NATIONAL
QUALITY FORUM

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 #: 0712
Corresponding Measures:
De.2. Measure Title: Depression Utilization of the PHQ-9 Tool
Co.1.1. Measure Steward: MN Community Measurement
De.3. Brief Description of Measure: The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia who have a completed PHQ-9 or PHQ-9M tool during the measurement period.
1b.1. Developer Rationale: Adults:
Depression is a common and treatable mental disorder. The Centers for Disease Control and Prevention states that an estimated 6.6% of the U.S. adult population (14.8 million people) experiences a major depressive disorder during any given 12-month period. Additionally, dysthymia accounts for an additional 3.3 million Americans. In 2006 and 2008, an estimated 9.1% of U.S. adults reported symptoms for current depression.1 Persons with a current diagnosis of depression and a lifetime diagnosis of depression or anxiety were significantly more likely than persons without these conditions to have cardiovascular disease, diabetes, asthma and obesity and to be a current smoker, to be physically inactive and to drink heavily.2 People who suffer from depression have lower incomes, lower educational attainment and fewer days working days each year, leading to seven fewer weeks of work per year, a loss of 20% in potential income and a lifetime loss for each family who has a depressed family member of $300,000.3 The cost of depression (lost productivity and increased medical expense) in the United States is $83 billion each year.4

Adolescents and Adults:
The Centers for Disease Control and Prevention states that during 2009-2012 an estimated 7.6% of the U.S. population aged 12 and over had depression, including 3% of Americans with severe depressive symptoms. Almost 43% of persons with severe depressive symptoms reported serious difficulties in work, home and social activities, yet only 35% reported having contact with a mental health professional in the past year.5
Depression is associated with higher mortality rates in all age groups. People who are depressed are 30 times more likely to take their own lives than people who are not depressed and five times more likely to abuse drugs.6 Depression is the leading cause of medical disability for people aged 14 – 44.7 Depressed people lose 5.6 hours of productive work every week when they are depressed, fifty percent of which is due to absenteeism and short-term disability.

Adolescents:
In 2014, an estimated 2.8 million adolescents age 12 to 17 in the United States had at least one major depressive episode in the past year. This represented 11.4% of the U.S. population. The same survey found that only 41.2 percent of those who had a Major Depressive Episode received treatment in the past year.8 The 2013 Youth Risk Behavior Survey of students grades 9 to 12 indicated that during the past 12 months 39.1% (F) and 20.8% (M) indicated feeling sad or hopeless almost every day for at least 2 weeks, planned suicide attempt 16.9% (F) and 10.3% (M), with attempted suicide 10.6% (F) and 5.4% (M).9 Adolescent-onset depression is associated with chronic depression in adulthood.10 Many mental health conditions (anxiety, bipolar, depression, eating disorders, and substance abuse) are evident by age 14.11 The 12-month prevalence of MDEs increased from 8.7% in 2005 to 11.3% in 2014 in adolescents and from 8.8% to 9.6% in young adults (both P < .001). The increase was larger and statistically significant only in the age range of 12 to 20 years. The trends remained significant after adjustment for substance use disorders and sociodemographic factors. Mental health care contacts overall did not change over time; however, the use of specialty mental health providers increased in adolescents and young adults, and the use of prescription medications and inpatient hospitalizations increased in adolescents. 12 In 2015, 9.7% of adolescents in MN who were screened for depression or other mental health conditions, screened positively.13

References
1. CDC. Current Depression Among Adults --- United States, 2006 and 2008. MMWR 2010;59(38);1229-1235.
2. Strine TW, Mokdad AH, Balluz LS, et al. Depression and anxiety in the United States: findings from the 2006 Behavioral Risk Factor Surveillance System. Psychiatr Serv 2008;59:1383--90.
3. Smith, J. P., & Smith, G. C. (2010). Long-term economic costs of psychological problems during childhood. Social Science & Medicine, 71, 110-115.
4. Greenberg, P. E., Kessler, R. C., Birnbaum, H. G., Leong, S. A., Lowe, S. W., Berglund, P. A., et al. (2003). The economic burden of depression in the United States: How did it change between 1990 and 2000? Journal of Clinical Psychiatry, 64, 1465-1475.
5. Pratt LA, Brody DJ. Depression in the U.S. household population, 2009–2012. NCHS data brief, no 172. Hyattsville, MD: National Center for Health Statistics. 2014.
6. Joiner, Thomas Myths about suicide. Cambridge, MA, US: Harvard University Press. (2010). 288 pp.7. Stewart, W. F., Ricci, J. A., Chee, E., Hahn, S. R., & Morganstein, D. (2003). Cost of lost productive work time among US workers with depression. Journal of the American Medical Association, 289, 3135-3144.
8. National Institute Mental Health/ National Institute Health 2014 prevalence of depression in adolescents statistics www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adolescents.shtml
9. 2013 Youth Risk Behavior Survey Suicide and suicide Attempts in Adolescents Clinical Report American Academy of Pediatrics July 2016
10. Lewinsohn, P. M., Rohde, P., Klein, D. N., & Seeley, J. R. (1999). Natural course of adolescent major depressive disorder: I. Continuity into young adulthood. Journal of the American Academy of Child & Adolescent Psychiatry, 38(1), 56-63.
11. Why do many psychiatric disorders emerge during adolescence? Giedd et al. Nat Rev Neurosci
Dec 2008 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2762785/
12. National Trends in the Prevalence and Treatment of Depression in Adolescents and Young Adults. Ramin, M et al Pediatrics November 2016 http://pediatrics.aappublications.org/content/early/2016/11/10/peds.2016-1878
13. New Measures Evaluate Rates of Obesity Counseling for Kids, Depression Screening for Teens Oct 2015 www.mncm.org/new-measures-evaluate-rates-of-obesity-counseling-for-kids-depression-screening-for-teens/

S.4. **Numerator Statement:** Adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) included in the denominator who have at least one PHQ-9 or PHQ-9M tool administered and completed during a four month measurement period.

S.6. **Denominator Statement:** Adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia.

S.8. **Denominator Exclusions:** Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis of bipolar or personality disorder, schizophrenia or psychotic disorder, or pervasive developmental disorder are excluded.

