

State Children's
Health Insurance
Program

Evaluation Tool

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American
Academy of
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Foreword

The State Children's Health Insurance Program (SCHIP) Evaluation Tool represents the efforts of the American Academy of Pediatrics (AAP) to assure that the nearly 4 million children currently without health insurance and eligible for Title XXI are provided health insurance and quality health services. We know that many of these children have working parents, are racially and ethnically diverse, speak primary languages other than English, and may not have seen a health care provider in many months or years. This tool, therefore, has been developed to address the specific needs of these children.

This effort is the culmination of dedicated work by a number of individuals, many of whom are identified in the appendices. Two of these individuals, John I. Takayama, MD, FAAP, who took the lead on this project for the AAP's Council on Pediatric Research, and Beth Yudkowsky, MPH, Director, AAP Division of Health Policy Research, are particularly to be congratulated. They worked tirelessly to develop the SCHIP Evaluation Tool Workshop and to revise and edit the materials throughout the process to make this evaluation tool a reality. A number of people provided valuable comments on the final drafts of the Evaluation Tool. We are also very grateful to Stephen J. Blumberg, PhD, National Center for Health Statistics, for the help he provided in identifying a number of possible measures for indicators identified in this tool.

Finally, we applaud the Agency for Health Care Policy and Research, the Maternal and Child Health Bureau of the Health Resources and Services Administration, the National Institute of Child Health and Human Development, Pfizer Pediatric Health, and the Friends of Children Corporate Fund, for the educational grants they provided that were critical in carrying out this project.

A handwritten signature in black ink, reading "Joseph R. Zanga". The signature is written in a cursive style with a large initial "J" and a long, sweeping underline.

Joseph R. Zanga, MD, FAAP
President
American Academy of Pediatrics

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EXECUTIVE SUMMARY

Introduction

The State Children's Health Insurance Program (SCHIP), created as Title XXI of the Social Security Act by the Balanced Budget Act of 1997, offers an unprecedented opportunity to provide health insurance to nearly 4 million uninsured children in the United States. With support from both federal grants and individual state contributions, each state has the flexibility of offering health insurance through a Medicaid expansion, a separate state program, or a combination of both approaches. The challenges for each state are to effectively identify and enroll eligible low-income children and to assure that newly enrolled children receive quality comprehensive health care. States must include in their program an evaluation component that accurately assesses progress in reducing the number of uninsured low-income children and assuring their access to quality health services. The SCHIP Evaluation Tool is a document developed by the American Academy of Pediatrics (AAP) to assist states in this effort.

This tool provides 30 indicators that measure the impact of Title XXI on three closely linked dimensions of quality assessment of health care: access, process, and outcomes. These three domains comprise a logical sequence from making health insurance available to achieving improved health status. In adapting these indicators, we encourage states to address populations of children who have special health care needs or who have experienced barriers to access, eg, children with chronic illness, adolescents, minority populations, and families experiencing language barriers. We expect that all states can provide periodic evaluations that report comparisons with baseline and among subgroups of enrollees by age, gender, race/ethnicity, household income, and health plan. We recognize, finally, that certain outcomes may be influenced by circumstances beyond health insurance and health care, such as living conditions, education, and nutrition. Additional comparisons with other groups of children, eg, children with commercial insurance or Medicaid, may prove useful to disentangle the impact of such factors.

Access Indicators:

Successful identification and enrollment of uninsured children into Title XXI is critical in the next year. To assure that the maximum number of eligible children benefit from the program, the recommended access questions are:

- How many uninsured children are eligible for the state's Title XXI program?
- How many eligible children are enrolled?
- How many children are enrolled continuously for one year or longer?
- How many enrolled children have special health care needs?

- How many Medicaid-eligible children are enrolled in the Medicaid program as a result of new state efforts to reach uninsured children?
- How successfully are eligible children retained between the state's Medicaid and Title XXI programs, ie, when children are disenrolled from one program but become eligible for the other, what proportion are enrolled into the other program?
- How successfully does the state's Title XXI program provide health insurance to uninsured low-income children without replacing existing forms of health insurance, ie, what proportion of children enrolled in Title XXI were previously eligible for or enrolled in a commercial (employment-based) health insurance plan?
- Do pediatricians, family physicians, and dentists participate in Medicaid and Title XXI so that children have access to care?

Process Indicators:

The success of the SCHIP program will depend not only on whether children are enrolled in an insurance program, but also on whether they receive appropriate and needed care. Process measures describe the content and quality of health services provided to children. The recommended process questions are:

- Do children and adolescents receive all the immunizations recommended for their age groups?
- Do children and adolescents receive the recommended number of well-child visits for their age groups?
- Are adolescents, ages 12 through 18 years, counseled about sexually transmitted diseases?
- Do children, ages 4 through 18 years, receive annual dental examinations?
- Do children, ages 3 through 6 years, receive vision screening examinations?
- Do children consistently see the same health professional for their health care?
- Are families, whose primary language is not English, served by health professionals who can communicate effectively with them?
- Do children with a chronic illness, such as asthma, receive appropriate care?
- Do Title XXI-enrolled children with special health care needs receive subspecialty care?

Outcome Indicators:

When appropriate and timely services are provided under SCHIP, the health and well being of children and adolescents in the program are expected to improve over time. Responses to the following questions will provide states with the information necessary to assess health status changes of enrolled children and adolescents:

- Are preventable hospitalizations for asthma, diabetes, gastroenteritis, dehydration, pneumonia, urine infection, and/or epilepsy, reduced?
- Are hospitalizations related to injuries reduced?
- Is there a reduction in the number of days lost from school for illness?
- Are behaviors that place adolescents at risk for injury or illness reduced?
- Do fewer adolescents attempt suicide?
- Do families report a reduction in the number of unmet health, dental, and vision needs for their children?
- Do families report a reduction in the proportion of their income they spend on medical and dental care?

