



## 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 #:** 0418:3148

**Corresponding Measures:** 0418:3132

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

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

**De.3. Brief Description of Measure:** Percentage of patients aged 12 years and older screened for clinical 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.

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

The World Health Organization describes major depression as the leading cause of disability worldwide (Pratt & Brody, 2008).

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

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

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

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

**S.4. Numerator Statement:** Patients screened for clinical 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

**S.6. Denominator Statement:** All patients aged 12 years and older

<p><b>S.8. Denominator Exclusions:</b> Not Eligible – A patient is not eligible if one or more of the following conditions are documented:</p> <ul style="list-style-type: none"> <li>•Patient refuses to participate</li> <li>•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</li> <li>•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</li> <li>•Patient has an active diagnosis of Depression</li> <li>•Patient has a diagnosed Bipolar Disorder</li> </ul>
<p><b>De.1. Measure Type:</b> Process</p> <p><b>S.17. Data Source:</b> Claims (Only), Registry</p> <p><b>S.20. Level of Analysis:</b> Clinician : Group/Practice, Clinician : Individual</p>
<p><b>IF Endorsement Maintenance – Original Endorsement Date:</b> Jul 31, 2008 <b>Most Recent Endorsement Date:</b> Feb 28, 2014</p>
<p><b>IF this measure is included in a composite, NQF Composite#/title:</b></p> <p><b>IF this measure is paired/grouped, NQF#/title:</b></p> <p><b>De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?</b> N/A</p>

<p><b>1. Evidence, Performance Gap, Priority – Importance to Measure and Report</b></p>
<p>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. <b><i>Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.</i></b></p>
<p><b>1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form</b>  <a href="#">Evidence_form_NQF_0418_012317.docx</a></p> <p><b>1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?</b>  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</p>
<p><b>1b. Performance Gap</b>  Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:</p> <ul style="list-style-type: none"> <li>• considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or</li> <li>• Disparities in care across population groups.</li> </ul> <p><b>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)</b>  <u>IF a PRO-PM</u> (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.)  <u>IF a COMPOSITE</u> (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.  This measure aligns with the U.S. Preventive Services Task Force's (USPSTF) guidelines recommending routine screening for depression as a part of primary care for both children and adults, seeking to increase detection and treatment of depression and reduce the associated economic burden. The measure is an important contribution to the quality domain of community and population health.  The World Health Organization describes major depression as the leading cause of disability worldwide (Pratt &amp; Brody, 2008). According to the Center for Behavioral Health Statistics and Quality (2015), in 2014, 11.7 percent of adolescents aged 12 to 17 and 6.6 percent of adults 18 years and older in the United States received a diagnosis of major depressive disorder. A study by Borner et al. (2010) found that 20 percent of adolescents are likely to have experienced depression by the time they are 18 years old. In adults,</p>

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

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

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.**

Provider-level performance scores using both claims and registry data suggest that there are still gaps in care and opportunities for improvement.

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

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

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

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

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

\*From the 2014 PQRS Reporting Experience Report and Appendix

Claims submitted 1/1/2015 through 12/31/2015

Number of Providers 26,169

Number of cases reported with valid denominator criteria: 3,002,169

Average Unweighted Score 63.8%

Average Weighted Score 36.5%

Standard Deviation 45.9%

Min 0%

Max 100%

Interquartile range 100%

10th percentile 0%

20th percentile 0%

30th percentile 5.9%

40th percentile 85.7%

50th percentile 100%

60th percentile 100%

70th percentile 100%

80th percentile 100%

90th percentile 100%

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

Registry submitted 1/1/2015 through 12/31/2015

Number of Providers 7,027

Number of cases reported with valid denominator criteria 989,092

Average Unweighted Score 50.7%

Average Weighted Score 28.9%

Min 0%

Max 100%

Interquartile range 99.7%

10th percentile 0%

20th percentile 0.3%

30th percentile 2.2%

40th percentile 17.8%

50th percentile 50.8%

60th percentile 85.7%

70th percentile 100%

80th percentile 100%

90th percentile 100%

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

**1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**

N/A

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (*This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.**

Below are aggregate performance rates by patients' age, race, and sex using 3,002,169 Medicare claims from calendar year 2015. These results represent only those providers who voluntarily reported this measure and may not be generalizable to the population of all eligible providers.

Age Groups

18–64: 35.7%

65+: 36.7%

( $\chi^2 = 207.5$ ; df: 1; N: 3,002,107;  $p < 0.0001$ )

We excluded age category 12-17 due to small sample size

Race

Asian: 58.4%

Black: 26.8%

Hispanic: 43.2%

Native American: 73.9%

White: 37.1%  
Other: 50.0%  
Unknown: 38.9%  
( $\chi^2 = 31,993.1$ ; df: 6; N: 3,002,169;  $p < 0.0001$ )

Sex  
Female: 37.6%  
Male: 34.8%  
( $\chi^2 = 2,575.2$ ; df: 1; N: 3,002,169;  $p < 0.0001$ )

Because Medicare claims do not provide data on patients' insurance status, socioeconomic status, and/or disability status, we were unable to determine the presence of disparities in performance based on these factors.