De.1. **Measure Type:** Process
S.17. **Data Source:** Electronic Health Record (Only), Paper Records
S.20. **Level of Analysis:** Clinician : Group/Practice, Facility

IF Endorsement Maintenance – Original Endorsement Date: Jan 17, 2011 **Most Recent Endorsement Date:** Mar 06, 2015

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:
2101:Paired Measures 0710 and 0712
2102:Paired Measures 0711 and 0712
2103:Paired Measures 0710, 0711 and 0712

De.4. **IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?** This process PRO-based measure is paired with the outcome measures of NQF# 0711 Depression Remission at Six Months, NQF# 0711 Depression Remission at Twelve Months", NQF# 1884 Depression Response at Six Months- Progress Towards Remission and NQF# 1885 Depression Response at Twelve Months- Progress Towards Remission. This measure was selected by stakeholders for public reporting to promote the implementation of work flow processes within the provider's office to insure that the patient is being assessed on a routine basis with a standardized tool that supports the outcome measures for depression. Currently, only about 25 to 30% of the patients eligible for the denominator of remission or response at 6 or 12 months actually have a follow-up PHQ-9 or PHQ-9M score for calculating remission (PHQ-9 score < 5) or response (PHQ-9 or PHQ-9M reduced by 50% or greater).

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
0712_Evidence_Depression_Util_PHQ-9_Nov_2016.docx
1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?
Please update any changes in the evidence attachment in red. Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. If there is no new evidence, no updating of the evidence information is needed.
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 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.)
IF a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and provide rationale for composite in question 1c.3 on the composite tab.
Adults:
Depression is a common and treatable mental disorder. The Centers for Disease Control and Prevention states that an estimated 6.6% of the U.S. adult population (14.8 million people) experiences a major depressive disorder during any given 12-month period. Additionally, dysthymia accounts for an additional 3.3 million Americans. In 2006 and 2008, an estimated 9.1% of U.S. adults reported symptoms for current depression.1 Persons with a current diagnosis of depression and a lifetime diagnosis of depression or anxiety were significantly more likely than persons without these conditions to have cardiovascular disease, diabetes, asthma and obesity and to be a current smoker, to be physically inactive and to drink heavily.2 People who suffer from depression have lower incomes, lower educational attainment and fewer days working days each year, leading to seven fewer weeks of work per year, a loss of 20% in potential income and a lifetime loss for each family who has a depressed family member of $300,000.3 The cost of depression (lost productivity and increased medical expense) in the United States is $83 billion each year.4

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References

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8. National Institute Mental Health/ National Institute Health 2014 prevalence of depression in adolescents statistics www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adolescents.shtml

9. 2013 Youth Risk Behavior Survey Suicide and suicide Attempts in Adolescents Clinical Report American Academy of Pediatrics July 2016

10. Lewinsohn, P. M., Rohde, P., Klein, D. N., & Seeley, J. R. (1999). Natural course of adolescent major depressive disorder: I. Continuity into young adulthood. Journal of the American Academy of Child & Adolescent Psychiatry, 38(1), 56-63.

11. Why do many psychiatric disorders emerge during adolescence? Giedd et al. Nat Rev Neurosci Dec 2008 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2762785/

12. National Trends in the Prevalence and Treatment of Depression in Adolescents and Young Adults. Ramin, M et al Pediatrics November 2016 http://pediatrics.aappublications.org/content/early/2016/11/10/peds.2016-1878

13. New Measures Evaluate Rates of Obesity Counseling for Kids, Depression Screening for Teens Oct 2015 www.mncm.org/new-measures-evaluate-rates-of-obesity-counseling-for-kids-depression-screening-for-teens/

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 (4b) under Usability and Use.*

Adults:
Depression Utilization of the PHQ-9
Measurement Period Dates of Service 10/1/2015 to 1/31/2016
Number of MN Clinics: 734

Denominator/ Patients: 209,220
Numerator: 144,918
Statewide Average: 69.3%

95% Confidence Interval: 69.1% to 69.5%

Range: 0.0% to 100%
Median: 71.3%
Standard Deviation: 26.5%

Distribution Rate Range (# of Clinics)

0.0 to 9.9%   42
10 to 19.9%   18
20 to 29.9%   31

30 to 39.9%	42
40 to 49.9%	44
50 to 59.9%	69
60 to 69.9%	109
70 to 79.9%	121
80 to 89.9%	136
90 to 100%	74
100%	48
	734

Rates Over Time

Period	Statewide Avg	95% CI	Numerator	Denominator
(10/1/2015 – 1/31/2016)	69.3%	69.1% - 69.5%	144,918	209,220
(6/1/2015 – 9/30/2015)	70.5%	70.3% - 70.7%	133,428	189,202
(2/1/2015 – 5/31/2015)	70.0%	69.7% - 70.2%	128,871	184,232
(10/1/2013 – 1/31/2014)	69.7%	69.4% - 69.9%	105,593	151,570
(6/1/2014 – 9/30/2014)	70.2%	69.9% - 70.4%	105,548	150,458
(2/1/2014 – 5/31/2014)	70.6%	70.4% - 70.9%	107,073	151,595
(10/1/2013 – 1/31/2014)	70.0%	69.7% - 70.2%	105,724	151,096
(6/1/2013 – 9/30/2013)	68.9%	68.7% - 69.2%	101,208	146,809
(2/1/2013 – 5/31/2013)	68.2%	68.0% - 68.5%	103,208	151,242
(10/1/2012 – 1/31/2013)	65.6%	65.3% - 65.8%	100,678	146,135
(6/1/2012 – 9/30/2012)	64.9%	64.7% - 65.2%	93,233	138,256
(2/1/2012 – 5/31/2012)	65.2%	64.9% - 65.4%	84,885	126,369
(10/1/2011 – 1/31/2012)	63.9%	63.7% - 64.2%	86,062	127,794
(6/1/2011 – 9/30/2011)	64.8%	64.5% - 65.0%	82,106	123,123
(2/1/2011 – 5/31/2011)	63.3%	63.0% - 63.5%	78,357	121,000
(10/1/2010 – 1/31/2011)	55.4%	55.1% - 55.7%	69,078	112,947
(6/1/2010 – 9/30/2010)	55.0%	54.7% - 55.2%	63,654	108,261

Adolescents:
We are adding the adolescent population to this measure and show performance results from testing the measure in the adolescent population with three testing sites. The sites included two integrated delivery systems and one network of community health centers that met the following participation criteria: established clinical workflows for using the PHQ-9 or PHQ-9M, use of searchable coded fields for documenting PHQ results in EMRs, and at least 500 adolescents who had a diagnosis of depression in 2012.
Results from testing in these three sites demonstrated a similar gap in care as seen in the adult population.

Site	Denominator	Numerator	Rate
Site 1	705	210	29.8%
Site 2	1,436	1,005	70.0%
Site 3	1,654	1,200	72.6%
Overall	3,795	2,415	63.6%

Denominator = adolescents age 12-17 with major depression or dysthymia and a visit during a four-month time period. The year was segmented into three four-month time periods and adolescents could be included in the denominator up to three times if they had a visit during each of the time periods (Time period 1: January 1, 2013 through April 30, 2013; Time period 2: May 1, 2013 through August 31, 2013; Time period 3: September 1, 2013 through December 31, 2013)
Numerator = adolescents who had a PHQ-9/PHQ-9M administered during the same time period as when a visit occurred

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.

