



## Measure Information - Composite

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

### Brief Measure Information

**NQF #: 0011**

**De.2. Measure Title:** Promoting Healthy Development Survey (PHDS)

**Co.1.1. Measure Steward:** CAHMI

**De.3. Brief Description of Measure:** The Promoting Healthy Development Survey (PHDS) is a 43-item parent survey that can be used by health care providers, health systems, Medicaid agencies, and other stakeholders to measure and improve the quality of preventive and developmental care for children ages 0-48 months. The survey is designed to measure parent's experience with care and the extent to which they received preventative and developmental services in accordance with nationally recommended guidelines put forth by the American Academy of Pediatrics and Bright Futures practice guidelines (3rd edition).<sup>1</sup>

The PHDS contains 11 modules. The first six items represent measures. Taken together, the six measures also make up a composite PHDS Comprehensive Care Measure. These measures are the focus of this application. Items #7-11 are, respectively, an individual quality measure submitted separately by another steward (Standardized developmental and behavioral screening; NQF measure number 1448), not a quality of care measure (Access to care), used for stratification (Follow-up for children at risk and the CHSCN screener), or provide demographic and background information. Taken individually or as a whole, the PHDS provides valid measures for system, plan, and provider-level assessments.<sup>2</sup>

1. Anticipatory guidance
2. Parenting information, resources in community
3. Family centered care
4. Ask about and address parental concerns
5. Assessment of family safety, alcohol use and substance abuse
6. Assessment of family psychosocial screening
7. Standardized developmental and behavioral screening
8. Access to care and care coordination
9. Follow-up for children at risk
10. CSHCN screener;
11. Parent and family behaviors and respondent health;

#### References:

1. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition. <https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx>
2. Bethell, C. Peck, C et. al. Assessing Health System Provision of Well-Child Care: The Promoting Healthy Development Survey. Pediatrics. Vol 107(5) 2001. 1084-1094

**1c.3. Developer Rationale:** The PHDS was designed to measure these communication-dependent aspects of care because studies have shown that medical chart reviews and claims or billing data do not reliably or validly measure clinical recommendations that providers discuss with their patients. A second goal of the PHDS is not only to assess whether recommended care was provided, but also to measure the degree to which the parent have their informational needs met and whether the care provided is family-centered. Again, these important characteristics of a high-quality health system are best measured by asking the parent(s) directly.

The individual measures allow for the examination of quality and patient experience by specific aspect of care. This is helpful for providers, practices and health systems wishing to implement a quality improvement activity because it allows them to identify, measure and implement action plans on specific aspects of care and conduct these activities within resource constraints. Taken together, the composite PHDS measure allows the provider, practice or health plan to measure the extent to which national recommendations for pediatric preventive care are generally being met.

Well child visits present an essential leverage point for engaging parents in the health and well-being of their child, early identification of physical, social, emotional and behavioral issues, providing critical anticipatory guidance and education for parents, and promoting positive child and family health, resilience, social and emotional skills. However, substantial evidence exists documenting the persistent and alarming gap between what is recommended and what is actually provided in the context of well-child care for young children. Gaps exist for 9 out of 10 children, whose parents report not receiving at least one of a core set of recommended services for psychosocial, developmental and other screening and anticipatory guidance, and parental education. For example, findings from national and regional studies indicate improvements are specifically needed on the clinical recommendations focused on anticipatory guidance and parental education (1 out of 2 children have parents with unmet informational needs<sup>1-4</sup>), surveillance of children's development (2 out of 5 children have parents who were not asked about their<sup>11</sup> concerns about their child's learning, development or behavior<sup>5,6</sup>), and assessment of the family for risk (only 10% of children's families are screened for risk factors<sup>7,8</sup>). In addition, there are significant variations in the quality of care across individual health care providers and office-settings and within the population of children an individual health care provider cares for, demonstrating disparities by child/family characteristics and a lack of standardization in the preventive services received by young children.

Population differences for well child care have also been identified. Patients from ethnic minorities generally report being less involved in their healthcare, having lower levels of trust in their providers, and having less overall satisfaction with their care. 9-15 The Commonwealth Fund's 2001 Health Care Quality Survey reported that ethnic minority patients experience greater difficulty communicating with their providers and report being treated with disrespect more frequently than their Caucasian counterparts.<sup>16</sup> Evidence suggests that engaging parents in active partnerships reduces errors, improves compliance, leads to fewer no shows, encourages better self-care, reduces repeat procedures, fosters better care coordination, builds greater trust, and enhances communication. 17-23

Most patient engagement tools. However, are focused on adults and chronic illness. Tools are needed to engage parents and providers in identifying and evaluating the quality of well child services received to ensure that they are in alignment with national guidelines. There is a substantial and increasing focus among healthcare consumers on the quality of care they receive.,<sup>24,25</sup> Consumers are increasingly interested in knowing how fellow patients evaluate healthcare providers and systems, and are giving weight to these accounts.<sup>26,27</sup> The PHDS measures the quality of well child care and parent experience of care. The measures for which we are seeking endorsement allow providers, practices and health plans to select specific aspects of care for quality improvement activities as well as a full assessment of the extent to which families are receiving care in accordance with national recommendations for pediatric preventive care.

#### References:

1. Rosenthal MS, Lannon CM, Stuart JM, Brown L, Miller WC, Margolis PA. A Randomized Trial of Practice-Based Education to Improve Delivery Systems for Anticipatory Guidance. *Arch Pediatr Adolesc Med* 2005;159(5):456-463.
2. Center for Children's Healthcare Improvement, Vermont Child Health Improvement Program. A Practical Guide for Healthy Development. The Commonwealth Fund, February 2007.
3. Pelletier, H. Abrams, M., ABCD: Lessons from a Four State Consortium. National Academy for State Health Policy, support from the Commonwealth Fund. December 2003.
4. Margolis PA, Stevens R, Bordley WC, Stuart J, Harlan C, Keyes-Elstein L, et al. From Concept to Application: The Impact of a Community-Wide Intervention to Improve the Delivery of Preventive Services to Children. *Pediatrics* 2001;108(3).
5. Bethell C, Reuland CHP, Halfon N, Schor EL. Measuring the Quality of Preventive and Developmental Services for Young Children: National Estimates and Patterns of Clinicians' Performance. *Pediatrics* 2004;113(6):1973-1983.
6. Success: Implementation of Developmental and Behavioral Screening and Surveillance in Primary Care Practice--The North Carolina Assuring Better Child Health and Development (ABCD) Project. *Pediatrics* 2006;118(1):e183-188.
7. Kogan, MD, Schuster, MA, Yu, Sm, et al. Routine assessment of family and community health risks: parent views and what they receive. *Pediatrics*. 2004, Vol 113. 1934-1943.
8. Olson, AL, Dietrich, AF, Prazar, G, et al. Brief maternal depression screening at well-child visits.
9. Bethell C, Peck C, Schor E. Assessing health system provision of well-child care: The Promoting Healthy Development Survey. *Pediatrics*. 2001 May;107(5):1084-94.
10. Cooper L and Powe N. Disparities in Patient Experiences, Health Care Processes, and Outcomes: the Role of Patient-Provider Racial, Ethnic, and Language Concordance. The Commonwealth Fund. New York, NY. July 2004. Available at: [http://www.cmwf.org/programs/minority/cooper\\_raceconcordance\\_753.pdf](http://www.cmwf.org/programs/minority/cooper_raceconcordance_753.pdf). Last accessed January 3, 2007.
11. Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Committee on Quality Health Care in America, editor. Washington, DC: National Academies Press; 2003.
12. Cooper-Patrick L, Gallo J, Gonzales J, Vu H, Powe N, Nelson C, and Ford D. Race, gender, and partnership in the patient-

