

Measure #134 (NQF 0418): Preventive Care and Screening: Screening for Depression and Follow-Up Plan – National Quality Strategy Domain: Community/Population Health

2017 OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 12 years and older screened for depression on 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 positive screen

INSTRUCTIONS:
This measure is to be reported a minimum of **once per performance period** for patients seen during the performance period. This measure may be reported by eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening".

Measure Reporting:

The listed denominator criteria is used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions allowed by the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 12 years and older

Denominator Criteria (Eligible Cases):

Patients aged ≥ 12 years on date of encounter

AND

Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96118, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439, G0444

AND NOT

DENOMINATOR EXCLUSION:

Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required: G9717

NUMERATOR:

Patients screened for depression on 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 positive screen

Numerator Instructions: 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.

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. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.

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), and PRIME MD-PHQ2
- **Adult Screening Tools (18 years and older)**
Patient Health Questionnaire (PHQ-9), 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 Screening, and PRIME MD-PHQ2

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

Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusion) –

- Patient has an active diagnosis of Depression
- Patient has a diagnosed Bipolar Disorder

Patients with a Documented Reason for not Screening for Depression (Denominator Exception) –

One or more of the following conditions are documented:

- Patient refuses to participate
- 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
- Situations where the patient's 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

Numerator Options:

Performance Met:

Screening for depression is documented as being positive AND a follow-up plan is documented (**G8431**)

OR

Performance Met:

Screening for depression is documented as negative, a follow-up plan is not required (**G8510**)

OR

Denominator Exception:

Screening for depression not completed, documented reason (**G8433**)

OR

Performance Not Met:

Depression screening not documented, reason not given (**G8432**)

OR

Performance Not Met:

Screening for depression documented as positive, follow-up plan not documented, reason not given (**G8511**)

RATIONALE:

In 2008, the Geriatric Mental Foundation reported that of the population aged 65 and older in the United States, 15-20 percent of adults had experienced depression (Geriatric Mental Health Foundation, 2008), while 7 million of the same

population were affected by depression (Steinman, 2007, p. 175) and accounted for 16 percent of suicide deaths in 2004 (Centers for Disease Control and Prevention, 2007).

The World Health Organization (WHO), as cited by Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. "Overall, approximately 80% of persons with depression reported some level of difficulty in functioning because of their depressive symptoms. In addition, 35% of males and 22% of females with depression reported that their depressive symptoms make it very or extremely difficult for them to work, get things done at home, or get along with other people. More than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their symptoms" (Pratt & Brody, 2008, p.2). Pratt & Brody (2008) found that depression rates were higher in the 40-59 age brackets, is more common in females than in males, and higher in non-Hispanic black persons than in their non-Hispanic white counterparts (Pratt & Brody, 2008, p. 2). Disparities due to income have also been observed, as those with lower income (below the federal poverty line) in the 18-39 and 40-59 age brackets, whom experience higher depression rates than those with higher income. This disparity is not observable in other age categories (Pratt & Brody, 2008, p. 2).

Among children, the rate of current or recent depression stands at 3% and at 6% for adolescents, whose lifetime incidence rate of major depressive disorder (MDD) could be as high as 20% (Williams et al., 2009, p. e716). Borner (2010), states that 20% of adolescents are likely to have experienced depression by the time they are 18 years old and that there is an observed increased onset around puberty. Onset of MDD during adolescence is particularly significant because it is associated with higher risks of suicide attempt, death by suicide and MDD recurrence in young adulthood. Additionally MDD is "associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning during young adulthood" (Williams et al., 2009, p. e716). According to Zalsman et al., (2006) as reported in Borner et al. (2010), "depression ranks among the most commonly reported mental health problems in adolescent girls" (p. 947).

"The negative outcomes associated with early onset depression, make it crucial to identify and treat depression in its early stages" (Borner, 2010, p. 948). While Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients, purportedly because of time constraints and a lack of brief, sensitive, easy-to administer psychiatric screening instruments" (Borner, 2010, p. 948). "Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated" (Borner, 2010, p. 948).

The substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. This measure seeks to achieve this goal and aligns with the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014). The measure makes important contribution to the quality domain of community and population health.

CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years)

"The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up" (AHRQ, 2010, p.141).

"Clinicians and health care systems should try to consistently screen adolescents ages 12-18 for major depressive disorder, but only when systems are in place to ensure accurate diagnosis, careful selection of treatment, and close follow-up" (ICSI, 2013, p.16).

Adult Recommendation (18 years and older)

"The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up" (AHRQ, 2010, p.136).

"A system that has embedded the elements of best practice and has capacity to effectively manage the volume should consider routine screening of all patients, based on the recommendations of the U.S. Preventive Services Task Force"

(ICSI, 2013, p.7). "Clinicians should use a standardized instrument to screen for depression if it is suspected based on risk factors or presentation. Clinicians should assess and treat for depression in patients with some comorbidities. Clinicians should acknowledge the impact of culture and cultural differences on physician and mental health. Clinicians should screen and monitor depression in pregnant and post-partum women" (ICSI, 2013, p.4).

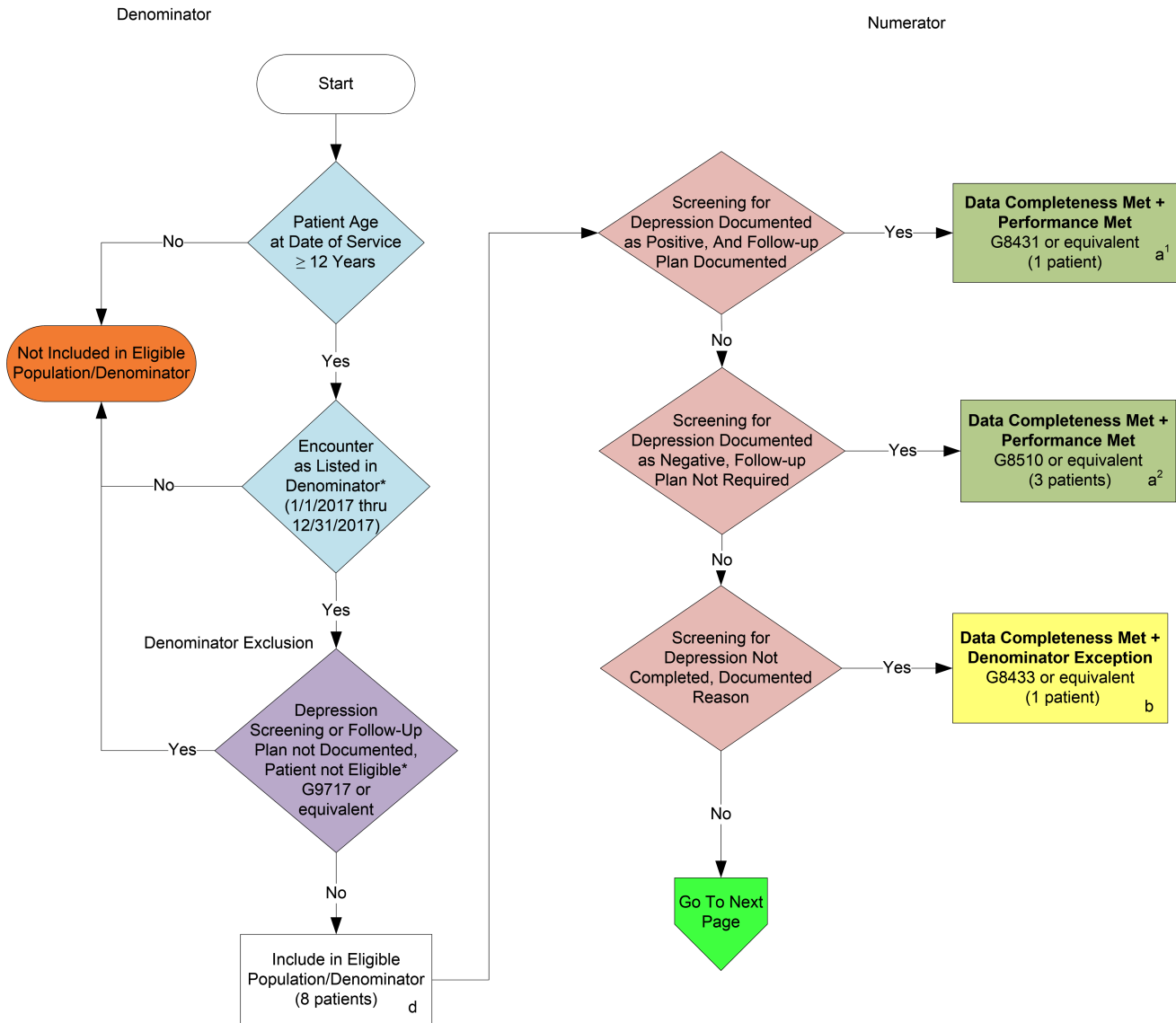
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2017 Registry Individual Measure Flow #134 NQF #0418: Preventive Care and Screening: Screening for Depression and Follow-Up Plan