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 (4b) under Usability and Use.*

This process, PRO based measure is paired with outcome measures, such as Depression Remission at Six Months (NQF # 0711) for which there is publicly reported data on disparities; please see below:

Annual Health Care Disparities Report
Publicly available at http://mncm.org/health-care-disparities-report/

MHCP (Minnesota Health Care Programs) patients continue to have a significantly lower Depression Remission at Six Months rate than patients insured by Other Purchasers. The Other Purchaser rate has continued to increase at a steady one percentage point rate each year while the MHCP rate has increased at a variable rate each year.

Year I MHCP Rate I MHCP CI (U/L) I Denominator I Other Purchaser Rate I Difference
2015 I 5.5% I 5.2% - 5.9% I 22,195 I 9.9% I 4.4%
2014 I 5.3% I 5.0% - 5.6% I 19,294 I 9.4% I 4.1%
2013 I 4.7% I 4.4% - 5.0% I 18,072 I 8.1% I 3.4%
2012 I 3.7% I 3.4% - 4.0% I 13,600 I 7.2% I 3.5%
2011 I 3.5% I 3.1% - 3.9% I 9,108 I 6.1% I 2.1%

The difference between purchasers for Depression Remission at Six Months has widened since 2011, but it is not statistically significant. For every year this measure has been active, the rate gap between MHCP and Other Purchasers has been statistically significant. The gap decreased slightly in 2013 (by less than one tenth of a percentage point) but increased by one percentage point in 2014. From 2014 to 2015 the increase in the rate gap between MHCP and Other Purchasers was less than one percentage point.

In testing of this measure in the adolescent population (described in 1b.2), only a slight difference in performance was observed between males and females. In a study of 684 adolescents who met the denominator criteria, 63.5% of males were routinely monitored with the PHQ-9, while 63.8% of females were routinely monitored.

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**
Source: ICSI Guideline for Major Depression in Adults in Primary Care 17th edition March 2016
https://www.icsi.org/_asset/fnhdm3/Depr.pdf

Many patients with major depression do not initially complain of depressed mood or anehdonia (American Psychiatric Association, 2013). Clinicians need to suspect this diagnosis based on a profile of common presentations and risk factors, taking into account cultural considerations (American Psychiatric Association, 2013).
Clinicians should acknowledge the impact of culture and cultural differences on physical and mental health. There is evidence that non-majority racial and cultural groups in the U.S. are less likely to be treated for depression than European Americans. In an epidemiological study that compared rates of diagnosing and treating depression in the early 1990s to patterns 10 years later, only 4.9% of minorities were treated with antidepressants compared with 12.4% of non-Hispanic Caucasians (Mojtabai, 2008).

A person´s cultural and personal experiences influence his/her beliefs and therefore attitudes and preferences. If these experiences are taken into consideration, openness to and readiness to change (including readiness to seek and adhere to treatment) will be enhanced. People of differing racial/ethnic groups are optimally treated using currently available evidence-based interventions when differential personal elements, from biological to environmental to cultural, are considered during the treatment planning process (Schraufnagel, 2006).

Cultural beliefs and common presentations
• When dealing with patients from diverse cultures, the impact of patient´s cultural beliefs around depression, cultural stigma and

manifestation of depression in physical symptoms vs. psychological can play a role in how patients perceive depression and subsequently seek treatment (Kleinman, 2004).
• Clinicians can create a more comfortable environment for a patient of another culture by acknowledging the impact of culture and cultural differences on physical and mental health (Muñoz, 2005; Miranda, 2004).
• Bodily idioms of distress are very common in many cultures. In place of psychosomatic theories that emphasize individuals´ inner conflict, many traditions of medicine have sociosomatic theories that link bodily and emotional distress to problems in the social world (Kirmayer, 2001).
• The concept of depression varies across cultures. For example, in many cultures, for depression to become a problem for which a person seeks medical treatment, symptoms may include psychosis, conversion disorders or significant physical ailments (Karasz, 2005).

Age disparities have also been documented. Depression in the elderly is widespread, often undiagnosed and usually untreated. It is a common misperception that it is a part of normal aging. Losses, social isolation and chronic medical problems that older patients experience can contribute to depression. The rate of depression in adults older than 65 years of age ranges from 17% to 37% in primary care settings and is between 14 and 42% in the elderly who live in long term care facilities. Among adolescents, some estimates suggest that only 25 percent of adolescents diagnosed with depression receive treatment; among those who go undetected, 20 percent develop recurrent or chronic depression (O'Connor, 2009; Garber, 2009).

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 : Depression

De.6. Non-Condition Specific*(check all the areas that apply):*
Health and Functional Status : Change

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

S.1. Measure-specific Web Page *(Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)*
http://mncm.org/cycle-a-dds-guides/ and http://mncm.org/?s=depression

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:** PDF_of_CMS160v5_HumanReadable_Feb_2016.pdf

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:** MNCM_Depression_Care_VS_Specs_Definitions_w_Redesign_11-9-2017-636162830143430795.xlsx

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.
Yes

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.

Since the last maintenance update, we convened our multi-stakeholder expert workgroup to consider modifying the measure to include adolescents and as well as reviewing related measure construct components. As a result of our process, we are updating the measure to add the adolescent population; widen the follow-up assessment window; add the PHQ-9M tool; tighten up the personality disorders exclusions list; add exclusions for schizophrenia and pervasive developmental disorders and simplify the diagnosis criterion. Details are as follows:

For 2020 Report Year (dates of index event 1/1/2018 to 12/31/2018)
1. Incorporate adolescents into the depression measures
? Modify age range to include adolescents; age 12 and older
? Report measures as two separate stratifications by age (not combined); ages 12 to 17 and ages 18 and older
Reason: The U.S. Preventive Services Task Force and other guideline organizations recommend screening adolescents for depression. Depression is a significant problem for adolescents, affecting an estimated 11% of the population. Many mental health conditions are evident by age 14 and the consequences of adolescent depression can have lifelong impact.

2. Widen the follow-up assessment window to +/- 60 days for all populations and all response and remission measures
? Six-month measure's assessment window expands from 5 to 7 months to 4 to 8 months
? Twelve-month measure's assessment window expands from 11 to 13 months to 10 to 14 months
Reason: Allowing a more reasonable assessment window that still fits the clinical course of recovery, allows for a comprehensive course of treatment and increases provider buy-in.