- physician relationship. Journal of the American Medical Association. 1999;282(6):583-589.
13. Doescher M, Saver B, Franks P, Fiscella K. Racial and ethnic disparities in perceptions of physician style and trust. Archives of Family Medicine. 2000;9(10):1156-1163.
  14. Boulware L, Cooper L, Ratner L, LaVeist T, and Powe N. Race and trust in the health care system. Public Health Reports. 2003;118(4):358-365.
  15. Saha S, Komaromy M Koepsell T, and Bindman A. Patient-physician racial concordance and the perceived quality and use of health care. Archives of Internal Medicine. 1999;159(9):997-1004.
  16. Collins K, Hughes D, Doty M, Ives B, Edwards J, and Tenney K. Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans. The Commonwealth Fund. New York, NY. March 2002.
  17. iMatteo RM. Enhancing patient adherence to medical recommendations. JAMA 1994;271:79-83.
  18. Hibbard JH, Mahoney ER, Stock R, Tusler M. Do increases in patient activation result in improved self-management behaviors? Health Serv Res. 2007 Aug;42(4):1443-63. PubMed PMID: 17610432.
  19. Bethell, CD. Moving Beyond the Tipping Point to Create a Person-Centered Health-Care System in America One Patient at a Time. Prepared on behalf of The Commonwealth Fund and Nuffield Trust International Meeting to Improve the Quality of Health Care: Strategies for Change and Action. July 2004.
  20. Lorig KR, Sobel DS, Stewart AL, et al. Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial. Medical Care 1999;37:5-14.
  21. Thom, DH, Hall, MA, Pawlson, LG. Measuring patients trust in physicians when assessing quality of care. Health Affairs, 23, no 4 (2004): 124-132.
  22. J. H. Hibbard, J. Greene, and V. Overton, "Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' 'Scores,'" Health Affairs, Feb. 2013 32(2): 216–22.
  23. Coulter, A. Patient Engagement – What works? Journal of Ambulatory Care Management, 2012; 35(2):80-89.
  24. Bethell C, Peck C, Schor E. Assessing health system provision of well-child care: The Promoting Healthy Development Survey. Pediatrics. 2001 May;107(5):1084-94.

**S.4. Numerator Statement:** The PHDS consists of 43 items in 11 distinct modules. We are asking for endorsement of 6 individual quality measures -- each contained within its own module within the PHDS -- and a composite PHDS Composite measure that includes the combination of all 6 measures. Complete instructions for measure score calculations as well as a copy of the PHDS are provided in Attachment 4: PHDS\_Final\_Appendix. Numerators are calculated for each of the six individual quality measures: (1) Anticipatory Guidance; (2) Parenting Information and Resources in the Community; (3) Family Centered Care; (4) Asking about and addressing parental concerns; (5) Family assessment for safety, alcohol use and substance abuse; and (6) Family assessment for psychosocial screening. We also calculate a numerator for the PHDS Composite measure.

**S.6. Denominator Statement:** The target population is parents with children ages 0-48 months who have completed a well child visit within the last 12 months. There is no exclusion for who can receive the survey. This is based solely on the interest and actions of the provider; additionally the parent can access the survey directly at [www.wellvisitsurvey.org](http://www.wellvisitsurvey.org).

**S.8. Denominator Exclusions:** There are no exclusions for parent target population, however, missing and substantially incomplete data are excluded.

**De.1. Measure Type:** Composite

**S.17. Data Source:** Instrument-Based Data

**S.20. Level of Analysis:** Clinician : Group/Practice, Clinician : Individual

**IF Endorsement Maintenance – Original Endorsement Date:** Jul 01, 2007 **Most Recent Endorsement Date:** Jul 01, 2007

**1c.1. Composite Measure Construction:** two or more individual performance measure scores combined into one score  
**Component Measures (if endorsed or submitted for endorsement):**

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

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

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

[0011\\_CAHI\\_PHDS\\_NQF\\_Evidence\\_Attachment\\_Form\\_12\\_22\\_16.pdf](#)

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

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

Yes

**1b. Performance Gap**

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

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

**1b.1. Briefly explain the rationale for this measure** (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

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

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

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Most patient engagement tools. However, are focused on adults and chronic illness. Tools are needed to engage parents in identifying priorities for their child's health and promoting open discussion of child and family relationships and issues to fill this gap. There is a substantial and increasing focus among healthcare consumers on the quality of care they receive.,<sup>24,25</sup> Consumers are increasingly interested in knowing how fellow patients evaluate healthcare providers and systems, and are giving weight to these accounts.<sup>26,27</sup> CAHMI recently conducted a comprehensive literature review and environmental scan of web-based family engagement tools and identified a number of benefits, gaps and needs for both families and providers. Gallo et al further found that

interventions directed at patients and families are more effective at changing their experience, while interventions targeted at providers to foster change in family experience are less effective. 28 A study of web-based family engagement tools in the US, Canada, Australia and Europe by Burns et al<sup>29</sup> identified a series of benefits of these tools, including: (1) identifying specific patient enablers; (2) improved communication between families and providers; (3) improved care through quick and appropriate problem solving; (4) improved legitimacy and credibility of decision making; (5) improved education and compliance with health care decisions; and improved health outcomes. They also identified patient, provider and health system barriers to engagement, which were classified into seven areas: legal, political, administrative, professional, personal, communication, and resources. Consistent with these findings, Bell et al's study<sup>30</sup> of patient portals in ICU settings also noted that patient portals promoted education and engagement while improving clinician workflow but that stress and uncertainty in such environments can pose a challenge to using web-based engagement tool. They also identified two additional barriers – the fear of human connection being supplanted by technology, and the tension between access to information and the potential for overwhelming families. A recent study of patient engagement in 102 practice-based research networks<sup>31</sup> identified three specific types of practice barriers with web-based tools: (1) the need for information technology (IT) support; (2) low rates of portal enrollment; and, (3) workload and practice leadership issues. These findings align closely with CAHMI's evaluation of the WVP and implementation experiences. Finally, Lafta et al<sup>32</sup> found that there were tradeoffs between benefits and challenges. For example, patient reminder lists increased active patient communication behaviors but simultaneously decreased physician communication behaviors facilitating patient involvement. The authors conclude that web-based tools to promote patient centered care can have both positive and negative as well as unintended outcomes; thus, specific implementation methods require close scrutiny. These findings suggest that while barriers exist, web-based tools have the potential to significantly increase positive experiences and health outcomes for children and families.

The PHDS includes the Parents Evaluation of Developmental Health Status (PEDS) as a screening tool for children at-risk for developmental, behavioral or social delays as well as a screener for children with special health care needs. According to one study of PHDS, "Psychometric analyses demonstrated that the PHDS quality measure scales have strong construct validity (mean factor loading: 0.69) and internal consistency (mean Cronbach's alpha: 0.80). Parents reporting positive parenting behaviors had significantly higher scores on the anticipatory guidance quality measure compared with parents not reporting positive behaviors. Parents who reported that their questions on specific anticipatory guidance topics were answered were more likely to report higher confidence in related parenting activities (odds ratio [OR]: 5.9, 95% confidence interval [CI]: 3.4-10.2; OR: 8.3, 95% CI: 5-13.8) and were less likely to report concerns about their child's development in related areas compared with parents who reported they wished they had talked more with their child's doctor about these topics (OR: 0.46, 95% CI: 0.29-0.72; OR: 0.58, 95% CI: 0.37-0.89). The 7 PHDS quality measure scores for health plans ranged from 17 to 67 (on a 0-100 scale; where 100 is the best score possible) and varied significantly across health plans. Performance was highest for provision of anticipatory guidance information from health plans and lowest for family psychosocial assessment." 33

