



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 #: 0418e

Corresponding Measures: 0418

De.2. Measure Title: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Co.1.1. Measure Steward: Centers for Medicare & Medicaid Services

De.3. Brief Description of Measure: Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter

1b.1. Developer Rationale: This measure aligns with the U.S. Preventive Services Task Force's (USPSTF) guidelines recommending routine screening for depression as a part of primary care for both children and adults, seeking to increase detection and treatment of depression and reduce the associated economic burden. The measure is an important contribution to the quality domain of community and population health.

The World Health Organization describes major depression as the leading cause of disability worldwide (Pratt & Brody, 2008). According to the Center for Behavioral Health Statistics and Quality (2015), in 2014 11.7 percent of adolescents aged 12 to 17 and 6.6 percent of adults 18 years and older in the United States received a diagnosis of major depressive disorder. A study by Borner et al. (2010) found that 20 percent of adolescents are likely to have experienced depression by the time they are 18 years old. In adults, depression is the leading cause of disability in high-income countries and is associated with increased mortality due to suicide and impaired ability to manage other health-related issues (Siu, 2016).

The effects of depression in adults can include difficulties in functioning at home, in the workplace, and in social situations (Pratt & Brody, 2008). For example, 35 percent of men and 22 percent of women with depression reported that their depressive symptoms make it difficult for them to work, accomplish tasks at home, or get along with other people (Pratt & Brody, 2008). Effects of depression in adolescents are similar to those in adults; however, Siu (2016) noted depression has a negative effect on developmental trajectories in children and adolescents younger than 18 years old. Also, major depressive disorder in the adolescent population is especially problematic because it is linked with higher possibility of suicide attempt, death by suicide, and recurrence of the disorder in young adulthood.

Evidence strongly recommends screening for depression in adolescent and adult patients. Specifically, the USPSTF found convincing evidence that screening improves accurate identification of adolescent and adult patients with depression in primary care settings (Siu, 2016). Yet Borner et al. (2010) cite evidence that physicians are identifying and treating depression among adolescents even less than among adults, and that more than "70 percent of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated" (Borner, 2010, p. 948). Additionally, according to the 2016 USPSTF guideline for screening for depression in children and adolescents, only 36 to 44 percent of children and adolescents with depression receive treatment, further evidence that the majority of depressed children and adolescents go untreated. Although primary care providers (PCPs) are the first line of defense in detecting depression, studies show that PCPs fail to identify up to 50 percent of depressed patients, due to both lack of time and a lack of brief, sensitive, and easy-to administer psychiatric screening tools (Borner, 2010).

Finally, according to the 2016 USPSTF guideline for screening depression among adults, the United States spent about \$22.8 billion on depression treatment in 2009, and an additional estimated \$23 billion on lost productivity (Siu, 2016). This substantial economic burden warrants regular screening for depression, as screening is the first step in identifying those at risk for developing major depressive disorder and closing the performance gap.

S.4. Numerator Statement: Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter

S.6. Denominator Statement: All patients aged 12 years and older at the beginning of the measurement period with at least one

eligible encounter during the measurement period

S.8. Denominator Exclusions: Denominator Exclusions:

Patients with an active diagnosis for depression or a diagnosis of bipolar disorder

Denominator Exceptions:

Patient Reason(s)

Patient refuses to participate

OR

Medical Reason(s)

Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

OR

Situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

De.1. Measure Type: Process

S.17. Data Source: Electronic Health Data, Electronic Health Records

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

IF Endorsement Maintenance – Original Endorsement Date: Jun 28, 2017 **Most Recent Endorsement Date:** Jun 28, 2017

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 sub criteria to pass this criterion and be evaluated against the remaining criteria.***

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

[Evidence_form_NQF_0418-636178223236625911.docx](#)

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

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.

Yes

1b. Performance Gap

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

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

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

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), *SKIP* this question and answer the composite questions.

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According to the Center for Behavioral Health Statistics and Quality (2015), in 2014 11.7 percent of adolescents aged 12 to 17 and

6.6 percent of adults 18 years and older in the United States received a diagnosis of major depressive disorder. A study by Borner et al. (2010) found that 20 percent of adolescents are likely to have experienced depression by the time they are 18 years old. In adults, depression is the leading cause of disability in high-income countries and is associated with increased mortality due to suicide and impaired ability to manage other health-related issues (Siu, 2016).