Methods

The SCHIP Evaluation Tool was developed by leading experts in children's health care at an AAP-sponsored workshop in Washington, DC, May 11-12, 1998. The workshop was coordinated by the AAP's Council on Pediatric Research; over 100 participants attended including pediatricians, academic researchers, government officials, representatives of private foundations, and members of advocacy groups. Separate workgroups were established to address the three domains of quality: access, process, and outcomes. After prepared papers had been presented, a modified Delphi method was used to identify the most important indicators to determine the effectiveness of SCHIP. Criteria used to select the indicators included measurability, demonstrated effectiveness, availability, and consideration for special populations.

Acknowledgment

Funding for the SCHIP Evaluation Tool Workshop was provided by the Agency for Health Care Policy and Research, the Maternal and Child Health Bureau of the Health Resources and Services Administration, the National Institute of Child Health and Human Development, Pfizer Pediatric Health, and the AAP Friends of Children Corporate Fund.

SCHIP Evaluation Tool

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Background

The State Children's Health Insurance Program (SCHIP), created as Title XXI of the Social Security Act by the 1997 Balanced Budget Act, offers an opportunity to provide health insurance to a large proportion of uninsured children. The Act makes nearly \$48 billion in federal grants available to states over the next 10 years and allows them great flexibility in designing and implementing their health insurance programs. It also challenges each state participating in the program to assure that these newly insured children receive quality, comprehensive health care that leads to improved health status.

The federal legislation that created Title XXI requires each state to include an evaluation component in its plan that assesses progress in (1) reducing the number of uninsured low-income children, (2) increasing the availability of health insurance, and (3) improving health care for children. Yet the 1997 law provides limited guidance on what should be measured.

To assist states in evaluating their programs, the American Academy of Pediatrics (AAP) has created a Title XXI Evaluation Tool. The tool provides indicators to measure the impact of Title XXI on three closely linked dimensions of the assessment of the quality of health care--access, process, and outcomes. These three domains are part of a logical sequence of steps from making health insurance available to achieving improved health status. The first step in assessing the impact of Title XXI on children is to determine whether they have access to care, as intended by the legislation. Once children have access to care, the next step is to demonstrate that they are receiving the types of examinations, procedures, and counseling that meet accepted standards. The third step is to assure that children are healthier. It

should be recognized, however, that health insurance and health care are but two of many factors influencing outcomes. Other factors, such as living conditions, nutrition, and family income, may have a more profound impact on health outcomes.

Evaluation Tool Development

The development of the SCHIP Evaluation Tool was initiated at an AAP-sponsored workshop in Washington, DC, May 11-12, 1998 (Appendix A, B). Funding for the workshop was provided by the Agency for Health Care Policy and Research, the Maternal and Child Health Bureau of the Health Resources and Services Administration, the National Institute of Child Health and Human Development, Pfizer Pediatric Health, and the AAP Friends of Children Corporate Fund. The workshop was planned and coordinated by the AAP's Council on Pediatric Research and included more than 100 participants who represented a broad spectrum of those interested in the provision of health care to children - pediatricians, academic researchers, government officials, representatives of private foundations, and members of parent groups (Appendix C). Before the workshop, three work groups were established to address the three domains of quality: access, process, and outcomes. Each work group consisted of a primary presenter, responders, facilitators, and assigned participants (Appendix B). The presenters prepared papers that summarized the current status of quality indicators and recommended those that might be most applicable to the SCHIP population. These were distributed to all participants and were presented at the workshop, prepared comments were made by the

responders, and detailed discussions held by participants in each work group. By using a modified Delphi method to achieve group consensus, each of the three groups identified approximately 10 important indicators in their domain that could measure the effectiveness of SCHIP. All workshop participants were brought together and given the opportunity to comment on the key indicators being developed by all three of the work groups.

Following the workshop, members of the AAP's Council on Pediatric Research, members of the AAP Board, and staff of the AAP further refined the indicators and the recommendations for measurement. Criteria used to select the final indicators included: (1) measurability, whether an activity or outcome can be assessed reliably and validly, (2) demonstrated effectiveness, based on published literature suggesting that a particular activity, eg, physician visit, is in fact related to an outcome of concern, eg, hospitalization for asthma, (3) availability of data, recognizing that this may vary from state to state, and (4) attention to special populations, underscoring the fact that SCHIP, as a program to assure access to care for uninsured children, must include in its evaluation children particularly at risk for being under-served, eg, children with special health care needs.

Questions Addressed by the Evaluation Tool

Access:

The implementation of SCHIP offers a critical opportunity to increase children's access to health insurance. An estimated 3.9 million currently uninsured children younger than 19 years could be eligible for

insurance under Title XXI.¹ It will be essential to ensure that the maximum number of eligible children benefit from the program. Questions states should ask are:

- How many uninsured children are eligible for the state's Title XXI program?
- How many eligible children are enrolled?
- How many children are enrolled continuously for a year or longer?
- How many enrolled children have special health care needs?
- How many Medicaid-eligible children are enrolled in the Medicaid program as a result of new state efforts to reach uninsured children?
- How successfully are eligible children retained between the state's Medicaid and Title XXI programs, ie, when children are disenrolled from one program but become eligible for the other, what proportion are enrolled into the other program?
- How successfully does the state's Title XXI program provide health insurance to uninsured low-income children without replacing existing forms of health insurance, ie, what proportion of children enrolled in Title XXI were previously eligible for or enrolled in a commercial (employment-based) health insurance plan?
- Do pediatricians, family physicians, and dentists participate in Medicaid and Title XXI so that children have access to care?

¹ American Academy of Pediatrics Division of Health Policy Research. 1998 projections of Medicaid and Title XXI eligibility, Title XXI funds, if states fully implemented Title XXI using the federal criteria. Available at: <http://www.aap.org/advocacy/schip&f.htm>.

Process:

The success of the SCHIP program will depend not only on whether children are enrolled in an insurance program, but also on whether they receive appropriate and needed care. Process measures describe the content and quality of health services provided to children. The recommended process questions are:

- Do children and adolescents receive all the immunizations recommended for their age groups?
- Do children and adolescents receive the recommended number of well-child visits for their age groups?
- Are adolescents counseled about sexually transmitted diseases?
- Do children, ages 4 through 18, receive annual dental examinations?
- Do children, ages 3 through 6, receive vision screening examinations?¹
- Are children consistently seen at the same health care site for their care?
- Are families, whose primary language is not English, served by health professionals who can communicate effectively with them?
- Do children with a chronic illness, such as asthma, receive appropriate care?
- Do Title XXI-enrolled children with special health care needs receive subspecialty care?