3. Patient Reported Outcome Tools for index/denominator and measuring outcomes of remission and response are the PHQ-9 and PHQ-9M
? Add the PHQ-9M as a PRO tool that can be used
? Providers may elect to use either tool; no measure construct restriction for age. For example if a family practice clinic is currently using the PHQ-9 tool for their adult patients, they can elect to use the same tool for ages 12 to 17. Likewise, if a pediatric clinic is using the PHQ-9M in their practice, they can decide to administer the PHQ-9M to their 18/19/20 year old patients.
Reason: The expert panel reviewed 21 additional tools against standardized criteria and concluded very few had cut-points for severity levels of depression or remission. Further, using PRO tools with significantly different numbers of questions could impact the response measures (50% or greater in improvement of scores) in addition to adversely affecting denominator comparability. For example, if one practice is using the Beck BDI-II tool (21 questions/ total score 63/ denominator > 19/ remission < 14) and another practice is using the PHQ-9 (9 questions/ total score 27/ denominator > 9/ remission < 5), it can't be assured that the two tools are identifying the denominator of patients in the exact same way.

4. Modifications to exclusions include the following:
? Personality disorders narrowed to emotionally labile conditions and moved to the allowable exclusion category
? Add exclusion value set for schizophrenia or psychotic disorder as a required exclusion
? Add exclusion value set for pervasive developmental disorder as an allowable exclusion
Reason: The expert panel determined these conditions may require a different course of treatment, and holding a provider responsible for remission/response within the time frames defined by the measure may be inappropriate. In addition, the NQF Behavioral Steering Committee requested we examine the personality disorder exclusion.

5. For behavioral health settings, remove the requirement that the diagnosis of major depression or dysthymia must be in the primary position.
? Relates to new exclusion for schizophrenia or psychotic disorder; no longer necessary
Reason: simplification of measure, position order of diagnosis is irrelevant in behavioral health settings.

Please refer to either the data dictionary (S.2b.) for the summary of redesign activities and changes to value sets or the electronic newsletter with links to details at http://mncm.org/?s=depression.

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).
Adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) included in the denominator who have at least one PHQ-9 or PHQ-9M tool administered and completed during a four month measurement period.

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).
The total number of unique adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) in the denominator who had a least one PHQ-9 or PHQ-9M tool administered and completed during a four month measurement period in which a visit or contact with the patient has occurred.
Partially completed tools (e.g. answering 6 of the 9 questions) do not count as a completed tool. A valid PHQ-9 or PHQ-9M requires the completion of all nine questions for accurate scoring.
The numerator rate is calculated as follows:
pts with major depression or dysthymia with one or more completed PHQ-9 or PHQ-9M tools/
pts with major depression or dysthymia with a visit or contact during the measurement period
Rates are stratified by adolescents (12 to 17 years of age) and adults (18 years of age or older).
Time period for data collection: four month measurement periods (In the MN program 2/01 to 5/31, 6/01 to 9/30 and 10/01 to 1/31) with dates of service occurring within the four month period.

S.6. **Denominator Statement** *(Brief, narrative description of the target population being measured)*
Adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia.

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).
The target population, patients age 12 and older with the diagnosis of major depression or dysthymia, regardless of severity level of the PHQ-9 or PHQ-9M.

The number of unique patients who had a least one visit or contact with a provider during the measurement period with a diagnosis of major depression or dysthymia (Major Depression or Dysthymia Value Set). Contact is defined as visit, telephone call, e-visit or other contact that is associated with a PHQ-9 tool being completed by the patient.

S.8. **Denominator Exclusions** *(Brief narrative description of exclusions from the target population)*
Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure.
Additionally, patients who have a diagnosis of bipolar or personality disorder, schizophrenia or psychotic disorder, or pervasive developmental disorder are excluded.

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.)*
Required exclusions:
•Patient had an active diagnosis of bipolar disorder (Bipolar Disorder Value Set)
•Patient had an active diagnosis of schizophrenia or psychotic disorder (Schizophrenia or Psychotic Disorder Value Set)
Allowable exclusions:
•Patient was a permanent nursing home resident any time during the measurement period
•Patient was in hospice or receiving palliative care any time during the measurement period
•Patient died prior to the end of the measurement period
•Patient had an active diagnosis of personality disorder (Personality Disorder Value Set)

[These are the same exclusions as the related outcome measures]
Please see field specifications in the attached data dictionary.

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.)*
This measure is stratified by age range and results are reported separately by age: Adolescents (12-17 years of age) and Adults (18 years of age and older).

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.)*
This measure is calculated by submitting a count of patients for the denominator and a count of patients in the numerator to a HIPAA secure data portal as part of the process in uploading a detailed patient file to calculate the six and twelve month remission outcome rates.
The numerator rate is calculated as follows:
pts with major depression or dysthymia with one or more completed PHQ-9 or PHQ-9M tools/
pts with major depression or dysthymia with a visit or contact during the measurement period
Query processes that medical groups follow to obtain counts:
During the four month measurement period (e.g. dates of service 6/1/2016 to 9/30/2016) how many patients had an office visit or other contact and diagnosis codes for major depression or dysthymia? (Major Depression or Dysthymia Value Set). (denominator)
Of these patients, how many had a PHQ-9 tool completed? (numerator)
The counting process is validated during the denominator certification process (where groups document all steps in identifying the depression population). Groups are asked to describe the process they use for obtaining the counts. Denominator documents are reviewed (certified) by MNCM staff prior to data collection and submission. This is to insure that all groups are identifying their population correctly.

S.15. 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.
The measure and its denominator is not based on a sample.
For this PRO based measure, the tool is completed by the patient (no proxy) and missing data (administration of a PHQ-9) is managed by the inclusion of patients without a completed PHQ-9 in the denominator.

S.16. Survey/Patient-reported data *(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)*
IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.
PROM Developer Instruction manual: www.phqscreeners.com
PHQ-9 Depression Severity. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all", "several days", "more than half the days", and "nearly every day" respectively. PHQ-9 total score for the nine items ranges from 0 to 27. Scores of 5, 10, 15, and 20 represent cut-points for mild, moderate, moderately severe and severe depression, respectively. Sensitivity to change has also been confirmed.

Use of the tool for measurement: All nine questions need to be completed/ answered for a valid score. Patient responses are not imputed and the tool score is derived from a simple summation of the responses.

The internal reliability of the PHQ-9 was excellent, with a Cronbach´s a of 0.89 in the PHQ Primary Care Study and 0.86 in the PHQ Ob-Gyn Study. Test-retest reliability of the PHQ-9 was also excellent. Correlation between the PHQ-9 completed by the patient in the clinic and that administered telephonically by the MHP within 48 hours was 0.84, and the mean scores were nearly identical (5.08 vs 5.03).
PHQ-9 has been validated in adolescent populations (age 13 to 17), as well as adults and elderly.

Kronke K., Spitzer R. The PHQ-9 Validity of a Brief Depression Severity Measure J Gen Intern Med 2001 September; 16(9): 606–613. doi: 10.1046/j.1525-1497.2001.016009606.x PMCID: PMC1495268
Lowe B., Unutzer J. Monitoring Depression Treatment outcomes with the Patient Health Questionnaire-9 Medical Care Volume 42 Number 12 December 2004
Duffy F., Chung H. Systematic Use of Patient-Rated Depression Severity Monitoring: Is It Helpful and Feasible in Clinical Psychiatry? Psychiatric Services October 2008Vol. 59 No. 10
Richardson L., McCauley E. Evaluation of the Patient Health Questionnaire (PHQ-9) for Detecting Major Depression among Adolescents Pediatrics 2010 December; 126(6): 1117–1123. doi:10.1542/peds.2010-0852.

The PHQ-9M Modified for Teens is the PHQ-9 tool with slight wording adjustment (in CAPS below) in three questions in order to tailor the tool for the adolescent population with age-appropriate terms.

Q2: Feeling down, depressed, IRRITABLE, or hopeless?
Q5: Poor appetite, WEIGHT LOSS, or overeating?
Q7: Trouble concentrating on things like SCHOOL WORK, reading, or watching TV?
Otherwise, the nine questions used in scoring the tool are identical to the PHQ-9.
The copyright statement on the PHQ-9M tool is stated: "Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams & Kroenke, 1999), Revised PHQ-A (Johnson, 2002) and the CDS (DISC Development Group, 2000)"
Although widely used in pediatric practices and endorsed by the AAP, APA and AACAP, the modified version of the PHQ-9 tool has not had separate validation studies, as the nine questions are essentially the same as the original PHQ-9, which was been validated for the adolescent population (ages 13 and older). The APA recommends using the modified version of the PHQ-9 for children ages 11 to 17 to assess depression symptom severity (APA, 2015).
American Psychiatric Association. 2015. Online Assessment Measures. Severity Measure for Depression, Child Age 11 to 17 (PHQ-9 modified for Adolescents [PHQ-A], Adapted). https://www.psychiatry.org/psychiatrists/practice/dsm/dsm-5/online-assessment-measures

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 Record (Only), Paper 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 is collected.)*
IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.
PROM
The PHQ-9 depression assessment tool is a patient reported outcome tool that is in the public domain and can be obtained for free use on the Patient Health Questionnaire (PHQ) Screeners website at www.phqscreeners.com. Modes of administration include traditional paper, mail, electronic and telephonic. The tool is available on the website with 79 language translations available.

The PHQ-9 tool is validated for use as a measure to assess the level of depression severity (for initial treatment decisions) as well as an outcome tool (to determine treatment response). [Löwe B, Unutzer J, Callahan CM, Perkins AJ, Kroenke K. Monitoring depression treatment outcomes with the Patient Health Questionnaire-9. Med Care 2004;42:1194-1201 and Kroenke K, Spitzer RL, Williams JBW, Löwe B. The Patient Health Questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. Gen Hosp Psychiatry 2010]

The PHQ-9M is a modified version of the PHQ-9 tool for adolescents. Please refer to discussion in S.16.

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)*

Available at measure-specific web page URL identified in S.1

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

Clinician : Group/Practice, Facility

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

Behavioral Health : Outpatient, Clinician Office/Clinic

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.)*

2. Validity – See attached Measure Testing Submission Form

0712_Meas_Testing_Depression_Utilization_PHQ.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. (Do not remove prior testing information – include date of new information in red.)

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. (Do not remove prior testing information – include date of new information in red.)

Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes SDS factors is no longer prohibited during the SDS Trial Period (2015-2016). Please update sections 1.8, 2a2, 2b2, 2b4, and 2b6 in the Testing attachment and S.14 and S.15 in the online submission form in accordance with the requirements for the SDS Trial Period. NOTE: These sections must be updated even if SDS factors are not included in the risk-adjustment strategy. If yes, and your testing attachment does not have the additional questions for the SDS Trial please add these questions to your testing attachment:

What were the patient-level sociodemographic (SDS) variables that were available and analyzed in the data or sample used? For example, patient-reported data (e.g., income, education, language), proxy variables when SDS data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate).

Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or sociodemographic factors) used in the statistical risk model or for stratification by risk (e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of p<0.10; correlation of x or higher; patient factors should be present at the start of care)

What were the statistical results of the analyses used to select risk factors?

Describe the analyses and interpretation resulting in the decision to select SDS factors (e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects)

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)
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).

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: CMS160_Updated_TestCase-636131740568652558.xlsx

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 a PRO-PM, consider implications for both individuals providing PRO data (patients, service recipients, respondents) and those whose performance is being measured.
MNCM has developed a direct data submission process in 2006, whereby medical groups submit a patient level data file of a minimal data set (only those elements needed for measure calculation, risk adjustment and stratification/ analysis) to our HIPAA secure data portal for rate calculation and public reporting. Over the years we have learned the following:
1. Data Submission- Providing data collection software for medical groups wishing to submit data was not always the best and most efficient way of collecting data. As electronic health records use becomes more pervasive in our state, providing templates of data file submissions proved to be more efficient.
2. Specifications- Detailed specifications with instructions on how to handle most situations (e.g. detailed instructions on blood pressure values) has been valuable to medical groups, increased data accuracy is reflected by 98-99% of medical groups meeting validation standards for submitted data against the medical record.
3. Audit- Audit methods have insured the accuracy of our data and we are able to successfully compare providers because everyone is pulling their data the same way and subject to the same rules.
4. Confidentiality- Patient confidentiality has been addressed by numerous mechanisms. MNCM only receives the patient level information needed to calculate the rates, determine eligibility for inclusion in the measure and support the administration of pay for performance programs. The PHI submitted is minimal and the data is protected by 1) password protection with password only available to the medical group submitting data, 2) file upload process is encrypted as data is transferred and 3) Data is stored on a separate secure server and meets all HIPAA protection rules.

6. Acceptance of Data- Vast improvement in terms of the timeliness of the data submitted by medical groups six weeks after the end of the measurement period as compared to prior method of health plan's samples and the results over a year old. Providers are more accepting of the results as compared to previous methods of pooling health plan samples.

7. Data Collection Burden- We have learned that for additional future measures we will need to stagger the data collection time frames and submission deadlines as to not burden the medical groups in terms of abstraction/ extraction.

8. Health Plans: pay for performance and the inclusion of measures within contracts significantly impacts the number of groups participating in each measure.

9. Patient Reported Outcome (PROM) assessment tools. Consideration for inclusion of a PROM includes the following: a tool that is psychometrically sound (valid/ reliable/ specific and sensitive to change), providers are amenable to the use of the tool, can be implemented into clinical work flows, can be administered by multiple modes including electronic administration and tool is valuable to patients and does not cause undue completion burden.

