NATIONAL QUALITY FORUM

Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0105
Corresponding Measures:
De.2. Measure Title: Antidepressant Medication Management (AMM)
Co.1.1. Measure Steward: National Committee for Quality Assurance
De.3. Brief Description of Measure: The percentage of members 18 years of age and older who were treated antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported.

a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).
b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).
b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).
1b.1. Developer Rationale: Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects. If pharmacological treatment is initiated, appropriate dosing and continuation of therapy through the acute and continuation phases decrease recurrence of depression. Thus, evaluation of duration of pharmacological treatment serves as an important indicator in promoting patient compliance with the establishment and maintenance of an effective medication regimen.

S.4. Numerator Statement: Adults 18 years of age and older who were newly treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.
S.6. Denominator Statement: Patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.
S.8. Denominator Exclusions: Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.

Exclude patients who filled a prescription for an antidepressant 105 days prior to the IPSD.

De.1. Measure Type: Process
S.17. Data Source: Claims
S.20. Level of Analysis: Health Plan

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Oct 26, 2018

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
0105._evidence_attachment_7.1_FINAL.docx
1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?
Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.
Yes

1b. Performance Gap
    Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:
    - considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
    - Disparities in care across population groups.

1b.1. **Briefly explain the rationale for this measure** *(e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)*
If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.
Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects. If pharmacological treatment is initiated, appropriate dosing and continuation of therapy through the acute and continuation phases decrease recurrence of depression. Thus, evaluation of duration of pharmacological treatment serves as an important indicator in promoting patient compliance with the establishment and maintenance of an effective medication regimen.

1b.2. **Provide performance scores on the measure as specified (<u>current and over time</u>) at the specified level of analysis**. *(<u>This is required for maintenance of endorsement</u>. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.)*
This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.
The following data are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. It includes the number of health plans and the average eligible population across plans for which the measure applies. Performance data is summarized at the health plan level. Performance of health plans is represented by percentiles, inter-quartile range, mean, min, max and standard deviations. Data is stratified by year and product line (i.e. commercial, Medicare, Medicaid).

Commercial – Effective Acute Phase Treatment
Measurement Year: 2011; 2010; 2009
Number of Plans: 385; 398; 414
Mean Eligible Population: 864; 828; 819
Mean: 65.3; 64.6; 63
Standard Deviation: 6.23; 6.48; 6.57
Standard Error: 0.32; 0.32; 0.32
Minimum: 38.9; 35.5; 31.7
Maximum: 85.5; 90.4; 89
P10: 58; 57.4; 55.9

P25: 61.5; 60.7; 59.1
P50: 64.8; 64.8; 63
P75: 69.1; 68.1; 66.6
P90: 72.3; 72.2;70.8

Commercial – Effective Acute Phase Treatment
Measurement Year: 2017; 2016; 2015
Number of Plans: 403; 407; 398
Mean Eligible Population: 1,958; 1,927; 1,939
Mean: 67.5; 66.5; 66.1
Standard Deviation: 6.5; 6.9; 6.9
Standard Error: 0.32; 0.34; 0.35
Minimum: 39.1; 27.0; 30.7
Maximum: 84.4; 85.1; 82.7
P10: 58.6; 58.6; 58.1
P25: 64.0; 62.7; 62.0
P50: 67.5; 66.6; 65.7
P75: 71.8; 71.0; 71.0
P90: 75.7; 74.3; 75.2

Commercial – Effective Continuation Phase Treatment
Measurement Year: 2011; 2010; 2009
Number of Plans: 385; 398; 414
Mean Eligible Population: 864; 828; 819
Mean: 49.1; 48.2; 46.3
Standard Deviation: 6.57; 6.95; 7.12
Standard Error: 0.33; 0.35; 0.35
Minimum: 27;19.4; 15.8
Maximum: 76.6; 87.2; 77
P10: 41.9; 39.8; 38.2
P25: 44.8; 44.2; 42
P50: 48.9; 48.2; 45.7
P75: 53.3; 52.3; 50
P90: 56.9; 55.7; 54.5