Outcomes:

When appropriate and timely services are provided under SCHIP, the health and well-being of children and adolescents in the program are expected to improve over time. Responses to the following questions will provide states with the information necessary to assess the changes in health status of enrolled children and adolescents:

- Are preventable hospitalizations reduced?
- Are hospitalizations for injuries reduced?
- Is there a reduction in the number of days lost from school for illness?
- Are behaviors that place adolescents at risk for injury or illness reduced?
- Do fewer adolescents attempt suicide?
- Do families report a reduction in the number of unmet health, dental, and vision needs for their children?
- Do families report a reduction in the proportion of their income they spend on medical and dental care?

Using the Tool

The information collected through the application of the SCHIP Evaluation Tool will be helpful in three ways. First, the tool provides clear and concrete indicators to assist legislators, members of Congress, and other policy makers to assure that program goals are reached. Second, the information will be useful to states in improving the quality of their children's health insurance programs.

¹ Children should be screened for amblyopia and strabismus. Amblyopia is the most common cause of visual loss among children in the United States and is related to insufficient visual stimulation during the critical early period of visual development. Strabismus, or "crossed" eyes, is a common condition that can cause amblyopia. If strabismus is identified and treated before 6 years of age, related visual loss can be prevented.

Finally, these data will provide information to legislators on the effect of Title XXI on the health status of previously uninsured children.

This tool was developed by leading experts in children's health care to measure the quality of care provided by Title XXI. It is recognized that the measurement of the quality of children's health care is a rapidly changing field, and new performance measures and information systems are currently under development. The AAP is participating in several efforts to develop measures of the quality of children's health care, including those initiated by the National Committee on Quality Assurance and the Foundation for Accountability. States are likely to find that the results of those and similar work, when they become available, will supplement the evaluation tool described in this document.

The SCHIP Evaluation Tool is presented in the following section in a tabular format. Column headings include (1) recommended child health indicators, (2) target population, (3) recommended data source, (4) model instruments that could be used, and (5) direction of expected changes in the indicator. The development and adaptation of specific evaluation methods will depend on state and local issues and data capacity; therefore, this document cannot provide comprehensive solutions to all SCHIP evaluation issues. A technical appendix is included to describe model instruments and to provide resources for implementation and/or adaptation of each of the instruments (Appendix D).

Explanation of Evaluation Tool

General Comments: SCHIP evaluations should include comparisons of indicators not only with baseline, but also with other groups of children (eg, children with commercial health insurance, children receiving Medicaid, and children without health insurance and not eligible for SCHIP). Similar changes in a particular indicator for children enrolled in SCHIP and for those with other types of health insurance may reflect factors beyond health insurance and health care.

Analyses comparing subpopulations of children enrolled in SCHIP (eg, comparisons by age, sex, race or ethnicity, household income, payer source, health plan, severity of illness, existence of language barriers), are critical to ensure that vulnerable groups of children receive adequate care. Given the growing diversity of the pediatric population, several indicators are included to assess communication between health care professionals and children and their parents. States are encouraged to evaluate language barriers, especially in households where the primary language spoken is not English.

Reporting Frequency: Indicators should be reported annually by age, sex, race or ethnicity, household income, payer source, and health plan. Access indicators, such as enrollment data, will need to be provided at baseline and on a continuing basis, while process indicators may not be measurable until a sufficient period has passed (eg, 1 year) for enrolled children to obtain health services. Finally, some outcome measures may not be stable until children have been insured for a longer period.

Target Populations: This column refers to the specific population of children for whom a particular indicator is applicable. Indicators have been identified to address several vulnerable populations. Children with special health care needs, for example, refers to children with chronic conditions.

Recommended Data Sources: These include administrative data and household surveys. Administrative data are those collected as part of routine monitoring of health care utilization, such as hospital discharge data or Medicaid claims data. For such databases to be useful for SCHIP evaluation, they must include individual identifiers, demographic characteristics (eg, age, sex, race), SCHIP eligibility criteria (eg, household income), diagnosis (eg, asthma), and service provider for every interaction with medical and dental professionals. Many states may have larger databases, eg, Medicaid, that include SCHIP participants, and in those situations, it would be critical that children enrolled in SCHIP are readily

identifiable. Household surveys are ongoing or new surveys that should be conducted to obtain information that is otherwise unavailable (eg, parental report of difficulty communicating with a health care professional because of a language problem). It may be particularly important to survey not only Title XXI enrollees, but also the Title XXI eligible population, eg, all uninsured children who meet a state's Title XXI family income requirement. Other surveys, such as an employer/employee survey, are needed to determine the type of health insurance coverage offered by employers.

Model Instruments: These are existing instruments (usually national surveys) that contain questions that can be used or adapted to obtain the necessary data to produce the recommended indicators. Descriptions are included in Appendix D and specific questions applicable to a particular indicator are footnoted. The use of these instruments is advantageous for SCHIP evaluation because they have already been tested and used for other populations, thus assuring comparative data.

Expected Change: Recommended indicators should naturally reflect ongoing improvements in the quality of health care provided by SCHIP and ultimately improvements in the health status of enrollees. The expected directions of change, in relation to baseline measures, are provided.