#### References:

1. Rosenthal MS, Lannon CM, Stuart JM, Brown L, Miller WC, Margolis PA. A Randomized Trial of Practice-Based Education to Improve Delivery Systems for Anticipatory Guidance. *Arch Pediatr Adolesc Med* 2005;159(5):456-463.
2. Center for Children's Healthcare Improvement, Vermont Child Health Improvement Program. A Practical Guide for Healthy Development. The Commonwealth Fund, February 2007.
3. Pelletier, H. Abrams, M., ABCD: Lessons from a Four State Consortium. National Academy for State Health Policy, support from the Commonwealth Fund. December 2003.
4. Margolis PA, Stevens R, Bordley WC, Stuart J, Harlan C, Keyes-Elstein L, et al. From Concept to Application: The Impact of a Community-Wide Intervention to Improve the Delivery of Preventive Services to Children. *Pediatrics* 2001;108(3).
5. Bethell C, Reuland CHP, Halfon N, Schor EL. Measuring the Quality of Preventive and Developmental Services for Young Children: National Estimates and Patterns of Clinicians' Performance. *Pediatrics* 2004;113(6):1973-1983.
6. Success: Implementation of Developmental and Behavioral Screening and Surveillance in Primary Care Practice--The North Carolina Assuring Better Child Health and Development (ABCD) Project. *Pediatrics* 2006;118(1):e183-188.
7. Kogan, MD, Schuster, MA, Yu, Sm, et al. Routine assessment of family and community health risks: parent views and what they receive. *Pediatrics*. 2004, Vol 113. 1934-1943.
8. Olson, AL, Dietrich, AF, Prazar, G, et al. Brief maternal depression screening at well-child visits.
9. Bethell C, Peck C, Schor E. Assessing health system provision of well-child care: The Promoting Healthy Development Survey. *Pediatrics*. 2001 May;107(5):1084-94.
10. Cooper L and Powe N. Disparities in Patient Experiences, Health Care Processes, and Outcomes: the Role of Patient-Provider Racial, Ethnic, and Language Concordance. The Commonwealth Fund. New York, NY. July 2004. Available at: [http://www.cmwf.org/programs/minority/cooper\\_raceconcordance\\_753.pdf](http://www.cmwf.org/programs/minority/cooper_raceconcordance_753.pdf). Last accessed January 3, 2007.
11. Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Committee on Quality



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12. Cooper-Patrick L, Gallo J, Gonzales J, Vu H, Powe N, Nelson C, and Ford D. Race, gender, and partnership in the patient-physician relationship. *Journal of the American Medical Association*. 1999;282(6):583-589.
  13. Doescher M, Saver B, Franks P, Fiscella K. Racial and ethnic disparities in perceptions of physician style and trust. *Archives of Family Medicine*. 2000;9(10):1156-1163.
  14. Boulware L, Cooper L, Ratner L, LaVeist T, and Powe N. Race and trust in the health care system. *Public Health Reports*. 2003;118(4):358-365.
  15. Saha S, Komaromy M Koepsell T, and Bindman A. Patient-physician racial concordance and the perceived quality and use of health care. *Archives of Internal Medicine*. 1999;159(9):997-1004.
  16. Collins K, Hughes D, Doty M, Ives B, Edwards J, and Tenney K. *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans*. The Commonwealth Fund. New York, NY. March 2002.
  17. iMatteo RM. Enhancing patient adherence to medical recommendations. *JAMA* 1994;271:79-83.
  18. Hibbard JH, Mahoney ER, Stock R, Tusler M. Do increases in patient activation result in improved self-management behaviors? *Health Serv Res*. 2007 Aug;42(4):1443-63. PubMed PMID: 17610432.
  19. Bethell, CD. *Moving Beyond the Tipping Point to Create a Person-Centered Health-Care System in America One Patient at a Time*. Prepared on behalf of The Commonwealth Fund and Nuffield Trust International Meeting to Improve the Quality of Health Care: Strategies for Change and Action. July 2004.
  20. Lorig KR, Sobel DS, Stewart AL, et al. Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial. *Medical Care* 1999;37:5-14.
  21. Thom, DH, Hall, MA, Pawlson, LG. Measuring patients trust in physicians when assessing quality of care. *Health Affairs*, 23, no 4 (2004): 124-132.
  22. J. H. Hibbard, J. Greene, and V. Overton, "Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' 'Scores,'" *Health Affairs*, Feb. 2013 32(2): 216–22.
  23. Coulter, A. Patient Engagement – What works? *Journal of Ambulatory Care Management*, 2012; 35(2):80-89.
  24. Bethell C, Peck C, Schor E. Assessing health system provision of well-child care: The Promoting Healthy Development Survey. *Pediatrics*. 2001 May;107(5):1084-94.
  25. Kaiser Family Foundation and the Agency for Healthcare Research and Quality (AHRQ). *National Survey on Americans as Health Care Consumers: An update on the Role of Quality Information*, 2000. Available at: <http://www.kaisernetwork.org>. Accessed January 3, 2007.
  26. Kaiser Family Foundation, AHRQ, and Harvard School of Public Health. *National Survey on Consumers' Experiences with Patient Safety and Quality Information. Summary of Findings*. November 2004. Available at: <http://www.kaisernetwork.org>. Accessed January 3, 2007.
  27. Edgman-Levitan A and Cleary P. What information do consumers want and need? *Health Affairs*. 1996;15(4):42-56.
  28. Gallo, K.P., Hill, L.C., Hoagwood, K.E., & Olin, S.C. (2016). A narrative synthesis of the components of and evidence for patient- and family-centered care. *Clinical Pediatrics*, 55(4), 333-46.
  29. Dalal, AK, Patricia C Dykes, PC, Collins, S, Soleymani Lehmann, L, Ohashi, K, Rozenblum R, Stadel D, McNally, K, Morrison CRC, Ravindran S, Mlaver E, Hanna J, Chang, F, Kandala, R, Getty, G, Bates, DW. A web-based, patient-centered toolkit to engage patients and caregivers in the acute care setting: a preliminary evaluation. *J Am Med Inform Assoc* 2016; 23:80–87. doi:10.1093/jamia/ocv093.
  30. Davies, B., Steele, R., Krueger, G., Albersheim, S., Baird, J., Bifrie, M., Cadell, S., Doane, G., Garga, D., Siden, H., Strahlendorf, C., & Zhao, Y. (2016). Best practice in provider/parent interaction. *Qualitative Health Research*, in press.
  31. Dennis, C., Baxter, P., Ploeg, J., & Blatz, S. (2016). Models of partnership within family centered care in the acute pediatric setting: A discussion paper. *Journal of Advanced Nursing*, in press.
  32. Family Engagement Inventory (FEI): A Brief Costs-Disciplinary Synthesis. Child Welfare Information Gateway, The Children's Bureau, US Administration for Children and Families, August 2014, accessed at <https://www.childwelfare.gov/FEI/practice-strategies/>. See also Commonalities Across the Practice Level Strategy Domain: <https://www.childwelfare.gov/pubPDFs/Common-practice.pdf>.
  33. Bethell C, Peck C, Schor E. Assessing health system provision of well-child care: The Promoting Healthy Development Survey. *Pediatrics*. 2001 May;107(5):1084-94.

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.**

The Online PHDS contains n=5,670 surveys reporting on quality of care provided by individual pediatricians and primary care

providers from 88 clinics in 36 states. Over one fourth of completed surveys (20.6%, n=1736) are linked to individual providers. All surveys are linked to clinics.

Participation: Voluntary self-selection process based on knowledge and interest in PHDS and quality improvement in their practice or health system.

Table 1a and 1b show prevalence of quality measures for top 5 providers (1a) and 5 clinics (1b).

