



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 #: 1406

Corresponding Measures:

De.2. Measure Title: Risky Behavior Assessment or Counseling by Age 13 Years

Co.1.1. Measure Steward: National Committee for Quality Assurance

De.3. Brief Description of Measure: The percentage of children with documentation of a risk assessment or counseling for risky behaviors by 13 years of age. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Use, Risk Assessment or Counseling for Sexual Activity.

1b.1. Developer Rationale: This measure promotes counseling to educate adolescents on the dangers of risky behavior (sexual activity and alcohol, tobacco and substance use). The need to prevent tobacco and other substance use early in a child's life is important. Tobacco use and addiction usually begin in adolescence. Of adults that smoke daily, 82 percent tried their first cigarette before age 18, and 53 percent became daily smokers before that age. Age of onset of drinking is connected to the amount of alcohol dependency over a lifetime: 40 percent of people that begin drinking at age 14 or under develop alcohol dependency sometime in their life compared to ten percent of those that begin at age 21 or older (CDC, 2008).

S.4. Numerator Statement: Children with documentation of a risk assessment or counseling for risky behaviors by 13 years of age.

S.7. Denominator Statement: Children with a visit who turned 13 years old in the measurement year.

S.10. Denominator Exclusions: None

De.1. Measure Type: Process

S.23. Data Source: Electronic Health Records, Paper Medical Records

S.26. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

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? This measure appears in the composite Comprehensive Well Care by Age 13 Years

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
1406_Evidence_MSFS.0_Data.doc

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)

This measure promotes counseling to educate adolescents on the dangers of risky behavior (sexual activity and alcohol, tobacco and substance use). The need to prevent tobacco and other substance use early in a child's life is important. Tobacco use and addiction usually begin in adolescence. Of adults that smoke daily, 82 percent tried their first cigarette before age 18, and 53 percent became daily smokers before that age. Age of onset of drinking is connected to the amount of alcohol dependency over a lifetime: 40 percent of people that begin drinking at age 14 or under develop alcohol dependency sometime in their life compared to ten percent of those that begin at age 21 or older (CDC, 2008).

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.

Of students grade 9-12 nationwide who have had sexual intercourse at least once, seven percent had sexual intercourse before they were age 13. Of the 35 percent considered sexually active, only 62 percent of students used condoms during the last encounter, and 23 percent had consumed drugs or alcohol before their last sexual encounter (CDC, 2008). Unintended pregnancies and STDs may be the consequences of this behavior. Sexually transmitted diseases remain a large national public health problem despite efforts to curb them.

Approximately one quarter of teenage girls in the United States currently have a sexually transmitted disease (STD), which suggests that an estimated 3.2 million teenagers between the ages of 14 and 19 are infected with HPV, Chlamydia, herpes or trichomoniasis. This is evidence there is a lack of STD screening and counseling in contraceptive services for teens and young women (Hampton, 2008).

In 2008, 1,210,523 Chlamydia trachomatis infection cases were reported to CDC, the largest number of cases ever reported for any condition. This is a 9.7 percent increase from 2007 (CDC, 2008).

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.

Centers for Disease Control and Prevention (2009, November) 'Sexually Transmitted Disease Surveillance, 2008', Atlanta, GA: U.S. Department of Health and Human Services

Tracy Hampton. Researchers Seek Ways to Stem STDs. "Alarming" STD Rates Found in Teenaged Girls. JAMA. 2008;299(16):1888-1889.

University of Texas at Austin (2010, June 6). Adolescent brains biologically wired to engage in risky behavior, study finds. ScienceDaily. Retrieved August 26, 2010, from <http://www.sciencedaily.com/releases/2010/06/100603132458.htm>.

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.

Overall, the prevalence of sexual intercourse among students in grades nine through 12 was higher among African American and Hispanic males and females than white males and females; among African Americans and Hispanics, prevalence was higher in males than females. Prevalence of sex before age 13 was higher among males than females and higher among African American and Hispanic males and females than white males and females. Prevalence of condom use during last sexual intercourse was higher among African Americans than whites and higher among African American male than white male students (CDC, 2008). STDs disproportionately affect adolescents. Overall, women have more serious STDs than men, and African Americans and Hispanics have the highest rates of STDs (CDC, 2008).

Overall, whites and Hispanics are more likely to use alcohol and illicit drugs than African Americans (CDC 2008). Heavy episodic drinking was more common among males than females, in white males and females and Hispanics males and females than in African Americans males and females.

Males are more likely to smoke tobacco than females. American Indians or Alaska Natives are more likely to smoke than other racial/ethnic groups and Hispanics, and Asians are least likely to smoke (JAMA, 2009). Among students, frequent smoking was more common among white students in grades 9-12 (both males and females) than among African American and Hispanic males and females (CDC, 2009).

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.

Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance — United States, 2009. Surveillance Summaries, June 4, 2010. MMWR 2010;59(No. SS-5)

State-Specific Prevalence and Trends in Adult Cigarette Smoking—United States, 1998-2007. JAMA. 2009;302(3):250-252. MMWR. 2009;58:221-226.

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

A leading cause of morbidity/mortality, Severity of illness, 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.