Access Indicators

Indicator	Target Population	Recommended Data Source	Model Instruments	Expected Change
1. Percent of uninsured children who meet state's Title XXI program family income requirement.	Uninsured children	Household survey ¹	National Health Interview Survey (NHIS) ²	Decreases and stabilizes at low level
2. Percent of Title XXI-eligible children enrolled in Title XXI (participation rate).	Title XXI eligibles	Administrative data ³		Increases and stabilizes at high level
3. Percent of Title XXI enrollees who are enrolled for a full year.	Title XXI enrollees	Administrative data		Increases and stabilizes at high level
4. Percent of Title XXI enrollees who are identified as children with special health care needs.	Title XXI-enrolled children with special health care needs	Household survey	Health Plan Employer Data and Information Set (HEDIS), Consumer Assessments of Health Plans (CAHPS) ⁴	Initially increases and stabilizes
5. Percent of Medicaid-eligible children who enroll in Medicaid.	Uninsured Medicaid-eligible children	Administrative data		Increases and stabilizes at high level
6. Percent of children whose eligibility ⁵ switches between Title XXI and Medicaid who enroll in the appropriate program (or who maintain health insurance).	Title XXI eligible, Medicaid eligible	Administrative data ⁶		Remains high
7. Percent of employers offering health insurance coverage to employees.	Employers, Employees	Employer, employee survey ----- If unavailable, household survey	National Employer Health Interview Survey (NEHIS) ⁷ -----National Longitudinal Surveys of Youth (NLSY), Current Population Survey (CPS) ⁸	Remains stable
8. Percent of employers offering health insurance coverage for dependent children.	Employers, Employees	Employer, employee survey ----- If unavailable, household survey	NEHIS ⁷ ----- NLSY, CPS ⁸	Remains stable
9. Percent of Title XXI enrollees whose parents decline employer-sponsored dependent health insurance coverage.	Families with children enrolled in Title XXI programs	New enrollees survey	NLSY, CPS ⁸	Remains stable
10. Percent of pediatricians, family physicians and dentists who participate in Medicaid and Title XXI.	Pediatricians, family physicians and dentists	Physician and dentist survey	AAP Participation Survey ⁹	Increases from baseline

1. If multiple families reside in the same household, a survey needs to be conducted for each family in the household.
2. States should design their survey to capture information required on the state's Title XXI application forms. In addition to the suggested model questions, states should include questions applicable toward state-specific income disregards and asset tests, if any. National Health Interview Survey (NHIS), examples of questions to determine family income requirement: (1) What are the names of all persons living or staying here? (2) What is (person's name)'s relationship to (reference person's name—usually the name of the person who owns or rents the home)? (3) What is your best estimate of (person's name)'s earnings (include hourly wages, salaries, tips, and commissions) before taxes and deductions from ALL jobs and businesses in (recall period)? (4) Now I am going to ask about the total combined income of your family (defined as all related persons living and eating together in this household) in (recall period) including income from all sources we have just talked about, such as wages, salaries, Social Security or retirement benefits, help from relatives and so forth. Can you tell me that amount before taxes? (5) Is anyone covered by health insurance or some other kind of health care plan? (6) Who has coverage? (7) What kind of health insurance or health care coverage does (person's name) have? Exclude commercial plans that only provide extra cash while hospitalized or pay for one type of service (nursing home care, accidents, dental care).
3. All states are required to use the Health Care Financing Administration (HCFA)21E form to report the total number of children enrolled in Title XXI and enrollment duration (Appendix E). Use existing Medicaid reporting forms for comparison and tracking of children to and from different programs.
4. HEDIS and CAHPS, examples of survey questions to identify children with special health care needs and their utilization of health services: (1) In general, how would you rate your child's overall health now? (2) Specialists are doctors like surgeons, heart doctors, psychiatrists, allergy doctors, skin doctors, and others who specialize in one area of health care. During the last 12 months, did your child see a specialist? (3) Does (name) now have any medical condition that has lasted at least 3 months? (4) During the past 12 months, have you seen or talked to the following about [name's] health? A medical doctor who specializes in a particular disease or problem such as surgeons, heart doctors, psychiatrists, allergy doctors, and skin doctors. Do not include obstetricians or gynecologists.
5. Consists of children whose family income or other qualifications change so that they are no longer eligible for Title XXI but instead eligible for Medicaid, and vice versa. All children who become eligible for Medicaid, for example, should be enrolled in Medicaid and maintain their health insurance.
6. A unique identifier should be available so that these can be used to link records across Medicaid and Title XXI administrative databases to identify transferees.
7. NEHS—see Centers for Disease Control and Prevention, National Center for Health Statistics, Hyattsville, Maryland, December 1997, DHHS Publication No. (PHS) 98-1017.
8. NLSY/CPS, examples of survey questions to determine health insurance coverage: (1) Does your employer (or union) offer a health insurance plan to any of its employees?(2) If yes, are you eligible to enroll in this plan? (3) If eligible and not participating, what is the main reason you are not participating in your employer's plan? (4) Does your employer (or union) offer a health insurance plan to dependents of any of its employees?
9. AAP Physician Participation Survey—The AAP has developed a survey of pediatrician participation in the Medicaid program at the state and national level that could be adapted for use in measuring the participation rates of other child health providers: family physicians and dentists.

Process Indicators

Indicator	Target Population	Recommended Data Source	Model Instruments	Expected Change
1. Percent of Title XXI-enrolled children who turned 2 years old during the reporting year who have received the following immunizations: 4 DTP or DTaP, 3 Polio (IPV or OPV), 1 MMR, 4 Hib, 3 hepatitis B, and 1 varicella (or had evidence of chicken pox between ages 1 and 2 years).	Title XXI enrollees 2 years of age	Administrative data ----- If unavailable, household survey	HEDIS ¹ ----- National Immunization Survey (NIS) ²	Increases
2. Percent of Title XXI-enrolled adolescents who turned 13 years old during the reporting year who received a second dose of MMR vaccine or who had a seropositive test result for these conditions (measles, mumps, and rubella); who received the hepatitis B vaccine; and who received one chicken pox vaccine or had evidence of chicken pox by age 13.	Title XXI enrollees 13 years of age	Administrative data ----- If unavailable, household survey	HEDIS ³ -----	Increases
3. Percent of Title XXI-enrolled children who turned 15 months during the reporting year who received four or more well-child visits with a primary care provider during the reporting year.	Title XXI enrollees 15 months of age	Administrative data ----- If unavailable, household survey	HEDIS ⁴ -----	Increases
4. Percent of Title XXI-enrolled children and adolescents who turned ages 3, 4, 5, 6, 8, 10, 12, 13, 14, 15, 16, 17 or 18 years during the reporting year who had at least one comprehensive well-child visit with a primary care provider during the reporting year.	Title XXI enrollees who turned ages 3-6, 8, 10, 12-18 years during the reporting year	Administrative data ----- If unavailable, household survey	HEDIS ⁵ -----	Increases
5. Percent of Title XXI-enrolled adolescents ages 12 through 18 years who were counseled during the year for symptoms or risk factors for sexually transmitted diseases.	Title XXI enrollees who turned ages 12 – 18 years during the reporting year	Adolescent survey	FACCT/NCQA Child Health Measurement Initiative ⁶	Increases
6. Percent of Title XXI-enrolled children and adolescents who turned ages 4 through 18 years during the reporting year who received a dental examination during that time.	Title XXI enrollees ages 4-18 years	Administrative data ----- If unavailable, household survey	HEDIS ⁷ -----	Increases
7. Percent of Title XXI-enrolled children ages 3 through 6 years who received a vision screening examination during the reporting year.	Title XXI enrollees who turned ages 3-6 during the reporting year	Household survey		Increases
8. Percent of Title XXI-enrolled children and adolescents with all well-child visits provided at one health care site during the reporting year. ⁸	Title XXI enrollees	Administrative data ----- If unavailable, household survey	----- Medical Expenditure Panel Survey (MEPS) ⁹	Increases

