NATIONAL QUALITY FORUM

Measure Evaluation 4.1
December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized)**:** Complete all yellow highlighted areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: *If there is no TAP or workgroup, the SC also evaluates the subcriteria (yellow highlighted areas).*

Steering Committee: Complete all pink highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) **NQF Review #:** OT3-043-10 **NQF Project:** Patient Outcomes Measures: Child Health and Mental Health (Phase III)
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Pediatric Symptom Checklist (PSC)
De.2 **Brief description of measure***:* The Pediatric Symptom Checklist (PSC)is a brief parent report questionnaire that is used to measure overall psychosocial functioning in children from 4 to 16 years of age. Originally developed to be a screen that would allow pediatricians and other health professionals to identify children with poor overall functioning who were in need of further evaluation or referral, the PSC has seen such wide use in large systems that it has been used as an outcome measure to assess changes in functioning over time. In addition to the original 35 item parent report form of the PSC in English, there are now many other validated forms including translations of the original form into more than a dozen other languages, a youth self report, a pictorial version, and a briefer 17 item version for both the parent and youth forms.
1.1-2 **Type of Measure:** Outcome De.3 **If included in a composite or paired with another measure, please identify composite or paired measure**
De.4 **National Priority Partners Priority Area:** Population health, Patient and family engagement De.5 **IOM Quality Domain**: Patient-centered, Effectiveness De.6 **Consumer Care Need:** Getting better

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	**NQF Staff**
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.* A.1 **Do you attest that the measure steward holds intellectual property rights to the measure and the**	**A** **Y**☐ **N**☐

right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes A.2 **Indicate if Proprietary Measure** (*as defined in measure steward agreement*)**:** A.3 **Measure Steward Agreement:** Agreement will be signed and submitted prior to or at the time of measure submission A.4 **Measure Steward Agreement attached:** txNQFMeasureStewardAgreement.pdf	
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	**B** Y☐ N☐
C. The intended use of the measure includes both public reporting and quality improvement. ►**Purpose:** Public reporting, Internal quality improvement Accountability, Payment incentive	**C** Y☐ N☐
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. D.1**Testing:** Yes, fully developed and tested D.2 **Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?** Yes	**D** Y☐ N☐
(for NQF staff use) **Have all conditions for consideration been met?** **Staff Notes to Steward** (*if submission returned*)**:**	**Met** Y☐ N☐
Staff Notes to Reviewers (*issues or questions regarding any criteria*)**:**	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. *Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.* (evaluation criteria) **1a. High Impact**	Eval Rating
(for NQF staff use) Specific NPP goal:	
1a.1 **Demonstrated High Impact Aspect of Healthcare:** Affects large numbers, Leading cause of morbidity/mortality, Patient/societal consequences of poor quality, Frequently performed procedure, High resource use 1a.2 1a.3 **Summary of Evidence of High Impact:** Psychosocial problems are among the most common and debilitating concerns of childand adults (1,2, 3). Depending on the criteria used, estimates of prevalence range between 5% and 20% with 12% an often cited single figure. The World Health Organization reports that depression--just one of many types of psychosocial problem--is the fourth leading cause of global disease burden and the leading cause of disability worldwide.(4) 1a.4 **Citations for Evidence of High Impact:** (1)Costello EJ, Costello AJ, Edelbrock C et al. (1988a), Psychiatric disorders in pediatric primary care: prevalence and risk factors. Arch Gen Psychiatry 45:1107Y1116	**1a** C☐ P☐ M☐ N☐

(2) Kelleher KJ, McInerny TK, Gardner W, Childs GE, Wasserman R (2000),
Increasing identification of psychosocial problems: 1979Y1996.
Pediatrics 105:1313Y1321
(3) O'Connell, et al. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. National Research Council, 2009.
(4)Steve Hyman et al., "Mental Disorders," in Disease Control Priorities in Developing Countries, 2d ed., ed. Dean T. Jamison et al. (New York: Oxford University Press, 2006