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4**

Race/ethnicity: Literature indicates that depression rates are higher in non-Latino black people than in their non-Latino white counterparts (Pratt & Brody, 2008). Clinical practice guidelines also indicate that minority racial and cultural groups in the United States are less likely to receive treatment for depression than white Americans (Trangle et al., 2016). Data collected from electronic health records of approximately 65,079 adult primary care patients from 2010 to 2012 showed that (1) individuals from minority groups are less likely to undergo screening for mental disorders, such as depression screening; (2) minority groups have less access to mental health care and receive less than adequate health care compared to non-Latino whites, and (3) women from racial/ethnic minority groups are less likely than white women to have access to mental health care (Hahm et al., 2015). Medicare beneficiary survey data analyzed by Akincigil et al. showed that about 6.4 percent of white Americans, 4.2 percent of black Americans, and 7.2 percent of Latino Americans had a diagnosis of depression. Among those diagnosed, 73 percent of whites received treatment (either with antidepressants, psychotherapy, or both); 60 percent of blacks received treatment; and 63.4 percent of Latinos received treatment (Akincigil et al., 2012). These findings are consistent with other studies that show depression is under-recognized and undertreated among adult minorities. According to Davis et al. (2011, p.1282), "Recent data suggest that the proportion of depressed adults who seek treatment is significantly lower among African Americans (53%) than among Caucasians (67%)."

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

Gender: Literature indicates that depression is more common in women than in men (Pratt & Brody, 2008). Studies showed that men were less likely than women to receive screening for mental health problems, such as depression (Hahm et al., 2015). Among Latino and Asian Americans, women were more likely than men to receive screening for depression and visit a health care provider for depression care after depression was detected. Asian and black Americans, particularly black women, were less likely to receive screening for depression and less likely to receive any depression care than their white and Latino counterparts (Hahm et al., 2015). Socioeconomic status: People with incomes below the federal poverty line and in the 18-39 and 40-59 age brackets experience higher depression rates than those with higher incomes, although this disparity is not observable in other age categories (Pratt & Brody, 2008).

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

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

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

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

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

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

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

[https://www.icsi.org/guidelines\\_\\_more/catalog\\_guidelines\\_and\\_more/catalog\\_guidelines/catalog\\_behavioral\\_health\\_guidelines/depression/](https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/)

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

**De.5. Subject/Topic Area** (check all the areas that apply):

Behavioral Health, Behavioral Health : Depression

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

Primary Prevention, Screening

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

Children, Elderly

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

[https://www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/2016\\_PQRS\\_IndMeasuresSpecs\\_ClaimsRegistry\\_022316.zip](https://www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/2016_PQRS_IndMeasuresSpecs_ClaimsRegistry_022316.zip)

**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 not an eMeasure Attachment:

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

Attachment Attachment: NQF\_0418\_Coding\_Table\_S2b\_3148\_PQRS\_134.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.

We made minor denominator coding updates for the 2015 program year; see release note or code table in S.2b for specific details. We did not make any updates for the 2016 program year. We are making updates for the 2017 program year, which will be published after this submission. Changes for program year 2017 include: addition of Patient Health Questionnaire (PHQ-9) and Pediatric Symptom Checklist (PSC-17) to the Definition section of the specification; addition of examples of depression screening tools to clarify available standardized options for provider use, including depression screening tools for adolescents; CPT coding changes per expert panel recommendations, for example, deletion of one CPT code (90839) for the 2017 program year; changed term clinical depression to depression because the word clinical could reduce the sensitivity of screening; and incorporated new literature into rationale.

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Patients screened for clinical 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

**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).

Numerator Quality-Data Coding Options for Reporting Claims and Registry Satisfactorily:

G8431: Screening for clinical depression is documented as being positive AND a follow-up plan is documented

OR

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

G8432 Clinical depression screening not documented, reason not given

OR

G8511 Screening for clinical depression documented as positive, follow-up plan not documented, reason not given

Definitions in relation to the Numerator include:

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), and PRIME MD-PHQ2

Adult Screening Tools (18 years and older)

Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale 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

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

All patients aged 12 years and older

**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 denominator is defined by the patient's age, encounter date, denominator CPT or HCPCS codes.

Patients aged > = 12 years on date of encounter AND

90791, 90792, 90832, 90834, 90837, 90839, 92625, 96116, 96118, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439, G0444



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

Not Eligible – A patient is not eligible if 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
- Patient has an active diagnosis of Depression
- Patient has a diagnosed Bipolar Disorder

**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.)*

Denominator Exclusions are identified with the following provider reported HCPCS numerator clinical quality codes:

G8433 Screening for clinical depression not documented, documentation stating the patient is not eligible  
OR

G8940 Screening for clinical depression documented as positive, a follow-up plan not documented, documentation stating the patient is not eligible.

**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.)*

No stratification.

**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.)*

PERFORMANCE CALCULATION – Claims and Registry

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

Numerator (A): Number of patients meeting numerator criteria

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

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

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



2) identify which of those patients meet the numerator criteria (A)

3) for those patients who do not meet the numerator criteria, determine whether an appropriate exclusion applies (B) and subtract those patients from the denominator with the following calculation: Numerator (A)/[Performance Denominator (PD) - Denominator Exclusions (B)]

**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.

N/A

**S.16. Survey/Patient-reported data** (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

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

N/A

**S.17. Data Source** (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims (Only), Registry

**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.

No specific data source/data collection instrument.

**S.19. Data Source or Collection Instrument** (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

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

Clinician : Group/Practice, Clinician : Individual

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

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.)

Not a composite.

## 2. Validity – See attached Measure Testing Submission Form

Testing\_form\_NQF\_0418\_3148\_\_PQRS\_134\_012317.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.)

No

### 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 or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), 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 a combination of electronic sources

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement,** if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

N/A

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.**

Attachment:

#### 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.**

We did not encounter any difficulties related to data availability. Based on our experience working with providers who report this measure for CMS quality reporting programs, the measure is feasible and its reporting is facilitated by the use of Quality Data Codes in claims and registry data that identify encounters that meet or fail to meet performance, or are ineligible or excluded from performance. This measure is not a PRO-PM.

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

None

## 4. Usability and Use

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

### 4a. Accountability and Transparency

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

#### 4.1. Current and Planned Use

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

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

#### 4a.1. For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

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

**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?)

N/A

**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.)

N/A

#### 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.

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

The average performance rate has fluctuated substantially over the past four years, decreasing from 82.6 percent in 2011 to 52.4 percent in 2014. However, the number of EPs reporting the measure has increased significantly over this time frame, from just 0.6 percent of EPs in 2011 to 7.5 percent in 2014. This makes it difficult to assess trends over time, as the EPs who recently began reporting the measure may have lower performance rates than those who have been reporting it for a longer period. Although the reporting increased each year, a substantial number of EPs are still not reporting the measure, and the average performance rate illustrates that there is still a gap in care.

#### 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.**

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

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

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

**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.

N/A

**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.**

N/A

**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.

N/A

**4d2.2. Summarize the feedback obtained from those being measured.**

N/A

**4d2.3. Summarize the feedback obtained from other users**

N/A

**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.**

N/A

## 5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

### 5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

#### 5.1a. List of related or competing measures (selected from NQF-endorsed measures)

0518 : Depression Assessment Conducted

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

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

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

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

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

### 5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

**5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**

**Are the measure specifications harmonized to the extent possible?**

Yes

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

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

**5b. Competing Measures**

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

**OR**

Multiple measures are justified.

**5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):**

**Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)**

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

## Appendix

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

[Attachment](#) **Attachment:** [NQF\\_0418\\_Summary\\_Materials.pdf](#)

## Contact Information

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

**Co.2 Point of Contact:** Sophia, Autrey, [Sophia.Autrey@cms.hhs.gov](mailto:Sophia.Autrey@cms.hhs.gov)

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

**Co.4 Point of Contact:** Anita, Somplasky, [asomplasky@wvmi.org](mailto:asomplasky@wvmi.org), 877-346-6180-7852

## Additional Information

**Ad.1 Workgroup/Expert Panel involved in measure development**

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

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

Jean Carter, PhD  
Psychology

Washington Psychological Center, P.C.

Paula Hartman-Stein, PhD

Clinical psychology

Center for Healthy Aging; clinical psychologist, founder

Bracken Babula, MD

Internal medicine

Department of Medicine; Thomas Jefferson University; associate quality officer

Alan Axelson, MD

Adolescent psychiatry

InterCare Psychiatric Services; medical director and chief

Justin Schreiber, DO, MPH

Psychiatry

Western Psychiatric Institute and Clinic; co-triple board chief

Gregory M. Martino, PhD

Clinical psychology

Independent practice, DuBois, Pennsylvania

Tracy Murphy, AuD

Audiology

North Shore Audio-Vestibular Lab

Virginia Clark, PhD

Psychology (adolescent)

Western Reserve Psychological Associates, Inc.; president

Donald Wilson, MD

Obstetrics/gynecology

Women's Care Florida; chief medical officer

Harold Manley, PharmD

Pharmacology

Dialysis Clinic, Incorporated; director of medication management and pharmacovigilance

#### Measure Developer/Steward Updates and Ongoing Maintenance

**Ad.2 Year the measure was first released:** 2008

**Ad.3 Month and Year of most recent revision:** 09, 2016

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

**Ad.5 When is the next scheduled review/update for this measure?** 09, 2017

**Ad.6 Copyright statement:** These measures were developed by Quality Insights of Pennsylvania as a special project under the Quality Insights' Medicare Quality Improvement Organization (QIO) contract HHS-500-2005-PA001C with the Centers for Medicare & Medicaid Services. These measures are in the public domain.

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**Ad.7 Disclaimers:** This measure and specifications are provided "as is" without warranty of any kind. This measure does not represent a practice guideline.



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