Commercial – Effective Continuation Phase Treatment
Measurement Year: 2017; 2016; 2015
Number of Plans: 403; 407; 398
Mean Eligible Population: 1,958; 1,927; 1,939
Mean: 51.8; 50.7; 50.3
Standard Deviation: 6.8; 7.1; 7.4
Standard Error: 0.34; 0.35; 0.37
Minimum: 21.9; 18.9; 22.7
Maximum: 70.4; 75.9; 75.0
P10: 43.4; 42.6; 42.0
P25: 47.6; 46.7; 45.7
P50: 51.5; 50.5; 49.8
P75: 56.0; 55.3; 54.6
P90: 60.4; 58.8; 59.9

Medicaid – Effective Acute Phase Treatment
Measurement Year: 2011; 2010; 2009
Number of Plans: 97; 90; 76
Mean Eligible Population: 505; 493; 380
Mean: 51.1; 50.7; 49.7

Standard Deviation: 7.7; 8.16; 8.69
Standard Error: 0.78; 0.86; 1
Minimum: 37.5; 30; 30.2
Maximum: 81; 78.9; 84.7
P10: 43.4; 43; 40.9
P25: 47; 46.4; 45.2
P50: 49.4; 50.1; 48.1
P75: 52.7; 53.6; 53.2
P90: 61.6; 59.9; 58.4

Medicaid – Effective Acute Phase Treatment
Measurement Year: 2017; 2016; 2015
Number of Plans: 226; 216; 188
Mean Eligible Population: 2,301; 1,855; 1,377
Mean: 53.2; 54.5; 52.4
Standard Deviation: 8.9; 9.9; 9.6
Standard Error: 0.59; 0.67; 0.70
Minimum: 17.1; 23.6; 17.7
Maximum: 99.1; 94.8; 92.3
P10: 44.5; 44.0; 42.8
P25: 48.2; 48.4; 46.7
P50: 51.9; 53.5; 50.5
P75: 57.5; 60.0; 56.3
P90: 64.2; 67.6; 62.7

Medicaid – Effective Continuation Phase Treatment
Measurement Year: 2011; 2010; 2009
Number of Plans: 97;90; 76
Mean Eligible Population: 505; 493; 380
Mean: 34.4; 34.4; 33
Standard Deviation: 7.91; 9.11; 9.86
Standard Error: 0.8; 0.96; 1.13
Minimum: 20.4; 17.6; 12.5
Maximum: 67.1; 74.6; 80.5
P10: 26.7; 25.7; 24.8
P25: 30; 29.2; 27.8
P50: 32.4; 32.7; 31
P75: 37.3; 37.5; 35.4
P90: 42.9; 44.2; 43.3

Medicaid – Effective Continuation Phase Treatment
Measurement Year: 2017; 2016; 2015
Number of Plans: 226; 218; 188
Mean Eligible Population: 2,301; 1,855; 1,377
Mean: 38.0; 39.5; 37.1
Standard Deviation: 9.4; 10.6; 10.6
Standard Error: 0.63; 0.72; 0.77
Minimum: 8.6; 11.5; 8.8
Maximum: 82.3; 84.2; 88.8
P10: 29.1; 28.1; 27.4
P25: 32.6; 32.8; 30.9
P50: 36.3; 38.1; 34.0
P75: 41.6; 43.5; 40.8
P90: 50.4; 54.3; 49.8

Medicare – Effective Acute Phase Treatment
Measurement Year: 2011; 2010; 2009
Number of Plans: 335; 278; 241
Mean Eligible Population: 220; 195; 186
Mean: 67.6; 65.6; 63.6
Standard Deviation: 10.4; 10.5; 10.8
Standard Error: 0.57; 0.63; 0.7
Minimum: 33.3; 25.9; 25.5
Maximum: 94.7; 92.8; 93.5
P10: 52.4; 53.5; 50.8
P25: 62.2; 59.3; 57.5
P50: 68.4; 65.6; 63.8
P75: 74.3; 72.4; 70.1
P90: 79.6; 77.6; 76.3

Medicare – Effective Acute Phase Treatment
Measurement Year: 2017; 2016; 2015
Number of Plans: 401; 384; 388
Mean Eligible Population: 1,010; 943; 807
Mean: 70.2; 70.1; 69.4
Standard Deviation: 8.8; 9.8; 8.8
Standard Error: 0.44; 0.50; 0.45
Minimum: 38.7; 13.9; 38.6
Maximum: 99.2; 100.0; 90.9
P10: 59.4; 58.1; 57.8
P25: 64.8; 64.6; 64.0
P50: 70.7; 70.3; 70.0
P75: 76.0; 76.1; 75.4
P90: 80.3; 82.5; 79.2

Medicare – Effective Continuation Phase Treatment
Measurement Year: 2011; 2010; 2009
Number of Plans: 335; 278; 241
Mean Eligible Population: 220; 195; 186
Mean: 54.8; 52.8; 50.6
Standard Deviation: 11.3; 11.4; 11.7
Standard Error: 0.62; 0.68; 0.75
Minimum: 20.2; 14.1; 16.9
Maximum: 89.4; 84.5; 87.1
P10: 39.1; 38.1; 36.9
P25: 48.5; 46.4; 43.5
P50: 55.8; 53; 50.9
P75: 62.4; 60.7; 57.1
P90: 68.2; 66.1; 65.8

Medicare – Effective Continuation Phase Treatment
Measurement Year: 2017; 2016; 2015
Number of Plans: 401; 384; 388
Mean Eligible Population: 1,010; 943; 807
Mean: 55.5; 56.2; 55.7
Standard Deviation: 10.3; 11.3; 10.3
Standard Error: 0.52; 0.58; 0.52
Minimum: 8.6; 11.5; 8.8
Maximum: 93.0; 96.7; 86.1
P10: 42.1; 42.9; 42.6

P25: 48.9; 49.5; 49.2
P50: 55.6; 56.2; 55.9
P75: 61.2; 61.9; 62.4
P90: 67.5; 70.3; 68.5

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.**
The data in 1b.2 are HEDIS health plan performance rates.

1b.4. **Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.** (_This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use._
• The percentage of adults with a major depressive episode in 2008, who received treatment for it, was significantly lower for blacks than for whites (58.9 vs. 71.1 percent) and for Hispanics than non-Hispanic whites (51.8 vs. 73.3 percent). (AHRQ, 2009)
• A study examining antidepressant treatment patterns found that, compared to younger adults, older adults tended to be more likely to discontinue antidepressant treatment (Sanglier et al., 2011).
• A study that examined the treatment disparities for respondents with major depressive disorders showed that blacks and Hispanics were less likely to use antidepressants than whites. Of the respondents who were screened, only 34% reported antidepressant use in the previous 12-month period; however, blacks (17.5%) and Hispanics (21.8%) reported statistically significant lower overall use of antidepressants in analysis compared with whites (37.6%) (Fleming et al., 2003).
• Compared to whites, blacks and Hispanics in primary care were less likely to be prescribed antidepressants for their depression. Whites also received more antidepressant prescriptions after a visit to psychiatrists when compared to blacks (Lagomasino et al., 2011).

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**
Agency for Healthcare Research and Quality. Mental Health Research Findings. Program Brief. AHRQ Publication No. 09-P011, September 2009. Rockville, MD. http://www.ahrq.gov/research/mentalhth.htm

Sanglier T, Saragoussi D, Milea D, Auray JP, Valuck RJ, Tournier M., Comparing antidepressant treatment patterns in older and younger adults: a claims database analysis. J Am Geriatr Soc. 2011 Jul;59(7):1197-205. doi: 10.1111/j.1532-5415.2011.03457.x. Epub 2011 Jun 30. http://www.ncbi.nlm.nih.gov/pubmed/21718261

Fleming M, Barner JC, Brown CM, Smith T. Treatment disparities for major depressive disorder: Implications for pharmacists.J Am Pharm Assoc. 2003. 2011 Sep-Oct;51(5):605-12.

Lagomasino IT, Stockdale SE, Miranda J. Racial-ethnic composition of provider practices and disparities in treatment of depression and anxiety, 2003-2007. Psychiatr Serv. 2011 Sep;62(9):1019-25

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, <u>as specified</u>, 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):*
Care Coordination

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

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

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:** 0105_AMM_Value_Sets_updated_4.11.18.xlsx

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.
No, this is not an instrument-based measure **Attachment:**

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.
Not an instrument-based measure

S.3.1. **For maintenance of endorsement:** Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.
No

S.3.2. **For maintenance of endorsement,** please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.
No important changes have been made to the measure since the last update.

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).
Adults 18 years of age and older who were newly treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.

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).
a) Effective Acute Phase Treatment: At least 84 days (12 weeks) of treatment with antidepressant medication (Table AMM-C) during the 114-day period following the Index Prescription Start Date (IPSD) (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment

gaps to refill the same medication.

b) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) during the 231-day period following the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

TABLE AMM-C: ANTIDEPRESSANT MEDICATIONS
Miscellaneous antidepressants: Bupropion, Vilazodone, Vortioxetine

Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline, Tranylcypromine

Phenylpiperazine antidepressants: Nefazodone, Trazodone

Psychotherapeutic combinations: Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, Fluoxetine-olanzapine

SNRI antidepressants : Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine

SSRI antidepressants: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline

Tetracyclic antidepressants: Maprotiline, Mirtazapine

Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine

S.6. **Denominator Statement** *(Brief, narrative description of the target population being measured)*
Patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.

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).
Step 1: Determine the Index Prescription Start Date (IPSD). Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period (The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year).

Step 2: Required exclusion: Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Patients who meet any of the following criteria remain in the eligible population:

• An outpatient visit, ED visit, telehealth, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria:
– AMM Stand Alone Visits Value Set with Major Depression Value Set. with or without a telehealth modifier (Telehealth Modifier Value Set).
– AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). .
• Telephone Visits Value Set with Major Depression Value Set.
• An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).
• An acute or nonacute inpatient stay discharge with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges:
First, identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). Second, identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.

Step 3: Test for Negative Medication History. Exclude patients who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

Step 4: Calculate continuous enrollment. Patients must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

TABLE AMM-C: ANTIDEPRESSANT MEDICATIONS
Miscellaneous antidepressants: Bupropion, Vilazodone, Vortioxetine

Monoamine oxidase inhibitors: Isocarboxazid, Phenelzine, Selegiline, Tranylcypromine

Phenylpiperazine antidepressants: Nefazodone, Trazodone

Psychotherapeutic combinations: Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, Fluoxetine-olanzapine

SNRI antidepressants : Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine

SSRI antidepressants: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline

Tetracyclic antidepressants: Maprotiline, Mirtazapine

Tricyclic antidepressants: Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine

*See corresponding Excel file for value sets referenced above.

S.8. **Denominator Exclusions** (*Brief narrative description of exclusions from the target population*)
Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.

Exclude patients who filled a prescription for an antidepressant 105 days prior to the IPSD.

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.*)
Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Patients who meet any of the following criteria remain in the eligible population:

• An outpatient visit, ED visit, telehealth, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria:
– AMM Stand Alone Visits Value Set with Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

– AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
• Telephone Visits Value Set with Major Depression Value Set.

• An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).

• An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges:

First, identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). Second, identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.

Exclude patients who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

*See corresponding Excel file for value sets referenced above.

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.)*
NCQA asks that health plans collect the measure data for each of the three product lines each year (i.e. commercial, Medicare, Medicaid) if applicable.

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.)*
Step 1: Determine the eligible population, or denominator.
Step 1a: Determine the Index Prescription Start Date (IPSD). Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period (the 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year).
Step 1b: Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.

Step 1c: Test for Negative Medication History. Exclude patients who filled a prescription for an antidepressant medication 105 days prior to the IPSD.
Step 1d: Calculate continuous enrollment. Exclude patients who are not continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

Step 2: Determine the numerators for the two reported rates.
Step 2a (Effective Acute Phase Treatment): Identify at least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table AMM-C) during the 114-day period following the Index Prescription Start Date (IPSD) (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.
Step 2b (Effective Continuation Phase Treatment): Identify at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) during the 232-day period following the IPSD. Continuous treatment allows gaps in

medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.
Step 3: Calculate the two reported rates by dividing both the numerators from steps 2a and 2b by the denominator in step 1d.

S.15. **Sampling** *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*
IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.
N/A

S.16. **Survey/Patient-reported data** *(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)*
Specify calculation of response rates to be reported with performance measure results.
N/A

S.17. **Data Source** *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*
If other, please describe in S.18.
 Claims

S.18. **Data Source or Collection Instrument** *(Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)*
IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.
This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via the Interactive Data Submission System (IDSS) portal.

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)*
 Health Plan

S.21. **Care Setting** *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*
 Outpatient Services
If other:

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

2. Validity – See attached Measure Testing Submission Form
0105_-_Antidepressant_Medication_Management_-_Testing_Form_v7.1_FINAL.docx

2.1 For maintenance of endorsement
Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.
Yes

2.2 For maintenance of endorsement
Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.
Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.
No - This measure is not risk-adjusted

3. Feasibility

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

3a. Byproduct of Care Processes
For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.
Generated 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 instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.
This measure is precisely specified using the administrative data collection method. This measure has detailed, precise specifications that clearly define the numerator, denominator, data sources, allowable values, methods of measurement and reporting.

NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as

well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO's ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.

The HEDIS Compliance Audit addresses the following functions:

1) Information practices and control procedures

2) Sampling methods and procedures

3) Data integrity

4) Compliance with HEDIS specifications

5) Analytic file production

6) Reporting and documentation

In addition to the HEDIS audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system, NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measure. This system is vital to the regular re-evaluation of NCQA measures.

Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence. During re-evaluation information from NCQA auditing and Policy Clarification Support System is used to inform evaluation of the scientific soundness and feasibility of the measure.

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).*
Broad public use and dissemination of these measures are encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license, or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed, or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

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)

4a1.1 For each CURRENT use, checked above (update for <u>maintenance of endorsement</u>), provide:
- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

MEDICAID ADULT CORE SET: There are a core set of health quality measures for Medicaid-enrolled adults. The Medicaid Adult Core Set was identified by the Centers of Medicare & Medicaid (CMS). The data collected from these measures helps CMS to better understand the quality of health care that adults enrolled in Medicaid receive nationally. Beginning in January 2014 and annually thereafter, the Secretary is required to publicly report the information that states voluntarily report to CMS on the quality of health care received by adults enrolled in Medicaid.

MERIT BASED INCENTIVE PAYMENT SYSTEM (MIPS) QUALITY PAYMENT PROGRAM (QPP): Eligible clinicians who elect to participate in MIPs earn a performance-based payment adjustment to Medicaid payments upon submission of evidence which attests that they provided high quality, efficient care supported by technology. Eligible clinicians can select up to six quality measures to report to CMS, including one outcome measure, that best fit their needs or specialty. The data collected from this program will help CMS to better understand the quality of health care that Medicare enrollees receive nationally.

HEALTH INSURANCE EXCHANGE QUALITY RATING SYSTEM (QRS): Qualified Health Plan (QHP) issuers and Multi-State Plan (MSP) issuers that offered coverage through a Health Insurance Marketplace (Marketplace) in the year prior to the current year are required to collect and submit QRS measure data to CMS. CMS produces quality ratings on a 5-star scale for each issuer in each State. Health plan level clinical quality measures and survey measures based on questions from the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey) are included in the QRS measure set. CMS collects data and calculates quality ratings for each QHP issuer's product type within each state and applies these ratings to each product type's QHPs in that State.

STATE OF HEALTH CARE ANNUAL REPORT: This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2017, the report included results from calendar year 2016 for health plans covering a record 136 million people, or 43 percent of the U.S. population

HEALTH PLAN RATINGS/REPORT CARDS: This measure is used to calculate health plan ratings, which are reported on the NCQA website. These ratings are based on a plan's performance on their HEDIS, CAHPS and accreditation standards scores. In 2017, a total of 521 Medicare Advantage health plans, 614 commercial health plans and 294 Medicaid health plans across 50 states, D.C., Guam, Puerto Rico, and the Virgin Islands were included in the Ratings.

HEALTH PLAN ACCREDITATION: This measure is used in scoring for accreditation of Medicare Advantage Health Plans. As of Fall 2017, a total of 184 Medicare Advantage health plans were accredited using this measure among others covering 9.2 million Medicare beneficiaries; 451 commercial health plans covering 113 million lives; and 125 Medicaid health plans covering 35 million lives. Health plans are scored based on performance compared to benchmarks.

QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting health plans, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (*e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?*)
N/A

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (*Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.*)

N/A

4a2.1.1. **Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.**
How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.
Health plans that report HEDIS calculate their rates and know their performance when submitting to NCQA. NCQA publicly reports rates across all plans and also creates benchmarks in order to help plans understand how they perform relative to other plans. Public reporting and benchmarking are effective quality improvement methods.

4a2.1.2. **Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**
NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS Update and Best Practices Conference, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System.

4a2.2.1. **Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.**
Describe how feedback was obtained.
NCQA measures are evaluated regularly. During this "reevaluation" process, we seek broad input on the measure, including input on performance and implementation experience. We use several methods to obtain input, including vetting of the measure with several multi-stakeholder advisory panels, public comment posting, and review of questions submitted to the Policy Clarification Support System. This information enables NCQA to comprehensively assess a measure's adherence to the HEDIS Desirable Attributes of Relevance, Scientific Soundness and Feasibility.

4a2.2.2. **Summarize the feedback obtained from those being measured.**
In general, health plans have not reported significant barriers to implementing this measure, as it uses the administrative data collection method. Questions have generally centered around minor clarification of the specifications, such as defining gaps in calculating days of medication treatment and questions about the supporting guidelines for the measure. NCQA responded to all questions to ensure consistent implementation of the specifications.

4a2.2.3. **Summarize the feedback obtained from other users**
This measure has been deemed a priority measure by NCQA and other entities, as illustrated by its use in programs such as the CMS Quality Rating System (QRS), CMS Merit-Based Incentive Payment System (MIPS) Program, and the Medicaid Adult Core Set.

4a2.3. **Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.**
Feedback has not required modification to this measure.

Improvement
Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. **Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)**
If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.
Over the past three years, this measure has shown slight improvement (approximately an increase in performance by 1 percentage point across all product lines) across health plans (see section 1b.2 for summary of data from health plans). Of note, the highest performance continues to be seen in the Medicare population, for both the acute and continuation indicators. The Medicaid product continues to show the largest gap in performance, with performance consistently averaging about 17 percentage points

lower than Medicare for both indicators.

4b2. Unintended Consequences
The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.
There were no identified unexpected findings during implementation of this measure.

4b2.2. Please explain any unexpected benefits from implementation of this measure.
There were no identified unexpected benefits during implementation of this measure.

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures
Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.
No

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

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.
N/A

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.)
N/A

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.
No appendix **Attachment:**

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance
Co.2 Point of Contact: Bob, Rehm, nqf@ncqa.org, 202-955-1728-
Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance
Co.4 Point of Contact: Kristen, Swift, Swift@ncqa.org, 202-955-5174-

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.

The NCQA Behavioral Health Measurement Advisory Panel (BHMAP) is a balanced group of experts who have collaboratively advised NCQA throughout the development and maintenance of this measure. The BHMAP evaluated the measure specification at different stages of development and during reevaluations, reviewed field test results, and assessed NCQA's overall desirable attributes of relevance, scientific soundness, and feasibility. In addition to this advisory panel, this measure has been vetted with a host of other stakeholders, including our Committee on Performance Measurement (CPM), who voted on the measure for use in NCQA and related programs. All CPM recommendations are also reviewed and approved by NCQAs Board of Directors. Our measures are the result of consensus from a broad and diverse group of stakeholders.

Committee on Performance Measurement (CPM)

- Bruce Bagley, MD, American Academy of Family Physicians
- Andrew Baskin, MD, Aetna
- Jonathan Darer, MD, MPH, Medicalis
- Helen Darling, MA, City of Washington, DC
- Andrea Gelzer, MD, MS, FACP, AmeriHealth Caritas
- Kate Goodrich, MD, MHS, Centers for Medicare & Medicaid Services
- David Grossman, MD, MPH, Kaiser Permanente Washington
- Christine S. Hunter, MD, US Office of Personnel Management
- Jeffrey Kelman, MMSc, MD, Centers for Medicare & Medicaid Services
- Nancy Lane, PhD, Newton, MA
- Bernadette Loftus, MD, The Permanente Medical Group
- Adrienne Mims, MD, MPH, Alliant Quality
- Amanda Parsons, MD, MBA, Montefiore Health System
- Wayne Rawlins, MD, MBA, ConnectiCare
- Rodolfo Saenz, MD, MMM, FACOG, Riverside Medical Clinic
- Eric Schneider, MD, MSc, FACP, The Commonwealth Fund
- Marcus Thygeson, MD, MPH, San Rafael, CA
- JoAnn Volk, MA, Georgetown University Center on Health Insurance Reforms
- Lina Walker, PhD, AARP

Behavioral Health Measurement Advisory Panel:

- Katharine Bradley, MD, MPH, Kaiser Permanente Washington Health Research Institute
- Christopher Dennis, MD, MBA, FAPA, Landmark Health, LLC
- Ben Druss, MD, MPH, Emory University
- Frank Ghinassi, PhD, ABPP, Rutgers University Behavioral Health Care

• Connie Horgan, ScD, Brandeis University
• Laura Jacobus-Kantor, PhD, SAMHSA
• Jeffrey Meyerhoff, MD, Optum
• Harold Pincus, MD, College of Physicians and Surgeons, Columbia University, New York Presbyterian Hospital, RAND
• Michael Schoenbaum, PhD, National Institute of Mental Health
• John Straus, MD, Massachusetts Behavioral Health Partnership-A Beacon Health Options Company

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 1998

Ad.3 Month and Year of most recent revision: 04, 2018

Ad.4 What is your frequency for review/update of this measure? Approximately every 3 years, sooner if the clinical guidelines have changed significantly.

Ad.5 When is the next scheduled review/update for this measure? 12, 2019

Ad.6 Copyright statement: The performance measures and specifications were developed by and are owned by the National Committee for Quality Assurance ("NCQA"). The performance measures and specifications are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in these materials and can rescind or alter these materials at any time. These materials may not be modified by anyone other than NCQA. Anyone desiring to use or reproduce the materials without modification for an internal, quality improvement non-commercial purpose may do so without obtaining any approval from NCQA. All other uses, including a commercial use and/or external reproduction, distribution and publication must be approved by NCQA and are subject to a license at the discretion of NCQA.

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Ad.7 Disclaimers: These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

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Ad.8 Additional Information/Comments: