



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 subcriterion 1b).

Brief Measure Information

NQF #: 0103

Corresponding Measures:

De.2. Measure Title: Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity

Co.1.1. Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

De.3. Brief Description of Measure: Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with evidence that they met the DSM-IV-TR criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified

1b.1. Developer Rationale: Chronic depression often goes unrecognized and untreated. The recognition and appropriate treatment of MDD is dependent on a thorough diagnostic assessment and an evaluation of the degree of severity of the disorder. A diagnostic assessment can help clinicians tailor a patient's treatment to their needs. It can help clinicians rule out general medical conditions or other psychiatric conditions which may be contributing to depressive symptomology. An assessment of severity can also help clinicians tailor a patient's treatment.

S.4. Numerator Statement: Patients with evidence that they met the DSM-IV-TR criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified

S.7. Denominator Statement: All patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD)

S.10. Denominator Exclusions: None

De.1. Measure Type: Process

S.23. Data Source: Other, Registry Data

S.26. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Aug 10, 2009

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

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

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

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form
0103_Evidence_MS5.0_Data.doc

1b. Performance Gap

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

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

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

Chronic depression often goes unrecognized and untreated. The recognition and appropriate treatment of MDD is dependent on a thorough diagnostic assessment and an evaluation of the degree of severity of the disorder. A diagnostic assessment can help clinicians tailor a patient's treatment to their needs. It can help clinicians rule out general medical conditions or other psychiatric conditions which may be contributing to depressive symptomology. An assessment of severity can also help clinicians tailor a patient's treatment.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. 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 included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

MDD is associated with functional impairment, impairments in interpersonal relationships and family functioning, work or school performance, maintenance of health and hygiene, deficits in quality of life and the risk of suicide. It results in a significant economic burden in the United States. At the same time, provider assessment of depression underestimates the true occurrence of the MDD, because many individuals with the disorder never seek care for it and primary care providers (PCP) often do not recognize or diagnose it.(1) Hepner and colleagues (2007) found that only 34% of patients receive a depression history and symptom assessment by their PCP.(1)

CMS Physician Quality Reporting Initiative:

This measure was used in the 2010 CMS Physician Quality Reporting Initiative/System. There is a gap in care as shown by this data; 91.70% is the aggregate performance rate in the total patient population and 93.10% is the mean performance rate of TIN/NPI's.(2)

10th percentile: 80.77%

25th percentile: 100.0%

50th percentile: 100.0%

75th percentile: 100.0%

90th percentile: 100.0%

Exception Rate: N/A*

*This measure has no exceptions

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.

(1) Hepner KA, Rowe M, Rost K, Hickey SC, Sherbourne CD, Ford DE, Meredith LS, Rubenstein LV. The Effect of Adherence to Practice Guidelines on Depression Outcomes. Ann Intern Med 2007;147:320-329.

(2) Confidential CMS PQRI 2010 Performance Information by Measure. Jan 2010-Feb 2011 TAP file

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 endorsement maintenance. 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 subcriterion on improvement (4b.1) under Usability and Use.

Non-Hispanic blacks, Hispanics, and non-Hispanic persons of other races are more likely to report major depression than non-Hispanic whites, based on responses to the Patient Health Questionnaire 8 (PHQ-8), which covers eight of the nine criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) for diagnosis of major depressive disorder.(1)

For individuals who experienced a depressive disorder in the past year, 63.7% of Latinos, 68.7% of Asians, and 58.8% of African

Americans, compared with 40.2% of non-Latino whites, did not access any mental health treatment in the past year.(2)

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

(1) Current Depression Among Adults: United States, 2006 and 2008. Morbidity and Mortality Weekly Report. Centers for Disease Control and Prevention. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5938a2.htm?s_cid=mm5938a2_e%0D%0A>. Accessed November 22, 2010.

(2) Alegria M, Chatterji P, Wells K, Cao Z, Chen C, Takeuchi D, Jackson J, Meng X. Disparity in Depression Treatment Among Racial and Ethnic Minority Populations in the United States. Psychiatr Serv 2008; 59:1264-1272.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, Patient/societal consequences of poor quality, Severity of illness

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.

Major depressive disorder (MDD) affects approximately 14.8 million American adults, or about 6.7 percent of the U.S. population aged 18 and older in a given year. (1)

MDD is the leading cause of disability in the U.S. for ages 15-44. (1)

The rate of depression in adults older than 65 years of age ranges from 7% to 36% in medical outpatient clinics and increases to 40% in the hospitalized elderly. (2)

Depression is the cause of over two-thirds of the 30,000 reported suicides in the U.S. each year. (3)

1c.4. Citations for data demonstrating high priority provided in 1a.3

(1) The Numbers Count: Mental Disorders in America. National Institute of Mental Health.

<<http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml>>. Accessed November 22, 2010.

(2) Major Depression in Adults in Primary Care. Institute for Clinical Systems Improvement.

<http://www.icsi.org/depression_5/depression__major__in_adults_in_primary_care_3.html>. Accessed November 22, 2010.

(3) Statistics on Depression. Depression and Bipolar Support Alliance.

<http://www.dbsalliance.org/site/PageServer?pagename=about_statistics_depression>. Accessed November 22, 2010.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

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 subcriteria 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):

Behavioral Health, Behavioral Health : Depression

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

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.)

physicianconsortium.org

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)

Attachment:

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

Attachment Attachment: [AMA-PCPI_eSpecification_AMDD-1DiagEvalSeverity_DEC2012.pdf](#)

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date 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)

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

Patients with evidence that they met the DSM-IV-TR criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

At the visit where new diagnosis or recurrent episode is identified [initial evaluation during the episode]

S.6. 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, 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.

Numerator definitions:

MDD diagnosis: For a diagnosis of MDD a patient must endorse five of nine symptoms, with one of those five being either 1) depressed mood or 2) loss of interest or pleasure. The other symptoms include significant weight loss or gain, or decrease or increase in appetite nearly every day; insomnia or hypersomnia nearly every day; psychomotor agitation or retardation nearly every day; fatigue or loss of energy nearly every day; feelings of worthlessness or guilt nearly every day; diminished ability to think or concentrate, or indecisiveness, nearly every day; and recurrent thoughts of death or suicidal ideation.

These symptoms must be present for a duration of 2 weeks or longer and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

These symptoms must:

- not meet criteria for a mixed episode,
- not be due to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition (eg, hypothyroidism), OR
- not be better accounted for by Bereavement, ie, after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Severity is judged to be mild, moderate, or severe based on the number of criteria symptoms, the severity of the symptoms, and the degree of functional disability and distress. (DSM-IV-TR, 2000). See Supporting Guidelines and Other References for additional information on defining severity levels.

Please refer to the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) (version IV-TR as of 2012) for more information regarding diagnosing Major Depressive Disorder.

For EHR:

See PCPI eSpecification attached in Data Dictionary or Code Table (2a1.30) field.

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

All patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD)

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, 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)

For EHR:

See PCPI eSpecification attached in Data Dictionary or Code Table (2a1.30) field.

S.10. Denominator Exclusions (Brief narrative description of exclusions from the target population)

None

S.11. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, 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.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, 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 with at S.2b)

We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

No risk adjustment or risk stratification.

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

S.16. Type of score:

Rate/proportion

If other:

S.17. 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.18. Calculation Algorithm/Measure Logic (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; aggregating data; risk adjustment; etc.)

To calculate performance rates:

1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address).

2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.

3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

If the patient does not meet the numerator, this case represents a quality failure.

Calculation algorithm is included in data dictionary/code table attachment (2a1.30).

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

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

Not applicable. The measure does not require sampling or a survey.

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

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

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Other, Registry Data

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

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

Not Applicable

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Other, Outpatient Services

If other: Emergency Department, Behavioral Health Day Treatment

S.28. 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.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

0103_MeasureTesting_MSFS.0_Data.zip

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 by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition

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)

ALL data elements are in defined fields in electronic health records (EHRs)

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.

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.

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. 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 and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

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

The greatest challenge for this measure was much of the patient care performed was not documented in the available structured, searchable fields. Most mismatched patients were found to meet the numerator upon manual review of the patient record because diagnostic evaluation was most consistently documented in free text notes by providers. EHR system design and workflow improvement efforts could allow for higher reliability for these measures.

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).

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.

Planned	Current Use (for current use provide URL)
Public Reporting	
Quality Improvement (Internal to the specific organization)	

4a.1. For each CURRENT use, checked above, provide:

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

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

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6

years of initial endorsement. (*Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.*)

4b. Improvement

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

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (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

4b.2. 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.

4c. Unintended Consequences

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

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

We are not aware of any unintended consequences related to this measurement.

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)

1364 : Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation

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

5a. Harmonization

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 completely harmonized?

No

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

This measure represent an update to the original measure created in 2006; during the review process, the Adult MDD Work Group felt that it was important to include certain enhancements given their focus on the adult population.

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.)

These measures are not competing, as they have different target populations.

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

Co.2 Point of Contact: Mark S., Antman, DDS, MBA, mark.antman@ama-assn.org, 312-464-5056-

Co.3 Measure Developer if different from Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

Co.4 Point of Contact: Mark S., Antman, DDS, MBA, mark.antman@ama-assn.org, 312-464-5056-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

Richard Hellman, MD, FACP, FACE (Co-Chair) (endocrinology, methodology)

John S. McIntyre, MD (Co-Chair) (psychiatry, methodology)

Alan A. Axelson, MD (general psychiatry, child/adolescent psychiatry)

Stanley Borg, DO (family medicine)

Andrea Bostrom, PhD, PMHCNS-BC (nursing, psychiatric nursing)

Gwendolen Buhr, MD, MHS, CMD (geriatrics)

Katherine A. Burson, MS, OTR/L, CPRP (occupational therapy)

Mirean Coleman, MSW, LICSW, CT (social work)

Thomas J. Craig, MD, MPH, DLFAPA, FACPM (psychiatry)

Allen Doederlein (patient representative)

William E. Golden, MD, FACP (internal medicine)

Molly Finnerty, MD (psychiatry, methodology)

Jerry Halverson, MD (psychiatry, methodology)

Paul R. Keith, MD (health plan representative)
Clifford K. Moy, MD (psychiatry)
John M. Oldham, MD (psychiatry)
Shaunte R. Pohl, PharmD, BCPS (pharmaceutical science)
Mark A. Reinecke, PhD (psychology)
Leslie H. Secrest, MD (psychiatry)
Carl A. Sirio, MD (critical care medicine, methodology)
Sharon S. Sweede, MD (family medicine)
Roberta Waite, EdD, APRN, CNS-BC (psychiatric nursing, methodology)

PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study are invited to participate as equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2006

Ad.3 Month and Year of most recent revision: 12, 2012

Ad.4 What is your frequency for review/update of this measure? See Ad.9.

Ad.5 When is the next scheduled review/update for this measure? 12, 2013

Ad.6 Copyright statement: Physician Performance Measures (Measures) and related data specifications have been developed by the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement® (PCPI®).

These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

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