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

No fees associated with the PROMs; PHQ-9 is publicly available at www.phqscreeners.com and PHQ-9M at https://www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/GLAD-PC_PHQ-9.pdf. In MN, no fees for data submission and rate calculation, however groups do incur the costs of data collection/ extraction/ abstraction needed to submit data.

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)
	Public Reporting MN HealthScores http://www.mnhealthscores.org/clinic-measure-detail/use-phq-9-0/#/results MN HealthScores http://www.mnhealthscores.org/clinic-measure-detail/use-phq-9-0/#/results Payment Program CMS Meaningful Use (MU2) # CMS160v5 https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html CMS Meaningful Use (MU2) # CMS160v5 https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html Regulatory and Accreditation Programs CMS Meaningful Use (MU2) # CMS160v5 https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html CMS Meaningful Use (MU2) # CMS160v5 https://www.cms.gov/regulations-and-

guidance/legislation/ehrincentiveprograms/ecqm_library.html

4a.1. For each CURRENT use, checked above (update for <u>maintenance of endorsement</u>), provide:
- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

Program:
MN HealthScores A consumer facing public reporting website at www.mnhealthscores.org
Sponsor:
MN Community Measurement- a non-profit 501 (c)(3) whose mission is to accelerate the improvement of health by publicly reporting health care information. Founding members include: Blue Cross and Blue Shield of MN, HealthPartners, Medica, Metropolitan Health Plan, Minnesota Medical Association, Minnesota Hospital Association, PreferredOne, PrimeWest Health System, South Country Alliance and Ucare Minnesota.
Geographic Area:
All primary care clinics in MN and bordering communities in Wisconsin, North Dakota, South Dakota and Iowa. 403 individual clinic sites for 86,166 patients (annual denominator for depression measures)

Program:
CMS eHR Incentive Program (Meaningful Use of Health Information Technology MU2 Stage 2)
The Stage 2 final rule expanded upon the Stage 1 criteria with a focus on ensuring that the meaningful use of EHRs supported the aims and priorities of the National Quality Strategy. Stage 2 criteria encouraged the use of health IT for continuous quality improvement at the point of care and the exchange of information in the most structured format possible.
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

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.*)

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. 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.
This measure has demonstrated improvement (14% over the last 6 years) and the number of patients included in the denominator has doubled (from 100,000 to 200,000) indicating that more clinics are participating in the measure and more patients are being identified with depression for inclusion in the denominator. The number of patients with depression who are being assessed with a PHQ-9 tool as almost tripled on a statewide level.

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. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.
No unintended negative consequences identified.

4c.2. Please explain any unexpected benefits from implementation of this measure.
Benefits include:
* Increasing widespread use of a simple but effective PRO tool that can be used for screening, diagnosis and the monitoring of treatment outcomes for depression
* Increased national use of the measure, adaptation of the measure for use by health plans (HEDIS)
* Incorporation of adolescents helps address a significant condition that can have lifelong impacts

4d1.1. 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.
Performance results are provided to those being measured: (all primary care and psychiatry setting clinics in MN) in all of the following modalities/ processes on an annual basis:
* Preliminary rate displayed to the practice immediately after file upload to the MNCM Data Portal
* Practices receive a password protected email that allows them to see their rates along with all other reporting practices prior to publication on MN HealthScores. There is a two week review process in which practices can identify issues or concerns with their data which can either be resolved or formal appeal submitted. (detail below)
* Practices receive actual and expected (risk adjusted) outcome rates and rating (top, above average, average and below average) prior to publication on the MNHealthScores.
* Data is published and updated on an annual basis on our consumer-facing website MNHealthscores at www.mnhealthscores.org
* Hard-copy reports are also provided on an annual basis (Health Care Quality Report, Health Care Disparities Report) at http://mncm.org/reports-and-websites/reports-and-data/

Assistance is provided to all practices via our support@mncm.org email or by telephone helpline at 612-746-4522.

Webinars are provided to users prior to data collection and submission. New measures are announced via the MNCM e-newsletter Measurement Minute http://mncm.org/news/ and introduced in webinar format as well.
4d1.2. Process involved Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.
Communication about Depression Measures Redesign:
Depression Measure Changes Proposed at MARC Meeting
By Admin 31 Oct, 2016 Articles, Newsletters

In October, MNCM's Measurement and Reporting Committee (MARC) approved recommendations for redesign of the depression measures. The consideration for redesign is in response to use of the measures in federal programs, a desire to include adolescents and a recent adaptation of the measures for use in the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) program.

The depression measure development workgroup, led by Michael Trangle from HealthPartners, included provider representation from primary care, pediatrics, adult and adolescent psychiatry. The scope of redesign consideration focused on the inclusion of adolescents, expansion of the window for follow-up, consideration of additional patient reported outcome (PRO) tools, and a review of appropriate exclusions.

Incorporate adolescents into the depression measures and expand the follow-up assessment window:

After a through discussion on the relevance of measuring depression outcomes for adolescents, the workgroup reached consensus that it was important to include adolescents in the measurement of depression outcomes. Further, the recommendation would modify the age range to include adolescents age 12 and older and report measures as two separate stratifications by age (not combined) into ages 12 to 17 and ages 18 and older.

The workgroup also reviewed the concept of expanding the window for follow-up among adolescents, in part, due to the challenges in following up with adolescent patients. In the end, the workgroup acknowledged that follow-up is challenging for adults as well and determined it is reasonable to expand the follow-up assessment window for all patients. The follow-up assessment window will be expanded to +/- 60 days for all patients and all outcome measures.

Additional Patient Reported Outcome tools reviewed:

MNCM is frequently asked "Why just the PHQ-9 tool?" In response, the workgroup considered 21 Patient Reported Outcome (PRO) tools. Information on each was collected using standardized criteria and compiled for review. Many tools did not have the required cut-points for remission or scoring levels that address severity of depression symptoms. Many of the tools listed were acceptable for screening for potential depression but did not support the diagnosis of depression or measuring progress of symptoms (outcomes) over time. Ultimately, the workgroup reached consensus on adding only the PHQ-9M tool.

The workgroup decided to allow the use of both tools (PHQ-9 and PHQ-9M) and not restrict tool use by age. They believed it was best to leave the decision up to the medical groups in terms of which tool best fits their practice (e.g., a pediatric practice could use the PHQ-9M for all their patients including "older" patients and a family practice clinic could use the PHQ-9 for all their patients ages 12 and older).

MARC also approved modifications to exclusions.

In order to minimize disruption, allow time for medical groups to make changes and to permit future comparability of performance over time, MARC approved the workgroup's recommendations in their entirety for 2018 dates of index reported in 2020 (i.e., for 2020 Report Year dates of index event January 1, 2018 to December 31, 2018).

Feedback about these changes will be accepted at publiccomment@mncm.org until Friday, December 9, 2016.

For more information, see the summary document link, or contact support@mncm.org.
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Example of Communication 2 Week Review:
Review Preliminary 2016 Report Year Results for Cycle C Measures by COB Monday, Oct 17th
This is your official opportunity to review and comment on the preliminary performance measure results of your medical group. This email includes information on data review, comment process, appeal process and expected public reporting timeline.

Measures and Reporting
Measures included in Cycle C are:
1. Optimal Asthma Control – Adult
2. Optimal Asthma Control – Child
3. Asthma Education and Self-Management – Adult
4. Asthma Education and Self-Management – Child
5. Colorectal Cancer Screening
6. Maternity Care: Primary C-section Rate

The Optimal Asthma Control and Colorectal Cancer Screening measures are publicly reported by MNCM at the clinic and medical group levels. The Maternity Care: Primary C-section Rate measure is reported by MNCM at the medical group level only. All six measures are calculated from data abstracted and submitted by clinics and are independently validated by MNCM. These measures are also included in the Statewide Quality Reporting and Measurement System (SQRMS) slate; however, MNCM does not publicly report the Asthma Education and Self-Management measures. MNCM plans to publicly report final results on MN HealthScores later this fall.

Results Review and Public Reporting
Data files are available for your review here. The file password is xxxxxxxxxx. Please note that the results in the data files are preliminary and are not final until all data validation activities are complete, including this review period.

If you do not see one or more of your clinic(s) listed in the file, the clinic had less than 30 patients reported for that site or the measure did not apply to your practice. To be publicly reported, a clinic must meet data reliability standards by having at least 30 eligible patients; this file only includes results of clinics and medical groups that will be publicly reported. However, it should be noted, data from all clinics – both publicly reported and not – are included in the rolled up medical group rates and statewide rates.

Performance ratings (Top, Above Average, Average, Below Average) are not included in this review. You will have another opportunity in December to review the final, risk-adjusted results; the performance ratings will be included in that file. We anticipate final, risk-adjusted results will be published on MNHealthScores.org soon thereafter.

Comment Process
Feedback related to errors will be accepted until Monday, October 17th at 5 p.m. If you have questions or concerns about your preliminary results, please contact us at support@mncm.org or 612-746-4522, ext. 1.

Each medical group is responsible for reviewing its own preliminary results, investigating any concerns and submitting evidence to MNCM if a change in results is requested. In that event, MNCM staff will review the information provided and decide whether to publicly report the results based upon the evidence submitted.

Appeals Process
If our decision does not favor the medical group, a formal written appeal may be submitted. Medical groups have two weeks from the date of our decision to submit a formal appeal. Supporting evidence must be submitted with the appeal. However, before submitting a formal appeal, please contact us well before the October 17th deadline with questions, concerns and/or evidence as indicated above.

Only concerns about publicly reported results are subject to appeal. It is extremely rare for MNCM to change performance results unless a medical group/clinic provides evidence of an error, or a pattern of data errors can be identified by MNCM based on multiple comments. Concerns with the definition of a measure, patient attribution methodology, or other data collection methods are not subject to appeal; however, they will be forwarded to the MNCM Measurement and Reporting Committee.

To file an appeal, medical groups must submit it in writing (by letter or email) to xxxxxxx, MN Community Measurement President, at Broadway Place East #455, 3433 Broadway Street NE, Minneapolis, MN 55413; or chase@mncm.org. The President will review your appeal and make a recommendation to the MNCM Quality Audit Committee, which makes final decisions about the dispensation.

4d1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.
See process described in 4d1.1

4d2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.
Describe how feedback was obtained.
MNCM convenes the Measure Review Committee, a subcommittee of the Measurement and Reporting Committee every six months. This multi-stakeholder committee consisting of representatives from providers, health plans, consumers and purchasers of healthcare, reviews each measure publicly reported by MNCM against NQF criteria (Evidence/ Importance to Measure (gap)/ Scientific Acceptability/ Use and Feasibility). Committee members complete a structured preliminary survey of each measure and results and comments are tabulated and committee discussion occurs culminating in a vote for: continue/ refer for ad-hoc review or redesign/ transition to monitoring or retiring the measure.

Feedback from users is also obtained in the following ways:
* Questions and comments coming through our support email and telephone hotlines at MNCM
* Public comment email publiccomment@mncm.org
* Formal annual public comment process in collaboration with the MN Department of Health
* Questions and comments from national use in federal programs (QNet and JIRA help-desks)
* NCQA's adaptation of the depression remission, response and utilization of the PHQ-9 measures into the HEDIS program, currently undergoing pilot testing with the new Electronic Clinical Data Systems (ECDS) methodology.

4d2.2. Summarize the feedback obtained from those being measured.
Measure Review Committee and many medical groups identify challenges with the technical replication of this measure in the medical group's internal systems (index event and follow-up window and the difficulty in maintaining ongoing contact with patients who are depressed.

4d2.3. Summarize the feedback obtained from other users
2015 at the request of the measure review committee, implemented technical change to MNCM data portal programming for the re-indexing of patients following the held assessment period.
2016 request for the consideration of incorporating adolescents into the current measure construct, increasing the follow-up window, use of additional PRO tools and review of exclusions.

4d.3. Describe how the feedback described in 4d.2 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.
For 2020 Report Year (dates of index event 1/1/2018 to 12/31/2018)
1. Incorporate adolescents into the depression measures
* Modify age range to include adolescents; age 12 and older
* Report measures as two separate stratifications by age (not combined); ages 12 to 17 and ages 18 and older
Reason: Depression is a significant problem for adolescents, affecting an estimated 11% of the population. Many mental health conditions are evident by age 14 and the consequences of adolescent depression can have lifelong impact.

2. Widen the follow-up assessment window to +/- 60 days for all populations and all response and remission measures
* Six month measures assessment window expands from 5 to 7 months to 4 to 8 months
* Twelve month measures assessment window expands from 11 to 13 months to 10 to 14 months
Reason: Allowing a more reasonable assessment window that still fits the clinical course of recovery, allows for a comprehensive course of treatment and increases provider buy-in.

3. Patient Reported Outcome Tools for index/denominator and measuring outcomes of remission and response are the PHQ-9 and PHQ-9M
* Add the PHQ-9M as a PRO tool that can be used
* Providers may elect to use either tool; no measure construct restriction for age
Reason: 21 additional tools were reviewed against standardized criteria, very few had cut-points for severity levels of depression or remission. Potential threat to comparability was determined; using PRO tools with significantly different numbers of questions could impact the response measures (50% or greater in improvement of scores) in addition to denominator comparability.

4. Modifications to exclusions include the following:
* Personality disorders narrowed to emotionally labile conditions and moved to the allowable exclusion category
* Add exclusion value set for schizophrenia or psychotic disorder as a required exclusion
* Add exclusion value set for pervasive developmental disorder as an allowable exclusion
Reason: Recommendation from NQF behavioral steering committee to examine the personality disorder exclusion.

5. Remove denominator criteria for behavioral health settings that stipulates the diagnosis of major depression or dysthymia needs to be in the primary position.
* Relates to new exclusion for schizophrenia or psychotic disorder; no longer necessary
Reason: simplification of measure, behavioral health providers determine position order of diagnosis is irrelevant.

Please refer to either the data dictionary (S.2b.) for the summary of redesign activities and changes to value sets or the electronic newsletter with links to details at http://mncm.org/?s=depression.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria <u>and</u> 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)
0710 : Depression Remission at Twelve Months
0711 : Depression Remission at Six Months
1884 : Depression Response at Six Months- Progress Towards Remission
1885 : Depression Response at Twelve Months- Progress Towards Remission

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

5a. Harmonization of Related Measures
The measure specifications are harmonized with related measures;
OR
The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):
Are the measure specifications harmonized to the extent possible?
Yes

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

5b. Competing Measures
The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);
OR
Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):
Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)
There are related, complimentary measures for depression remission, response that are PAIRED with this process measure. MN Community Measurement is the measure steward for these related measures and they are completely harmonized. The remission measures are considered the "gold standard" of depression outcomes and measure the same population of patients at two different points in time, six and twelve months after index contact with diagnosis and elevated PHQ-9. The response measures, also at six and twelve months are considered as progress towards the desired goal of remission with a reduction in PHQ-9 score of greater than 50% representing a reduction in the severity of symptoms.

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.
Available at measure-specific web page URL identified in S.1 **Attachment:**

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): MN Community Measurement
Co.2 Point of Contact: Collette, Pitzen, pitzen@mncm.org, 612-454-4815-

Co.3 Measure Developer if different from Measure Steward: MN Community Measurement
Co.4 Point of Contact: Collette, Pitzen, pitzen@mncm.org, 612-454-4815-

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.

List the workgroup/panel members´ names and organizations.

Describe the members´ role in measure development.

Original Workgroup Members (2006)

Nancy Jaeckels - Institute for Clinical Systems Improvement, Vice President Member Relations & Strategic Initiatives

Katrina Beckstrom - HealthPartners - Care Innovation & Measurement, Senior Quality Coordinator

Michael Trangle, MD - HealthPartners Clinics/ Regions Hospital, Associate Medical Director

Kenneth Joslyn, MD - Medica Health Plan, Medical Director Quality and Population Health

Jim Chase - MN Community Measurement, President

Diane Mayberry - MN Community Measurement, Chief Operating Officer

Anne Snowden - MN Community Measurement, Director of Performance Measurement & Reporting

Carrie Trygstad- MN Community Measurement, Project Manager

This group worked in concert with the ICSI DIAMOND project for measure development; the original charter of the workgroup includes:

o Develop population-wide, ambulatory care measures(s) of the quality of care for patients diagnosed with Depression, consistent with the work of the ICSI DIAMOND project.

• Process measures (ie: quality of coding, depression screening, completion of PHQ-9 survey, 3 month follow-up visit)

• Outcome measures (response and remission rates)

o Develop direct data collection, submission and reporting plan

• Physicians and non-physicians

• Primary care and Behavioral Health Care

Updated Workgroup Members: (2010)

Name Specialty/ Representation Organization

Katrina Beckstrom Sr. Quality Coordinator HealthPartners

Sara Bonneville MDH/ Health Reform MN Department of Health

Ron Brand Community Mental Health MN Association Community Mental H.

Katie Burns MDH/ Health Reform MN Department of Health

Rod Christensen, MD Primary Care Allina

Jane Duncan MNCM State Contract MN Community Measurement

Paul Goering, MD Behavioral Allina

Tim Hernandez, MD Primary Care Family Health Services

Nancy Jaeckels ICSI/ DIAMOND ICSI

Roger Kathol, MD Behavioral Minnesota Psychiatric Society

Diane Mayberry MNCM Measure Dev. MN Community Measurement

Collette Pitzen MNCM Measure Dev. MN Community Measurement

Mary Rains Health Plan Blue Cross Blue Shield MN

Jerry Storck DHS Behavioral Department Human Services

Michael Trangle, MD Behavioral HealthPartners

Mark Williams, MD Behavioral Mayo Clinic

Mark Zipper Behavioral Allina (alternate)

This workgroup was convened to and to recommend appropriate clinical risk adjustment variables and discuss appropriate settings for the measures.

Measure Development Workgroup for Re-design (2016)

Name Member Type Organization

Michael Trangle, MD Clinical Provider; Psychiatrist; Chair Health Partners Medical Group

Mark Williams, MD Clinical Provider; Psychiatrist Mayo Clinic

Parnjai Johnson, MD Clinical Provider; Psychiatrist Park Nicollet Clinic

David Rossmiller, MD Clinical Provider; Family Medicine Entira Family Clinics

Shannon Neale, MD Clinical Provider; Family Medicine Park Nicollet Clinic

Laura Saliterman, MD Clinical Provider; Pediatrics/ MARC South Lake Pediatrics

Amelia Versland, PhD Clinical Provider; Psychologist Hennepin County Medical Center

Julie Erickson, PhD LP Clinical Provider; Psychologist Children´s Minnesota

Dianne Burd, MSW LICSW Clinical Provider, Social Worker Gillette Children's Specialty Health

Terry Murray, MEd Data Analyst Allina Health

Leif Solberg, MD Quality Improvement/ Family Medicine HealthPartners Institute

Wendy Scheckel, RN Quality Improvement Olmsted Medical Center

Terri Lloyd, BSN MA Clinic Administration Children´s Health Network

Cara Broich, RN CPHQ Health Plan/ Quality Improvement Medica

Kimberley Witczak Consumer Co-Founder Woody Matters

Collette Pitzen Facilitator/ Measure Development MN Community Measurement

Jasmine Larson Measure Development MN Community Measurement

NCQA's Adaptation of depression measures for HEDIS included input on the inclusion of the adolescent population from the following advisory panels:
* NCQA Behavioral Health Measurement Advisory Panel
* NCQA Committee on Performance Measurement (CPM)
* NCQA Technical Measurement Advisory Panel
* National Collaborative for Innovation in Quality Measurement(NCINQ) Measurement Advisory Panel
* NCINQ Consumer Panel
* NCINQ Foster Care Panel
* NCINQ Mental Health Panel
* NCINQ State Panel

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: 10, 2016
Ad.4 What is your frequency for review/update of this measure? Annual
Ad.5 When is the next scheduled review/update for this measure? 10, 2017

Ad.6 Copyright statement: © MN Community Measurement, 2016. All rights reserved.
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Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: