Title: Screening for Clinical Depression and Follow-up Quality Measure
Date Created: 11/15/2016
Date Modified:
Date Approved by Board of Directors: 02/23/2017
Policy# CGC-CG-31

Purpose:

Our goal is to promote effective and proper documentation for our partners which will improve patient health outcomes, communication between clinicians and care management team. The purpose of the measure is to capture early identification and interventions for patients who screen positive using an evidence based screening tools. The guideline and implementation will position our partners and PPS to ensure we achieve our pay for performance quality measure related to Screening for Clinical Depression and Follow-up care.

Policy:

All Patients ages 18-64 and 65+ who screen positive using a nationally-accepted best practice screenings must indicate one or more of the follow- up care within 30 days (inclusive) of the date of the positive screening.

Positive Patient Identification:

- PHQ-9 with a score > or = to 5 is considered to have been screened positive for depression.
- PHQ-2 with a score of "yes" to either of the two questions is considered to have screened positive for depression. Positive PHQ-2 must be followed by the administration of the PHQ-9.

Examples of acceptable follow up care are:

- Recommended or made referral or follow-up visit with behavioral health provider;
- Recommended or scheduled follow-up outpatient visit with any provider, including the PCP or other provider administering the original screen, for further assessment within 30 days of the positive screen;
- Further assessment on the same day of the positive screen which includes documentation of additional depression assessment indicating no depression (such as positive score from PHQ-2 with a negative PHQ-9 or documented negative findings after further evaluation);
- Referral to emergency department for crisis services on the same day of the positive screen; or
- Arrangement for inpatient admission for mental health diagnosis on the same day as the positive screen.
- Recommended or prescribed antidepressant medication.

Required Documentation to be compliant:

3 components must be clearly documented in the patient's medical records.

1. **The Screening:** Patients who were screened for clinical depression with a standardized tool in the measurement year
2. **The Result:** Patients who screened positive for depression
3. **The Follow-up of positive screens:** Patients had appropriate follow up care within 30 days of the positive screening and it is documented in the patient's chart.

This quality metric applies directly or indirectly to the following projects for which our PPS and partners will be evaluated on:

- Project 3.a.i - Integration of Behavioral Health with Primary Care – Model 1
- Project 3.a.i – Integration of Primary Care in Behavioral Health – Model 2
- Project 4.aii – Strengthening Mental Health and Substance Abuse Infrastructure Across Systems

It should be noted that our clinician indicated that a score of 5 is relatively low to be considered positive and may create an administrative burden on the primary care clinic. However, it should be clarified that the standardized depression screening tools do not diagnose depression but rather indicate whether or not there is a need for more detailed follow-up by a clinician.

Attached is the DSRIP:
Measure specification and reporting manual on Screening for Clinical Depression and Follow up. This will provide a deeper insight on how the denominator and numerator is derived, documentation and exclusions.

Source: Delivery System Reform Incentive Payment Program – DSRIP: Measure Specification and Reporting Manual – Screening for Clinical Depression and Follow Up Plan

Policy Board Approval History:

Policy Revisions:

Date	Revision Log	Updated By
11/15/2016	Initial	B. Rosetti
03/08/2017	Updated per CGC recommendation on 2/23/2017	B. Rosetti

This Policy and Procedure shall be reviewed periodically and updated consistent with the requirements established by the Board of Directors, Care Compass Network's senior management, Federal and State law(s) and regulations, and applicable accrediting and review organizations.

Appendix D –Screening for Clinical Depression and Follow Up Technical Specifications

Screening for Clinical Depression and Follow Up Plan

Description:

Percentage of Medicaid enrollees age 18 and older who were screened for clinical depression using a standardized depression screening tool, and if positive screen received appropriate follow-up care. The intention of the measure is to capture early identification and intervention for persons with positive scores on screening tools within the context of routine preventive care visits.

Definitions:

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition. This measure looks for screening being conducted in the practitioner's office during preventive care or evaluation and management visits.
Adult Standardized Screening tool (Ages 18 and older)	An assessment tool that has been normalized and validated for the adult population (e.g. Patient Health Questionnaire [PHQ-9], Beck Depression inventory [BDI or BDI-II], Mood Feeling Questionnaire [MFQ], Center for Epidemiologic Studies Depression Scale [CES-D], Depression Scale [DEPS], Duke Anxiety-Depression Scale [DADS], Geriatric Depression Scale [GDS], Hopkins Symptom Checklist [HSCL], Zung Self-Rating Depression Scale [SDS], Cornell Scale Screening and PRIME MD-PHQ-2, Edinburgh Postnatal Depression Scale [EPDS]).
Follow Up Plan	Documentation of follow up must include one or more of the following in the 30 day period following the initial positive screen (inclusive of the screening visit date): • Recommended or prescribed antidepressant medication; • Recommended or made referral or follow up visit with behavioral health provider; • Recommended or scheduled follow up outpatient visit with any provider for further assessment within 30 days of the positive screen; • Further assessment on the same day of the positive screen which includes documentation of additional depression assessment indicating no depression (such as positive score from PHQ2 with a negative PHQ9 or documented negative findings after further evaluation); • Referral to emergency department for crisis services on the same day of the positive screen; or • Arrangement for inpatient admission for mental health diagnosis on the same day as the positive screen.
Intake Period	July 1 of the prior year through June 1 of the measurement year.
DSRIP Measurement Year	July 1 of the prior year through June 30 of the current year. For example, measurement year 1 is July 1, 2014 to June 30, 2015.

Eligible Population:

Product Line: Medicaid

Ages: 18 years or older as of July 1 of the measurement year. Report two age stratifications and a total result.

- 18 - 64 years
- 65 years and older
- Total

Continuous Enrollment: Continuous enrollment in Medicaid for the measurement year. The allowable gap is no more than one month during the measurement year.

Anchor Date: June 30 of the measurement year.

Event diagnosis Members who had a qualifying outpatient visit during the intake period (listed in table CDF-A)

CDF-A: Qualifying outpatient visits

Coding System	Qualifying Codes
CPT	96150, 96151, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
HCPCS	G0402, G0438, G0439, G0444

Denominator

A systematic sample drawn from the eligible population.

Required Denominator Exclusions

Remove members with (listed in table CDF-B):

- a diagnosis of Major Depression in the year prior to the measurement year or prior to the date of the first standardized screen in the measurement year. If there is no standardized screen in the measurement year, remove any member with a diagnosis at any time in the measurement year.
- a diagnosis of Bipolar disorder in the year prior to the measurement year or prior to the date of the first standardized screen in the measurement year. If there is no standardized screen in the measurement year, remove any member with a diagnosis at any time in the measurement year.

CDF-B: Diagnoses codes for exclusions

Diagnosis	**ICD-9-CM Codes**	**ICD-10-CM Codes**
Depression	296.20-296.25, 296.30-296.35, 298.0, 311	F32.0-F32.4, F32.9, F33.1-F33.41, F33.9
Bipolar Disorder I or II	296.00-296.05, 296.10-296.15, 296.40-296.45, 296.50-296.55, 296.60-296.65,296.7	F30.10-F30.13, F30.2, F30.3, F30.8, F30.9, F31.10-F31.13 F31.2, F31.30-F31.32, F31.4, F31.5, F31.60-F31.64, F31.70-F31.77, F31.81, F31.89, F31.9

Numerator

Members who were screened for clinical depression with a standardized tool in the measurement year and if positive, had appropriate follow up care within 30 days (inclusive) of the positive result.

Administrative Specifications

HCPCS Code	Description
G8431	Screening for clinical depression is documented as positive and follow up plan is documented
G8510	Screening for clinical depression is documented as negative; a follow up plan is not required

NOTE: Use of HCPCS codes in administrative data will need to be verified by the PPS to ensure the use of this code by a provider is associated with a standardized depression screening tool and follow up plan as indicated. If providers are encouraged to use the HCPCS codes to allow monitoring of improvement in administrative data, the PPS needs to ensure the coding is associated with the standardized tools, with scoring and follow up documentation.

Medical Record Specifications

Numerator The following steps are used to determine numerator compliance:

Step 1 Review all qualifying visits within the intake period to determine if a standardized depression screen was conducted. This may involve records from more than one provider.

Step 2 Identify all of the members with a standardized screening tool documented during the intake period. If a member has more than one visit with a standardized screen during the intake period, use the result from the first date.

Step 3 For all the members with a documented screening, determine the result of the screening. Identify members whose result is negative using the criteria specified for the screening tool. (e.g. A member with a PHQ-9 score is < 5 is considered to have screened negative for depression).

Step 4 For all the members with a documented screening, determine the result of the screening. Identify members whose result is positive using the criteria specified for the screening tool. (e.g. A member with a PHQ-9 score is ≥ 5 is considered to have screened positive for depression).

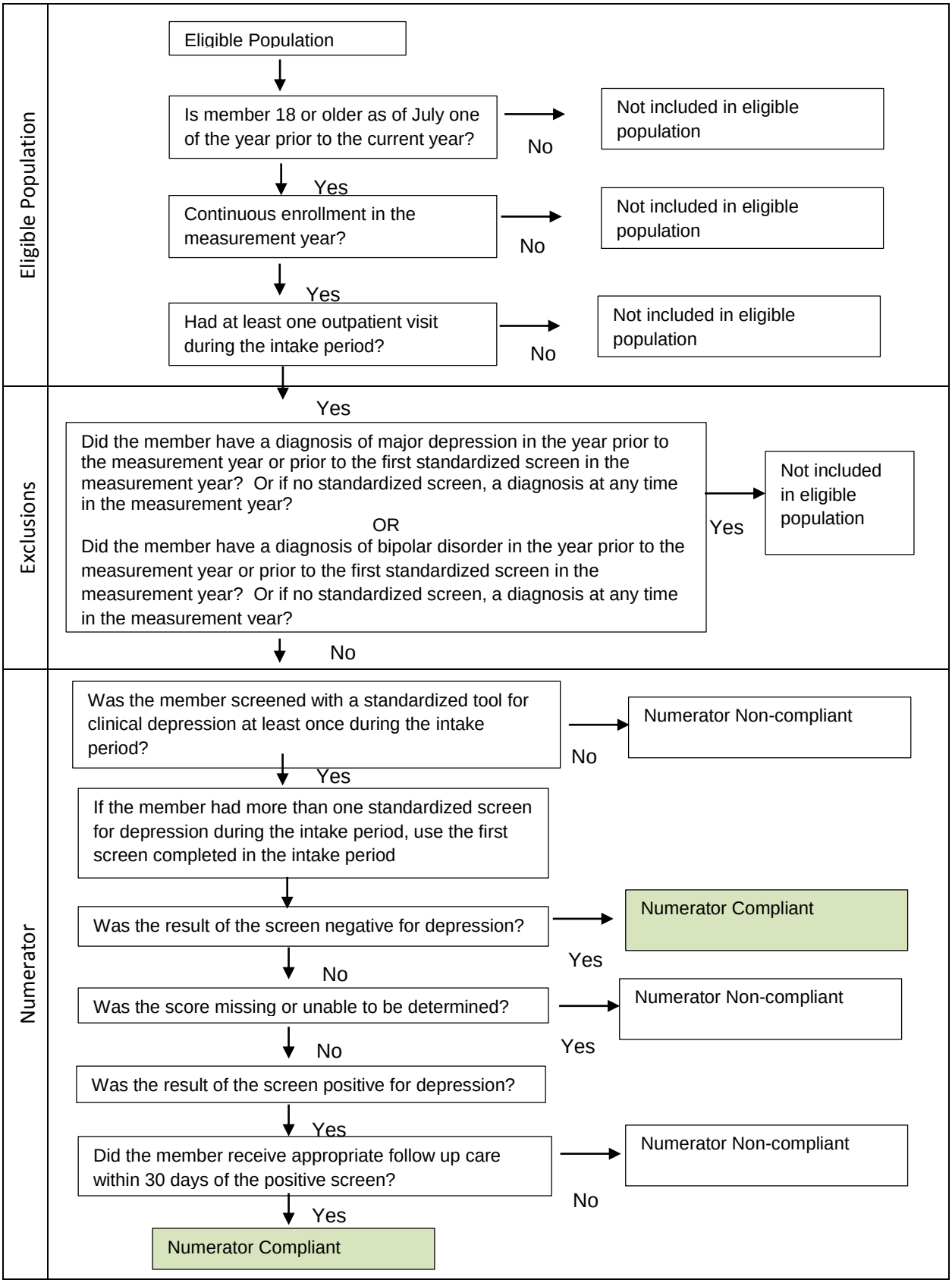
Step 5 For all of the members from Step 4, count members for whom follow-up care was provided within 30 days (inclusive) of the date of the positive screen.

Follow up documentation must include one or more of the following within 30 days following the positive screen:

- Recommended or prescribed antidepressant medication;
- Recommended or made referral or follow up visit with behavioral health provider;
- Recommended or scheduled follow up outpatient visit with any provider for further assessment within 30 days of the positive screen;
- Further assessment on the same day of the positive screen which includes documentation of additional depression assessment indicating no depression (such as positive score from PHQ2 with a negative PHQ9 or documented negative findings after further evaluation);
- Referral to emergency department for crisis services on the same day of the positive screen; or
- Arrangement for inpatient admission for mental health diagnosis on the same day as the positive screen.

Step 6 Sum the total of the members identified in Step 3 with a negative screening result and members who received appropriate follow-up from Step 5 for the total numerator events.

Screening for Clinical Depression Flow chart



Additional Notes on documentation of screening and results:

Use of standardized tools embedded in forms or electronic medical records –

If all of the questions and response categories from a standardized screening tool are used within medical records that allow the same consistency of creating a score for determining positive and negative results, the information would be acceptable evidence of numerator compliance whether the name of the tool is present or not. The key requirements for numerator compliance are:

- All questions included
- Same response options
- Documented score or finding of negative or positive screen
- Follow up plan documented if positive

Example: PHQ2 questions, with responses, score or finding, and follow up if indicated = numerator compliant

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

"Score 5; Positive screen, Referral and appointment made with Capital Psychiatric Clinic on XX/XX/XXXX" (within 30 days of the positive screen).

Use of Summary of Findings from Standardized tools –

Documentation that indicates a standardized tool was used for screening for clinical depression with a score, and if the score indicates a positive screen, the follow up plan is documented.

Example: Standardized tool completed, with score or finding and follow up if indicated = numerator compliant

"PHQ2 assessment completed, negative screen. No follow up indicated"

Use of Summary of Findings from Symptom Queries –

Documentation about findings from queries or discussion without specific questions or scores is not numerator compliant.

Example: No indication of tool, or finding, or general query statements = numerator non-compliant

"depression screening negative" or "depression screen done" or "denies depression"