



## Measure Information

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

### Brief Measure Information

**NQF #:** 3332

#### Corresponding Measures:

**De.2. Measure Title:** Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)

**Co.1.1. Measure Steward:** Massachusetts General Hospital

**De.3. Brief Description of Measure:** Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

**1b.1. Developer Rationale:** Psychosocial problems in children are common and treatable with prevalence estimates of about 12% of all children and adolescents (Gardner, Lucas, Kolko, & Campo, 2007; Kelleher et al., 1997; Murphy et al., 2016). Studies have shown that children with these problems are often unrecognized by their pediatricians (~50% of cases) (Kelleher et al., 1997) and that only a fraction of them receive treatment (Hacker et al., 2014b; Kelleher et al., 1997). Children with psychosocial problems are more likely to have poorer health, academic, behavioral, and social outcomes in both the short and long term (Murphy et al., 2015). Children who receive psychosocial screening as a part of pediatric well child visits are more likely to receive outpatient mental health services (Hacker et al., 2014a; Hacker et al., 2014b; Savageau et al., 2016) than are children who are not screened. As the dates of the studies just cited attest, it is only within the last three years that strong evidence documenting the relationship between psychosocial screening and increased mental health treatment has become available.

A series of RCT studies by Kolko and his associates have shown that pediatric outpatients with a wide range of problems who are found to be at risk when screened with the PSC and go on to receive pediatric office based mental health interventions have significantly lower mental health symptom scores and better functioning at immediate and longer term follow up than do similar outpatients randomized to treatment as usual (Kolko et al., 2014; Kolko, Campo, Kelleher, & Cheng, 2010). For these reasons, we believe that an increase in mental health treatment is the most appropriate (and a measurable) benchmark for assessing the positive impact of routine psychosocial screening. The logic model for screening in pediatrics is that more children will receive help, fewer children will develop mental, emotional, and behavioral disorders (Guzmán et al., 2015; Kieling et al., 2011), and more children who received help will enjoy better life outcomes (Kellam et al., 2014).

Requiring screening for psychosocial problems as part of routine well child care in pediatrics is one of the most frequently recommended ways to improve recognition and intervention for such problems (Hacker et al., 2014a) and an increasing number of states (Massachusetts (Savageau et al., 2016)), insurers (Medicaid/EPSTD (Mann, 2013)), standard setting organizations (American Academy of Pediatrics (Foy, Kelleher, Laraque, & Health, 2010; Weitzman & Wegner, 2015)), blue ribbon panels (President's New Freedom Commission on Mental Health (Hogan, 2003) (Institute of Medicine (O'Connell, Boat, & Warner, 2009))), and advocacy organizations such as the Kennedy Forum (Fortney et al., 2015) and Mental Health America (<http://www.mentalhealthamerica.net/positions/early-identification>) have now required, endorsed, or recommended the principle of including a psychosocial screen as a part of every well child visit for children aged 3-17.

The PSC is probably the most frequently recommended and widely used tool for routine psychosocial screening in pediatrics (Semansky, Koyanagi, & Vandivort-Warren, 2003), with the Strengths and Difficulties Questionnaire (Goodman, Meltzer, & Bailey, 1998) and Child Behavior Checklist (Achenbach, 2009) instruments that are similar in many ways and also frequently mentioned and validated in this context. Many of the endorsements noted above include these three and/or a few other instruments.

The reference list is included in the attached appendix.

**S.4. Numerator Statement:** Number of patients with documentation that the PSC tool was administered as part of the well child

visit. S.6. Denominator Statement: Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit. S.8. Denominator Exclusions: No exclusions.
De.1. Measure Type: Process S.17. Data Source: Claims, Electronic Health Records, Paper Medical Records S.20. Level of Analysis: Clinician : Group/Practice, Population : Regional and State
IF Endorsement Maintenance – Original Endorsement Date: May 16, 2018 Most Recent Endorsement Date: May 16, 2018
IF this measure is included in a composite, NQF Composite#/title:  IF this measure is paired/grouped, NQF#/title:  De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

<b>1. Evidence, Performance Gap, Priority – Importance to Measure and Report</b>
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. <i>Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.</i>
<b>1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form</b> <a href="#">Evidence_Form_PSC_Resubmitted_20171214.docx</a> <b>1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?</b> Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.
<b>1b. Performance Gap</b> Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating: <ul style="list-style-type: none"> <li>considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or</li> <li>Disparities in care across population groups.</li> </ul> <b>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)</b> <i>If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.</i> Psychosocial problems in children are common and treatable with prevalence estimates of about 12% of all children and adolescents (Gardner, Lucas, Kolko, & Campo, 2007; Kelleher et al., 1997; Murphy et al., 2016). Studies have shown that children with these problems are often unrecognized by their pediatricians (~50% of cases) (Kelleher et al., 1997) and that only a fraction of them receive treatment (Hacker et al., 2014b; Kelleher et al., 1997). Children with psychosocial problems are more likely to have poorer health, academic, behavioral, and social outcomes in both the short and long term (Murphy et al., 2015). Children who receive psychosocial screening as a part of pediatric well child visits are more likely to receive outpatient mental health services (Hacker et al., 2014a; Hacker et al., 2014b; Savageau et al., 2016) than are children who are not screened. As the dates of the studies just cited attest, it is only within the last three years that strong evidence documenting the relationship between psychosocial screening and increased mental health treatment has become available.  A series of RCT studies by Kolko and his associates have shown that pediatric outpatients with a wide range of problems who are found to be at risk when screened with the PSC and go on to receive pediatric office based mental health interventions have significantly lower mental health symptom scores and better functioning at immediate and longer term follow up than do similar outpatients randomized to treatment as usual (Kolko et al., 2014; Kolko, Campo, Kelleher, & Cheng, 2010). For these reasons, we believe that an increase in mental health treatment is the most appropriate (and a measurable) benchmark for assessing the positive impact of routine psychosocial screening. The logic model for screening in pediatrics is that more children will receive help, fewer children will develop mental, emotional, and behavioral disorders (Guzmán et al., 2015; Kieling et al., 2011), and more children who

received help will enjoy better life outcomes (Kellam et al., 2014).

Requiring screening for psychosocial problems as part of routine well child care in pediatrics is one of the most frequently recommended ways to improve recognition and intervention for such problems (Hacker et al., 2014a) and an increasing number of states (Massachusetts (Savageau et al., 2016)), insurers (Medicaid/EPSDT (Mann, 2013)), standard setting organizations (American Academy of Pediatrics (Foy, Kelleher, Laraque, & Health, 2010; Weitzman & Wegner, 2015)), blue ribbon panels (President's New Freedom Commission on Mental Health (Hogan, 2003) (Institute of Medicine (O'Connell, Boat, & Warner, 2009))), and advocacy organizations such as the Kennedy Forum (Fortney et al., 2015) and Mental Health America (<http://www.mentalhealthamerica.net/positions/early-identification>) have now required, endorsed, or recommended the principle of including a psychosocial screen as a part of every well child visit for children aged 3-17.

The PSC is probably the most frequently recommended and widely used tool for routine psychosocial screening in pediatrics (Semansky, Koyanagi, & Vandivort-Warren, 2003), with the Strengths and Difficulties Questionnaire (Goodman, Meltzer, & Bailey, 1998) and Child Behavior Checklist (Achenbach, 2009) instruments that are similar in many ways and also frequently mentioned and validated in this context. Many of the endorsements noted above include these three and/or a few other instruments.

The reference list is included in the attached appendix.

**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 (4b1) under Usability and Use.**

Several studies based on data from the Massachusetts Medicaid (MassHealth) pediatric behavioral health screening program and the Children's Behavioral Health Initiative (CBHI), demonstrate the currently wide variation in the rates of mental health screening with formal, standardized tools as well as the possibility of improvement and the potential benefits of doing so.

Data Source 1: CBHI Cohort Data for chart review sample

Measurement Period dates of service in 2007, 2010, and 2012

Denominator /Well child visits for all children: 4,977

Numerator (screen at WCV): ~1,700

Average: 51.7%

Min: 1.5%

Max: 88.9%

Standard Deviation : 35.1%

95% Confidence interval: 35.5% to 87.2%

This first data source is a ~ 6000 visits subsample of the CBHI statewide data retrieved from chart reviews supplemented by administrative claims data.

Differences in rates of screening in three cohorts of about 2000 cases of pediatric outpatients (age 4-17 years) seen before (2007) and after (2010, 2012) the start of CBHI. As shown in Table 1, consistent with the statewide CBHI data, the Southeast and Western regions consistently demonstrated significantly higher rates of screening, the Northeast and Metro West demonstrated the lowest rates of screening, and Central Massachusetts and Boston demonstrated screening rates in the middle.

Table 1. Rates of Formal Screening for each year for children ages 4-17

	Formal Screen in 2007		Formal Screen in 2010		Formal Screen in 2012	
Region	No *1	Yes	No ***2	Yes	No	Yes ***3
Western	139(95.2%)	7 (4.8%)	22(11.9%)	163(88.1%)	33(15.2%)	184(84.8%)
Central	64(94.1%)	4(5.9%)	30(23.3%)	99(76.7%)	31(23.9%)	99(76.1%)
Northeast	125 (91.2%)	12(8.8%)	63(37.5%)	105(62.5%)	71(39.0%)	111(61.0%)
Metro West	84 (94.4%)	5(5.6%)	54(32.5%)	112(67.5%)	62(37.4%)	104(62.7%)
Southeastern	197(98.5%)	3(1.5%)	52(23.0%)	174(77.0%)	27(11.1%)	217(88.9%)

Boston 149(98.0%) 3(2.0%) 51(25.4%) 150(74.6%) 33(18.2%) 148(81.8%)  
 2007: 1x2=13.33 p=.021 2010: 2x2=36.33 p<.001 2012: 3x2=75.21 p<.001

#### Data source 2:

Summary data from the CBHI Behavioral Health Screening Cumulative Quarterly Report; posted on BHSCQR website  
 Measurement Period dates of service from 1/1/2008 to 3/31/2017

#### Data Source 2a: Statewide data for all children

Denominator/Well child visits for all children .5 -20 years of age: 4,721,790

Numerator (screens with visit): 2,965,923

Statewide average: 62.8%

Minimum: 14.2%

Maximum: 71.9%

Standard Deviation: 12.4%

95% Confidence interval: 58.8% to 66.8%

The CBHI BHSCQR also presents the same statewide Medicaid screening data broken down for each of the state's regions for each of the 37 calendar quarters from Q1 (January through March of 2008) to Q37 (January through March of 2017) of CBHI. Table 1 (below) reports the rates of screening in the state's six regions with data from the four quarters in each year averaged for simpler presentation in this proposal. Because the BHSCQR website does not break out the data by age group, the information in the table below is for the full sample of all ages, but the trends should be large enough that that the patterns shown below should be quite similar to those for just the 3-17 year olds. As the table shows, the range in rates of screening vary widely, from a low of 21.55 in the Boston region in 2008 to a high of 85.27 in the Western region in first quarter of 2017. The percentages of well child visits with screens goes up substantially in all regions over the first few years of the initiative but after that the rank ordering remains relatively consistent across regions. Western Massachusetts always has the highest rate of screening, Metro West and Boston the lowest and Northeast, Southeast, and Central Massachusetts in the middle.

Table 1. Rates of Screening in different regions of Massachusetts from 2013-2017 by Region

Region	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017*
Western	38.14%	66.13%	75.34%	79.16%	79.79%	80.33%	81.62%	83.76%	81.27%	85.27%
Central	32.61%	51.99%	60.61%	63.22%	67.23%	70.59%	71.09%	70.90%	72.33%	72.31%
Northeast	32.70%	56.36%	60.93%	60.31%	55.35%	65.08%	67.16%	68.43%	71.46%	67.38%
Metro West	25.89%	47.45%		51.92%	51.80%	57.72%	60.47%	59.83%	54.90%	49.84%
Southeast	36.88%	61.89%	70.57%	75.94%	78.18%	80.19%	80.66%	77.87%	75.91%	73.95%
Boston	21.55%	45.91%	55.28%	57.26%	60.53%	64.49%	67.57%	65.12%	63.27%	58.76%

Note. Rates of screening were calculated by the year from 2008-2016 and for the first quarter of 2017 \*Data available only for the 1st quarter of 2017

Table 2 below presents the distribution of rates of screening in greater detail, taken from this time directly from BHSCQR website for all 222 measurement points (37 quarters in all six regions), illustrating even more dramatically the wide range of rates of screening across the state and over nearly a decade.