Table 1a. Quality performance measures by providers (Online PHDS) – Top 5 providers out of 372 providers

Provider ID	Anticipatory guidance and parental education				Parenting information and resources in community				Ask about concerns and addressing concerns	
	Family centered care				Assessment of smoking, drug and alcohol use and safety				Assessment of family psychosocial well-being	
	Total n	% met criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)
criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)
948	50	62.0% (31)	50	70.0% (35)	50	86.0% (43)	50	92.0% (46)	50	6% (3)
	50	6% (3)								
802	39	74.4% (29)	42	81.0% (34)	42	90.5% (38)	-	-	42	21.4% (9)
	42	16.7% (7)								
747	32	81.3% (26)	32	87.5% (28)	32	65.6% (21)	-	-	33	42.4% (14)
	33	39.4% (13)								
756	32	71.9% (32)	35	85.7% (30)	35	74.3% (26)	-	-	35	11.4% (4)
	35	34.3% (12)								
927	29	86.2% (25)	28	92.9% (26)	29	96.6% (28)	29	100% (29)	29	34.5%
(10)	29	44.8% (13)								
978	-	-	-	-	28	78.6% (22)	-	-	-	-
954	-	-	-	-	23	82.6% (19)	-	-	-	-
942	-	-	-	-	20	90.9% (20)	-	-	-	-

Table 1b. Quality performance measures by clinic (Online PHDS) - Top 5 clinics out of 88 clinics

Clinic ID (description)	Anticipatory guidance and parental education				Parenting information and resources in community				Ask about concerns and addressing concerns	
	Family centered care				Assessment of smoking, drug and alcohol use and safety				Assessment of family psychosocial well-being	
	Total n	% met criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)
criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)	Total n	% met criteria (n)
146 (urban pediatric PC clinic)	411	59.6% (245)	393	78.4% (208)	400	70.0% (280)	414	85.7%		
(355)	404	29.5% (119)	405	28.6% (116)						
39 (urban children's hospital)	287	67.2% (193)	285	73.7% (210)	286	78.0% (223)	-	-		
	284	20.8% (59)	286	17.5% (50)						
126 (rural pediatric clinic)	287	61.7% (177)	276	76.1% (210)	285	74.4% (212)	287	88.2% (253)		
	287	12.9% (37)	285	14.4% (41)						
152 (rural pediatric and women clinic)	196	60.7% (119)	185	77.3% (143)	196	58.7% (115)	201			
	188	30.9% (58)	188	39.9% (75)						
64 (urban outpatient clinic)	163	60.1% (98)	165	83.0% (137)	170	70.0% (119)	-	-		
	169	20.7% (35)	171	12.3% (21)						
132 (urban pediatric outpatient clinic)	-	-	-	-	-	146	88.4% (129)	-		
	-	-	-	-	-					
172 (rural community health center)	-	-	-	-	-	138	81.9% (113)	-		
	-	-	-	-	-					

Using the Online PHDS data, Table 1a and 1b above present the proportion of children whose care met for each measure (for top 5 providers and 5 clinics). The proportion of parents who reported discussion of all anticipatory guidance and parental education topics or reported no need of discussion among unaddressed topics ranged 60-86%. Only 6%-45% of parents of young children reported that their child's pediatric clinician discussed psychosocial topics such as parent emotional well-being and partner support in parenting.

**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.**

Not applicable

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.**

CAHMI evaluated the PHDS in three pediatric primary care sites in Oregon at two points in time (HRSA Study data): baseline data collection (2010) and post-implementation assessment (2011-12). We analyzed the data for disparities for all sites based on demographic and health information from the survey including age, race, insurance type, at risk of developmental delay (from the CSCHN screener embedded in the PHDS). We provide results below for six of the seven modules for which we are requesting endorsement: (1) anticipatory guidance; (2) parent was asked about health concerns and concerns were addressed; (3-4) family assessment for safety, alcohol and substance abuse and psychosocial screening (combination of two family assessment modules); (5) family centered care; and (6) comprehensive care measure (the composite PHDS measure). Because of data limitations, it was not possible to assess the parenting information, resources in the community measure by demographic and health characteristics.

Anticipatory Guidance & Parent Education Measure by Children's Characteristics:  
Parent had their needs met on all AGPE topics

Characteristics	Baseline % (n)	Follow-up % (n)	Fisher's Exact Test-p value
Age			
3-9 months	38.9% (216)	45.2% (146)	0.08*
10-18 months	48.5% (208)	45.7% (150)	0.46
19-48 months	55.0% (193)	65.9% (147)	0.01*
Race			
Hispanic	46.0% (46)	47.8% (46)	0.86
White	46.2% (475)	51.9% (372)	0.02*
Asian	35.7% (10)	52.9% (9)	0.35
Multiple or other	62.5% (15)	33.3% (6)	0.12
Insurance type			
Private or private and public	46.4% (502)	49.9% (339)	0.15
Public only (includes Medicaid, Medicare, CHIP, and Military)	44.7% (85)	54.9% (89)	0.07*
Other insurance type	(3)	(1) -	
Uninsured	50.0% (6)	(4) -	
At risk of developmental delay			
Low/no risk	47.5% (487)	52.1% (285)	0.09*
High/moderate risk	40.7% (114)	44.4% (76)	0.49

\*Statistically significant improvement in quality of care at the 90% confidence interval or higher.

Asking about Parent's Concerns about Development Measure, by Children's Characteristics:  
Parent was asked if they had concerns about their child's development

Characteristics	Baseline % (n)	Follow-up % (n)	Fisher's Exact Test p value
Age			
3-9 months	64.6% (357)	73.7% (235)	0.01*
10-18 months	78.6% (319)	76.6% (246)	0.59
19-48 months	80.3% (282)	82.3% (181)	0.59
Race			
Hispanic	72.0% (72)	84.1% (37)	0.14
White	72.5% (745)	76.4% (542)	0.07*



Asian	75.0% (21)	70.6% (12)	0.74
Multiple or other	87.5% (21)	77.8% (14)	0.44
Insurance type			
Private or private and public	72.4% (784)	75.5% (509)	0.16
Public only (includes Medicaid, Medicare, CHIP, and Military)	78.4% (149)	82.2% (129)	0.42
Other insurance type	71.4% (5)	(3)	-
Uninsured	50.0% (6)	100% (7)	0.04*
At risk of developmental delay			
Low/no risk	72.2% (741)	76.3% (411)	0.09*
High/moderate risk	76.2% (214)	82.4% (140)	0.13

\*Statistically significant improvement in quality of care at the 90% confidence interval or higher.

#### Family Assessment\*, by Children's Characteristics

Parent was asked about one or more family assessment topics

Characteristics	Baseline % (n)	Follow-up % (n)	Fisher's Exact Test p value
Age			
3-9 months	23.9% (132)	45.0% (145)	<0.0001*
10-18 months	21.5% (87)	34.4% (111)	<0.0001*
19-48 months	29.3% (103)	50.5% (112)	<0.0001*
Race			
Hispanic	26.0% (26)	47.8% (22)	0.01*
White	24.5% (252)	42.7% (305)	<0.0001*
Asian	28.6% (8)	(4)	-
Multiple or other	50.0% (12)	50.0% (9)	1.00
Insurance type			
Private or private and public	22.9% (248)	37.9% (257)	<0.0001*
Public only (includes Medicaid, Medicare, CHIP, and Military)	33.5% (64)	39.1% (63)	<0.0001*
Other insurance type	(2)	(1)	N/A
Uninsured	(4)	(3)	N/A
At risk of developmental delay			
Low/no risk	24.3% (248)	41.6% (227)	<0.0001*
High/moderate risk	26.0% (73)	44.7% (76)	<0.0001(

\*Statistically significant improvement in quality of care at the 99% confidence interval or higher.