Indicator <i>(continued)</i>	Target Population	Recommended Data Source	Model Instruments	Expected Change
9. Percent of Title XXI-enrolled children and adolescents, parents, or caretakers with a. Difficulty communicating with health care professionals because of a language problem or b. Difficulty understanding health care professionals	a. Title XXI enrollees and families whose primary language is not English b. Title XXI enrollees and families	Household survey	CAHPS ¹⁰	Decreases
10. Percent of Title XXI-enrolled children and adolescents with asthma who (choose one of the following): a. Regularly use a peak flow meter during the reporting year b. Regularly use a spacer with a metered-dose inhaler during the reporting year c. Receive influenza vaccine during the reporting year	Title XXI enrollees with asthma a. Ages 7-18 b. Ages 2-18 c. All ages	Administrative data ----- If unavailable, household survey	Requires development	Increases
11. Percent of Title XXI enrollees with special health care needs who received subspecialty care during reporting year.	Title XXI-enrolled children with special health care needs	Administrative data ----- If unavailable, household survey	----- CAHPS ¹¹	Increases or remains high

1. The indicator has been adapted from the following Health Plan Employer Data and Information Set (HEDIS) Performance Measure on childhood immunization: The percentage of Medicaid- and commercial insurance-enrolled children who turned 2 years old during the reporting year, who were continuously enrolled for 12 months immediately preceding their second birthday (including members who have had not more than one break in enrollment of up to 45 days during the 12 months immediately preceding their second birthday), and who have received the following immunizations: four DTP or DTaP vaccinations by the second birthday; three polio (IPV or OPV) vaccinations by the second birthday; one MMR between the first and second birthdays; at least one Haemophilus influenzae type b vaccination between the first and second birthdays; two hepatitis B vaccinations by the second birthday (with one of them falling between 6 months and the second birthday); a combined rate including children who have received all of the immunizations listed. The indicator has been modified to reflect the expectations of the federal Centers for Disease Control and Prevention and the American Academy of Pediatrics regarding the hepatitis B vaccine and the varicella (chicken pox) vaccine (Appendix F).
2. The NIS is a national survey to determine rates of immunizations.
3. HEDIS: The percentage of Medicaid- and commercial insurance-enrolled adolescents whose 13th birthday was in the reporting year, who were continuously enrolled for 12 months immediately preceding their 13th birthday, and who received a second dose of MMR by age 13. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure (Appendix F).
4. HEDIS: The percentage of Medicaid- and commercial insurance-enrolled members who turned 15 months old during the reporting year, who were continuously enrolled in the plan from 31 days of age, and who received zero, 1, 2, 3, 4, 5, 6, or more well-child visits with a primary care provider during their first 15 months of life. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

5. HEDIS: The percentage of Medicaid- and commercial insurance-enrolled members who were ages 3, 4, 5, or 6 during the reporting year, who were continuously enrolled during the reporting year, and who received one or more well-child visits with a primary care provider during the reporting year. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure; the percentage of Medicaid- and commercial insurance-enrolled members who were ages 12 through 21 years during the reporting year, who were continuously enrolled during the reporting year, and who have had at least one comprehensive well-child visit with a primary care provider during the reporting year. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.
6. FACCT/NCQA: Specific survey questions are currently being developed by FACCT/NCQA and will be available soon.
7. HEDIS: example of survey questions to identify children and adolescents who receive a dental examination: (1) About how long has it been since [name] last saw or talked to a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists. (2) During the past 12 months, that is, since [Fill 12 month date] a year ago, about how many visits did (name) make to a dentist?
8. All children should have a medical home where their health records are maintained and where they can be followed up by a familiar health care provider(s).
9. MEPS: example of survey question to identify one health care site for primary care: Is there a particular doctor's office, clinic, health center, or other place that (person) usually (goes) if (person) (is) sick or (needs) advice about (person)'s health?
10. Consumer Assessments of Health Plans (CAHPS): examples of survey questions to identify problems with communication: In the last 12 months, how often have you (or your child) had a hard time speaking with or understanding your child's doctor or other health provider because you (or your child) spoke different languages? In the last 12 months, did you need an interpreter to help you speak with your child's doctors or health providers? In the last 12 months, when you needed an interpreter to help you speak with your child's doctors or other health providers, how often did you get one? In the last 12 months, how often did your child's doctors or other health providers explain things in a way you (or your child) could understand?
11. CAHPS: examples of survey questions to identify children with special health care needs and their utilization of health services: (1) In general, how would you rate your child's overall health now? (2) Specialists are doctors like surgeons, heart doctors, psychiatrists, allergy doctors, skin doctors, and others who specialize in one area of health care. In the last 12 months, did your child see a specialist? (3) Does (name) now have any medical condition that has lasted for at least 3 months? (4) During the past 12 months, have you seen or talked to the following about [name's] health? A medical doctor who specializes in a particular disease or problem such as surgeons, heart doctors, psychiatrists, allergy doctors, and skin doctors. Do not include obstetricians or gynecologists.

Outcome Indicators

Indicator	Target Population	Recommended Data Source	Model Instruments	Expected Change
1. Rate of hospitalization (per 10 000 Title XXI-enrolled children/adolescents) for ambulatory sensitive conditions. Choose one OR MORE from among the following: Asthma Diabetes Epilepsy Dehydration Gastroenteritis Pneumonia UTI/kidney infection	Title XXI enrollees (If asthma, diabetes or epilepsy selected, target population is Title XXI enrollees with those conditions)	Administrative data ----- If unavailable, household survey	NHIS ¹	Decreases
2. Rate of hospitalization (per 10 000 Title XXI-enrolled children/adolescents) for injuries.	Title XXI enrollees 0-18 years	Administrative data ----- If unavailable, household survey	Modified NHIS ²	Decreases
3. Percent of Title XXI-enrolled children and adolescents reporting days lost from school due to health problems.	Title XXI enrollees 7-18 years	Household survey	NHIS ³	Decreases
4. Percent of Title XXI-enrolled adolescents reporting risky health behavior, in one or more of the following areas: Injuries Tobacco use Alcohol/drug use Sexual behavior Dietary behavior Physical activity	Title XXI enrollees 12-18 years	Adolescent survey	Youth Risk Behavior Surveillance System (YRBSS) ⁴	Decreases
5. Percent of Title XXI-enrolled adolescents reporting attempted suicide.	Title XXI enrollees 12-18 years	Adolescent survey	YRBSS ⁵	Decreases
6. Percent of Title XXI-enrolled children and adolescents with reported unmet medical needs.	Title XXI enrollees	Household survey	NHIS ⁶	Initially increases as unmet needs are addressed, then decreases
7. Percent of Title XXI-enrolled children and adolescents with reported unmet dental needs.	Title XXI enrollees	Household survey	NHIS ⁷	Initially increases as unmet needs are addressed, then decreases
8. Percent of Title XXI-enrolled children and adolescents with reported unmet vision needs.	Title XXI enrollees	Household survey	Modified NHIS ⁸	Initially increases as unmet needs are addressed, then decreases
9. Percent of family income used for medical and dental care.	Title XXI enrollees	Household survey	NHIS ⁹	Rate could increase or decrease for those previously uninsured, depending on prior use of health services

1. 1998 National Health Interview Survey (NHIS): example of survey questions to determine hospitalization: (1) In the past 6 months, has (name) been hospitalized for "asthma"? (2) You said earlier that (name) was a patient in the hospital since (13 month hospital data) a year ago. On what date did (name) enter the hospital? How many nights was (name) in the hospital? For what condition did (name) enter the hospital?
2. 1998 NHIS: example of survey questions to determine hospitalization: (1) During the past 3 months, was anyone in the family injured seriously enough that they got medical advice or treatment? (2) Who was this? (3) How many different times in the past 3 months was (person's name) injured seriously enough to seek medical care? (4) (For each time): Was (person's name) hospitalized for at least one night as a result of this injury? How many nights was (person's name) in the hospital?
3. 1998 NHIS: example of survey questions to determine days lost from school: During the past 12 months, about how many days did (child's name) miss school because of illness or injury? Note: This answer is given in days and is continuous.
4. 1999 YRBSS: example of survey questions to determine risky health behavior by adolescents (example for tobacco use): (1) Have you ever tried cigarette smoking, even one or two puffs? (2) How old were you when you smoked a whole cigarette for the first time? (3) During the past 30 days, on how many days did you smoke cigarettes? (4) During the past 30 days, on the days you smoked, how many cigarettes did you smoke per day? (5) Have you ever smoked cigarettes regularly, that is, at least one cigarette every day for 30 days? (6) During the past 30 days, on how many days did you use chewing tobacco or snuff, such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, or Copenhagen? (7) During the past 30 days, on how many days did you smoke cigars, cigarillos, or little cigars?
5. 1999 YRBSS: example of survey questions to determine suicide attempts by adolescents: (1) During the past 12 months, did you ever seriously consider attempting suicide? (2) During the past 12 months, did you make a plan about how you would attempt suicide? (3) During the past 12 months, how many times did you actually attempt suicide? (4) If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?
6. 1998 NHIS: example of survey questions to determine unmet medical needs: (1) Sometimes people have difficulties in getting medical care when they need it. During the past 12 months, was there any time when someone in the family needed medical care but did not get it because the family couldn't afford it? (2) Who delayed getting needed care? (3) There are many reasons people delay getting medical care. Have you delayed getting care for (child's name) for any of the following reasons in the past 12 months? (a) You couldn't get through on the telephone? (b) You couldn't get an appointment for (child's name) soon enough? (c) Once you get there, (child's name) had to wait too long to see the doctor? (d) The clinic/doctor's office wasn't open when you could get there? (e) You didn't have transportation?
7. NHIS: example of survey question to determine unmet dental needs: (1) During the past 12 months, was there any time when someone in the family needed dental care but could not get it? (2) Who was this? Anyone else?
8. Modification of NHIS: example of survey question to determine unmet vision needs: (1) Sometimes people have difficulties in getting medical care when they need it. During the past 12 months, was there any time when someone in the family needed vision care or eyeglasses, but did not get it? (2) Who didn't get care? Anyone else?
9. 1998 NHIS: example of survey question to determine income used for medical and dental care: (1) During the past 12 months, how much did your family spend for health insurance premiums for (plan name)? Please include payroll deductions for premiums. [Respondents are then given categories to choose from: Less than \$500, \$500-\$999, \$1000-\$1999, \$2000-\$2999, and \$3000 or more.] (2) During the past 12 months, about how much did your family spend for medical care, including dental care? Do not include the cost of health insurance premiums, over-the-counter remedies, or any costs for which you expect to be reimbursed. [Respondents are given same monetary categories.]