Table 2 The distribution of screening rates by decile broken down by quarters for each region from January 2008 through March 2017 (6 regions x 4 quarters x 9.25 years) for children of all ages

0-9%	1
10-19%	5
20-29%	4
30-39%	8
40-49%	23
50-59%	40
60-69%	63
70-79%	58
80-89%	20

90-100%

Total (Regions\*Quarters\*Years) 222

Min: 8.21%  
 Max: 85.65%  
 Range: 77.44%  
 Median: 64.53%

Data Source 2b: Statewide data broken down by for children ages 3-17 years

Denominator /Well child visits for all children 3 -17 years of age: 2,361,475

Numerator (screens with visits): 1,681,764

Statewide average: 71.2%

Minimum: 39.98%

Maximum: 79.14%

Standard Deviation: 11.3%

95% Confidence Interval: 64.2% to 78.2%

We included data source 2b focusing just on the 3-17 year old children in the BHSCQR website data as this is the age group that was screened with the PSC, and prior studies (Hacker et al., 2016; Savageau et al., 2016) have shown that the PSC was the measure used for 67% of the children in the CBHI 3-17 year old age group. By multiplying the total number of screens in this age group by 67%, we can estimate that approximately 1,126,782 PSC's were administered over the first 9.25 years of CBHI.

Table 3 (below) shows the Massachusetts statewide number of well child visits, number of screens, and percent of visits with screens, for just the 3-17 year old (PSC screened) children with Medicaid from January 2008 (start of CBHI) to March of 2017. Data in this table are taken directly from the CBHI BHSCQR but with the four quarters of each year aggregated together so that the totals for each year could be seen more clearly. As the table shows, the rate of screening rose from approximately 39.98% for its first year (2008) to 65.72% for its second year to over 70% for its third year, and then remaining in the 70% range in all of the six years since. Not shown in this table but present in the data shown on the CBHI BHSCQR are the figures for the first quarter of 2008 (which show a base rate of 17.8% during the first three months of the program). Although not posted on the CBHI BHSCQR but reported by two different groups (Hacker et al., 2016; Savageau et al., 2016) with access to claims data for 2007 is that the rate of formal screening during the year prior to the start of CBHI was less than 5%. A rate of formal screening that started and then remained at less than 5% was also reported for the state of California (which had no requirement for the use of formal screens) for 2008 and 2009 when the rate in Massachusetts had climbed to about 65%.

Table 3. Statewide rates of formal psychosocial screening for 3-17 year olds during WCV from 1/1/2007 to 3/31/2017

Year	Denominator (Total Visits)	Numerator (Total with Screens)	% Visits with Screens
12/31/07-12/31/2008	202,376	80,910	39.98%
1/1/2009-12/31/2009	219,548	144,276	65.72%
1/1/2010-12/31/2010	234,823	171,114	72.87%
1/1/2011-12/31/2011	243,209	179,305	73.72%
1/1/2012-12/31/2012	252,357	190,286	75.40%
1/1/2013-12/31/2013	265,826	208,549	78.45%
1/1/2014-12/31/2014	287,690	228,467	79.14%
1/1/2015-12/31/2015	290,313	217,282	74.84%
1/1/2016-12/31/2016	300,307	215,611	71.80%
1/1/2017-3/31/2017	65,026	45,964	70.69%
Total	2,361,475	1,681,764	71.22%

Data Source 3: Medicaid screening data from four Massachusetts General Hospital outpatient clinics

Measurement Period dates of service from 7/1/2014 to 12/31/2016  
 Denominator /Well child visits for all children 4-17 years of age: 10,334  
 Numerator (screen at WCV): 7,915  
 Average: 76.6%  
 Min: 9.4%  
 Max: 91.7%  
 Standard Deviation: 38.5%  
 95% Confidence interval: 38.8% to 100.0%

One of the most important criteria for a quality measure is differences in performance across sites. Although the data from the CBHI BHSCQR summarized above provide strong evidence that there are consistent differences in screening rates for different regions of the state and different age groups, our lack of access to the actual data made it impossible to explore differences between different pediatric practices, one of the intended uses of this type of quality measurement. Since it was not possible for us to obtain the actual data from the state of Massachusetts and since the sample from Data Source 2 was too small to permit analyses by clinic, we turned to our own hospital system and were able to obtain billing data for pediatric psychosocial screens for a relatively large sample of well child visits in four MGH-affiliated outpatient pediatric clinics. Using the same CPT billing code for screening (96110) used by the state and focusing only on children with Medicaid health insurance, we obtained data on 10,827 children aged 4-17 who had at least one pediatric well child visit from July 2014 through December 2016 in one of the four clinics.

Differences in rates by clinic: As shown in Table 5 below, the differences in rates of mental health screening at well-child visits were substantial and statistically significant between these four clinics. In 2016, for example, rates ranged from 0% to 88.1% ( $p < .001$ ) to in the four clinics. Over the three years of data, the rank orders of screening rates among the four clinics were relatively constant with Clinic A and B as always the highest and C the lowest in each of the three years (not shown).

2016 (n=6,801 children): January 1 2016 – December 31 2016					
Variable	Overall*	Clinic A	Clinic B	Clinic C	Clinic D
Billed for					
MH screen	69.7% (4743)	86.1% (3422)	88.1% (1215)	0.0% (0)	24.1% (106)
(yes)					
p<.001					

The reference list is included in the attached appendix.

**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.**

N/A

**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 (4b1) under Usability and Use.**

Differences by age:

As presented below in Table 6 (below) from Data Source 2, the CBHI BHSCQR shows significant differences in rates of screening by age group with very young (< 3) children and older (> 17) youth less likely to be screened than 3-17 year olds. Even within the 3-17 year old group there were differences in screening rates with younger (3-6 year olds) and older (13 to 17 year olds) patients showing lower rates of screening than 7-12 year olds (72.41% vs 67.32% vs 73.08%) respectively.

Table 6 (December 31 2007 - March 31 2017)

Age	Total Visits	Total Visits with Screens	% Visits with Screens
<6mos to 2 years	2,136,135	1,205,607	56.44%
<6mos	882,43	336,179	38.10%
6mos to 2yrs	1,253,701	869,428	69.35%

3 yrs to 17 yrs	2,361,475	1,681,764	71.22%
3 yrs to 6 yrs	776,570	562,311	72.41%
7 yrs to 12 yrs	911,693	666,266	73.08%
13 yrs to 17 yrs	673,212	453,187	67.32%
18 yrs to 20 yrs	224,180	78,552	35.04%
Total	4,721,790	2,965,923	62.80%

Lack of disparities by race, ethnicity, and language:

Although none of the published papers on the CBHI sample (Hacker et al., 2014a; Hacker et al., 2014b; Savageau et al., 2016) explore data on disparities by race, ethnicity, or language, the chart review study of a subsample of these cases from Data Source 1 (Savageau et al., 2016; Savageau, Simons, Lucke, Jellinek, & Murphy, 2017, May) explored screening by demographics in a subsample of ~ 6000 visits from 2007, 2007, and 2010. As shown in Table 7 below, there were no significant disparities by race, ethnicity, or language. It may be important to note that disparities by socioeconomic status cannot be meaningfully assessed in this sample since by CBHI is a program only for children with Medicaid and SES is confounded with insurance type.

Table 7. Lack of Significant Disparities of Children 4-17 years insured by MassHealth, FYs 2007\*, 2010, and 2012

	Had a Formal Screen in 2007	Had a Formal Screen in 2010	Had a Formal Screen in 2012
Race			
White	7 (2.9%)	374 (73.6%)	397 (73.7%)
Non-White	20 (6.4%)	276 (77.7%)	290 (79.2%)
Ethnicity			
Non-Hispanic	17 (4.4%)	321 (75.3%)	369 (78.7%)
Hispanic	10 (5.8%)	224 (79.4%)	246 (80.9%)
Primary Language			
English	24 (3.8%)	676 (75.4%)	716 (76.8%)
Non-English	10 (6.5%)	128 (71.1%)	149 (76.4%)

The reference list is included in the attached appendix.

**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**

N/A

## 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):

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



**S.1. Measure-specific Web Page** (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

[http://www.massgeneral.org/psychiatry/services/psc\\_home.aspx](http://www.massgeneral.org/psychiatry/services/psc_home.aspx)

**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)

[No data dictionary](#) Attachment:

**S.2c.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

[No, this is not an instrument-based measure](#) Attachment:

**S.2d.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

[Not an instrument-based measure](#)

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

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

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

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

[Number of patients with documentation that the PSC tool was administered as part of the well child visit.](#)

**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).

[Patients passing this quality measure are identified through a review of the medical record. In a chart review, the presence of a PSC score or PDF scan of it in the progress note, or score shown in the visit template or flowsheet documents the completion of the screen on the same day of the WCV. To receive credit, progress notes must indicate the name of the specific measure and actual score \(eg, PSC given, score = not at risk\).](#)

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

[Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.](#)

**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).

Cases are identified from administrative data for site. Number of unique patients ages 3.00 to 17.99 seen for a well-child visit (CPT 99381-99394) in a defined evaluation period, often a year.

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

No exclusions.

**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.)

N/A

**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.)

N/A

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

No risk adjustment or risk stratification

If other:

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

Rate/proportion

If other:

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

Better quality = Higher score

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

Step 1. Count number of children aged 3-17 seen for a well child visit in state, region, clinic or other group during defined period (often, one year) using administrative data (CPT 99381-99394). N=total population. This is the denominator.

Step 2. Assess whether PSC was administered as a part of WCV, for the eligible population, using the chart for indicator status. Pass if documentation that screen was given on the day of the WCV is present.

Step 3. Compute numerator = count of patients with completed PSC.

Step 4. Calculate clinic or other entity rate as numerator/denominator. No risk adjustment.

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

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

This measure and its denominator are not based on samples. This PRO measure is based on a parent or child completing the PSC (no proxy) and noting its presence/absence. Missing data (no administration of PSC) is managed by the inclusion of patients without a completed PSC in the denominator.

**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.)

Specify calculation of response rates to be reported with performance measure results.

N/A

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

If other, please describe in S.18.

Claims, Electronic Health Records, Paper Medical Records

**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 are collected.)*)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

In medical record (paper or electronic):

If patient age => 3.0 & age =< 17.99; claim for well child visit (99382 or 99383 or 99385 or 99392 or 99393 or 99394), assess progress note, templated note, flowsheet, scanned in PSC, for evidence that screen was administered.

**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)*

No data collection instrument provided

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

Clinician : Group/Practice, Population : Regional and State

**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.*)

N/A

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

Measure3\_Form\_PediatricSymptomChecklist\_12\_1\_2017.docx

**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. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.*

No

**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. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.*

No

**2.3 For maintenance of endorsement**

*Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.*

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.

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

### 3b. Electronic Sources

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

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

ALL data elements are in defined fields in a combination of electronic sources

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

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

Attachment:

### 3c. Data Collection Strategy

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

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

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

The degree of difficulty for data collection varies considerably depending on the system used. For chart abstraction the progress note, templated note, flowsheet, or scanned PSC's would be checked to assess whether the screen was administered on the same date as the WCV.

Data collection can be relatively non-burdensome if all entities in a system use a common electronic medical record (EMR) and if specific fields for noting the presence of the screen are agreed to in advance. For example, in one of the earliest evaluations of the pediatric psychosocial screening as a process measure, Hacker and her associates describe a system in which PSC forms were administered on paper and clinicians noted the exact score in a single field in the EMR (Hacker, Williams, Myagmarjav, Cabral, & Murphy, 2009). A more elaborate version of this system is being used in the outpatient pediatric clinic on at Boston Medical Center. Parents complete the PSC on paper and then medical assistants enter the answers to each item into a template in the EMR (Epic) where scores are computed and data are displayed in flowsheets along with data on height, weight, blood pressure, etc. The outpatient pediatric clinics at Massachusetts General Hospital follow a similar procedure in that PSC scores and items appear in a flowsheet in Epic but are entered by parents who complete the PSC in the waiting room on iPads or at home over a patient portal. There are also standalone electronic systems like CHADIS that can be used independent of EMR that keep track of WCV and which of them included a completed PSC.

For sites that lack a common EMR or standalone system, it is still possible to use claims data to create a list of WCV and then to open each electronic or paper chart to look in specific areas for documentation that a PSC was given (Romano-Clarke et al., 2014).

Although feasible, this is a much more difficult and time consuming method.

The reference list is included in the attached appendix.

**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).**

No proprietary elements are used in implementing this measure. There are no fees, licenses or other requirements needed to use any aspect of the measure or the instrument.

## 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)
	<p>Payment Program Massachusetts Medicaid (MassHealth) <a href="http://www.mass.gov/eohhs/consumer/insurance/cbhi/cbhi-screening/">http://www.mass.gov/eohhs/consumer/insurance/cbhi/cbhi-screening/</a></p> <p>Professional Certification or Recognition Program American Board of Pediatrics Maintenance of Certification <a href="https://www.abp.org/content/maintenance-certification-moc">https://www.abp.org/content/maintenance-certification-moc</a></p> <p>Quality Improvement (external benchmarking to organizations) Massachusetts Medicaid (MassHealth) PCC Plan <a href="http://www.mass.gov/eohhs/docs/masshealth/provider-services/forms/pcc-handbook.pdf">http://www.mass.gov/eohhs/docs/masshealth/provider-services/forms/pcc-handbook.pdf</a></p>

#### 4a1.1 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

#### Public Reporting:

Program: Behavioral Health (BH) Screening Cumulative Quarterly Report

Sponsor: MassHealth

Purpose: To demonstrate compliance with federal EPSDT regulations requiring screening and the mandate to measure and document progress toward the goal of having 100% of all pediatric well child visits receiving a screen that were a part of the consent decree in the Rosie D vs Romney lawsuit, Massachusetts state Medicaid officials are required to post quarterly reports of the number of behavioral health screenings and well child visits (Behavioral Health Screening Cumulative Quarterly Report BHSCQR) on the MassHealth website.

Level of Measurement and Setting: The geographical area is the state of Massachusetts. Accountable entities include all providers of WCV to MassHealth members and results are reported at the state and regional level.

Professional Certification or Recognition Program:

Program MOC Part 4 Certification

Sponsor: American Board of Pediatrics

Purpose: To maintain of certification with the ABP, pediatricians must complete a number of requirements every 5 years. A system of record keeping that tracks the percentage of well child visits receiving the PSC over a multi-month period as the basis of the MOC quality improvement has been used by the Pediatric Specialty Group of Maine Medical Partners. CHADIS, a commercial software company provides a software system for keeping track of behavioral health screening (96110) to meet this requirement.

Level of Measurement and Setting: The geographical area is variable. Accountable entities are pediatricians/pediatric practices.

Level of reporting is usually at the clinician and practice level.

Quality improvement with Benchmarking (external benchmarking to multiple organizations)

Program: PCC Profile Report

Sponsor: Massachusetts Medicaid (MassHealth) Primary Care Clinician (PCC) Plan.

Purpose: The MassHealth PCC plan covers about 170,000 children, about half of those with Medicaid coverage in the state of Massachusetts. The PCC plan monitors and provides biannual feedback to all clinics with a Profile Report that shows clinic rates of behavioral health screening in WCV along with rates of other psychosocial and medical quality measures for that clinic and in comparison with benchmarks from the state as whole.

Level of Measurement and Setting: The geographical area is the state of Massachusetts. Accountable entities include all pediatric practices with 180 or more MassHealth members in enrolled in the PCC Plan (membership ~170,000 children). Level of reporting is at clinic and state.

**4a1.2. 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?)**

N/A

**4a1.3. 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.)**

N/A

**4a2.1.1. 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.**

According to the PCC Plan Provider Handbook (<http://www.mass.gov/eohhs/docs/masshealth/provider-services/forms/pcc-handbook.pdf>) "The PCC Profile Report provides information on selected clinical measures, such as pediatric behavioral health, well-child care, and women's cancer screening, that may be used to improve health care delivery and, ultimately, the health outcomes of PCC Plan members. Most of the profile measures display rates of performance for a PCC's practice as well as rates for each service location, if applicable, and for the PCC Plan as a whole. Prior rates for PCC practices and the PCC Plan are also presented to show trended rates for these clinical indicators. Summary data are provided to help with the identification of barriers to care." (page 24). For sites with at least 180 PCC Plan members... a Regional Network Managers (RNMs) ... visits in order to review with the PCC the PCC Profile Report, the PCC Reminder Report, and the PCC Care Monitoring Registries. By reviewing the reports and discussing how rates reflect the PCC practice's performance, RNMs assist practices to identify areas for improvement and to develop action plans to improve performance and the delivery of high-quality health care to members". (page 23).

**4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**

Not known

**4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.**

**Describe how feedback was obtained.**

Not known

**4a2.2.2. Summarize the feedback obtained from those being measured.**

Not known

**4a2.2.3. Summarize the feedback obtained from other users**

Not known

**4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.**

Not known

**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.

**4b1. 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.

Table 3 (section 1b.2) shows the increase in rates of screening in the full sample of 3-17 year olds over the first 9.25 years of CBHI. Table 1 shows that these increases were present in all regions of the state. Rates of screening for all ages increased dramatically, 14-fold, from ~ 5% of all WCV to > 70% over the first three years of the program and have been sustained at that level ever since. For 3-17 year olds who were screened primarily with the PSC, the number of visits screened rose steadily over the first 7 years of the program (from ~80,000 to over 218,000 per year and from 40% to 79%). Almost as important as the large increase in screening is the fact that it has been sustained at over 70% for the past eight years.