*See the posted Measure Specification for specific coding and instruction to report this measure.

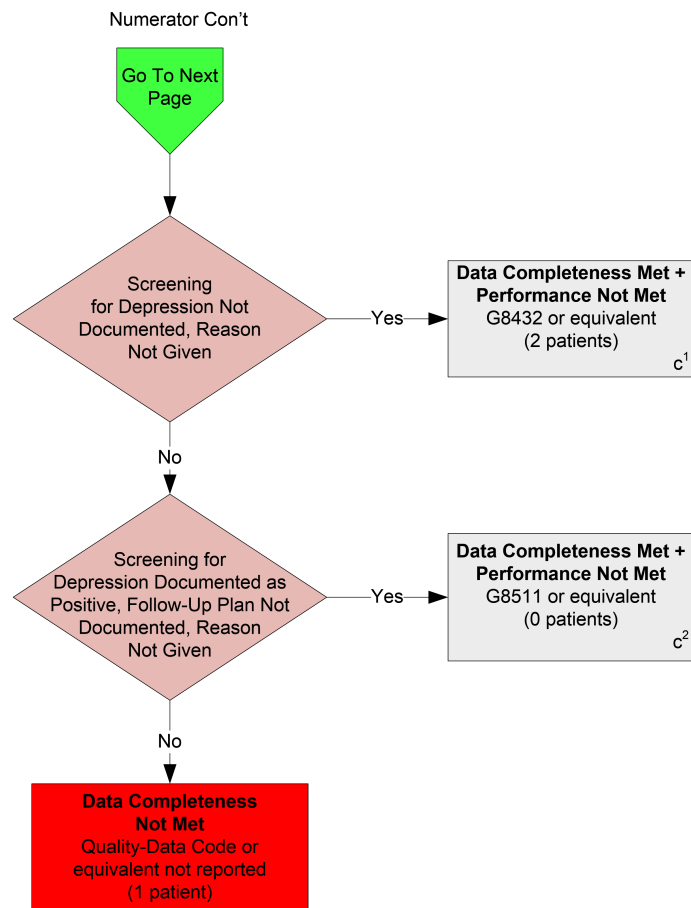
NOTE: Reporting Frequency: Patient-process

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V1.1

2017 Registry Individual Measure Flow

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SAMPLE CALCULATIONS:

Data Completeness Rate=

$$\frac{\text{Performance Met (a}^1 + a^2 = 4 \text{ patients)} + \text{Denominator Exception (b=1 patient)} + \text{Performance Not Met (c}^1 + c^2 = 2 \text{ patients)}}{\text{Eligible Population / Denominator (d=8 patients)}} = \frac{7 \text{ patients}}{8 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a}^1 + a^2 = 4 \text{ patients)}}{\text{Data Completeness Numerator (7 patients) - Denominator Exception (b=1 patient)}} = \frac{4 \text{ patients}}{6 \text{ patients}} = 66.67\%$$

*See the posted Measure Specification for specific coding and instruction to report this measure.

NOTE: Reporting Frequency: Patient-process

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2017 Registry Individual Measure Flow

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Please refer to the specific section of the Measure Specification to identify the denominator and numerator information for use in reporting this Individual Measure.

1. Start with Denominator
2. Check Patient Age:
 - a. If the Age is greater than or equal to 12 years of age on Date of Service and equals No during the measurement period, do not include in Eligible Patient Population. Stop Processing.
 - b. If the Age is greater than or equal to 12 years of age on Date of Service and equals Yes during the measurement period, proceed to check Patient Encounter.
3. Check Encounter Performed:
 - a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Patient Population. Stop Processing.
 - b. If Encounter as Listed in the Denominator equals Yes, proceed to check Denominator Exclusion.
4. Check Denominator Exclusion:
 - a. If Depression Screening or Follow up Plan Not Documentation Patient Not Eligible equals Yes, do not include in Eligible Patient Population. Stop Processing
 - b. If Depression Screening or Follow up Plan Not Documentation Patient Not Eligible equals No, proceed to Eligible Patient Population.
5. Denominator Population:
 - a. Denominator population is all Eligible Patients in the denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 8 patients in the sample calculation.
6. Start Numerator
7. Check Screening for Depression Documented as Positive, And Follow-up Plan Documented:
 - a. If Screening for Depression Documented as Positive, And Follow-up Plan Documented equals Yes, include in Data Completeness Met and Performance Met.
 - b. Data Completeness Met and Performance Met letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a¹ equals 1 patient in Sample Calculation.
 - c. If Screening for Depression Documented as Positive, And Follow-up Plan Documented equals No, proceed to Screening for Depression Documented as Negative, Follow-up Plan Not Required.
8. Check Screening for Depression Documented as Negative, Follow-up Plan Not Required:
 - a. If Screening for Depression Documented as Negative, Follow-up Plan Not Required equals Yes, include in Data Completeness Met and Performance Met.

- b. Data Completeness Met and Performance Met letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter a² equals 3 patients in the Sample Calculation.
 - c. If Screening for Depression Documented as Negative, Follow-up Plan Not Required equals No, proceed to Screening for Depression Not Documented, Documented Reason.
9. Check Screening for Depression Not Completed, Documented Reason:
- a. If Screening for Depression Not Completed, Documented Reason equals Yes, include in the Data Completeness Met and Denominator Exception.
 - b. Data Completeness Met and Denominator Exception letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter b equals 1 patient in the Sample Calculation.
 - c. If Screening for Depression Not Completed, Documented Reason equals No, proceed to Screening for Depression Not Documented, Reason Not Given.
10. Check Screening for Depression Not Documented, Reason Not Given:
- a. If Screening for Depression Not Documented, Reason Not Given equals Yes, include in the Data Completeness Met and Performance Not Met.
 - b. Data Completeness Met and Performance Not Met letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c¹ equals 2 patients in the Sample Calculation.
 - c. If Screening for Depression Not Documented, Reason Not Given equals No, proceed to Screening for Depression Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given.
11. Check Screening for Depression Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given:
- a. If Screening for Depression Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given equals Yes, include in the Data Completeness Met and Performance Not Met.
 - b. Data Completeness Met and Performance Not Met letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c² equals 0 patients in the Sample Calculation.
 - c. If Screening for Depression Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given equals No, proceed to Data Completeness Not Met
12. Check Data Completeness Not Met:
- a. If Data Completeness Not Met equals No, Quality Data Code or equivalent not reported. 1 patient has been subtracted from the data completeness numerator in the sample calculation.

SAMPLE CALCULATIONS:

Data CompletenessRate=

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=4 patients) + Denominator Exception (b}^1\text{+b}^2\text{=1 patient) + Performance Not Met (c}^1\text{+c}^2\text{=2 patients)}}{\text{Eligible Population / Denominator (d=8 patients)}} = \frac{7 \text{ patients}}{8 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=4 patients)}}{\text{Data Completeness Numerator (7 patients) - Denominator Exception (b}^1\text{+b}^2\text{=1 patient)}} = \frac{4 \text{ patients}}{6 \text{ patients}} = 66.67\%$$