Screening for Clinical Depression and Follow Up Plan

*This measure is to be reported for all patients aged 18 years and older seen by the clinician — a minimum of **once** per reporting period.*

Measure description

Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND documentation of follow up plan

What will you need to report for each patient aged 18 and older?

If you select this measure for reporting, you will report:

- Whether or not the patient was screened for depression using a standardized tool[1] AND documentation of a follow up plan[2], if appropriate

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to screen for depression, due to:

- Documented reasons (eg, patient refuses to participate, patient is in urgent or emergent situation and to delay treatment would jeopardize the patient's health status, patient's motivation to improve may impact the accuracy of results, patient was referred with a diagnosis of depression, patient has been participating in ongoing treatment with screening of clinical depression in a previous reporting period, severe mental and/or physical incapacity)

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exclusions).

[1]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).

[2]Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.