



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 #: 0104

Corresponding Measures:

De.2. Measure Title: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Co.1.1. Measure Steward: AMA-convened Physician Consortium for Performance Improvement

De.3. Brief Description of Measure: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

1b.1. Developer Rationale: Research has shown that more than 90% of people who kill themselves have depression or another diagnosable mental or substance abuse disorder.(1) The intent of this measure is for a clinician to assess suicide risk at initial intake or at visit in which depression was diagnosed. Better assessment and identification of suicide risk/suicidal intent should lead to improved treatment and reduction in patient risk/suicide attempts/patient deaths.

(1) Conwell Y, Brent D. Suicide and aging I: patterns of psychiatric diagnosis. International Psychogeriatrics, 1995; 7(2): 149-64.

S.4. Numerator Statement: Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

S.6. Denominator Statement: All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)

S.8. Denominator Exclusions: None

De.1. Measure Type: Process

S.17. Data Source: Electronic Health Record (Only), Registry

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

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Feb 28, 2014

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

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

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

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

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

[0104_Evidence_MSF5.0_Data.doc](#)

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.

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.

Research has shown that more than 90% of people who kill themselves have depression or another diagnosable mental or substance abuse disorder.(1) The intent of this measure is for a clinician to assess suicide risk at initial intake or at visit in which depression was diagnosed. Better assessment and identification of suicide risk/suicidal intent should lead to improved treatment and reduction in patient risk/suicide attempts/patient deaths.

(1) Conwell Y, Brent D. Suicide and aging I: patterns of psychiatric diagnosis. *International Psychogeriatrics*, 1995; 7(2): 149-64.

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.

Hepner and colleagues (2007) found that primary care physicians (PCPs) assess for suicide only 24% of the time in patients with depression.(1) In the same study, only 28% of PCPs adhered to the quality indicator "Treatment for suicidal ideation among patients not already followed in mental health care."(1) McGlynn and colleagues (2003) found that only 25.8% of PCPs document the presence or absence of suicidal ideation during the first or second diagnostic visit.(2) The same study showed that only 28.9% of patients who have suicidality and have any of the following risk factors: psychosis, current alcohol or drug abuse or dependency, and specific plans to carry out suicide (eg, obtaining a weapon, putting affairs in order, making a suicide note) are hospitalized.(2) Additionally, Luoma and colleagues (2002) found that 40% of patients who completed suicide had seen their primary care physician in the past month.(3)

CMS Physician Quality Reporting Initiative:

This measure was used in the 2010 CMS Physician Quality Reporting Initiative/System. There is a gap in care as shown by this data; 96.59% is the aggregate performance rate in the total patient population and 95.45% is the mean performance rate of TIN/NPI's.(4)

10th percentile: 94.44%

25th percentile: 100.0%

50th percentile: 100.0%

75th percentile: 100.0%

90th percentile: 100.0%

Exception Rate: N/A*

*This measure has no exceptions

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

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

(2) McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. The Quality of Health Care Delivered to Adults in the United States. *N Engl J Med* 2003;348:2635-2645.

(3) Luoma, J.B., Martin, C.E., & Person, J.L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry*, 159, 909-916.

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

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for 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.*

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

For individuals who experienced a depressive disorder in the past year, 63.7% of Latinos, 68.7% of Asians, and 58.8% of African Americans, compared with 40.2% of non-Latino whites, did not access any mental health treatment in the past year.(2)

Findings from the CDC Health Disparities and Inequalities Report – United States, 2011:

Key Findings in Suicide Disparities

- In 2007, a total of 34,598 suicides occurred in the United States — 83.5% of the suicides were among non-Hispanic whites, 7.1% among Hispanics, 5.5% among non-Hispanic blacks, 2.5% among Asian/Pacific Islanders, and 1.1% among American Indians/Alaska Natives.
- Suicide rates by race/ethnicity and age group demonstrated different patterns. Though the greatest percentage of suicides occurred among non-Hispanic whites, the highest race/ethnicity and age-specific rates were among American Indian/Alaska Native adolescents and young adults.
- In each of the racial/ethnic groups, suicide rates were higher for males than for females.

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

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

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

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, Behavioral Health : Suicide

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

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

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.)

Additional measure details at: CMS eCQM library webpage http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html. Value set details at VSAC webpage: <https://vsac.nlm.nih.gov/>

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is an eMeasure Attachment: [EP_CMS161v5_NQF0104_MDD_SuicideRisk.zip](#)

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

Attachment Attachment: [EP_eCQM_ValueSets_CMS161v5_NQF0104.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.

No

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

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

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

Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

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).

Time Period for Data Collection:

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

DEFINITIONS:

Suicide risk assessment - Must include questions about the following: 1) Suicidal ideation 2) Patient's intent of initiating a suicide attempt AND, if either is present, 3) Patient plans for a suicide attempt 4) Whether the patient has means for completing suicide

GUIDANCE:

Use of a standardized tool or instrument to assess suicide risk will meet numerator performance. Standardized tools can be mapped to the concept "Intervention, Performed: Suicide Risk Assessment" included in the numerator logic in the attached HQMF in field S.2a.

For EHR:

HQMF eMeasure developed and is attached to this submission in fields S.2a and S.2b.

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

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

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).

Time Period for Data Collection: 12 consecutive months

GUIDANCE:

It is expected that a suicide risk assessment will be completed at the visit during which a new diagnosis is made or at the visit during which a recurrent episode is first identified (ie, at the initial evaluation). This measure is an episode-of-care measure and should be reported for each instance of a new or recurrent episode of MDD; every new or recurrent episode will count separately in the Initial Patient Population.

The measure description outlined in the header for this measure states, 'patients aged 18 years and older' while the logic statement states, '>= 17 year(s) starts before start of "Measurement Period"'. The logic statement, as written, captures patients who turn 18 years old during the measurement period so that these patients are included in the measure. To ensure all patients with major depressive disorder (MDD) are assessed for suicide risk, there are two clinical quality measures addressing suicide risk assessment; CMS 177 covers children and adolescents aged 6 through 17, and CMS 161 covers the adult population aged 18 years and older.

For EHR:

HQMF eMeasure developed and is attached to this submission in fields S.2a and S.2b.

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

None

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.)*

Not Applicable

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)*

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

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic *(Diagram or describe the calculation of the measure score as an ordered sequence of*

steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.
3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

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

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.

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

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.

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), 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.

Not Applicable

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)

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)

Behavioral Health : Outpatient, Clinician Office/Clinic, Emergency Department, Other, Urgent Care - Ambulatory

If other: Behavioral Health Day Treatment

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

0104_MeasureTesting_MS5.0_Data.zip

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.)

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.)

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)

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

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

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) 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:

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.

The greatest challenge for this measure was that little to none of the patient care performed was documented in a structured, searchable field. More specifically, most patients were found to meet the numerator upon manual review of the patient record because suicide risk assessment was most consistently documented in free text notes by providers. System design improvement efforts could allow for higher reliability for these measures.

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

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

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

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

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.

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 are not aware of any unintended consequences related to this measurement.](#)

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

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.

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.

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.

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

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

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.

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)

[0111 : Bipolar Disorder: Appraisal for risk of suicide](#)

[1365 : Child and Adolescent Major Depressive Disorder \(MDD\): Suicide Risk Assessment](#)

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?

[No](#)

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

[This numerator components of this measure are very similar to/mostly harmonized with the components in Bipolar Disorder: Appraisal for risk of suicide. In regards to our Child & Adolescent MDD: Suicide Risk Assessment measure, our Adult MDD measure represents an update to the original measure created in 2006; during the review process, the Adult MDD Work Group felt it was important to include certain enhancements given their focus on the adult population. In addition, our Adult MDD: Suicide Risk Assessment measure is now focused only on the first visit and initial evaluation \(instead of every visit\) and therefore the assessment is more comprehensive than the Child & Adolescent measure, which is every visit.](#)

5b. Competing Measures

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

OR

Multiple measures are justified.

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

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

[These measures are not competing, as they have different target populations.](#)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific

submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): AMA-convened Physician Consortium for Performance Improvement
Co.2 Point of Contact: Samantha, Tierney, Samantha.Tierney@ama-assn.org, 312-464-5524-
Co.3 Measure Developer if different from Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
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Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

Richard Hellman, MD, FACP, FACE (Co-Chair) (endocrinology, methodology)
 John S. McIntyre, MD (Co-Chair) (psychiatry, methodology)
 Alan A. Axelson, MD (general psychiatry, child/adolescent psychiatry)
 Stanley Borg, DO (family medicine)
 Andrea Bostrom, PhD, PMHCNS-BC (nursing, psychiatric nursing)
 Gwendolen Buhr, MD, MHS, CMD (geriatrics)
 Katherine A. Burson, MS, OTR/L, CPRP (occupational therapy)
 Mirean Coleman, MSW, LICSW, CT (social work)
 Thomas J. Craig, MD, MPH, DLFAPA, FACPM (psychiatry)
 Allen Doederlein (patient representative)
 William E. Golden, MD, FACP (internal medicine)
 Molly Finnerty, MD (psychiatry, methodology)
 Jerry Halverson, MD (psychiatry, methodology)
 Paul R. Keith, MD (health plan representative)
 Clifford K. Moy, MD (psychiatry)
 John M. Oldham, MD (psychiatry)
 Shaunte R. Pohl, PharmD, BCPS (pharmaceutical science)
 Mark A. Reinecke, PhD (psychology)
 Leslie H. Secrest, MD (psychiatry)
 Carl A. Sirio, MD (critical care medicine, methodology)
 Sharon S. Sweede, MD (family medicine)
 Roberta Waite, EdD, APRN, CNS-BC (psychiatric nursing, methodology)

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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2006
Ad.3 Month and Year of most recent revision: 12, 2012
Ad.4 What is your frequency for review/update of this measure? See Ad.9.
Ad.5 When is the next scheduled review/update for this measure? 12, 2013

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Ad.7 Disclaimers: N/A

Ad.8 Additional Information/Comments: Coding/Specifications updates occur annually. The PCPI has a formal measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. The process can also be activated if there is a major change in scientific evidence, results from testing or other issues are noted that materially affect the integrity of the measure.