



## 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 #:** 0104e

**Corresponding Measures:**

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

**Co.1.1. Measure Steward:** Mathematica Policy Research

**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:** This measure aims to improve rates of clinician assessment of suicide risk during an encounter where a new or recurrent episode of major depressive disorder is identified. In an epidemiologic study (2010) of mental illness in the United States with a large, representative sample, 69% of respondents with lifetime suicide attempts had also met diagnostic criteria for major depressive disorder. When considering other mood disorders related to depression, such as dysthymia and bipolar disorders, this rate increases to 74%. (1) In a 2014 study conducted by Ahmedani et al, 50% of individuals who completed a suicide had been seen in a health care setting within four weeks prior. (2) Better assessment and identification of suicide risk in the health care setting should lead to improved connection to treatment and reduction in suicide attempts and deaths by suicide.

(1) Bolton, J. M., & Robinson, J. (2010). Population-Attributable Fractions of Axis I and Axis II Mental Disorders for Suicide Attempts: Findings From a Representative Sample of the Adult, Noninstitutionalized US Population. *American Journal of Public Health*, 100(12), 2473–2480. doi:10.2105/ajph.2010.192252

(2) Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., ... Solberg, L. I. (2014). Health Care Contacts in the Year Before Suicide Death. *Journal of General Internal Medicine*, 29(6), 870–877. doi:10.1007/s11606-014-2767-3

**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 Records

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

**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**

**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.

No

**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.*

This measure aims to improve rates of clinician assessment of suicide risk during an encounter where a new or recurrent episode of major depressive disorder is identified. In an epidemiologic study (2010) of mental illness in the United States with a large, representative sample, 69% of respondents with lifetime suicide attempts had also met diagnostic criteria for major depressive disorder. When considering other mood disorders related to depression, such as dysthymia and bipolar disorders, this rate increases to 74%. (1) In a 2014 study conducted by Ahmedani et al, 50% of individuals who completed a suicide had been seen in a health care setting within four weeks prior. (2) Better assessment and identification of suicide risk in the health care setting should lead to improved connection to treatment and reduction in suicide attempts and deaths by suicide.

(1) Bolton, J. M., & Robinson, J. (2010). Population-Attributable Fractions of Axis I and Axis II Mental Disorders for Suicide Attempts: Findings From a Representative Sample of the Adult, Noninstitutionalized US Population. *American Journal of Public Health*, 100(12), 2473–2480. doi:10.2105/ajph.2010.192252

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**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 (4b1) 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.**

Performance variability for suicide assessment in MDD is well demonstrated in clinical quality literature. In a 2012 study that examined provider intent to assess for suicidality in patients with MDD, 404 Primary Care Providers (PCPs) were shown a standardized virtual patient. 98% of the physicians accurately diagnosed that patient with depression. However, only 36% reported a recommendation to assess for suicide risk. Statistically significant variation also existed in provider demographics between assessors and non-assessors, suggesting inconsistent application of suicide assessment guidelines in patients with MDD. (1) In another study (2011) featuring primary care patients with positive depression screens, suicide-related discussion occurred in only 11% of encounters. (2) Finally, in their study that included 281 depression-related visits, 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. (3)

(1) Hooper, L. M., Epstein, S. A., Weinfurt, K. P., DeCoster, J., Qu, L., & Hannah, N. J. (2012). Predictors of Primary Care Physicians' Self-reported Intention to Conduct Suicide Risk Assessments. *The Journal of Behavioral Health Services & Research*, 39(2), 103–115. doi:10.1007/s11414-011-9268-5

(2) Vannoy, S. D., & Robins, L. S. (2011). Suicide-related discussions with depressed primary care patients in the USA: gender and quality gaps. A mixed methods analysis. *BMJ Open*, 1(2), e000198–e000198. doi:10.1136/bmjopen-2011-000198

(3) 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.

**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.**

While this measure is included in several federal reporting programs, those programs have not yet made disparities data available for us to analyze and report.

**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**

We were not able to identify any studies that examined disparities in suicide assessment rates among people with MDD. However, several well-established disparities exist among individuals who complete a suicide.

Key findings in suicide disparities from the CDC's 2017 Report: Suicide Trends Among and Within Urbanization Levels by Sex, Race/Ethnicity, Age Group, and Mechanism of Death—United States, 2001-2015.

- Suicide was the 10th leading cause of death in 2015, with a total count of 44,193 deaths.
- The age adjusted suicide rate increased 21.6% during 2001-2015.
- Suicide rates are higher for males than for females.
- Suicide rates are higher for adults aged ≥45 than for adolescents and young adults.
- Overall suicide rates are higher for non-Hispanic whites and American Indian/Alaskan Native populations than other ethnic groups.
- Suicide rates by sex, race/ethnicity, age group, and mechanism of death are higher in rural communities than urban ones.

## 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.)

The measure specifications are attached to this submission. Additional measure details may be found at: eCQI Resource Center <https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms>. Value set details at VSAC: <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: CMS161v8.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: NQF\_0104e\_ValueSets\_05102019.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.

Yes

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

This measure is intended to only require a suicide risk assessment at the visit in which a new or recurrent episode of Major Depressive Disorder (MDD) is diagnosed. Measure implementers have given us feedback that identifying the visit in which a new or recurrent episode of Major Depressive Disorder (MDD) is diagnosed has been challenging, as the measure logic had been indicating every visit for MDD as a new recurrent episode of MDD. After discussion, the clinical experts agreed that the initial population logic should be modified and to introduce a look back period of 105 days, such that an episode of MDD would only be considered to be a recurrence if the patient has not had an MDD-related encounter within the past 105 days, thus eliminating routine visits for an ongoing case of MDD from the measure. The 105-day look-back period is an operational provision and not a clinical recommendation, or definition of relapse, remission, or recurrence.

**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 Major Depressive Disorder is identified [initial evaluation during the episode]

Definition:

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

Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicide Severity Rating Scale (C-SSRS) and the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding.

**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.

Suicide risk assessments completed via telehealth services can also meet numerator performance.

As the guidelines state, it is important to assess for additional factors which may increase or decrease suicide risk, such as presence of additional symptoms (e.g., psychosis, severe anxiety, hopelessness, severe chronic pain); presence of substance abuse, history and seriousness of previous attempts, particularly, recent suicidal behavior, current stressors and potential protective factors (e.g., positive reasons for living, strong social support), family history of suicide or mental illness or recent exposure to suicide, impulsivity and potential for risk to others, including history of violence or violent or homicidal ideas, plans, or intentions, and putting one's affairs in order (e.g., giving away possessions, writing a will). In addition, although the measure focuses on the initial visit, it is critical that suicide risk be monitored especially for the 90 days following the initial visit and throughout MDD treatment.

HQMF eCQM developed and is included in this submission.

**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:**

This measure is an episode-of-care measure and should be reported for each instance of a new or recurrent episode of major depressive disorder (MDD); every new or recurrent episode will count separately in the Initial Population.

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). For the purposes of this measure, an episode of MDD would be considered to be recurrent if a patient has not had an MDD-related encounter in the past 105 days. If there is a gap of 105 or more days between visits for MDD, that would imply a recurrent episode. The 105-day look-back period is an operational provision and not a clinical recommendation, or definition of relapse, remission, or recurrence.

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) at: "Measurement Period"'. The logic statement for the age requirement, as written, captures patients who turn 18 years old during the measurement period so that these patients are included in the measure, so long as the minimum criteria noted above is evaluated. 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, as no individual suicide risk assessment tool or instrument would satisfy the requirements alone.

HQMF eCQM developed and is included in this submission.

**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.)

Calculating the performance rate:

1 Determine the initial population; The initial population is identified through a common set of characteristics that define the overall group of patients – or other unit of measurement – targeted for evaluation

2 Define the denominator by identifying the subset of the initial population that meets the denominator criteria. Note: in some



cases, the initial population and denominator are identical

3. Determine the numerator by identifying the subset of the denominator that meets the numerator criteria:

4. Calculate the performance rate

A patient not meeting the numerator criteria 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 an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

Not applicable. This measure is not based on a sample.

**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.

Not applicable. This measure is not based on a survey.

**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 Records

**S.18. Data Source or Collection Instrument** (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(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)

No data collection instrument provided

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

Clinician : Group/Practice, Clinician : Individual

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

Emergency Department and Services, Other:Behavioral Health Day Treatment, 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.)

Not applicable. This measure is not a composite.

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

### 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 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 instrument-based,** consider implications for both individuals providing 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).**



The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain.

Commercial uses of the Measures require a license agreement between the user and the PCPI® Foundation (PCPI®) or the American Medical Association (AMA). Neither the American Medical Association (AMA), nor the AMA-convened Physician Consortium for Performance Improvement® (AMA-PCPI), now known as the PCPI®, nor their members shall be responsible for any use of the Measures.

## 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 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

Merit-based Incentive Payment System (MIPS)-Sponsored by the Centers for Medicare and Medicaid Services (CMS)

Prior to 2016, this measure was used for Eligible Providers (EPs) in the Physician Quality Reporting System (PQRS). As of 2017, PQRS has been replaced by the Merit-based Incentive Payment System (MIPS). MIPS is a national performance-based payment program that uses performance scores across several categories to determine payment rates for EPs. MIPS takes a comprehensive approach to payment by basing consideration of quality on a set of evidence-based measures that were primarily developed by clinicians, thus encouraging improvement in clinical practice and supporting advances in technology that allow for easy exchange of information.

#### 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?)

According to the CY 2018 Quality Payment Program final rule, CMS intends to “make all measures under MIPS quality performance category available for public reporting on Physician Compare in the transition year of the Quality Payment Program, as technically feasible.” These measures include those reported via all available submission methods for MIPS-eligible clinicians and groups. Because this measure has been in use for at least one year and meets the minimum sample size requirement for reliability, this measure meets criteria for public reporting. 2018 data will be available for public reporting on Physician Compare in late 2019.

#### 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.)

Because this measure has been in use for at least one year and meets the minimum sample size requirement for reliability, this measure meets criteria for public reporting. 2018 data will be available for public reporting on Physician Compare in late 2019.

**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.**

**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.**

**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.**

**4a2.2.2. Summarize the feedback obtained from those being measured.**

**4a2.2.3. Summarize the feedback obtained from other users**

**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.**

#### **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.**

While the PCPI creates measures with an ultimate goal of improving the quality of care, measurement is a mechanism to drive improvement but does not equate with improvement. Measurement can help identify opportunities for improvement with actual improvement requiring making changes to health care processes and structure. In order to promote improvement, quality measurement systems need to provide feedback to front-line clinical staff in as close to real time as possible and at the point of care whenever possible. (1)

1. Conway PH, Mostashari F, Clancy C. The future of quality measurement for improvement and accountability. JAMA. 2013 Jun 5;309(21):2215-6.

#### **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.**

We are not aware of any unintended consequences related to this measurement.

**4b2.2. Please explain any unexpected benefits from implementation of this measure.**

We are not aware of any unexpected benefits from implementation of this measure.

## 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)

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

N/A

### 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.

The guidelines used as evidence in the NQF 1365: Child and Adolescent Major Depressive Disorder (MDD) Suicide Risk Assessment explicitly recommend suicide assessment at every visit for MDD whereas the guidelines used for evidence in this measure do not emphasize this level of assessment frequency.

### 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.)

Both of these measures (0104 and 1365) were developed by PCPI and updated and harmonized with each other on an annual basis. They are not competing because they are used in different patient populations and have different frequencies of suicide assessment based on their respective evidence.

## 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):** Mathematica Policy Research

**Co.2 Point of Contact:** Cynthia, Cullen, ccullen@mathematica-mpr.com

**Co.3 Measure Developer if different from Measure Steward:** Mathematica Policy Research

**Co.4 Point of Contact:** Cynthia, Cullen, ccullen@mathematica-mpr.com

### 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.**

PCPI measures are developed through cross-specialty, multi-disciplinary technical expert panels (TEPs). Representatives of all relevant disciplines of medicine and other health care professionals are invited to participate. In addition, the PCPI strives to include on its TEPs individuals representing the perspectives of patients, consumers, private health plans, and employers. Measure methodologists, and coding and informatics experts also are considered important members of the TEP. All TEP members participate as equal contributors to the measure development process. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. TEPs were convened in 2001 and 2010 to develop, refine and maintain a set of measures addressing mental health including measure #0104. More recently, in 2016, the PCPI reconvened the Mental Health TEP which included the following individuals.

John Absher, MD (neurology)  
 Alan Axelson, MD (psychiatry)  
 Andrea Bostrom, PhD, PMHCNS-BC (nursing, psychiatric nursing)  
 Mirean Coleman, MSW, LICSW, CT (social work)  
 Mary Dobbins, MD (psychiatry)  
 Mary Ann Forciea, MD (internal/geriatric medicine)  
 Elizabeth M. Galik, PhD, CRNP (nursing)  
 Jerry Halverson, MD (psychiatry, methodology)  
 Richard Hellman, MD, FACP, FACE (endocrinology, methodology)  
 Renee Kinder, MS, CCC-SLP (rehabilitation, gerontology)  
 Helen H. Kyomen, MD, MS (geriatric and adult psychiatry)  
 Katie Maslow, MSW (patient advocacy representative)  
 John S. McIntyre, MD, DFAPA, FACPpsych (psychiatry, methodology)  
 Karen Pierce, MD (psychiatry)  
 Joseph W. Shega, MD (geriatric medicine, hospice and palliative medicine)  
 Eric G. Tangelos, MD, FACP, AGSF, CMD (internal/geriatric medicine)  
 Roberta Waite, EdD, APRN, CNS-BC (psychiatric nursing, methodology)

#### 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:** 05, 2017

**Ad.4 What is your frequency for review/update of this measure?** Supporting guidelines, specifications, and coding for this measure are reviewed annually

**Ad.5 When is the next scheduled review/update for this measure?** 05, 2018

**Ad.6 Copyright statement:** © 2018 PCPI® Foundation and American Medical Association. All Rights Reserved.

**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.