

NATIONAL QUALITY FORUM—Evidence (subcriterion 1a)

Measure Number (if previously endorsed): 0011

Measure Title: [Promoting Healthy Development Survey](#)

IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here: [PHDS Composite Quality Measure](#)

Date of Submission: [12/20/2016](#)

Instructions

- Complete 1a.1 and 1a.12 for all measures.
- Complete ***EITHER 1a.2, 1a.3 or 1a.4*** as applicable for the type of measure and evidence.
- For composite performance measures:
 - A separate evidence form is required for each component measure unless several components were studied together.
 - If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.
- All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed.
- If you are unable to check a box, please highlight or shade the box for your response.
- Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](#).

Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF's evaluation criteria.

1a. Evidence to Support the Measure Focus

The measure focus is evidence-based, demonstrated as follows:

- **Health outcome:** ² a rationale supports the relationship of the health outcome to processes or structures of care. Applies to patient-reported outcomes (PRO), including health-related quality of life/functional status, symptom/symptom burden, experience with care, health-related behavior.
- **Intermediate clinical outcome:** a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence ⁴ that the measured intermediate clinical outcome leads to a desired health outcome.
- **Process:** ⁵ a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence ⁴ that the measured process leads to a desired health outcome.
- **Structure:** a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence ⁴ that the measured structure leads to a desired health outcome.
- **Efficiency:** ⁶ evidence not required for the resource use component.

Notes

3. Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.

4. The preferred systems for grading the evidence are the U.S. Preventive Services Task Force (USPSTF) [grading definitions](#) and [methods](#), or Grading of Recommendations, Assessment, Development and Evaluation ([GRADE](#)) [guidelines](#).

5. Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.

6. Measures of efficiency combine the concepts of resource use and quality (see NQF's [Measurement Framework: Evaluating Efficiency Across Episodes of Care](#); [AQA Principles of Efficiency Measures](#)).

1a.1. This is a measure of: *(should be consistent with type of measure entered in De.1)*

Outcome

- ☐ Health outcome: [Click here to name the health outcome](#)
 - ☒ Patient-reported outcome (PRO): [Click here to name the PRO](#)
PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors. (A PRO-based performance measure is not a survey instrument. Data may be collected using a survey instrument to construct a PRO measure.)
- ☐ Intermediate clinical outcome (e.g., lab value): [Click here to name the intermediate outcome](#)
- ☐ Process: [Click here to name what is being measured](#)
 - ☐ Appropriate use measure: [Click here to name what is being measured](#)
- ☐ Structure: [Click here to name the structure](#)
- ☒ Composite: [The PHDS Composite Quality Measure consists of six independent quality measures for the delivery of preventive care for children in accordance with nationally recommended guidelines. These measures include the delivery of \(1\) anticipatory guidance; \(2\) parenting information and resources in the community; \(3\) family centered care; \(4\) asking about and addressing parental concerns; \(5\) family assessment of safety, alcohol use and substance abuse; and \(6\) family psychosocial screening.](#)

1a.12 LOGIC MODEL Diagram or briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient's health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

The PHDS contains 11 modules; we are seeking endorsement for 6 individuals modules noted below and the PHDS composite which includes the six modules taken as a whole.

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

The PHDS is part of the CAHMI's *Cycle of Engagement* suite of tools (see Figure 1). The Well Visit Planner (www.wellvisitplanner.org) engages the parent in pre-visit planning, helps them identify their priorities for the visit and provides a summary visit guide that can be downloaded, printed, emailed, faxed to their provider prior to the visit, or they can take a hard copy with them to the visit. The PHDS assesses the quality of the visit after the encounter. The PHDS is a post-visit parent survey (www.wellvisitsurvey.org) that assesses whether parents' children received preventive care in accordance with recommended national guidelines.

Figure 2 shows how the PHDS works: First, providers register with CAHMI for the PHDS at www.phdstoolkit.org. This site allows the provider to customize the survey and select which modules or aspects of care they want to focus on, or they can select to send the full survey (11 modules). Each quality measure is contained within its own module – the questions that make up the measure cannot be separated from each other. Providers create a “site name”, recognizable to the parent. The site name generates a provider-specific URL or weblink to the parent survey (www.wellvisitsurvey.org) that the provider then sends to the parent. This unique URL allows CAHMI to identify responses at the

individual provider and clinic levels. The parents fill out the survey and receives a feedback report and a feedback report is also generated for the providers. However, the report given to the provider is anonymous; there is no patient identifiable information on the provider form. Using the PHDS Toolkit, The provider or clinic can generate a report that aggregates parent survey data completed during a specific time period (as determined by the provider or clinic).

We are currently seeking approval from the American Board of Pediatrics (ABP) for use of the PHDS as a quality improvement tool to receive Maintenance of Certification (Part 4) credit. To do this, the provider must engage in a quality improvement activity using a three stage Plan-Do-Study-Act (PDSA) process (e.g.: – repeating the process shown in Figure 2 three times). The provider first identifies areas for quality improvement (Plan) then conducts a baseline assessment (Do - Time #1) using selected modules of the PHDS, or the full survey, that represents the targeted areas for quality improvement (Baseline or Time 1). From the results, the provider identifies which aspects of care they wish to focus on for the quality improvement activity (Study), and then creates and implements a plan of action (Act) to improve that aspect within their practice environment. After a certain period of time in which improvements might be observable, the provider then sends a link to the parent survey to complete the relevant modules (or full) PHDS to any parents having a well child visit since the baseline assessment. Data collected represent the second data point or Time 2. This PDSA process is repeats again to generate a third time period - Time 3. To receive MOC (Part 4) credit, the provider must have at least 20 parent surveys at each of the three time periods, and there must be at least 2 months between each time period to allow for noticeable improvement. When these ABP QI requirements have been met, the provider can use the PHDS Toolkit website to generate a report that shows aggregate parent survey data for all three data collection periods and submit a full report to ABP through the PHDS website. Based on our recent communications with ABP, we are confident that our application will be accepted.

Figure 1: Cycle of Engagement

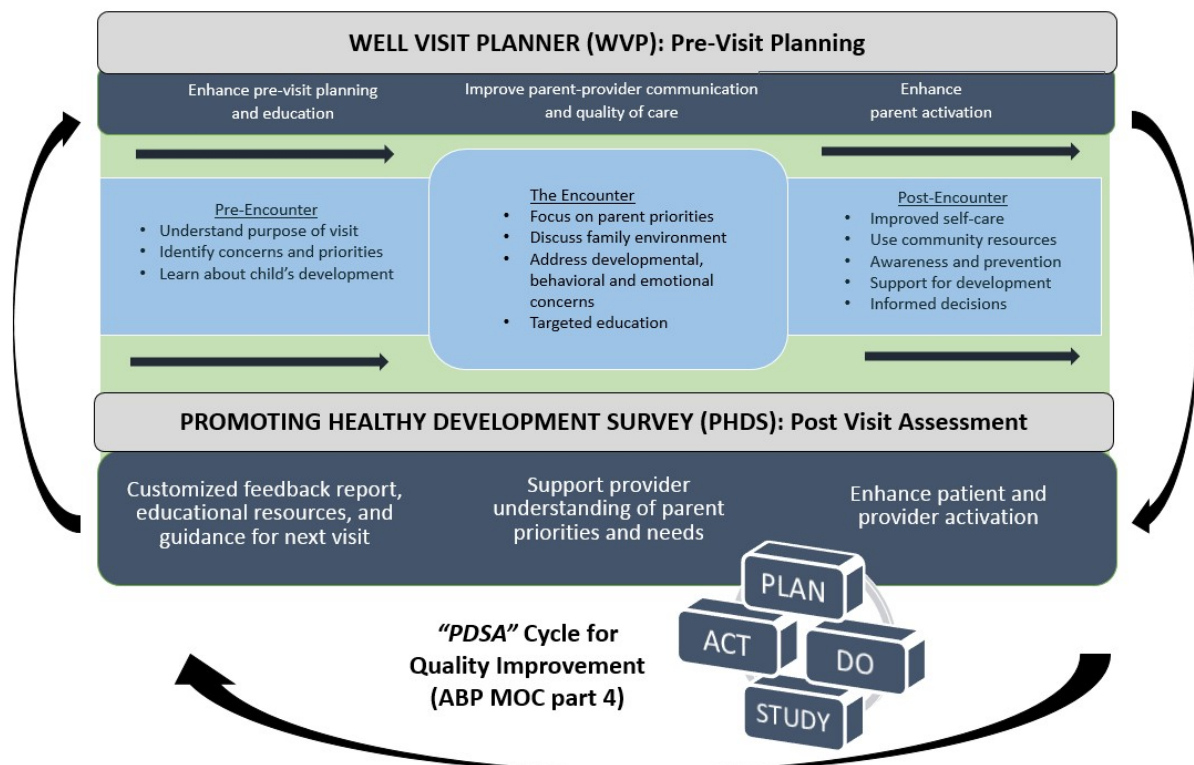


Figure 2: PHDS Model for Parent-Reported Quality Measures for Well Child Care



****RESPOND TO ONLY ONE SECTION BELOW -EITHER 1a.2, 1a.3 or 1a.4) ****

1a.2 FOR OUTCOME MEASURES including PATIENT REPORTED OUTCOMES- State the rationale supporting the relationship between the health outcome (or PRO) to at least one healthcare structure, process (e.g., intervention, or service).

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 needs¹⁻⁴), surveillance of children's development (2 out of 5 children have parents who were not asked about their child's learning, development or behavior^{5,6}), and assessment of the family for risk (only 10% of children's families are screened for risk factors^{7,8}). 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.¹⁶ **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.^{24,25} Consumers are increasingly interested in knowing how fellow patients evaluate healthcare providers and systems, and are giving weight to these accounts.^{26,27} 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:

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1a.3. SYSTEMATIC REVIEW(SR) OF THE EVIDENCE (for INTERMEDIATE OUTCOME, PROCESS, OR STRUCTURE PERFORMANCE MEASURES) If the evidence is not based on a systematic review go to section 1a.4) If you wish to include more than one systematic review, add additional tables.

What is the source of the systematic review of the body of evidence that supports the performance measure? A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data. (IOM)

- ☐ Clinical Practice Guideline recommendation (with evidence review)
- ☐ US Preventive Services Task Force Recommendation
- ☐ Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*)
- ☐ Other

Source of Systematic Review: <ul style="list-style-type: none"> • Title • Author • Date 	
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<ul style="list-style-type: none"> • Citation, including page number • URL 	
Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR.	
Grade assigned to the evidence associated with the recommendation with the definition of the grade	
Provide all other grades and definitions from the evidence grading system	
Grade assigned to the recommendation with definition of the grade	
Provide all other grades and definitions from the recommendation grading system	
Body of evidence: <ul style="list-style-type: none"> • Quantity – how many studies? • Quality – what type of studies? 	
Estimates of benefit and consistency across studies	
What harms were identified?	
Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR?	

1a.4 OTHER SOURCE OF EVIDENCE

If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.

1a.4.1 Briefly SYNTHESIZE the evidence that supports the measure. A list of references without a summary is not acceptable.

1a.4.2 What process was used to identify the evidence?

1a.4.3. Provide the citation(s) for the evidence.