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Evidence strongly recommends screening for depression in adolescent and adult patients. Specifically, the USPSTF found convincing evidence that screening improves accurate identification of adolescent and adult patients with depression in primary care settings (Siu, 2016). Yet Borner et al. (2010) cite evidence that physicians are identifying and treating depression among adolescents even less than among adults, and that more than “70 percent of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated” (Borner, 2010, p. 948). Additionally, according to the 2016 USPSTF guideline for screening for depression in children and adolescents, only 36 to 44 percent of children and adolescents with depression receive treatment, further evidence that the majority of depressed children and adolescents go untreated. Although primary care providers (PCPs) are the first line of defense in detecting depression, studies show that PCPs fail to identify up to 50 percent of depressed patients, due to both lack of time and a lack of brief, sensitive, and easy-to administer psychiatric screening tools (Borner, 2010).

Finally, according to the 2016 USPSTF guideline for screening depression among adults, the United States spent about \$22.8 billion on depression treatment in 2009, and an additional estimated \$23 billion on lost productivity (Siu, 2016). This substantial economic burden warrants regular screening for depression, as screening is the first step in identifying those at risk for developing major depressive disorder and closing the performance gap.

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.

Provider-level performance scores suggest that there are still gaps in care and opportunities for improvement.

Average Performance Rates by Year (PQRS – all reporting methods)*:

2011–82.6% (0.6% of eligible professionals reporting)

2012–65.2% (0.4% of eligible professionals reporting)

2013–71.0% (1.3% of eligible professionals reporting)

2014–52.4% (7.5% of eligible professionals reporting)

*From the 2014 PQRS Reporting Experience Report and Appendix

EHR data from convenience sample of two practices, 1/1/2015 through 12/31/2015

Number of Providers 57

Number of patients 54,349

Average Unweighted Score 70.7%

Average Weighted Score 68.3%

Standard deviation 20.2%

Minimum 0.0%

Interquartile range 18.2%

10th percentile 40.9%

20th percentile 61.5%

30th percentile 67.5%

40th percentile 70.0%

Median 72.6%

60th percentile 77.0%

70th percentile 79.4%

80th percentile 86.6%

90th percentile 93.8%

Maximum 100.0%

Please note: The unweighted average measure is the aggregated score for entire population. The weighted average is the average provider-level score, which is weighted by the number of patients in the denominator of each provider's score. All other statistics are based on weighted provider-level scores.

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.

Below are aggregate performance rates by patients' age, race, ethnicity, and sex from a convenience sample of two practices' EHR data from 2015. Because practices were not able to provide data on patients' insurance status, socioeconomic status, and/or disability status, we were unable to determine the presence of disparities in performance based on these factors. These results represent only those providers who participated in the testing of this measure and may not be generalizable to the population of all eligible providers.

Age Groups

12–17: 53.7%

18–64: 58.3%

65+: 91.4%

($\chi^2 = 5,252.569$; $df = 2$; $N = 47,782$; $p < 0.0001$)

Race

American Indian or Alaska Native: 46.2%

Asian: 52.9%

Black: 72.4%

Native Hawaiian or other Pacific Islander: 51.4%

White: 69.4%

Multiracial: 72.2%

Unknown: 58.7%

($\chi^2 = 270.069$; $df = 6$; $N = 47,782$; $p < 0.0001$)

Ethnicity

Hispanic or Latino: 59.6%

Not Hispanic or Latino: 68.4%

Unknown: 66.5%

($\chi^2 = 15.823$; $df = 2$; $N = 47,782$; $p = 0.0004$)

Sex

Female: 68.5%

Male: 68.0%

($\chi^2 = 1.362$; $df = 1$; $N = 47,768$; $p = 0.2431$)

We excluded 14 patients whose sex was unknown

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

Race/ethnicity: Literature indicates that depression rates are higher in non-Latino black people than in their non-Latino white

counterparts (Pratt & Brody, 2008). Clinical practice guidelines also indicate that minority racial and cultural groups in the United States are less likely to receive treatment for depression than European Americans (Trangle et al., 2016). Data collected from electronic health records of approximately 65,079 adult primary care patients from 2010 to 2012 showed that (1) individuals from minority groups are less likely to undergo screening for mental disorders, such as depression screening; (2) minority groups have less access to mental health care and receive less than adequate health care compared to non-Latino whites, and (3) women from racial/ethnic minority groups are less likely than white women to have access to mental health care (Hahm et al., 2015). Medicare beneficiary survey data analyzed by Akincigil et al. showed that about 6.4 percent of whites, 4.2 percent of black Americans, and 7.2 percent of Latino Americans had a diagnosis of depression. Among those diagnosed, 73 percent of whites received treatment (either with antidepressants, psychotherapy, or both); 60 percent of black Americans received treatment; and 63.4 percent of Latino Americans received treatment (Akincigil et al., 2012). These findings are consistent with other studies that show depression is under-recognized and undertreated among adult minorities. According to Davis et al. (2011), "Recent data suggest that the proportion of depressed adults who seek treatment is significantly lower among African Americans (53%) than among Caucasians (67%)."

Age: Literature indicates that depression rates are highest among adults ages 40 to 59 (Pratt & Brody, 2008).

Gender: Literature indicates that depression is more common in women than in men (Pratt & Brody, 2008). Studies showed that men were less likely than women to receive screening for mental health problems, such as depression (Hahm et al., 2015). Among Latino and Asian Americans, women were more likely than men to receive screening for depression and visit a health care provider for depression care after depression was detected. Asian and black Americans, particularly black women, were less likely to receive screening for depression and less likely to receive any depression care (Hahm et al., 2015).

Socioeconomic status: People with incomes below the federal poverty line and in the 18-39 and 40-59 age brackets experience higher depression rates than those with higher incomes, although this disparity is not observable in other age categories (Pratt & Brody, 2008).

We did not find any literature related to disparities associated with insurance status or disability.

Akincigil, A., Olsson, M., Siegel, M., Zurlo, K. A., Walkup, J. T., & Crystal, S. (2012). Racial and ethnic disparities in depression care in community-dwelling elderly in the United States. *American Journal of Public Health*, 102, 2, 319-328.

Davis, T. D., Deen, T., Bryant-Bedell, K., Tate, V., & Fortney, J. (2011). Does minority racial-ethnic status moderate outcomes of collaborative care for depression? *Psychiatric Services*, 62, 1282-1288.

Hahm, H. C., Cook, B. L., Ault-Brutus, A., & Alegria, M. (2015). Intersection of race-ethnicity and gender in depression care: Screening, access, and minimally adequate treatment. *Psychiatric Services*, 66, 258-264.

Pratt, L. A., & Brody, D. J. (2008). Depression in the United States household population, 2005-2006 (NCHS Data Brief No. 7).

Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Trangle, M., Gursky, J., Haight, R., Hardwig, J., Hinnenkamp, T., Kessler, D., Myszkowski, M. (2016, March). Adult depression in primary care. Bloomington, MN: Institute for Clinical Systems Improvement. Retrieved from

https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/

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):

Behavioral Health, Behavioral Health : Depression

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

Primary Prevention, Screening

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

Children, Elderly

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

The measure specifications are attached to this submission. Additional measure details may be found at: eCQI Resource Center <https://ecqi.healthit.gov/ecqm/ep/2020/cms002v9>. Value set details at VSAC: <https://vsac.nlm.nih.gov/>

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 an eMeasure Attachment: CMS2v9.zip

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: 0418e_CMS2_ValueSets_052019.xlsx

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.

No

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

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).

Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter

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).

Within the eCQM specification, value sets contain various codes to indicate clinical quality actions (See attached code table for S.2.b). Additionally, Clinical Quality Language (CQL) measure logic defines how the numerator is calculated (CQL logic is provided in the measure package attached in S.2a).

Time Period for Data Collection: At least once during the measurement period

Definitions:

Screening - Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or

condition, even in the absence of symptoms.

Standardized Depression Screening Tool - A normalized and validated depression screening tool developed for the patient population in which it is being utilized.

Examples of depression screening tools include but are not limited to:

Adolescent Screening Tools (12-17 years)

- Patient Health Questionnaire for Adolescents (PHQ-A)
- Beck Depression Inventory-Primary Care Version (BDI-PC)
- Mood Feeling Questionnaire (MFQ)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Patient Health Questionnaire (PHQ-9)
- Pediatric Symptom Checklist (PSC-17)
- PRIME MD-PHQ2

Adult Screening Tools (18 years and older)

- Patient Health Questionnaire (PHQ9)
- Beck Depression Inventory (BDI or BDI-II)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Depression Scale (DEPS)
- Duke Anxiety-Depression Scale (DADS)
- Geriatric Depression Scale (GDS)
- Cornell Scale for Depression in Dementia (CSDD)
- PRIME MD-PHQ2
- Hamilton Rating Scale for Depression (HAM-D)
- Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)
- Computerized Adaptive Testing Depression Inventory (CAT-DI)
- Computerized Adaptive Diagnostic Screener (CAD-MDD)

Perinatal Screening Tools

- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9 (PHQ-9)
- Beck Depression Inventory
- Beck Depression Inventory-II
- Center for Epidemiologic Studies Depression Scale
- Zung Self-rating Depression Scale

Follow-Up Plan - Documented follow-up for a positive depression screening must include one or more of the following:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Guidance from eQM:

A depression screen is completed on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression is documented on the date of the eligible encounter.

Depression screening is required once per measurement period, not at all encounters; this is patient based and not an encounter based measure.

Screening Tools:

- The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record
- The depression screening must be reviewed and addressed in the office of the provider, filing the code, on the date of the encounter. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider practice.
- The screening should occur during a qualified encounter or up to 14 days prior to the date of the qualifying encounter.
- Standardized depression screening tools should be normalized and validated for the age appropriate patient population in which they are used

Follow-Up Plan:

- The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."

Examples of a follow-up plan include but are not limited to:

- Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder
- Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale
- Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression
- Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options
- Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

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

All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period

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).

Within the eCQM specification, the denominator is defined as the initial patient population, which the specification defines as: "Patient Age 12 Years or Older at Start of Measurement Period." Additionally, CQL measure logic defines how the denominator is calculated (CQL logic is provided in the measure package attached in S.2a).

Time Period for Data Collection: 12 consecutive months

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

Denominator Exclusions:

Patients with an active diagnosis for depression or a diagnosis of bipolar disorder

Denominator Exceptions:

Patient Reason(s)

Patient refuses to participate

OR

Medical Reason(s)

Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

OR

Situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

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.)

Time Period for Data Collection: Once during the measurement period

Within the eQCM specification, the specification defines denominator exclusions as having an active diagnosis of depression or bipolar disorder starting before a qualifying encounter within the CQL measure logic and exceptions, patient reason(s), patient refuses to participate, or medical reason(s); patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status, are defined as occurring during a qualifying encounter within the CQL measure logic. Value sets contain relevant codes to capture the exclusions (See attached code table for S2.b for specific coding). Additionally, CQL measure logic that defines how the exclusions are calculated is provided in the measure package attached in S.2a.

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.)

Consistent with CMS's Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

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.)

To calculate provider performance, complete a fraction with the following measure components: Numerator (A), Performance Denominator (PD), Denominator Exclusions (B) and Denominator Exceptions (C).

Numerator (A): Number of patients meeting numerator criteria

Performance Denominator (PD): Number of patients meeting criteria for denominator inclusion

Denominator Exclusions (B): Number of patients with valid exclusions

Denominator Exceptions (C): Number of patients with valid exceptions

1) Identify the patients who meet the eligibility criteria for the denominator (PD) which includes patients who are 12 years and older with appropriate encounters as defined by encounter codes or encounter value set during the reporting period.

2) Determine whether a Denominator Exclusion (B) applies and subtract those patients from the denominator (PD).

3) Identify which of those patients meet the numerator criteria (A)

4) For those patients who do not meet the numerator criteria, determine whether an appropriate Denominator Exception (C) applies and subtract those patients from denominator (PD).

5) Calculate performance with the following:

$$\frac{\text{Numerator (A)}}{[\text{Performance Denominator (PD)} - \text{Denominator Exclusions (B)} - \text{Denominator Exceptions (C)}]}$$

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.

N/A

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.

Electronic Health Data, Electronic Health 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.

No specific data source/data collection instrument.

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, Clinician : Individual

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

Outpatient Services

If other:

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

Not a composite.

2. Validity – See attached Measure Testing Submission Form

Testing_form_NQF_0418-3132_CMS_2.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.

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. 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 by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), 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 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. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

N/A

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: [Feasibility_Scorecard_NQF_0418-3132.pdf](#)

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.

We conducted workflow assessments at three practices and worked with these practices to complete feasibility scorecards. Two practices experienced feasibility challenges with data elements identifying follow-up interventions, particularly "additional evaluation," "follow-up for depression," and "suicide risk assessment;" but the third practice was able to capture these data elements. All three practices faced challenges with at least one of the data elements identifying denominator exceptions: "medical

reason contraindicated” and “patient refused.” Since these are likely to be relatively infrequent, however, we do not expect these challenges to significantly impact measure performance. Overall, the measure was feasible in each of the three provider practices that contributed to testing of this eCQM. Most data elements necessary to capture the measure were regularly captured in structured fields.

This measure is not a PRO-PM.

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

None

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

Specific Plan for Use	Current Use (for current use provide URL)
Payment Program	Public Reporting Physician Quality-Reporting System http://www.cms.gov/PQRS

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

The Centers for Medicare & Medicaid Services (CMS) sponsors the Medicare and Medicaid EHR Incentive Programs (commonly referred to, collectively, as the Meaningful Use program) which provide financial incentives to entities that leverage certified EHR technology to improve patient care as outlined in specific program objectives. Eligible professionals (EPs), eligible hospitals, and critical access hospitals are required to report electronic clinical quality measures (eCQMs) during each year of participation in order to receive an incentive payment. More information about the Meaningful Use program is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html. At this time, no publicly available data are available on the frequency with which this measure is reported as part of the Meaningful Use Program.

The Physician Quality Reporting System (PQRS), also sponsored by CMS, is a national reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by EPs. To be eligible for an incentive payment, EPs must satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B Fee-for-Service beneficiaries. More information about PQRS is available at <http://www.cms.gov/PQRS>. According to the 2014 PQRS Reporting Experience, in 2014, this measure was one of six program measures in which more than 500,000 professionals were eligible to report, yet only 7.5 percent of those eligible actually reported. EP performance scores that rely on registry reporting are posted on Physician Compare. Individual eligible EPs and group practices participating under the PQRS Group Practice Reporting Option (GPRO) may report electronically using an EHR, and these results are also posted on Physician Compare.

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.

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.

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.

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

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

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.

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.

Average PQRS reporting rates from 2011 to 2014 reflect reporting by all participating providers, including those who reported the measure using EHR, claims, and registry data. EPs submit performance data voluntarily, and results may not be representative of all EPs. We do not have access to data on historical trends in performance specific to eCQM reporting, nor on performance rates by geographic area.

The average performance rate based on all data sources has fluctuated substantially over the past four years, decreasing from 82.6 percent in 2011 to 52.4 percent in 2014. However, the number of EPs reporting the measure has increased significantly over this time frame, from just 0.6 percent of EPs in 2011 to 7.5 percent in 2014. This makes it difficult to assess trends over time, as the EPs who recently began reporting the measure may have lower performance rates than those who have been reporting it for a longer

period. Although the reporting increased each year, a substantial number of EPs are still not reporting the measure, and the average performance rate illustrates that there is still a gap in care.

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.

We have not identified any unintended consequences in our recent testing, or in the measure's implementation.

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

We have not identified any unexpected benefits in our recent testing, or in the measure's implementation.

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)

0518 : Depression Assessment Conducted

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

There are no competing measures. Multiple related measures have lost their NQF endorsement, including:

- Percent of Residents Who Have Depressive Symptoms (Long-Stay) – Centers for Medicare & Medicaid Services (formerly NQF #0690)
- Depression Screening by 13 Years of Age – National Committee for Quality Assurance (formerly NQF #1394)
- Maternal Depression Screening – National Committee for Quality Assurance (formerly NQF #1401)
- Depression Screening by 18 Years of Age – National Committee for Quality Assurance (formerly NQF #1515)

We also identified the following measures in the National Quality Measures Clearinghouse that do not have NQF endorsement:

- Adult depression in primary care: percentage of perinatal patients with documentation of screening for major depression or persistent depressive disorder using either PHQ-2 or PHQ-9 (Institute for Clinical Systems Improvement [ICSI])
- Adult depression in primary care: percentage of patients with cardiovascular disease with documentation of screening for major depression or persistent depressive disorder using either PHQ-2 or PHQ-9 (ICSI)
- Adult depression in primary care: percentage of patients who had a stroke with documentation of screening for major depression or persistent depressive disorder using either PHQ-2 or PHQ-9 (ICSI)
- Pediatric preventive care: percentage of pediatric patients aged 12 to 17 years who have a documented mental health and/or depression screening using one of the specified validated tools at a well-child visit during the measurement period (Minnesota Community Measurement)

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.

The only related NQF endorsed measure identified is 0518: Depression Assessment Conducted. Measure 0518 is an episode-based measure and reported based on OASIS data specific to home health agencies. It is similar to 0418, as it assesses depression using a standardized tool, but it differs in two key ways: First, target population: the denominator incorporates only adults aged 18 years and older and includes the number of home health episodes of care ending during the reporting period. Second, measure focus: the measure focuses on home health care in which patients received screening for depression. It does not include any follow-up component. 0418 is a patient-based measure focused on patients 12 years and older and includes a follow-up plan for positive depression screening results. Both are process measures; however, data for 0518 are only reported electronically and 0418 data may be reported using claims, registry, and electronic sources. 0418 is more robust in that it includes a broader population and requires a follow-up plan of care.

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.)

There are no competing measures that target the same measure focus and or population.

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: NQF_0418_Summary_Materials-636173293393040868.pdf](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): Centers for Medicare & Medicaid Services

Co.2 Point of Contact: Joel, Andress, joel.andress@cms.hhs.gov

Co.3 Measure Developer if different from Measure Steward: Quality Insights of Pennsylvania

Co.4 Point of Contact: Anita, Somplasky, asomplasky@wvmi.org, 877-346-6180-7852

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.

Through a collaborative process, the expert workgroup annually reviews the measure specifications (description, numerator, denominator, definitions, and clinical recommendation); literature review findings; and feedback or questions about the measure during its implementation. When last convened in 2016, the expert workgroup included the following members:

Jean Carter, PhD

Psychology

Washington Psychological Center, P.C.

Paula Hartman-Stein, PhD

Clinical psychology

Center for Healthy Aging; clinical psychologist, founder

Bracken Babula, MD
Internal medicine
Department of Medicine; Thomas Jefferson University; associate quality officer

Alan Axelson, MD
Adolescent psychiatry
InterCare Psychiatric Services; medical director and chief

Justin Schreiber, DO, MPH
Psychiatry
Western Psychiatric Institute and Clinic; co-triple board chief

Gregory M. Martino, PhD
Clinical psychology
Independent practice, DuBois, Pennsylvania

Tracy Murphy, AuD
Audiology
North Shore Audio-Vestibular Lab

Virginia Clark, PhD
Psychology (adolescent)
Western Reserve Psychological Associates, Inc.; president

Donald Wilson, MD
Obstetrics/gynecology
Women's Care Florida; chief medical officer

Harold Manley, PharmD
Pharmacology
Dialysis Clinic, Incorporated; director of medication management and pharmacovigilance

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2008

Ad.3 Month and Year of most recent revision: 04, 2016

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

Ad.5 When is the next scheduled review/update for this measure? 04, 2017

Ad.6 Copyright statement: Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. Quality Insights of Pennsylvania disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT [R]) or other coding contained in the specifications.

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Ad.7 Disclaimers: 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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Ad.8 Additional Information/Comments: [N/A](#)