#### Family Centered Care Measure Comparison by Children's Characteristics

Parent received family-centered care

Characteristics	Baseline % (n)	Follow-up % (n)	Fisher's Exact Test p value
Age			
3-9 months	61.9% (343)	65.1% (209)	0.38
10-18 months	64.9% (261)	69.3% (224)	0.23
19-48 months	65.2% (227)	68.0% (151)	0.53
Race			
Hispanic	62.0% (62)	71.1% (32)	0.35
White	64.7% (667)	67.7% (485)	0.20
Asian	39.3% (11)	70.6% (12)	0.07*
Multiple or other	66.7% (16)	66.7% (12)	1.00
Insurance type			
Private or private and public	64.9% (704)	67.9% (461)	0.20
Public only (includes Medicaid,			

Medicare, CHIP, and Military)	58.1% (111)	66.9% (107)	0.10
Other insurance type	(4)	(2)	N/A
Uninsured	66.7% (8)	(4)	N/A
At risk of developmental delay			
Low/no risk	65.5% (669)	69.4% (379)	0.12
High/moderate risk	57.4% (159)	57.9% (99)	0.92

\*Statistically significant improvement in quality of care at the 90% confidence interval or higher.

#### Comprehensive Care Measure, by Children's Characteristics

##### Met comprehensive care measure

Characteristics	Baseline % (n)	Follow-up % (n)	Fisher's Exact Test p value
Age			
3-9 months	6.6% (36)	16.2% (51)	<0.0001*
10-18 months	9.5% (38)	10.7% (34)	0.62
19-48 months	13.5% (47)	25.5% (56)	<0.0001*
Race			
Hispanic	6.0% (6)	23.3% (10)	0.01*
White	9.4% (96)	16.7% (118)	<0.0001*
Asian	- (2)	- (1)	N/A
Multiple or other	29.2% (7)	- (2)	N/A
Insurance type			
Private or private and public	8.8% (95)	14.3% (96)	0.001*
Public only (includes Medicaid, Medicare, CHIP, and Military)	11.6% (22)	27.3% (42)	<0.0001*
Other insurance type	(1)	(0)	N/A
Uninsured	(2)	(1)	N/A
At risk of developmental delay			
Low/no risk	9.3% (94)	17.5% (94)	<0.0001*
High/moderate risk	9.4% (26)	11.8% (20)	0.43

\*Statistically significant improvement in quality of care at the 99% confidence interval or higher.

We also assessed disparities for all clinics using the Online PHDS dataset by individual quality measures. See Composite Testing Form, Section 2b4.4b.

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

Not applicable

#### 1c. Composite Quality Construct and Rationale

**1c.1. A composite performance measure is a combination of two or more component measures, each of which individually reflects quality of care, into a single performance measure with a single score.**

For purposes of NQF measure submission, evaluation, and endorsement, the following will be considered composites:

- Measures with two or more individual performance measure scores combined into one score for an accountable entity.
- Measures with two or more individual component measures assessed separately for each patient and then aggregated into one score for an accountable entity:
  - all-or-none measures (e.g., all essential care processes received, or outcomes experienced, by each patient);

**1c.1. Please identify the composite measure construction: two or more individual performance measure scores combined into one score**

**1c.2. Describe the quality construct, including:**

- the overall area of quality
- included component measures and
- the relationship of the component measures to the overall composite and to each other.

Area of Quality: The Promoting Healthy Development Survey (PHDS) assesses the extent to which young children ages 0-48 months receive preventive and developmental services in accordance with recommended national guidelines, such as those included in the Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents—Third Edition, by asking parents or guardians about their experience of the well child visit.

Measures and Their Relationship to Each Other: There are six individual quality measures embedded in the PHDS - each is a stand-alone part of the PHDS and is scored independently of the others. There is also a PHDS composite quality measure which combines all six individual quality measures into one score.

1. Anticipatory guidance
2. Parenting information, resources in community
3. Family centered care
4. Ask about and address parental concerns
5. Assessment of family safety, alcohol use and substance abuse
6. Assessment of family psychosocial screening
7. PHDS Composite measure (combined #1-6 above)

**1c.3. Describe the rationale for constructing a composite measure, including how the composite provides a distinctive or additive value over the component measures individually.**

The PHDS was designed to measure these communication-dependent aspects of care because studies have shown that medical chart reviews and claims or billing data do not reliably or validly measure clinical recommendations that providers discuss with their patients. A second goal of the PHDS is not only to assess whether recommended care was provided, but also to measure the degree to which the parent have their informational needs met and whether the care provided is family-centered. Again, these important characteristics of a high-quality health system are best measured by asking the parent(s) directly.

The individual measures allow for the examination of quality and patient experience by specific aspect of care. This is helpful for providers, practices and health systems wishing to implement a quality improvement activity because it allows them to identify, measure and implement action plans on specific aspects of care and conduct these activities within resource constraints. Taken together, the composite PHDS measure allows the provider, practice of health plan to measure the extent to which national recommendations for pediatric preventive care are generally being met.

Well child visits present an essential leverage point for engaging parents in the health and well-being of their child, early identification of physical, social, emotional and behavioral issues, providing critical anticipatory guidance and education for parents, and promoting positive child and family health, resilience, social and emotional skills. However, substantial evidence exists documenting the persistent and alarming gap between what is recommended and what is actually provided in the context of well-child care for young children. Gaps exist for 9 out of 10 children, whose parents report not receiving at least one of a core set of recommended services for psychosocial, developmental and other screening and anticipatory guidance, and parental education. For example, findings from national and regional studies indicate improvements are specifically needed on the clinical recommendations focused on anticipatory guidance and parental education (1 out of 2 children have parents with unmet informational needs<sup>1-4</sup>), surveillance of children's development (2 out of 5 children have parents who were not asked about their<sup>11</sup> concerns about their child's learning, development or behavior<sup>5,6</sup>), and assessment of the family for risk (only 10% of children's families are screened for risk factors<sup>7,8</sup>). In addition, there are significant variations in the quality of care across individual health care providers and office-settings and within the population of children an individual health care provider cares for, demonstrating disparities by child/family characteristics and a lack of standardization in the preventive services received by young children.

Population differences for well child care have also been identified. Patients from ethnic minorities generally report being less involved in their healthcare, having lower levels of trust in their providers, and having less overall satisfaction with their care. 9-15 The Commonwealth Fund's 2001 Health Care Quality Survey reported that ethnic minority patients experience greater difficulty communicating with their providers and report being treated with disrespect more frequently than their Caucasian counterparts.<sup>16</sup> Evidence suggests that engaging parents in active partnerships reduces errors, improves compliance, leads to fewer no shows, encourages better self-care, reduces repeat procedures, fosters better care coordination, builds greater trust, and enhances communication. 17-23

Most patient engagement tools. However, are focused on adults and chronic illness. Tools are needed to engage parents and

providers in identifying and evaluating the quality of well child services received to ensure that they are in alignment with national guidelines. There is a substantial and increasing focus among healthcare consumers on the quality of care they receive.,<sup>24,25</sup> Consumers are increasingly interested in knowing how fellow patients evaluate healthcare providers and systems, and are giving weight to these accounts.<sup>26,27</sup> The PHDS measures the quality of well child care and parent experience of care. The measures for which we are seeking endorsement allow providers, practices and health plans to select specific aspects of care for quality improvement activities as well as a full assessment of the extent to which families are receiving care in accordance with national recommendations for pediatric preventive care.