APPENDIX A

Planning Committee



**SCHIP Evaluation Tool Workshop
ANA Hotel
Washington, DC
MAY 11-12, 1998**

PLANNING COMMITTEE

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APPENDIX B

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**SCHIP Evaluation Tool Workshop
ANA Hotel
Washington, DC
May 11 - 12, 1998**

PRESENTERS AND RESPONDERS

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APPENDIX C

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**SCHIP Evaluation Tool Workshop
ANA Hotel
Washington, DC
May 11-12, 1998**

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APPENDIX D

Model Instruments

MODEL INSTRUMENTS

1. National Health Interview Survey:

This is an ongoing survey of households in the United States conducted by the National Center for Health Statistics (NCHS). A national probability sample of households is interviewed each week of the year about health and other characteristics of each member of the households. Model questions from the surveys have been included in the footnotes. NCHS Web site:

<http://www.cdc.gov/nchswww/nchshome.htm>

2. Health Plan Employer Data and Information Set (HEDIS 3.0):

This is a set of standardized performance measures produced and maintained by the National Committee for Quality Assurance to assure that purchasers and consumers of health care have information they need to compare the performance of health care plans. HEDIS contains a set of precisely defined measures for quality of care, member access and satisfaction, utilization, finance, health plan management, and activities. Data collection includes electronic submissions by individual health plans with external audits, as well as consumer surveys. Many of the questions cited in the footnotes are from the new 1999 Experiences with Children's Care Survey, which has been designed to capture accurate and complete parent- or caretaker-reported information about their experiences with their child's health care. Parental assessments of the quality of pediatric health services are strongly related to important health outcomes. This survey is designed to meet performance

assessment needs for populations covered by commercial insurance, Medicaid, and the new State Children's Health Insurance Program (SCHIP). The survey was developed as part of CAHPS (see no. 3). HEDIS Web site: www.ncqa.org

3. Consumer Assessments of Health Plans (CAHPS):

This questionnaire results from a collaborative project headed by the federal Agency for Health Care Policy and Research (AHCPR) to help consumers identify the best health care plans and services for their needs. The goals of CAHPS are to develop and test questionnaires that assess health plans and services, produce easily understandable reports for communicating survey information to consumers, and evaluate the usefulness of these reports for consumers in selecting health care plans and services. Public and private organizations survey consumers to collect information on access to care, use of health services, and satisfaction with care and services. AHCPR Web site: <http://www.ahcpr.gov> CAHPS Survey User Network Help Line: 800/492-9261.

4. National Employer Health

Insurance Survey: This survey was conducted in 1994. It was the first federally sponsored survey designed to produce state estimates of employer-sponsored health insurance. Data are based on 34 604 private establishments (business locations) obtained on computer-assisted telephone interviews. Internet Address:

<http://www.cdc.gov/nchswww/nchshome.htm>

5. National Longitudinal Surveys of Youth (NLSY):

This is a set of surveys sponsored by the Bureau of Labor Statistics, US Department of Labor, which has gathered information at multiple points in time on the labor market experiences of five groups of American men and women. The NLS cohorts include surveys of a group of children born to women of one of the national survey groups. Detailed information is being gathered at 2 year intervals on the home environment in which each child is being raised and the child's cognitive-socioemotional-physiological development. NLS Web site: <http://www.bls.gov/nlshome.htm>

6. Current Population Survey (CPS):

This survey has been conducted monthly since 1942 by the Bureau of the Census to estimate the number of employed and unemployed persons. The March survey includes a supplement that asks about health insurance coverage during the year. CPS Web site: <http://www.bls.census.gov/cps/cpsmain.htm>

7. AAP Pediatrician Participation Survey:

This survey was conducted in 1994 and can be modified to include participation rates of family physicians, dentists, and other child health professionals. To obtain a copy, please contact the AAP's Division of Health Policy Research at 800/433-9016, ext. 4908.

8. National Immunization Survey:

This survey collects information on the immunization coverage of children 19 months to 35 months of age across the United States. The survey is a collaborative effort between NCHS and the Centers for Disease Control and Prevention (CDC) National Immunization Program. CDC Web site: <http://www.cdc.gov/nchswww/about/major/slichs/slichs.htm>

9. Medical Expenditure Panel Survey (MEPS):

This is a nationally representative, ongoing survey conducted by AHCPH, that collects detailed information on health status, health care use and expenses, and health insurance coverage of individuals and families in the United States. AHCPH Web site: <http://www.ahcpr.gov>
MEPS information coordinator: 301/594-1406

10. Youth Risk Behavior Surveillance System:

This ongoing data collection effort is conducted by the Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion of the CDC. Data are collected on injuries, tobacco, alcohol and other drug use, sexual activity, dietary behavior, and physical activity. CDC Web site: <http://www.cdc.gov/nccdphp/youthris.htm>

APPENDIX E

Form HCFA-21E


DEPARTMENT OF HEALTH AND HUMAN SERVICES							
HEALTH CARE FINANCING ADMINISTRATION							
CHILDREN'S HEALTH INSURANCE PROGRAM						STATE	
NUMBER OF CHILDREN SERVED						AGENCY	
						QUARTER ENDED	
NAME OF PROGRAM _____	AGE				FEDERAL POVERTY LEVEL		
	CHILDREN						
	Under 1	1-5	6-12	13-18	<100%	100-150%	>150%
1. NUMBER OF UNDUPLICATED CHILDREN EVER ENROLLED IN THE QUARTER							
A. FEE-FOR-SERVICE PLANS							
B. MANAGED CARE ARRANGEMENTS							
2. NUMBER OF UNDUPLICATED NEW ENROLLEES IN THE QUARTER							
A. FEE-FOR-SERVICE PLANS							
B. MANAGED CARE ARRANGEMENTS							
3. NUMBER OF DISENROLLEES IN THE QUARTER							
A. FEE-FOR-SERVICE PLANS							
B. MANAGED CARE ARRANGEMENTS							
4. NUMBER OF MEMBER MONTHS OF ENROLLMENT IN THE QUARTER							
A. FEE-FOR-SERVICE PLANS							
B. MANAGED CARE ARRANGEMENTS							
5. AVERAGE NUMBER OF MONTHS OF ENROLLMENT (LINE 4 DIVIDED BY LINE 1)							
A. FEE-FOR-SERVICE PLANS							
B. MANAGED CARE ARRANGEMENTS							

FORM HCFA – 21E

APPENDIX F

Recommended Childhood Immunization Schedule
United States, January – December 1998

Membership
 Professional Education
 Advocacy
 Research
 Publications & Services
 You & Your Family
 Visit the AAP
 American Academy of Pediatrics



Immunization Protects Children 1998 Immunization Schedule

Regular checkups at your pediatrician's office or local health clinic are an important way to keep children healthy.