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Use of the PSC to screen and identify children with psychosocial problems and provide intervention sooner could result in better health and behavior, fewer mental, emotional and behavioral disorders in childhood, adolescence, and adulthood, which in turn could lead to better academic achievement and better life outcomes. Use of the PSC to measure outcomes could help to pinpoint which interventions work for which children under which circumstances.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
Studies over several decades have found that only about 50% of these children are identified by their primary care physicians and that once identified, only a fraction of these children receive appropriate mental health treatment. (5,6)

1b.3 Citations for data on performance gap:
(5) Costello, E. J., C. Edelbrock, A. J. Costello, M. Dulcan, B. J. Burns and D. Brent (1988). "Psychopathology in Pediatric Primary Care: The New Hidden Morbidity." Pediatrics 82: 415-424.
(6)Kelleher KJ, Childs GE, Wasserman RC, McInerney TK, Nutting PA, Gardner W (1997), Insurance status and recognition of psychosocial problems: a report from PROS and ASPN. Arch Pediatr Adolesc Med 151:1109Y1115

1b.4 Summary of Data on disparities by population group:
The rates of psychosocial impairment are higher in risk groups such as low income and/or single parent households.

1b.5 Citations for data on Disparities:
Jellinek, M. S., J. M. Murphy, M. Little, M. E. Pagano, D. M. Comer and K. J. Kelleher (1999). "Use of the Pediatric Symptom Checklist to screen for psychosocial problems in pediatric primary care: a national feasibility study." Archives of Pediatrics & Adolescent Medicine 153(3): 254-60.

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1c. Outcome or Evidence to Support Measure Focus

1c.1 Relationship to Outcomes (*For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population*)**:** Requiring pediatricians to use a standardized measure to screen for psychosocial problems can be used as a quality assurance tool to insure that psychosocial issues are explored as a part of routine healthcare. Using the cutoff score on the PSC to trigger further evaluation, treatment or referral is a way to prioritize and encourage increased attempts to promote mental health. Use of the PSC to track outcomes provides a way to measure the impacts of aspects of care in such a way that treatment approaches could be evaluated and ultimtaely made more effective.

1c.2-3. Type of Evidence: Cohort study, Observational study

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*)**:**
Routine screening for psychosocial problems in pediatric practice using the PSC has been found to be

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associated with higher rates of recognition and referral. The PSC has been used successfully to assess pre/post changes in overall functioning over time as a result of outpatient treatment in a child psychiatry clinic and school based interventions. 1c.5 **Rating of strength/quality of evidence (***also provide narrative description of the rating and by whom***):** Strong for teens, moderate for school aged children. The US Preventive Services Task Force and the American Academy of Pediatrics have recently concluded that the evidence is strong enough to recommend screening for depression for teens and possibly for younger children as well. 1c.6 **Method for rating evidence:** Expert task force from American Academy of Pediatrics 1c.7 **Summary of Controversy/Contradictory Evidence:** The degree to which screening is associated with improved outcomes has not been well demonstrated, nor have the benefits of charting changes in standardized measures as a part of treatment. 1c.8 **Citations for Evidence (***other than guidelines***):** Committee on Health Care Access and Economics TASK FORCE ON MENTAL HEALTH, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration. Pediatrics 2009;123;1248-1251 The US National Health Goals, Healthy People 2010, recommend routine screening for psychosocial problems as a part of both pediatric and adult primary care and increased treatment of children with emotional and behavioral problems. 1c.9 **Quote the Specific guideline recommendation (***including guideline number and/or page number***):** Objective 18-6: "Increase the number of persons seen in primary care who receive mental health screening and assessment" (USDHHS, 2000a) Objective 18-7: "Increase the proportion of children with mental health problems who receive treatment" (USDHHS, 2000a) 1c.10 **Clinical Practice Guideline Citation:** Unknown 1c.11 **National Guideline Clearinghouse or other URL:** N/A 1c.12 **Rating of strength of recommendation (***also provide narrative description of the rating and by whom***):** N/A 1c.13 **Method for rating strength of recommendation** (*If different from* USPSTF system*, also describe rating and how it relates to USPSTF)***:** Unknown 1c.14 **Rationale for using this guideline over others:** N/A	
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Importance to Measure and Report?*	**1**
Steering Committee: Was the threshold criterion, *Importance to Measure and Report***, met?** **Rationale:**	**1** **Y☐** **N☐**
2. 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. (evaluation criteria)	Eval Rating

