

Depression Screening and Follow-up

NQF 0418/CMS 2v8

Changes to 2019 Specifications

2019 reporting logic was updated so that **use of the PHQ9 as a follow-up to a positive PHQ2 no longer counts as additional evaluation (follow-up)** and cannot be counted for numerator compliance.

What is being measured?

Denominator includes all members age 12 and older who had a visit with your clinic during the measurement year.

There are two ways to meet numerator. At least once during the year:

1. members received an initial depression screening and it was negative
2. members received an initial depression screening and it was positive, AND they received appropriate follow up documented on the same date

What counts as follow-up

- **Additional evaluation or assessment** for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder. Follow-up can be provided by clinic BHC (psychologist, social worker, psychiatrist, or PMHNP).
- **Suicide Risk Assessment** such as Columbia Suicide Severity Rating Scale or SAFE-T, discussed during the visit and captured for reporting purposes.
- **Referral to a practitioner or program** for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression. This can be an internal or external referral, and either type should be documented in a way that is captured in reporting.
- **Other interventions designed to treat depression** such as psychotherapy, pharmacological interventions, or additional treatment options.
 - Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

Considerations

- When will my EHR update to report 2019 specifications (NQF 0418/CMS 2v8)?
- What PHQ-9 score do you consider to be a positive response that warrants additional follow-up?
- How would you document additional follow up in these scenarios?
 - A member is already getting care at specialty BH.
 - Counseling was done by the provider during the visit and additional follow up was not needed.
 - Medication was discussed during the visits but was declined; what other follow up options considered and documented?

- **Are all the follow-up activities listed above documented in a way that is configured to EHR reporting logic (i.e. captured in EHR reports)?** For example, dot phrases linked to reporting appropriately?

How data is captured?

This is an EHR-based measure and therefore does not rely on billing codes or claims.

Note for IT/Reporting specialist

It is important that your EHR specialists ensure the documentation method you use to capture the screening and follow-up methods listed above (e.g. check box, dot phrase, templates, etc.) is being pulled into the EHR reporting logic properly to count as follow-up.

Work flow Documentation Examples

Documentation

- The patient completed a (PHQ-9/Edinburgh) screening tool today and the total score suggests:
 - No risk or low risk of symptoms related to depression
 - an increased risk of symptoms related to depression and no suicidal ideation
 - an increased risk of symptoms related to depression and some suicide ideation
 - an increased risk of symptoms of depression and moderate to severe risk of suicidal ideation
- We did not discuss this further because:
 - The patient's low risk did not warrant further discussion
 - The patient expressed an unwillingness to do so
 - We ran out of time and scheduled a follow-up visit for further assessment (with PCP or BHC)
 - The patient is already getting specialty behavioral health services elsewhere
 - The patient needs specialty behavioral health services but declines to continue
- In discussing this issue, my medical advice was that the patient:
 - Be referred to internal BHC for depression (and/or suicidal ideation)
 - Consider an antidepressant medication
 - Referred to external behavioral health for further assessment
 - Further evaluated for suicidal ideation/and transported to ED for further assessment
 - Continue or resume follow up with their regular specialty behavioral health provider
- The patient agreed to:
 - Follow-up with BHC
 - Medication trial of SSRI/SNRI/other
 - Referral to external behavioral health treatment
 - Continue management of this condition with their behavioral health provider
 - Transport to ED due to suicide risk