By making sure that your child gets immunized on time, you can provide the best available defense against many dangerous childhood diseases. Immunizations protect children against: hepatitis B, polio, measles, mumps, rubella (German measles), pertussis (whooping cough), diphtheria, tetanus (lockjaw), *Haemophilus influenzae* type b, and chickenpox. All of these immunizations need to be given before children are 2 years old in order for them to be protected during their most vulnerable period. Are your child's immunizations up-to-date?

The chart below includes immunization recommendations from the American Academy of Pediatrics. Remember to keep track of your child's immunizations -- it's the only way you can be sure your child is up-to-date. Also, check with your pediatrician or health clinic at each visit to find out if your child needs any booster shots or if any new vaccines have been recommended since this schedule was prepared.

If you don't have a pediatrician, call your local health department. Public health clinics usually have supplies of vaccine and may give shots free.

Recommended Childhood Immunization Schedule United States, January - December 1998

Vaccines¹ are listed under the routinely recommended ages. Bars indicate range of acceptable ages for immunization. Catch-up immunization should be done during any visit when feasible. Shaded ovals indicate vaccines to be assessed and given if necessary during the early adolescent visit.

Age Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	4-6 yrs	11-12 yrs	14-16 yrs
Hepatitis B ^{2,3}	Hep B-1	Hep B-2		Hep B-3						Hep B ⁴	
Diphtheria, Tetanus, Pertussis ¹		DTaP or DTP	DTaP or DTP	DTaP or DTP		DTaP or DTP ⁴			DTaP or DTP	Td	
<i>H influenzae</i> type b ¹		Hib	Hib	Hib	Hib						
Polio ⁵		Polio ⁴	Polio	Polio ⁴					Polio		
Measles, Mumps, Rubella ⁷					MMR				MMR ⁷	MMR ⁷	
Varicella ⁸					Var					Var ⁸	

Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

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(For necessary footnotes and important information, see reverse side.)

1 This schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. Combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

2 Infants born to HBsAg-negative mothers should receive 2.5 µg of Merck vaccine (Recombivax HB) or 10 µg of SmithKline Beecham (SB) vaccine (Engerix-B). The 2nd dose should be administered at least 1 mo after the 1st dose. The 3rd dose should be given at least 2 mos after the second, but not before 6 mos of age.

Infants born to HBsAg-positive mothers should receive 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hrs of birth, and either 5 µg of Merck vaccine (Recombivax HB) or 10 µg of SB vaccine (Engerix-B) at a separate site. The 2nd dose of vaccine is recommended at 1-2 mos of age and the 3rd dose at 6 mos of age.

Infants born to mothers whose HBsAg status is unknown should receive either 5 µg of Merck vaccine (Recombivax HB) or 10 µg of SB vaccine (Engerix-B) within 12 hrs of birth. The 2nd dose of vaccine is recommended at 1 mo of age and the 3rd dose at 6 mos of age. Blood should be drawn at the time of delivery to determine the mother's HBsAg status; if it is positive, the infant should receive HBIG as soon as possible (no later than 1 wk of age). The dosage and timing of subsequent vaccine doses should be based upon the mother's HBsAg status.

3 Children and adolescents who have not been vaccinated against hepatitis B in infancy may begin the series during any visit. Those who have not previously received 3 doses of hepatitis B vaccine should initiate or complete the series during the 11- to 12-year-old visit, and unvaccinated older adolescents should be vaccinated whenever possible. The 2nd dose should be administered at least 1 mo after the 1st dose, and the 3rd dose should be administered at least 4 mos after the 1st dose and at least 2 mos after the 2nd dose.

4 DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is the preferred vaccine for all doses in the vaccination series, including completion of the series in children who have received 1 or more doses of whole-cell DTP vaccine. Whole-cell DTP is an acceptable alternative to DTaP. The 4th dose (DTP or DTaP) may be administered as early as 12 months of age, provided 6 months have elapsed since the 3rd dose, and if the child is unlikely to return at 15-18 mos. Td (tetanus and diphtheria toxoids) is recommended at 11-12 years of age if at least 5 years have elapsed since the last dose of DTP, DTaP or DT. Subsequent routine Td boosters are recommended every 10 years.

5 Three *H influenzae* type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB [Merck]) is administered at 2 and 4 mos of age, a dose at 6 mos is not required.

6 Two poliovirus vaccines are currently licensed in the US: inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). The following schedules are all acceptable to the ACIP, the AAP, and the AAFP. Parents and providers may choose among these options:

- 1) 2 doses of IPV followed by 2 doses of OPV.
- 2) 4 doses of IPV.
- 3) 4 doses of OPV.

The ACIP recommends 2 doses of IPV at 2 and 4 mos of age followed by 2 doses of OPV at 12-18 mos and 4-6 years of age. IPV is the only poliovirus vaccine recommended for immunocompromised persons and their household contacts.

7 The 2nd dose of MMR is recommended routinely at 4-6 yrs of age but may be administered during any visit, provided at least 1 mo has elapsed since receipt of the 1st dose and that both doses are administered beginning at or after 12 mos of age. Those who have not previously received the second dose should complete the schedule no later than the 11- to 12-year visit.

8 Susceptible children may receive varicella vaccine (Var) at any visit after the first birthday, and those who lack a reliable history of chickenpox should be immunized during the 11- to 12-year-old visit. Susceptible children 13 years of age or older should receive 2 doses, at least 1 month apart.