2a. MEASURE SPECIFICATIONS

S.1 Do you have a web page where current detailed measure specifications can be obtained?
S.2 If yes, provide web page URL:

2a. Precisely Specified

2a.1 Numerator Statement (*Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome***):**
This survey asks parents to rate the frequency/severity of 35 emotional or behavioral problems (using response categories of never, sometimes, or often present) order to determine the presence/absence and degree of psychosocial problems at a single point in time or to measure change over time.

2a.2 Numerator Time Window (*The time period in which cases are eligible for inclusion in the numerator***):**
The PSC is given at a single point with scores compared to population norms for total score or subscales. The PSC can can be readministered at at later point in time to calculate pre post change (total score change or change from 'case' to 'non case'. For example the PSC is given quarterly when used as an outcome tracking measure in child psychiatry or annually when used as a screen for psychosocial problems in pediatrics...or after a mental health intervention.

2a.3 Numerator Details (*All information required to collect/calculate the numerator, including all codes, logic, and definitions***):**
The weighted item score (0,1,2) is calcuated for each of the 35 items and the weighted total score is then calculated by summing the weighted socres for all items. Total score is compared to standards validated in a national sample. For school aged children scores of 28 or higher are considered to indicate the prsence of a psychosocial problem. Subscale scores can be calculated in the same way by summing the scores for clusters of items related to attention, conduct, or anxiety/depression problems.

2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured***):**
Children 4-16 years who are seeing their pediatrician or care provider for health maintainance visits or children who are particpating in mental health treatment or an intervention whose overall level of psychsocial functioning should be assessed at baseline or repeatedly.

2a.5 Target population gender: Female, Male
2a.6 Target population age range: 4-16

2a.7 Denominator Time Window (*The time period in which cases are eligible for inclusion in the denominator***):**
Children can be assessed at a single point in time or repeatedly. Time frames as small as six weeks or as long as six years have been used.

2a.8 Denominator Details (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions***):**
Populations of normal elementary school children, all pediatric outpatients seen for well child care or speciality populations like children in outpatient mental health care have been assessed.

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population***):** Virtually no exclusions. Children too far out of the validated range because too young (< 3) or too old (> 18) should be excluded.

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions***):**
N/A

2a.11 Stratification Details/Variables (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions***):**
N/A

2a.12-13 Risk Adjustment Type: No risk adjustment necessary

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2a.14 Risk Adjustment Methodology/Variables (*List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method***):**
N/A

2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score: Weighted score/composite/scale
2a.20 Interpretation of Score:
2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**
Score answers of never sometimes or often present for each item as 0,1, or 2.
Add weighted scores for all 35 items.
Use total score to calculate pre post change score for outcomes assessment.
Use total score to categorize as case (total score of 28 or higher if child is 6 or older and 35 item form is used) or non case (27 or lower). Other cut off scores for younger children or 17 item short form or subscales.

2a.22 Describe the method for discriminating performance *(e.g., significance testing)***:**
Changes in total scores can be assessed using parametric statistical significance testing or tests like chi square for categorical score analyses.

2a.23 Sampling (Survey) Methodology *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)*:
N/A

2a.24 Data Source (*Check the source(s) for which the measure is specified and tested)*
Documentation of original self-assessment, Electronic administrative data/claims, Electronic clinical data, Paper medical record/flow-sheet, Electronic Health/Medical Record

2a.25 Data source/data collection instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.***):**
Data should be conceived of as a single score per individual per time. Data can be stored in paper or electronic medical reocors as a total score or as individual items or as presence absence of administration (billing record).

2a.26-28 Data source/data collection instrument reference web page URL or attachment: URL N/A
http://www2.massgeneral.org/allpsych/psc/psc_home.htm

2a.29-31 Data dictionary/code table web page URL or attachment:

2a.32-35 Level of Measurement/Analysis (*Check the level(s) for which the measure is specified and tested)*
Clinicians: Group, Population: national, Population: regional/network, Population: states, Population: counties or cities, Program: Disease management, Program: QIO, Can be measured at all levels

2a.36-37 Care Settings (*Check the setting(s) for which the measure is specified and tested)*
Ambulatory Care: Office, Ambulatory Care: Clinic, Ambulatory Care: Emergency Dept, Ambulatory Care: Hospital Outpatient, Home, Hospice, Hospital, Long term acute care hospital, Behavioral health/psychiatric unit, All settings, Group homes

2a.38-41 Clinical Services (*Healthcare services being measured, check all that apply*)
Behavioral Health: Mental Health, Clinicians: Dietician/Nutritional professional, Clinicians: Physicians (MD/DO), Clinicians: Psychologist/LCSW Child psychiatrist

TESTING/ANALYSIS

2b. Reliability testing — **2b** C☐ P☐ M☐ N☐

2b.1 Data/sample *(description of data/sample and size)***:** The PSC was originally validated and normed on a middle class outpatient pediatric sample of 206 and 31 outpatient mental health patients (Jellinek, Murphy, and Burns, 1986).

Additional validation work was done on samples 300 middle class outpatients (Jellinek et al 1988) and 123 pediatric outpatients from lower income communities (Murphy, et al 1992) .
The national validation sample data were published in 1996 (11-14 years ago) by Kelley Kelleher and Bill Gardner (Kelleher, et al 1996; Gardner et al 1999) and their associates on a representative sample of 21,065 pediatric outpatients from the US and Canada.
As just noted, the cutoff scores, reliability and validity we published in 1986 and 1988 based on relatively small convenience samples were replicated (re-normed) in Kelleher et al's 1996 national samples. We did some recalibration work ourselves (Jellinek et al 1998) with this dataset in 1998 (12 years ago).

More recently (2007), as you know, Bill Gardner and his colleagues from Columbus and Pittsburgh have done additional work validating the PSC against diagnoses on the K-SADS-PL.

2b.2 **Analytic Method** *(type of reliability & rationale, method for testing)*:
Cronbach alpha and correlation of scores with retest several weeks later.

2b.3 **Testing Results** *(reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
Inter-rater reliability 84%
Test-retest reliability 84% - 91% (for middle class vs lower income samples)
Internal consistency (Cronbach alpha) 91%

2c. Validity testing

2c.1 **Data/sample** *(description of data/sample and size)*: The PSC was originally validated and normed on a middle class outpatient pediatric sample of 206 and 31 outpatient mental health patients (Jellinek, Murphy, and Burns, 1986).
Additional validation work was done on samples 300 middle class outpatients (Jellinek et al 1988) and 123 pediatric outpatients from lower income communities (Murphy, et al 1992) .
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As just noted, the cutoff scores, reliability and validity we published in 1986 and 1988 based on relatively small convenience samples were replicated (re-normed) in Kelleher et al's 1996 national samples. We did some recalibration work ourselves (Jellinek et al 1998) with this dataset in 1998 (12 years ago).

More recently (2007), as you know, Bill Gardner and his colleagues from Columbus and Pittsburgh have done additional work validating the PSC against diagnoses on the K-SADS-PL.

2c.2 **Analytic Method** *(type of validity & rationale, method for testing)*:
Correlation and sensitivity, specificity, and kappa with gold standard measures.

2c.3 **Testing Results** *(statistical results, assessment of adequacy in the context of norms for the test conducted)*:
The validity of the PSC was established by comparing case non case screening results found with the PSC with case classifications based on the Child Behavior Checklist, CGAS ratings by mental health clinicians, and receiving services in an outpatient children's mental health clinic. More recent work has explored validity against structured psychiatric interviews.Concurrent, criterion-related validity: Sensitivity 95% middle income, 88% lower income
Specificity 68% middle income, 95-100% low income.

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2d. Exclusions Justified

2d.1 **Summary of Evidence supporting exclusion(s):**
N/A

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2d.2 Citations for Evidence: N/A **2d.3 Data/sample** *(description of data/sample and size)*: N/A **2d.4 Analytic Method** *(type analysis & rationale)*: N/A **2d.5 Testing Results** *(e.g., frequency, variability, sensitivity analyses)*: N/A	**NA**☐
2e. Risk Adjustment for Outcomes/ Resource Use Measures **2e.1 Data/sample** *(description of data/sample and size)*: N/A **2e.2 Analytic Method** *(type of risk adjustment, analysis, & rationale)*: N/A **2e.3 Testing Results** *(risk model performance metrics)*: N/A **2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:** We have not explored this.	**2e** **C**☐ **P**☐ **M**☐ **N**☐ **NA**☐
2f. Identification of Meaningful Differences in Performance **2f.1 Data/sample from Testing or Current Use** *(description of data/sample and size)*: We have not explored this. **2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance** *(type of analysis & rationale)*: We have not explored this. **2f.3 Provide Measure Scores from Testing or Current Use** *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*: M=15.1, SD=10 in a national sample of pediatric outpatients aged 4-18.	**2f** **C**☐ **P**☐ **M**☐ **N**☐
2g. Comparability of Multiple Data Sources/Methods **2g.1 Data/sample** *(description of data/sample and size)*: In addition to the Kelleher et al national validation sample, the PSC has been used in large scale studies in several HMO's and several countries (Holland, Chile) as well as in a number of large intervention studies. **2g.2 Analytic Method** *(type of analysis & rationale)*: No systematic work like this done so far. **2g.3 Testing Results** *(e.g., correlation statistics, comparison of rankings)*: N/A	**2g** **C**☐ **P**☐ **M**☐ **N**☐ **NA**☐
2h. Disparities in Care **2h.1 If measure is stratified, provide stratified results** *(scores by stratified categories/cohorts)*: N/A **2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:** As noted earlier, differences in case rates have been noted for some minority groups and other risk factors but not explore systematially.	**2h** **C**☐ **P**☐ **M**☐ **N**☐ **NA**☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Scientific Acceptability of Measure Properties?*	**2**

Steering Committee: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties*, **met?** **Rationale:**	*2* **C☐** **P☐** **M☐** **N☐**
3. USABILITY	
Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)	Eval Rating
3a. Meaningful, Understandable, and Useful Information 3a.1 **Current Use:** In use 3a.2 **Use in a public reporting initiative (disclosure of performance results to the public at large)** (*If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years*)**:** The PSC is one of two psychsocial screens recommended by the state of Massachusetts for use during all well child visits. Over the past two years about one half million pediatrics visits have been screened, as many as one third of them with the PSC. Data have been reported to a court monitor so are a matter of public record but have not been published. The PSC is also a recommended screening instrument in at least one half dozen states. In the country of Chile, a national mental health program attempts to screen all first grade children in more than 1000 high risk schools, with as many as 40,000 children each year screened with the PSC. 3a.3 **If used in other programs/initiatives (***If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years***):** The PSC is also used as an outcome measure to monitor changes in children's functioning over the course in treatment within the Partners Psychiatry and Mental Health system of care. The PSC has been used at the Massachusett General Hospital Child Psychiatry Service as part of its outcomes rating project for three years for all cases at intake and then every three months. Scores for the PSC are now registered in the MGH electronic medical record. **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) 3a.4 **Data/sample** *(description of data/sample and size)***:** This has not been done 3a.5 **Methods** *(e.g., focus group, survey, QI project)***:** N/A 3a.6 **Results** *(qualitative and/or quantitative results and conclusions)***:** N/A	**3a** **C☐** **P☐** **M☐** **N☐**
3b/3c. Relation to other NQF-endorsed measures 3b.1 **NQF # and Title of similar or related measures:**	
(for NQF staff use) **Notes on similar/related** endorsed **or submitted measures:**	
3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source or different topic but same target population): 3b.2 **Are the measure specifications harmonized? If not, why?**	**3b** **C☐** **P☐** **M☐** **N☐** **NA☐**
3c. Distinctive or Additive Value 3c.1 **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:**	**3c** **C☐** **P☐**

5.1 **If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality:**	**M☐ N☐ NA☐**
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Usability?*	**3**
Steering Committee: Overall, to what extent was the criterion, *Usability*, **met?** **Rationale:**	**3** **C☐ P☐ M☐ N☐**
4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)	Eval Rating
4a. Data Generated as a Byproduct of Care Processes 4a.1-2 **How are the data elements that are needed to compute measure scores generated?** Survey	**4a** **C☐ P☐ M☐ N☐**
4b. Electronic Sources 4b.1 **Are all the data elements available electronically?** (*elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims*) Yes 4b.2 **If not, specify the near-term path to achieve electronic capture by most providers.**	**4b** **C☐ P☐ M☐ N☐**
4c. Exclusions 4c.1 **Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?** No 4c.2 **If yes, provide justification.**	**4c** **C☐ P☐ M☐ N☐ NA☐**
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences 4d.1 **Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.** The PSC is susceptible to all the inaccuracies that patient completed surveys face: respondents can misread questions, mark their answers incorrectly, etc. One way to audit for inaccuracies is to compare to previous or subsequent administrations. Scores that vary widely from time to time may indicate inaccuracies and could be checked by having respondents review their answers.	**4d** **C☐ P☐ M☐ N☐**
4e. Data Collection Strategy/Implementation 4e.1 **Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:** We have learned alot over the past 25 years. Most recently we have focussed on promoting administration and scoring methods that take advantage of electronic technologies like internet, digital pen, voice	**4e** **C☐ P☐ M☐ N☐**

recognition etc. **4e.2 Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*)**:** ~$7.26 (3 min) Costs/ screen**- Materials ~$0.06 Costs/ screen**- Admin. & Scoring ~$3.60 Costs/ screen**- Total Self-Report (based on time to score) ~$3.66 **4e.3 Evidence for costs:** N/A **4e.4 Business case documentation:** N/A	
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Feasibility*?	**4**
Steering Committee: Overall, to what extent was the criterion, *Feasibility*, **met?** **Rationale:**	**4** **C☐** **P☐** **M☐** **N☐**
RECOMMENDATION	
(for NQF staff use) **Check if measure is untested and only eligible for time-limited endorsement.**	**Time-limited ☐**
Steering Committee: Do you recommend for endorsement? **Comments:**	**Y☐** **N☐** **A☐**
CONTACT INFORMATION	
Co.1 Measure Steward (Intellectual Property Owner) **Co.1 Organization** Massachusetts General Hospital, Department of Child Psychiatry, Yawkey 6A, 35 Fruit St., Boston, Massachusetts, 02114 **Co.2 Point of Contact** Michael, Murphy, Ed.D, MMURPHY6@partners.org, 617-724-3163-	
Measure Developer If different from Measure Steward **Co.3 Organization** Massachusetts General Hospital, Department of Child Psychiatry, Yawkey 6A, 35 Fruit St., Boston, Massachusetts, 02114 **Co.4 Point of Contact** Michael, Murphy, Ed.D, MMURPHY6@partners.org, 617-724-3163-	
Co.5 Submitter If different from Measure Steward POC Michael, Murphy, Ed.D, MMURPHY6@partners.org, 617-724-3163-, Massachusetts General Hospital	
Co.6 Additional organizations that sponsored/participated in measure development	
ADDITIONAL INFORMATION	
Workgroup/Expert Panel involved in measure development **Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**	

Ad.2 If adapted, provide name of original measure: **Ad.3-5 If adapted, provide original specifications URL or attachment**
Measure Developer/Steward Updates and Ongoing Maintenance **Ad.6 Year the measure was first released:** 1990 **Ad.7 Month and Year of most recent revision:** 1 **Ad.8 What is your frequency for review/update of this measure?** Continuous review; new norms for each new population group in US and internatioal **Ad.9 When is the next scheduled review/update for this measure?** 07, 2010
Ad.10 Copyright statement/disclaimers: copyright 1984, Michael Jellinek and Michael Murphy, Massachusetts General Hospital
Ad.11 -13 Additional Information web page URL or attachment: URL http://www2.massgeneral.org/allpsych/psc/psc_home.htm
Date of Submission (*MM/DD/YY*)**:** 09/21/2010