Another demonstration of the increase in screening comes from a two state comparison (Hacker et al., 2016). involving almost 10 million well child visits over 4 years. In the year prior to the start of CBHI (2007), both Massachusetts and California were billing for formal BH screens in less than 2 per thousand enrolled youth per month. In the first nine months of 2008 the rates of the BH screening had risen to 13 per thousand children in Massachusetts while remaining at the same level in California.

**4b2. 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).

**4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.**

There have been no reports of unintended negative consequences to individuals or populations.

**4b2.2. Please explain any unexpected benefits from implementation of this measure.**

Benefits include:

- Increasing widespread use of a simple but effective PRO tool that can be used for screening, diagnosis and the monitoring of treatment outcomes for psychosocial problems (California and other states).
- Increased national use of the measure (PSC is being used in the SAMHSA National System of Care Expansion Evaluation and in the state of California child mental health outcomes assessment program), Mental Health America making the PSC and PSC-Y available for free and to tens of thousands of youth or their parents.

**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.

Yes

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

0712 : Depression Utilization of the PHQ-9 Tool

### 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.

## 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.)

The age range for the PHQ-9 (NQF 712) has recently been expanded to include youth 12 to 17 years of age with a diagnosis of depression. The currently submitted measure, the PSC, screens for a broader band of problems (other emotional problems like anxiety as well as other types of problems like attention and behavior) and a larger age range (3-17) than the PHQ-9. Along with the PHQ-9, the PSC is actually one of the specific tools mentioned by the US Preventive Services Task Force as a screen for depression in youth (Forman-Hoffman et al., 2016). Although studies have shown that the PSC identifies about 80% of the youth with depression who are found with the PHQ-9, only about half of the youth with serious psychosocial problems on the PSC are identified with the PHQ-9 (Richardson et al., 2010). The PSC is a representative of a broader class of screening tools (brief broadband psychosocial screens) that are required for use in conjunction with pediatric well child visits in the Massachusetts EPSDT program. Other similar broadband tools are the Strengths and Difficulties Questionnaires and the Child Behavior Checklist. The Massachusetts EPSDT CBHI program provides a short (now 13) list of approved tools (both broad and narrow band) and allows the pediatrician to use the one deemed most appropriate for each case. In a review of nearly 6000 medical charts, Savageau and her associates found that about 40% of all screens were PSC's compared to only about 1% that were PHQ-9's (Savageau et al., 2016; Savageau et al., 2017, May) suggesting that the PSC is at least in the past ten years more widely used by pediatricians in Massachusetts.

The reference list is included in the attached appendix.

## 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



<p>attachments. There is no guarantee that supplemental materials will be reviewed.  <a href="#">Attachment</a> <b>Attachment:</b> <a href="#">Appendix_PediatricSymptomChecklist.docx</a></p>
<p><b>Contact Information</b></p>
<p><b>Co.1 Measure Steward (Intellectual Property Owner):</b> <a href="#">Massachusetts General Hospital</a>  <b>Co.2 Point of Contact:</b> <a href="#">J. Michael, Murphy, mmurphy6@mgh.harvard.edu, 617-724-3163-</a>  <b>Co.3 Measure Developer if different from Measure Steward:</b> <a href="#">Massachusetts General Hospital</a>  <b>Co.4 Point of Contact:</b> <a href="#">J. Michael, Murphy, mmurphy6@mgh.harvard.edu, 617-724-3163-</a></p>
<p><b>Additional Information</b></p>
<p><b>Ad.1 Workgroup/Expert Panel involved in measure development</b>  <b>Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.</b>  <a href="#">N/A</a></p>
<p><b>Measure Developer/Steward Updates and Ongoing Maintenance</b>  <b>Ad.2 Year the measure was first released:</b>  <b>Ad.3 Month and Year of most recent revision:</b> <a href="#">10, 2017</a>  <b>Ad.4 What is your frequency for review/update of this measure?</b> <a href="#">continuous/ongoing</a>  <b>Ad.5 When is the next scheduled review/update for this measure?</b></p>
<p><b>Ad.6 Copyright statement:</b> <a href="#">©1988, M.S. Jellinek and J.M. Murphy, Massachusetts General Hospital</a>  <b>Ad.7 Disclaimers:</b> <a href="#">None</a></p>
<p><b>Ad.8 Additional Information/Comments:</b> <a href="#">N/A</a></p>