Adolescents are at risk for participating in risky behaviors that include sexual activity and alcohol, tobacco and substance use. Alcohol and drug abuse can have serious consequences for the user: heavy drinking increases one's risk for many forms of cancer and are connected to many injuries, abuse cases, and near-fatal and fatal accidents. Illegal drug use is connected to serious health consequences such as heart failure, convulsions, chronic sexual problems, depression, and societal costs such as increasing crime, loss of familial ties and employment. Adolescents that abuse drugs are more likely to engage in other risky behavior such as stealing, sexual intercourse, and more intense drug abuse (HHS, 2000). Nationwide, 45 percent of students had at least one alcoholic beverage in the past month; 20 percent had used marijuana one or more times in the month; seven percent had used some form of cocaine, four percent had used methamphetamine, two percent had used heroin, and eight percent had used hallucinogenic drugs one or more times in their life (CDC, 2008). The Youth Risk Behavior Surveillance national survey showed that, nationwide, 50 percent of teenagers have smoked at least one puff of a cigarette. Twenty percent of students in grades 9-12 are categorized as "currently smoking," and ten percent smoked ten or more cigarettes a day (CDC, 2008).

The annual direct and indirect costs to society due to sexually transmitted diseases (STDs) and the resulting complications are conservatively estimated at \$17 billion (HHS, 2000). For example: Many unintended pregnancies receive late to no prenatal care and result in low-birth-weight infants, children with behavioral problems, and child abuse. In 1995, the nation incurred \$246 billion in costs due to substance abuse to cover health care, vehicle accidents, crime, and other adverse effects. Direct costs due to tobacco use totaled at least \$50 billion per year.

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

Hagan, JF, Shaw JS, Duncan PM, eds. 2008. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition. Elk Grove, IL: American Academy of Pediatrics.

U.S. Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

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 : Alcohol, Substance Use/Abuse, Perinatal Health

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

Primary Prevention, Screening

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.)

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. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date 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)

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

Children with documentation of a risk assessment or counseling for risky behaviors by 13 years of age.

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.)

2 years

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.

Documentation must include a note indicating the date and that the provider asked or counseled about the following.

Report each rate separately.

- Alcohol use

- Tobacco use

- Other substance use (i.e. illegal street drugs or abuse of prescription medication)
- Sexual activity

Counseling is any of the following:.

- Engagement in discussion of current risky behaviors (e.g., sexual activity or substance use)
- Checklist indicating that risky behavior was addressed
- Counseling or referral for risky behavior education
- Patient received educational materials on risky behavior
- Anticipatory guidance for risky behavior

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

Children with a visit who turned 13 years old in the measurement year.

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)

Children who turned 13 years of age during the measurement year and who had documentation of a face-to-face visit between the clinician and the child that predates the child's birthday by at least 12 months.

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)

NA

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)

The measure is not stratified

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)

NA

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.)

Step 1: Determine the denominator

Children who turned the requisite age in the measurement year, AND

Who had a visit within the past 12 months of the child's birthday

Step 2: Determine the numerator

Children who had documentation in the medical record of the service during the measurement year or the year previous to the measurement year.

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.

For this physician-level measure, we anticipate the entire population will be used in the denominator. If a sample is used, a random sample is ideal. NCQA's work has indicated that a sample size of 30-50 patients would be necessary for a typical practice size of 2000 patients.

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.

Electronic Health Records, 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.

Medical Record

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

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

[1406_MeasureTesting_MSFS.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.

[generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information \(e.g., DRG, ICD-9 codes on claims\)](#)

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)*

[No](#)

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.

[NCQA plans to eventually adapt this measure for use in electronic health records.](#)

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.

[Based on field test results, we have specified the measure to assess whether physicians assessed OR counseled adolescents on the four risky behavior topics. Our field test results showed that these data elements are available in the medical record. In addition, our field test participants noted that many were able to program these requirements into their electronic health record systems, and several implemented point-of-service physician reminders for this measure.](#)

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.

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

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?)

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

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.

During the measure development process the Child Health MAP and measure development team worked with NCQA's certified auditors and audit department to ensure that the measure specifications were clear and auditable. The denominator, numerator and any exclusions are concisely specified and align with our audit standards.

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

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. Attachment:
Contact Information
Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance Co.2 Point of Contact: Bob, Rehm, nqf@ncqa.org, 202-955-1728- Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance Co.4 Point of Contact: Rita, Lewis, lewis@ncqa.org, 202-955-5102-
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. Child Health Measurement Advisory Panel: Jeanne Alicandro Barbara Dailey Denise Dougherty, PhD Ted Ganiats, MD Foster Gesten, MD Nikki Highsmith, MPA Charlie Homer, MD, MPH Jeff Kamil, MD Elizabeth Siteman Mary McIntyre, MD, MPH Virginia Moyer, MD, MPH, FAAP Lee Partridge Xavier Sevilla, MD, FAAP Michael Siegal Jessie Sullivan
Measure Developer/Steward Updates and Ongoing Maintenance Ad.2 Year the measure was first released: Ad.3 Month and Year of most recent revision: Ad.4 What is your frequency for review/update of this measure? Ad.5 When is the next scheduled review/update for this measure?
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