#### References:

1. Rosenthal MS, Lannon CM, Stuart JM, Brown L, Miller WC, Margolis PA. A Randomized Trial of Practice-Based Education to Improve Delivery Systems for Anticipatory Guidance. *Arch Pediatr Adolesc Med* 2005;159(5):456-463.
2. Center for Children's Healthcare Improvement, Vermont Child Health Improvement Program. A Practical Guide for Healthy Development. The Commonwealth Fund, February 2007.
3. Pelletier, H. Abrams, M., ABCD: Lessons from a Four State Consortium. National Academy for State Health Policy, support from the Commonwealth Fund. December 2003.
4. Margolis PA, Stevens R, Bordley WC, Stuart J, Harlan C, Keyes-Elstein L, et al. From Concept to Application: The Impact of a Community-Wide Intervention to Improve the Delivery of Preventive Services to Children. *Pediatrics* 2001;108(3).
5. Bethell C, Reuland CHP, Halfon N, Schor EL. Measuring the Quality of Preventive and Developmental Services for Young Children: National Estimates and Patterns of Clinicians' Performance. *Pediatrics* 2004;113(6):1973-1983.
6. Success: Implementation of Developmental and Behavioral Screening and Surveillance in Primary Care Practice--The North Carolina Assuring Better Child Health and Development (ABCD) Project. *Pediatrics* 2006;118(1):e183-188.
7. Kogan, MD, Schuster, MA, Yu, Sm, et al. Routine assessment of family and community health risks: parent views and what they receive. *Pediatrics*. 2004, Vol 113. 1934-1943.
8. Olson, AL, Dietrich, AF, Prazar, G, et al. Brief maternal depression screening at well-child visits.
9. Bethell C, Peck C, Schor E. Assessing health system provision of well-child care: The Promoting Healthy Development Survey. *Pediatrics*. 2001 May;107(5):1084-94.
10. Cooper L and Powe N. Disparities in Patient Experiences, Health Care Processes, and Outcomes: the Role of Patient-Provider Racial, Ethnic, and Language Concordance. The Commonwealth Fund. New York, NY. July 2004. Available at: [http://www.cmwf.org/programs/minority/cooper\\_raceconcordance\\_753.pdf](http://www.cmwf.org/programs/minority/cooper_raceconcordance_753.pdf). Last accessed January 3, 2007.
11. Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Committee on Quality Health Care in America, editor. Washington, DC: National Academies Press; 2003.
12. Cooper-Patrick L, Gallo J, Gonzales J, Vu H, Powe N, Nelson C, and Ford D. Race, gender, and partnership in the patient-physician relationship. *Journal of the American Medical Association*. 1999;282(6):583-589.
13. Doescher M, Saver B, Franks P, Fiscella K. Racial and ethnic disparities in perceptions of physician style and trust. *Archives of Family Medicine*. 2000;9(10):1156-1163.
14. Boulware L, Cooper L, Ratner L, LaVeist T, and Powe N. Race and trust in the health care system. *Public Health Reports*. 2003;118(4):358-365.
15. Saha S, Komaromy M Koepsell T, and Bindman A. Patient-physician racial concordance and the perceived quality and use of health care. *Archives of Internal Medicine*. 1999;159(9):997-1004.
16. Collins K, Hughes D, Doty M, Ives B, Edwards J, and Tenney K. Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans. The Commonwealth Fund. New York, NY. March 2002.
17. iMatteo RM. Enhancing patient adherence to medical recommendations. *JAMA* 1994;271:79-83.
18. Hibbard JH, Mahoney ER, Stock R, Tusler M. Do increases in patient activation result in improved self-management behaviors? *Health Serv Res*. 2007 Aug;42(4):1443-63. PubMed PMID: 17610432.
19. Bethell, CD. Moving Beyond the Tipping Point to Create a Person-Centered Health-Care System in America One Patient at a Time. Prepared on behalf of The Commonwealth Fund and Nuffield Trust International Meeting to Improve the Quality of Health Care: Strategies for Change and Action. July 2004.
20. Lorig KR, Sobel DS, Stewart AL, et al. Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial. *Medical Care* 1999;37:5-14.
21. Thom, DH, Hall, MA, Pawlson, LG. Measuring patients trust in physicians when assessing quality of care. *Health Affairs*, 23, no 4 (2004): 124-132.
22. J. H. Hibbard, J. Greene, and V. Overton, "Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' 'Scores,'" *Health Affairs*, Feb. 2013 32(2): 216-22.
23. Coulter, A. Patient Engagement – What works? *Journal of Ambulatory Care Management*, 2012; 35(2):80-89.
24. Bethell C, Peck C, Schor E. Assessing health system provision of well-child care: The Promoting Healthy Development

Survey. Pediatrics. 2001 May;107(5):1084-94.

**1c.4. Describe how the aggregation and weighting of the component measures are consistent with the stated quality construct and rationale.**

Each of the six individual quality measures is scored independently and expressed as a percentage of parents indicating that they received quality care in each area (see numerator and denominator information below for scoring of these measures). There is no weighting within each measure or for the PHDS composite measure. The composite PHDS score is an unweighted simple average of the 6 individual quality of care measures. For the PHDS Composite score, each individual measure is given a score of 100% if criteria for quality was met, or 0 if it was not. The PHDS composite score is the mean unweighted average of all six scores. A PHDS Composite score of 75% is needed to be considered achieving "quality."

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

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

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

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

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

Person-and Family-Centered Care, Primary Prevention, Screening

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

Children, Populations at Risk

**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.)

The survey is available at [www.wellvisitsurvey.com/Content/Default.aspx](http://www.wellvisitsurvey.com/Content/Default.aspx). Please be advised that the site is being upgraded. You must click "advanced" to be directed to the survey itself.

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

This is not an eMeasure Attachment:

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

Attachment Attachment: PHDS\_Codebook.xlsx

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

No

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

No changes.

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

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

The PHDS consists of 43 items in 11 distinct modules. We are asking for endorsement of 6 individual quality measures -- each contained within its own module within the PHDS -- and a composite PHDS Composite measure that includes the combination of all 6 measures. Complete instructions for measure score calculations as well as a copy of the PHDS are provided in Attachment 4: PHDS\_Final\_Appendix. Numerators are calculated for each of the six individual quality measures: (1) Anticipatory Guidance; (2) Parenting Information and Resources in the Community; (3) Family Centered Care; (4) Asking about and addressing parental concerns; (5) Family assessment for safety, alcohol use and substance abuse; and (6) Family assessment for psychosocial screening. We also calculate a numerator for the PHDS Composite measure.

**S.5. Numerator Details** *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

*IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*

The numerators for the six individual measures and the PHDS Composite measure are as follows:

1. Anticipatory Guidance:

The numerator is the number of survey respondents answering either “Yes and my questions were answered” or “No, but I already had information about this topic and did not need to talk about it anymore” to the anticipatory guidance questions. Necessarily, anticipatory guidance questions vary by age. Anticipatory guidance for children ages 0-9 months include 15 questions. Anticipatory guidance for children ages 10-18 months includes 16 questions; and anticipatory guidance for children ages 19-48 months includes 16 questions (see PHDS\_Final\_Appendix, Item #1 for a complete list of questions). A score of at least 75% positive response rate is needed to achieve quality for this aspect of care.

2. Parenting Information, Resources in the Community

The numerator is the number of survey respondents answering either “Yes and my questions were answered” or “No, but I already had information about this topic and did not need to talk about it anymore” to BOTH of the two questions. A 100% positive response is needed to achieve quality for this aspect of care.

3. Family Centered Care

The numerator is the number of survey respondents answering “Yes, Definitely” to all of the questions. A 100% positive response is needed to achieve quality for this aspect of care.

4. Ask About and Address Parental Concerns

The numerator is the number of survey respondents answering “Yes” to both questions in this module. A 100% positive response is needed to achieve quality for this aspect of care.

5. Assessment of Family Safety, Alcohol Use and Substance Abuse

The numerator is the number of survey respondents answering “Yes” to all three questions in this module. A 100% positive is needed to achieve quality for this aspect of care.

6. Assessment of Family Psychosocial Screening

The numerator is the number of survey respondents answering “Yes” to all three questions in this module. A 100% positive response indicates that families have received psychosocial screening in accordance with national guidelines.

7. PHDS Composite Measure (all 6 quality measures combined)

Each of the six quality measures is scored according to whether it met (100%) or did not meet (0%) the quality standard as described above. A simple average is calculated for all six measures. The numerator is the number of measures meeting the quality standard (eg: received a score of 100%). A mean score of 75% for the PHDS Composite measure is needed to achieve overall quality for the visit.

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



The target population is parents with children ages 0-48 months who have completed a well child visit within the last 12 months. There is no exclusion for who can receive the survey. This is based solely on the interest and actions of the provider; additionally the parent can access the survey directly at [www.wellvisitsurvey.org](http://www.wellvisitsurvey.org).

**S.7. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The denominator for each of the six individual measures is the number of parents completing that module. Because providers are able to select which of the modules they wish to send to the parents, the denominator for each module is assessed on an individual basis. For the combined PHDS Composite quality measure, the denominator is the number of parents completing ALL 6 modules.

**S.8. Denominator Exclusions** (Brief narrative description of exclusions from the target population)

There are no exclusions for parent target population, however, missing and substantially incomplete data are excluded.

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

Unknown values (responses coded missing) are not included in the denominator for the data analysis. If a parent answered less than half of the items in the module or the combined 6 modules, their data are considered to be missing and excluded from analysis.

**S.10. Stratification Information** (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

The data are stratified by demographic data (parent and child gender, first child, parent and child race/ethnicity, parent age, parent education, financial difficulties), Children with Special Health Care Needs (CSHCN) status (if parent answered “yes” to any of the 5 CSHCN screener questions; and whether the parent received follow-up guidance for at-risk children.

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

Other

If other: The data stratified as indicate above but data are not risk-adjusted

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

Rate/proportion

If other:

**S.13. Interpretation of Score** (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

**S.14. Calculation Algorithm/Measure Logic** (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Scoring methods and interpretation of the scored vary by measure. For Anticipatory Guidance, a score of 75% of better indicates that on average the parent has received nationally recommended services for anticipatory guidance. For the remaining five individual measures – parenting information/resources in the community, family centered care, asking about and addressing parent concerns, and family assessment for safety, alcohol, substance abuse and psychosocial screening – a score of 100% indicates that national recommendations for these aspects of care have been provided. For the composite PHDS measure, a score of 75% or better across all six individual measures indicates that on average children “usually” or “always” receive all aspects of nationally recommended preventive services.

**S.15. Sampling** (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

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

Not Applicable: There is no sampling frame. We are using all data from the voluntary public access database.

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

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

Measure is based on the CAHMI Promoting Healthy Development Survey (PHDS) collected from voluntary participation by parents who received a well child visit and whose primary care provider sent the survey. We therefore do not have a response rate but we do have the percentage of respondents who completed the survey: 97.4% of parents who started the survey completed the survey.

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

If other, please describe in S.18.

Instrument-Based Data

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

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

The PHDS instrument (Found in PHDS\_Final\_Appendix, Item #1) is sent by providers to parents whose child received a well child visit. The parent completes the survey and the data are collected in a database housed on a CAHMI HIPAA-compliant secure server. Both parents and providers receive a feedback report of the parent's experiences. In the case of the provider, the data are anonymous and do not contain patient identifiers. The process is entirely voluntary and free to both providers and parents. This process is shown in Figure 2 of the Evidence form

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

Available in attached appendix at A.1

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

Clinician : Group/Practice, Clinician : Individual

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

Outpatient Services

If other:

**S.22. COMPOSITE Performance Measure** - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

For the six individual quality measures, as noted above the numerators are calculated individually and are independent of each other. The denominator for each measure is the number of parents that completed the module. A percentage score is derived for from each numerator and denominator and represents the proportion of children who received that aspect of care in accordance with nationally recommended guidelines, the quality performance measure, for that provider or clinic. For the PHDS Composite score, the numerator is calculated as follows: Each of the six quality measures in the PHDS is scored according to whether it met (100%) or did not meet (0%) the standard for delivering quality care. A simple average is calculated for all six measures. The PHDS Composite denominator is the number of parents who completed all six modules. A mean PHDS Composite score of 75% across the six modules meets quality performance standards for that provider or clinic.

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

0011\_CAHMI=PHDS\_Composite\_testing\_attachment\_12\_22\_16.pdf

### 2.1 For maintenance of endorsement

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

Yes

### 2.2 For maintenance of endorsement

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

No

**2.3 For maintenance of endorsement**

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

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

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

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

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

No - This measure is not risk-adjusted

**3. Feasibility**

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

**3a. Byproduct of Care Processes**

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

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

Other

If other: Patient (parent) report

**3b. Electronic Sources**

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

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

Patient/family reported information (may be electronic or paper)

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).**

The data source is web-based parent-response only. No other sources of data are collected.

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.**

Attachment:

**3c. Data Collection Strategy**

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

**3c.1. Required for maintenance of endorsement.** Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

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

Data collection is plan, clinic or provider driven and parent response is completely voluntary. For use of the online PHDS, the provider voluntarily registers to use the PHDS at [www.phdstoolkit.org](http://www.phdstoolkit.org) and a unique URL linking the provider with the parent survey is generated during the registration process and sent via email to the provider. The provider then sends the URL link to the parent, who then voluntarily fills out the survey, accessed at [www.wellvisitsurvey.org](http://www.wellvisitsurvey.org). Survey data are fed into a secure database housed on a CAHMI HIPAA-compliant server. Both the parent and provider receive a "Feedback Report." (See PHDS\_Final\_Appendix, Item #8 for the PHDS Model). The PHDS is housed on a free public-access use website and can also be used independently by parents and providers by simply accessing the PHDS at [www.wellvisitsurvey.org](http://www.wellvisitsurvey.org). For example, the provider can send the link directly to the parents for their use, and the parent can access the site directly. If desired, the parent could take the feedback report to the provider for discussion during the next child health visit. However, provider registration on the PHDS toolkit is required to link the results of the parent-reported PHDS data with a specific provider. The survey is valuable for parents as an educational tool, as many parents are not familiar with national guidelines and do not know whether their child is receiving quality care. It is also useful as a feedback tool for the provider for assessment and improvement of quality of care.

Time and cost of data collection are low: provider registration takes about 10 minutes and the parent survey takes about 15-20 minutes to fill out all modules. To date, implementation has been limited by lack of funding and resources for outreach, communication and technical support. Our experience in the development and evaluation of the PHDS demonstrated a clear and compelling need to work closely with providers to overcome the many myths that both parents and providers have about patient-engagement quality improvement tools. For the PHDS to be adopted by providers, it is essential to demonstrate, for example, that tool adds value for both the parent and provider, that it fits into and typically improves work flow in the office; improves parent-provider communication, and most important, improve the quality and delivery of nationally recommended services for children. This can only really be accomplished by collaboration and partnership with providers.

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

None.

**4. Usability and Use**

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

**4a. Accountability and Transparency**

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

**4.1. Current and Planned Use**

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

Specific Plan for Use	Current Use (for current use provide URL)
Public Reporting	

Regulatory and Accreditation Programs

Quality Improvement (Internal to the specific organization)

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

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

Name of program and sponsor: CAHMI

Purpose: Improving the quality of well child visits

Geographic area and number and percentage of accountable entities and patients included: National: this is a completely voluntary process; thus there are no accountable entities.

Level of measurement and setting: Individual provider and clinic level of measurement, primary care or outpatient clinic setting

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

The PHDS toolkit ([www.phstoolkit.org](http://www.phstoolkit.org)) and the parent-reported PHDS ([www.wellvisitsurvey.org](http://www.wellvisitsurvey.org)) were used by 68 uniquely identified providers across the country through 2013. We are happy to provide a list of these providers to NQF if desired. In 2014, CAHMI moved from the Oregon Health & Sciences University, Portland OR to the Johns Hopkins University, Baltimore, MD. As a result of the move, and because both server and database technologies had rapidly evolved and improved over the past few years, it was necessary to upgrade our servers, which in turn caused some technical issues with the links between the provider toolkit, the PHDS, and the CAHMI PHDS database. Additionally, the PHDS was originally used to compare providers within a practice as well as between practices within a health system. The current use of the Online PHDS provides feedback only for individual providers and at the clinic or practice level but not between providers. The combination of these factors led to a decision to upgrade and redesign the PHDS toolkit, PHDS database and Parent Survey. (The PHDS itself, however, remains fully operational, although use has been nominal from 2014-present, and can be accessed at [www.wellvisitsurvey.org](http://www.wellvisitsurvey.org).) The redesign required additional time, IT and CAHMI staff resources and delays were incurred during 2014-2015. However, we are now in the process of finalizing the PHDS Toolkit and database redesign, which is anticipated to be completed in January 2017.

**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.)**

The redesigned PHDS system (registration toolkit, parent survey tool and PHDS database) is anticipated to be completed and fully functional by the end of January 2017. We have a communication and outreach plan to promote the PHDS as part of the CAHMI Cycle of Engagement (see PHDS\_Final\_Appendix, Item #7), which includes the CAHMI Well Visit Planner ([www.wellvisitplanner.org](http://www.wellvisitplanner.org)) - a free parent engagement tool that helps prepare parents for the upcoming well child visit - and the post-visit PHDS which assesses whether the parent received services in alignment with national guidelines as well as family centered care. We have been promoting the Cycle of Engagement in national meetings (AMCHP, PAS, APHA, AcademyHealth ARM, National Child Health Policy Meeting, and more) over the past several years. We presented the Cycle of Engagement at the CMS Quality Meeting December 13, 2016 and have further plans to unveil the redesigned version at meetings in 2017. The WVP and PHDS have also been endorsed tools that meet requirements for Bright Futures implementation.

We have received substantial interest in the CAHMI parent-engagement tools (both the WVP and the PHDS) from and are in extensive conversations with a number of organizations and agencies including health systems, payers, provider organizations - (CMS/Medicaid, Title V, Head Start, Kaiser Permanente and others); professional associations such as the American Academy of Pediatrics, Bright Futures, National Medicaid Medical Directors, the Children's Hospital Association (CHA), AcademyHealth, Association of Maternal and Child Health Programs (AMCHP), CityMatCH, National Initiative for Children's Healthcare Quality (NICHQ), Autism Speaks, Prevent Child Abuse America; National Prevention Information Network (NIPN); national community-based programs and organizations; philanthropic funders; software platform and electronic medical records systems developers and family organizations. We are in the process of securing funding for Cycle of Engagement EMR integration and implementation projects in

partnership with or from a number of interested parties. Further, we are finalizing our application to the American Board of Pediatrics to have the Online PHDS certified as a web-based Maintenance of Certification (MOC) (Part 4) quality improvement (QI) tool for pediatricians. ABP has expressed significant interest in the PHDS and provided some initial funding for the redesign efforts. The PHDS process for generating a data report is described above.

#### **Improvement**

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

**4b. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)**

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

Based on PHDS feedback results from an evaluation of the WVP conducted in 2011-2012 in Oregon, providers found that office work flow improved (qualitative assessment), anticipatory guidance for physical care increased by 10%; family assessment for one or more topics increased by 103%, families' needs being met for all family assessment topics increased by 7%, and the providers meeting the standards for comprehensive care increased by 75%. All increases were statistically significant at the 95% confidence level. The PHDS was also used to evaluate the use of the WVP in a randomized controlled trial of low income families served in Federally Qualified Health Centers in a large metropolitan city. The feedback reports demonstrated a 50% reduction in emergency visits and corroborated findings of increased preventive services including anticipatory guidance, developmental screening and psychosocial screening.

#### **4c. Unintended Consequences**

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

**4c.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.**

There were no unintended or unexpected findings that we are aware of.

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

There were no unexpected benefits that we are aware of.

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

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

Extensive qualitative interviews with parents and providers have been conducted and previously reported.

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

Key informant interviews and focus groups with parents and providers were held throughout the testing and evaluation period. We obtained baseline and post-implementation information from providers and post-implementation information from parents. It was necessary to work closely with practices to demonstrate value of the family engagement tools (Well Visit Planner and PHDS) as well as to modify the process to fit individual practice office culture and work flow. A significant amount of provider and staff education was needed to overcome fears and myths that the tool would add to, not help, time management and that parents would not want to participate. This was accomplished by continued and persistent relationship building, spending much time in the office setting with the staff and providers and holding frequent Q&A sessions as the process unfolded.

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

Describe how feedback was obtained.



Through key informant interviews and focus groups with parents and providers.

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

Initially providers were skeptical. However, once they experienced how much improved the well child visits were by parents using the Well Visit Planner, they became valuable champions of the tool. The PHDS is seen as an excellent tool and vehicle by which practices can improve the quality of the visit. In particular this matters a great deal to the providers who are being financially incentivized for family-centered care outcomes.

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

For the most part, parents appreciated being asked about their experience with their well child visits and used it as a way to provide confidential feedback to the providers.

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

The feedback was helpful for future implementation efforts of CAHMI's family engagement tools. The feedback, however, did not result in any changes to the PHDS tool itself.

## 5. Comparison to Related or Competing Measures

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

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

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.  
No

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

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

**5a. Harmonization of Related Measures**

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

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

**Are the measure specifications harmonized to the extent possible?**

Yes

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

Not applicable

**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.)**

Not applicable

## 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 **Attachment:** [0011\\_CAHMI-PHDS\\_Final\\_Appendix\\_12\\_22\\_16.pdf](#)

## Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** [CAHMI](#)

**Co.2 Point of Contact:** [Christina, Bethell, cbethell@cahmi.org](#), 443-287-5092-

**Co.3 Measure Developer if different from Measure Steward:** [CAHMI](#)

**Co.4 Point of Contact:** [Christina, Bethell, cbethell@cahmi.org](#), 443-287-5092-

## Additional Information

**Ad.1 Workgroup/Expert Panel involved in measure development**

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

[National Advisors for Patient Centered Quality Improvement of Well-Child Care:](#)

[Betsy Anderson, Family Voices](#)

[David Bergman, Stanford University](#)

[Dimitri Christakis, University of Washington](#)

[Paula Duncan, University of Vermont](#)

[Cynthia Minkovitz, Johns Hopkins School of Public Health](#)

[Amy Perritti, American Academy of Pediatrics](#)

[Ed Schor, The Commonwealth Fund](#)

[Judy Shaw, University of Vermont](#)

[Sara Slovin, Johns Hopkins Medicine](#)

**Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:** [2002](#)

**Ad.3 Month and Year of most recent revision:** [12, 2016](#)

**Ad.4 What is your frequency for review/update of this measure?** [3 years](#)

**Ad.5 When is the next scheduled review/update for this measure?** [01, 2017](#)

**Ad.6 Copyright statement:** [None](#)

**Ad.7 Disclaimers:** [None](#)

**Ad.8 Additional Information/Comments:** [None](#)