



## 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 sub criterion 1b).

### Brief Measure Information

NQF #: 1334

#### Corresponding Measures:

De.2. Measure Title: [Children Who Received Preventive Dental Care](#)

Co.1.1. Measure Steward: [The Child and Adolescent Health Measurement Initiative](#)

De.3. Brief Description of Measure: [Assesses how many preventive dental visits during the previous 12 months](#)

1b.1. Developer Rationale: [Health care providers, public health professionals and population-based health analysts can all benefit from knowing whether or not children are receiving preventive dental care. This measure allows for comparison across populations and demographic groups.](#)

S.4. Numerator Statement: [Percentage of children who had one or more preventive dental visits in the past 12 months.](#)

S.6. Denominator Statement: [Children age 1-17 years](#)

S.8. Denominator Exclusions: [Excluded from denominator if child does not fall in target population age range of 1-17 years.](#)

De.1. Measure Type: [Outcome](#)

S.17. Data Source: [Instrument-Based Data](#)

S.20. Level of Analysis: [Other, Population : Regional and State](#)

IF Endorsement Maintenance – Original Endorsement Date: [Aug 15, 2011](#) Most Recent Endorsement Date: [Aug 15, 2011](#)

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?

### 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 sub criteria to pass this criterion and be evaluated against the remaining criteria.***

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

[1334\\_Evidence\\_MSF5.0\\_Data.doc](#)

##### 1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Please update any changes in the evidence attachment in red. Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. If there is no new evidence, no updating of the evidence information is needed.

#### 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., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

*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.)

*IF a COMPOSITE* (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and provide rationale for composite in question 1c.3 on the composite tab.

Health care providers, public health professionals and population-based health analysts can all benefit from knowing whether or not children are receiving preventive dental care. This measure allows for comparison across populations and demographic groups.

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.** (*This is required for maintenance of endorsement.* 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 include.) This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

Nationally, 78.4% of children had at least 1 preventive dental visit in the past 12 months. There is a broad range in the proportion of children who have routine preventive dental visits. The range across states is 68.5% of children in Florida to 86.9% of children in Hawaii.

**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. Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. [www.nschedata.org](http://www.nschedata.org)

2. Dietrich T, Culler C, Garcia RI, Henshaw MM. Racial and ethnic disparities in children's oral health: the National Survey of Children's Health. J Am Dent Assoc. 2008;139(11):1507-1517.

3. Edelstein BL, Chinn CH. Update on disparities in oral health and access to dental care for America's children. Acad Pediatr. 2009;9(6):415-419.

4. Flores G, Tomany-Korman SC. The language spoken at home and disparities in medical and dental health, access to care, and use of services in US children. Pediatrics. 2008;121(6):e1703-14.

5. Kenney MK. Oral health care in CSHCN: state Medicaid policy considerations. Pediatrics. 2009;124 Suppl 4:S384-91.

6. Kenney MK, Kogan MD, Crall JJ. Parental perceptions of dental/oral health among children with and without special health care needs. Ambul Pediatr. 2008;8(5):312-320.

7. Liu J, Probst JC, Martin AB, Wang JY, Salinas CF. Disparities in dental insurance coverage and dental care among US children: the National Survey of Children's Health. Pediatrics. 2007;119 Suppl 1:S12-21.

8. Milgrom P, Zero DT, Tanzer JM. An examination of the advances in science and technology of prevention of tooth decay in young children since the Surgeon General's Report on Oral Health. Acad Pediatr. 2009;9(6):404-409.

9. Mouradian WE, Slayton RL, Maas WR, et al. Progress in children's oral health since the Surgeon General's Report on Oral Health. Acad Pediatr. 2009;9(6):374-379.

**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 maintenance of endorsement.* Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

Uninsured children are the least likely to receive preventive dental visits (58.5%), followed by publicly insured children (76.2%) and

privately insured children (82.4%).

Only 53.5% of 1 to 5-year-old children have preventive dental visits, while at least 87.8% of children age 6 years and older have preventive dental visits.

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4**

1. 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](http://www.nschdata.org)

2. Dietrich T, Culler C, Garcia RI, Henshaw MM. Racial and ethnic disparities in children's oral health: the National Survey of Children's Health. J Am Dent Assoc. 2008;139(11):1507-1517.

3. Edelstein BL, Chinn CH. Update on disparities in oral health and access to dental care for America's children. Acad Pediatr. 2009;9(6):415-419.

4. Flores G, Tomany-Korman SC. The language spoken at home and disparities in medical and dental health, access to care, and use of services in US children. Pediatrics. 2008;121(6):e1703-14.

5. Kenney MK. Oral health care in CSHCN: state Medicaid policy considerations. Pediatrics. 2009;124 Suppl 4:S384-91.

6. Kenney MK, Kogan MD, Crall JJ. Parental perceptions of dental/oral health among children with and without special health care needs. Ambul Pediatr. 2008;8(5):312-320.

7. Liu J, Probst JC, Martin AB, Wang JY, Salinas CF. Disparities in dental insurance coverage and dental care among US children: the National Survey of Children's Health. Pediatrics. 2007;119 Suppl 1:S12-21.

8. Milgrom P, Zero DT, Tanzer JM. An examination of the advances in science and technology of prevention of tooth decay in young children since the Surgeon General's Report on Oral Health. Acad Pediatr. 2009;9(6):404-409.

9. Mouradian WE, Slayton RL, Maas WR, et al. Progress in children's oral health since the Surgeon General's Report on Oral Health. Acad Pediatr. 2009;9(6):374-379.

## 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 sub criteria 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):

Access to Care

**De.7. Target Population Category** (Check all the populations for which the measure is specified and tested if any):

Children

**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/laits/2011NSCHQuestionnaire.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)

**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)

**Attachment:**

**S.3.1. For maintenance of endorsement:** Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

**S.3.2. For maintenance of endorsement**, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

**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) DO NOT include the rationale for the measure.

*IF an OUTCOME MEASURE*, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Percentage of children who had one or more preventive dental visits in the past 12 months.

**S.5. 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, time period for data collection, 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 (S.14).

For a child to be included in the numerator, they must have seen a dentist for preventive dental care at least once in the past 12 months.

**S.6. Denominator Statement** (Brief, narrative description of the target population being measured)

Children age 1-17 years

**S.7. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, 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 target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Children age 1-17 years.

**S.8. 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 1-17 years.

**S.9. Denominator Exclusion Details** (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, 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 child is older than 17 years of age, excluded from denominator.

If child is younger than 1 year of age, excluded from denominator.

**S.10. Stratification Information** (Provide all information required to stratify the measure results, if necessary, including the

*stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – 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.

When the Preventive Dental Visits measure was administered in its most recent form, in the 2011/12 National Survey of Children's Health, the survey included a number of child demographic variables that allow for stratification of the findings by possible vulnerability:

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

**S.11. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

**S.12. Type of score:**

Rate/proportion

If other:

**S.13. 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.14. Calculation Algorithm/Measure Logic** (Diagram or 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; time period for data, aggregating data; risk adjustment; etc.)

To receive numerator of child having preventive dental visit:

-Must have at 1 or more visits to the dentist for preventive care (K4Q21=1 or more).

**S.15. 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 2007 National Survey of Children's Health.

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

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

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

**S.16. Survey/Patient-reported data** (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

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

**S.17. Data Source** (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

[Instrument-Based Data](#)

**S.18. Data Source or Collection Instrument** (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data is collected.)

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

[2007 National Survey of Children's Health](#)

**S.19. Data Source or Collection Instrument** (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

[URL](#)

**S.20. Level of Analysis** (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

[Other, Population : Regional and State](#)

**S.21. Care Setting** (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

[Other](#)

If other: [Applies to any care setting in which child receives care. Can stratify by usual source of care.](#)

**S.22. 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.)

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

[1334\\_MeasureTesting\\_MS5.0\\_Data.doc](#)

### **2.1 For maintenance of endorsement**

*Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)*

### **2.2 For maintenance of endorsement**

*Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)*

### **2.3 For maintenance of endorsement**

*Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes SDS factors is no longer prohibited during the SDS Trial Period (2015-2016). Please update sections 1.8, 2a2, 2b2, 2b4, and 2b6 in the Testing attachment and S.14 and S.15 in the online submission form in accordance with the requirements for the SDS Trial Period. NOTE: These sections must be updated even if SDS factors are not included in the risk-adjustment strategy. If yes, and your testing attachment does not have the additional questions for the SDS Trial please add these questions to your testing attachment:*

*What were the patient-level sociodemographic (SDS) variables that were available and analyzed in the data or sample used? For example, patient-reported data (e.g., income, education, language), proxy variables when SDS data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate).*

*Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or*

*sociodemographic factors) used in the statistical risk model or for stratification by risk (e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of  $p < 0.10$ ; correlation of  $x$  or higher; patient factors should be present at the start of care)*

*What were the statistical results of the analyses used to select risk factors?*

*Describe the analyses and interpretation resulting in the decision to select SDS factors (e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects)*

### 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.

Other

If other: [Survey](#)

#### 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)** Update this field for **maintenance of endorsement**.

[Yes](#)

**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.** For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

**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. Please also complete and attach the NQF Feasibility Score Card.**

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. Required for maintenance of endorsement.** Describe difficulties (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 PRO data (patients, service recipients, respondents) and those whose performance is being measured.

[Items are well understood and easy to implement. Items yield very low levels of missing values, don't know or refused answers.](#)

**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).

## 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.*

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

#### 4a.1. For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

**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.)

### 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. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (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.)**

**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. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.**

**4c.2. Please explain any unexpected benefits from implementation of this measure.**

**4d1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.**

**How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.**

**4d1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**

**4d2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.**

**Describe how feedback was obtained.**

**4d2.2. Summarize the feedback obtained from those being measured.**

**4d2.3. Summarize the feedback obtained from other users**

**4d.3. Describe how the feedback described in 4d.2 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.**

#### **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.

**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 of Related Measures**

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 harmonized to the extent possible?**

**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.

**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@ohu.edu, 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@ohu.edu, 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.**

[The Maternal and Child Health Bureau convenes a Technical Expert Panel \(TEP\) comprised of more than a dozen members. Members include other federal agencies, health services researchers, survey methodology experts, consumer organizations and clinical health experts on children's health. The TEP consults in the identification and/or development of items for MCHB to consider for inclusion in the National Survey of Children's Health, including making recommendations for the scoring and reporting of measures resulting from the national survey.](#)

[Members of the committee are drawn from the public and private sector, including members from national universities and national parenting and family groups, the Child and Adolescent Health Measurement Initiative \(through the MCHB-sponsored Data Resource Center for Child and Adolescent Health\) as well as members from the National Center for Health Statistics, the Centers for Disease Control and Prevention and other federal agencies. There is a range of activity performed by different members of the TEP depending on which measure is being developed, areas of expertise etc. The TEP process usually consists of 1 or 2 in person meetings, 6 or more conference calls, and numerous email exchanges. Subcommittees are formed based on areas of expertise. Because this is a collaborative activity, there is not a single developer of this measure.](#)

<b>Measure Developer/Steward Updates and Ongoing Maintenance</b> <b>Ad.2</b> Year the measure was first released: 2007 <b>Ad.3</b> Month and Year of most recent revision: 04, 2007 <b>Ad.4</b> What is your frequency for review/update of this measure? Updated every 4 years when a new National Survey of Children's Health is developed <b>Ad.5</b> When is the next scheduled review/update for this measure? 01, 2011
<b>Ad.6</b> Copyright statement: <b>Ad.7</b> Disclaimers:
<b>Ad.8</b> Additional Information/Comments: