♠Measure #134: Screening for Clinical Depression

DESCRIPTION:
Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using G-codes:
CPT service codes and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patient's screening for clinical depression is documented

Definitions:
Screening – Testing done on people at risk of developing a certain disease, even if they have no symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease. This measure looks for the test being done in the practitioner's office that is filing the code.
Standardized tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some examples of depression screening tools include: Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), GDS - Short Version, Hopkins Symptom Checklist (HSCL), The Zung Self-Rating Depression Scale (SDS), and Cornell Scale Screening (this is a screening tool which is used in situations where the patient has cognitive impairment and is administered through the caregiver).
Not eligible/not appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases

- Patient was referred with a diagnosis of depression
- Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools

Numerator Coding:
Screening for Clinical Depression Documented
G8431: Documentation of clinical depression screening using a standardized tool

OR

Screening for Clinical Depression not Documented, Patient not Eligible/Appropriate
G8433: Patient not eligible/not appropriate for clinical depression screening

OR

Screening for Clinical Depression not Documented, Reason not Specified
G8432: No documentation of clinical depression screening using a standardized tool

DENOMINATOR:
Patients aged 18 years and older

Denominator Coding:
A CPT service code is required to identify patients for denominator inclusion.
CPT service codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97003

RATIONALE:
Major depression was the fourth leading cause of worldwide disease in 1990, with estimated direct and indirect costs to American businesses ranging from $36.2 to $80 billion annually. The U.S. Preventive Services Task Force compared the effects of integrated recognition and management depression screening programs with "usual care" in community primary care practices, and the results showed significantly improved patient outcomes.

CLINICAL RECOMMENDATION STATEMENTS:
USPSTF recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up. Small benefits have been observed in studies that simply feed back screening results to clinicians. Larger benefits have been observed in studies in which the communication of screening results is coordinated with effective follow-up and treatment. (Evidence: B)

The Canadian Task Force on Preventive Health Care used the rigorous USPSTF 2002 systematic review to update their recommendations regarding depression screening. The Canadian task force arrived at the same practice recommendations as USPSTF.

Evidence Supporting the Criterion of Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved recognition and diagnosis of depression, and improved depression outcomes, but not consistently high quality evidence

Ell, K. (2006). "Depression care for the elderly: Reducing barriers to evidence based practice." Home Health Care Services Quarterly 25: 115 - 148.

This review provides an overview of evidence identifying use of health services for depression, effective interventions, barriers to depression care, strategies to reduce barriers, and translating research into practice. There is strong empirical support for implementing strategies to improve depression care for older adults, and there is recent encouraging evidence from Medicare data that older adults may be more willing to seek and accept antidepressant treatment.
Study quality level 2 (limited-quality patient-oriented evidence)

Hickie, I. B., et al. (2002). "Screening for depression in general practice and related medical settings." The Medical Journal of Australia 177: S111-116.

This meta-analysis included reviews found by searching MEDLINE, Cochrane, and other databases. It found that screening increases the recognition and diagnosis of depression and, when integrated with a commitment to provide coordinated and prompt follow-up of diagnosis and treatment, clinical outcomes are improved.
Study quality level 1 (good quality patient-oriented evidence)

Kirkcaldy, R. D., Tynes, L.L. (2006). "Depression screening in a VA primary care clinic." Psychiatric Services 57: 1694 - 1696.

In 1998, the U.S. Department of Veterans Affairs (VA) mandated annual depression screening at all VA primary care clinics. This article reports on an evaluation of the screening program. Findings establish benchmarks for screening administration.
Study quality level 2 (limited-quality patient-oriented evidence)

Pignone, M. P., et al. (2002). "Screening for depression in adults: A summary of the evidence for the U.S. preventive services task force." Annals of Internal Medicine 136: 765-776.

This study aims to clarify whether screening adults for depression in primary care settings improves recognition, treatment, and clinical outcomes. It concludes that, compared with usual care, screening for depression can improve outcomes, particularly when screening is coupled with system changes that help ensure adequate treatment and follow-up.
Study quality level 2 (limited-quality patient-oriented evidence)

Sherman, S. E., et al. (2004). "Improving recognition of depression in primary care: A study of evidence-based quality improvement." Joint Commission Journal on Quality and Patient Safety 30(2).

Implemented at a VA ambulatory care center, this evidence-based QI intervention led to profound and lasting changes in primary care providers' recognition of depression or depressive symptoms.
Study quality level 2 (limited-quality patient-oriented evidence)