 Suppl 1:S29-37.
10. Subramanian SV, Kennedy MH. Perception of neighborhood safety and reported childhood lifetime asthma in the United States (U.S.): a study based on a national survey. *PLoS One*. 2009;4(6):e6091.

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.*

In 2011/12, parents of children who live in low income households are less likely to perceive their communities as usually or always safe (0-99% FPL; 74.3%), compared to parents of children who live in high income households (400% FPL and up; 95.1%).

In 2007, parents of children who live in low income households are less likely to perceive their communities as usually or always safe (0-99% FPL; 72.3%), compared to parents of children who live in high income households (400% FPL and up; 94.0%).

In 2003, parents of children who live in low income households are less likely to perceive their communities as usually or always safe (0-99% FPL; 69.8%), compared to parents of children who live in high income households (400% FPL and up; 92.6%).

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.

1. BeLue R, Francis LA, Rollins B, Colaco B. One size does not fit all: identifying risk profiles for overweight in adolescent population subsets. *J Adolesc Health*. 2009;45(5):517-524.
2. Bethell C, Simpson L, Stumbo S, Carle AC, Gombojav N. National, state, and local disparities in childhood obesity. *Health Aff (Millwood)*. 2010;29(3):347-356.
3. Howie LD, Lukacs SL, Pastor PN, Reuben CA, Mendola P. Participation in activities outside of school hours in relation to problem behavior and social skills in middle childhood. *J Sch Health*. 2010;80(3):119-125.
4. Larson K, Russ SA, Crall JJ, Halfon N. Influence of multiple social risks on children's health. *Pediatrics*. 2008;121(2):337-344.
5. Lutfiyya MN, Garcia R, Dankwa CM, Young T, Lipsky MS. Overweight and obese prevalence rates in African American and Hispanic children: an analysis of data from the 2003-2004 National Survey of Children's Health. *J Am Board Fam Med*. 2008;21(3):191-199.
6. Singh GK, Kogan MD, Siahpush M, van Dyck PC. Independent and joint effects of socioeconomic, behavioral, and neighborhood characteristics on physical inactivity and activity levels among US children and adolescents. *J Community Health*. 2008;33(4):206-216.
7. Singh GK, Kogan MD, van Dyck PC. A multilevel analysis of state and regional disparities in childhood and adolescent obesity in the United States. *J Community Health*. 2008;33(2):90-102.
8. Singh GK, Siahpush M, Kogan MD. Neighborhood socioeconomic conditions, built environments, and childhood obesity. *Health Aff (Millwood)*. 2010;29(3):503-512.
9. Smaldone A, Honig JC, Byrne MW. Sleepless in America: inadequate sleep and relationships to health and well-being of our nation's children. *Pediatrics*. 2007;119 Suppl 1:S29-37.
10. Subramanian SV, Kennedy MH. Perception of neighborhood safety and reported childhood lifetime asthma in the United States (U.S.): a study based on a national survey. *PLoS One*. 2009;4(6):e6091.

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

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.

Feeling safe and secure in all residential neighborhoods is a major policy goal and is included in Health People 2010 guidelines. Nationally, 7.7% of parents of children age 0-17 years only sometimes feel safe in their community, and 1.5% of parents feel that their children are never safe in their community.

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

Child and Adolescent Health Measurement Initiative. 2011-12 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. www.childhealthdata.org

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):

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

Health and Functional Status : Change

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.)

<http://www.cdc.gov/nchs/data/slats/2011NSCHQuestionnaire.pdf> and http://childhealthdata.org/docs/nsch-docs/spsscodebook_-2011_2012_nsch_v1_all.pdf?sfvrsn=6

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:

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)

URL Attachment:

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

No changes in specifications.

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.

Children whose parents report their neighborhood or community is usually/always safe for children

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.)

Encounter or point in time.

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.

"How often do you feel that [child] is safe in your community or neighborhood? Would you say never, sometimes, usually or always?"

Safe neighborhood numerator combines responses of usually and always.

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

Children age 0-17 years

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)

All children 0-17 years old

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

Excluded from denominator if child does not fall in target population age range of 0-17 years.

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)

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)

No stratification is required.

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)

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)

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.)

To receive the numerator of children whose parents report their neighborhood or community is usually/always safe, K10Q40=3 or K10Q40=4.

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)

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.

Best guideline to follow is the survey methodology used in the 2011-12 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 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 95,677 interviews were completed from February 2011 through June 2012 for the 2011-12 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.

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.

ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slaits/nsch07/1a_Survey_Instrument_English/NSCH_Questionnaire_052109.pdf and http://childhealthdata.org/docs/nsch-docs/spsscodebook_2011_2012_ns_ch_v1_all.pdf?sfvrsn=6

<http://www.cdc.gov/nchs/data/slaits/2011NSCHQuestionnaire.pdf> and http://childhealthdata.org/docs/nsch-docs/spsscodebook_2011_2012_ns_ch_v1_all.pdf?sfvrsn=6

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

Required for Composites and PRO-PMs.

Unknown values (responses coded as 'refused', 'don't know', or system missing) are not included in the denominator when calculating prevalence estimates and weighted population counts displayed in the data query results table. In nearly every case, the proportion of unknown values is less than 1% and the exclusion of these values does not change the prevalence estimates (%) and only marginally affects the weighted population counts (Weighted Est.). Exceptions are noted in the form of a "Data Alert" at the bottom of a results table.

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

If other, please describe in S.24.

Instrument-Based Data

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.

2011-12 National Survey of Children's Health

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)

Available at measure-specific web page URL identified in S.1

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

Other, Population : Regional and State

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

Other

If other: Survey was conducted over a telephone

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

[0720_MeasureTesting_MSF5.0_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.

[Survey](#)

If other:

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)

[ALL data elements are in defined fields in a combination of electronic sources](#)

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.

[Items generate high level of answerability, e.g. very few missing, don't know or refused cases are reported.](#)

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).

[None](#)

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)
	<p>Public Reporting Data Resource Center for Child and Adolescent Health http://childhealthdata.org/</p> <p>Public Health/Disease Surveillance Data Resource Center for Child and Adolescent Health http://childhealthdata.org/ Publication: The Relationship of Reported Neighborhood Conditions with Child Mental Health http://www.ncbi.nlm.nih.gov/pubmed/23009865</p>

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

Data Resource Center for Child and Adolescent Health sponsored by the National Maternal and Child Health Bureau: Public reporting and public health surveillance at www.childhealthdata.org for use by policymakers, MCH program leaders and professionals, family and child health advocates, and researchers in order to inform and advance key national and state child and youth health goals. National and state-level reporting for all of the United States.

Public health surveillance via journal publications.

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?)

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.)

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

Slight increasing trend nationally overall and for some socioeconomic subgroups.

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.

No unintended consequences

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.)

No related or competing measures.

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.

Available at measure-specific web page URL identified in S.1 Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): The Child and Adolescent Health Measurement Initiative

Co.2 Point of Contact: Christina, Bethell, CBethell@cahmi.org, 443-287-5092-

Co.3 Measure Developer if different from Measure Steward: The Child and Adolescent Health Measurement Initiative

Co.4 Point of Contact: Christina, Bethell, CBethell@cahmi.org, 443-287-5092-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2007

Ad.3 Month and Year of most recent revision: 02, 2014

Ad.4 What is your frequency for review/update of this measure? Updated every year a new National Survey of Children's Health is developed

Ad.5 When is the next scheduled review/update for this measure? 12, 2017

Ad.6 Copyright statement: CAHMI- The Child and Adolescent Health Measurement Initiative.

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: