# 2022 Health Equity Measure Specifications

**Steward: Connecticut Office of Health Strategy**
**As of September 8, 2021**

## SUMMARY OF CHANGES FOR 2022

- New measure for 2022.

## Background

The Connecticut Office of Health Strategy (OHS) is adopting a health equity-focused measure for its Core Measure Set for 2022.[1] The *Health Equity Measure* stratifies performance for select measures in the Core Measure Set by race, ethnicity and language (REL). OHS developed this measure in partnership with the Quality Council, a stakeholder body of payer, provider, state agency and consumer representatives. OHS prioritized stratification of measures in the Core Measure Set that have evidence of disparities in performance by REL in Connecticut and that are required to be stratified for reporting to the National Committee for Quality Assurance (NCQA).

## Description

The performance for each of the following measures, stratified by race, ethnicity and language:

- Measure #1: Child and Adolescent Well-Care Visits
- Measure #2: Comprehensive Diabetes Care: HbA1c Control
- Measure #3: Controlling High Blood Pressure
- Measure #4: Prenatal and Postpartum Care
- Measure #5: Screening for Depression and Follow-up Plan

## General Guidelines

| | |
|---|---|
| **Organizations Responsible and Data Source Used for Reporting Performance** | Advanced Networks (ANs) should use their own EHR-based clinical data and patient age, sex data and REL data to report stratified performance for all measures.<br><br>Because Measure #1 and Measure #4 use administrative data, ANs should leverage payer-provided data for measure performance and their own REL data to report stratified performance. For example, payers could share a spreadsheet with information on which patients meet the numerator for the measure. ANs could use this information to update data in their EHRs and report performance on the measure.<br><br>Alternatively, ANs could report performance for Measure #1 and Measure |

[1] Connecticut Office of Health Strategy. Quality Council 2022 Core Measure Set. https://portal.ct.gov/OHS/Pages/Quality-Council/Core-Measure-Set. Accessed August 9, 2021.

| | |
|---|---|
| | #4 using data from their EHRs if it includes information on whether a patient had a well-care visit. The limit of this approach, however, is that EHR data likely would not contain information on whether a patient received a well-care visit from another AN. |
| **Overall Parameters for Stratification** | ANs should report stratified performance:<br>• for each race, ethnicity and language stratification category separately (e.g., within race, report measure performance separately for White, Black or African American, etc.; within ethnicity, report measure performance separately for Hispanic/Latino and non-Hispanic/Latino; within language, report measure performance separately for English, Spanish, etc.);<br>• using patient self-reported data gathered by ANs rather than imputing a patient's REL,<br>• for their entire patient population meeting each measure's specifications, across health plans and lines of business, and<br>• only for measures relevant to the population served by the AN (e.g., a pediatric AN will not be expected to report performance for Measures #2-4). |
| **Data Completeness Threshold** | There is no REL data completeness threshold for reporting performance stratified by REL. ANs should report on all patients for whom they have REL data. |
| **Required REL Reporting Categories** | ANs should report stratified performance for the REL categories that the AN is currently using. ANs are not expected to modify their REL categories for the purpose of reporting performance.[2]<br><br>***Note**: Each of the categories within each race, ethnicity and language stratification is mutually exclusive. Therefore, the sum of all stratifications should equal the total population.* |
| **Measure Specifications** | The *Health Equity Measure* specifications can be accessed from the CMS eCQM specifications for Eligible Professionals / Eligible Clinicians for 2022 for Measure #2, Measure #3 and Measure #5.[3] These specifications are designed for reporting by provider organizations. ANs can simply run the specifications as provided by CMS, but stratify performance by race, ethnicity and language.<br><br>For Measure #1 and Measure #4, eCQM specifications are not available. Therefore, the *Health Equity Measure* specifications are adapted from NCQA's HEDIS MY 2022 specifications. The specifications are modified slightly to allow for reporting by AN. Any modifications made are within NCQA's list of Allowable Adjustments. |

[2] The language category does not distinguish whether the organization is collecting data for the patient's preferred language versus language spoken.

[3] See: https://ecqi.healthit.gov/ep-ec?qt-tabs_ep=1.

## Measure Specifications Table of Contents

## Measure #1: Child and Adolescent Well-Care Visits (Adapted HEDIS Specifications)[4]

### Measure #1 – Description

The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

### Measure #1 – Denominator

| | |
|---|---|
| **Initial Population** | Patients 3-21 years of age during the measurement period. Report three age stratifications and total rate:<br>• 3-11 years.<br>• 12-17 years.<br>• 18-21 years.<br>• Total, or the sum of the age stratifications. |
| **Denominator Statement** | Equals Initial Population |
| **Denominator Exclusions** | Patients in hospice or using hospice services anytime during the measurement year. |
| **Denominator Exceptions** | None |
| **Rate 1** | The denominator statement. |
| **Rate 2** | The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data. |
| **Rate 3** | The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data. |
| **Rate 4** | The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data. |

### Measure #1 – Numerator

| | |
|---|---|
| **Numerator Statement** | Patients who received one or more well-care visits during the measurement year. The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the patient. |
| **Numerator Exclusions** | None |
| **Guidance** | This measure requires use of administrative data to identify well-care visits. ANs should leverage payer-provided data for measure performance. For example, payers could share a spreadsheet with information on which patients meet the numerator for the measure. ANs could use this information to update data in their EHRs and report performance on the measure. |

[4] Source: Adapted from NCQA HEDIS MY 2021 specifications.

| | |
|---|---|
| | Alternatively, ANs could report performance for this measure using data from their EHRs if it includes information on whether a patient had a well-care visit. The limitation of this approach, however, is that EHR data likely would not contain information on whether a patient received a well-care visit from another AN. |
| **Codes to Identify Well-Care Visits** | 99381-99385; 99391-99395; 99461; G0438-G0439; S0302; S0610; S0612-S0613; Z00.00-Z00.01; Z00.110-Z00.111; Z00.121; Z00.129; Z00.2; Z00.3; Z01.411; Z01.419; Z02.5; Z76.1; Z76.2; 103740001; 170099002; 170107008; 170114005; 170123008; 170132005; 170141000; 170150003; 170159002; 170168000; 170250008; 170254004; 170263002; 170272005; 170281004; 170290006; 170300004; 170309003; 171387006; 171394009; 171395005; 171409007; 171410002; 171416008; 171417004; 243788004; 268563000; 270356004; 401140000; 410620009; 410621008; 410622001; 410623006; 410624000; 410625004; 410626003; 410627007; 410628002; 410629005; 410630000; 410631001; 410632008; 410633003; 410634009; 410635005; 410636006; 410637002; 410638007; 410639004; 410640002; 410641003; 410642005; 410643000; 410644006; 410645007; 410646008; 410647004; 410648009; 410649001; 410650001; 442162000; 783260003; 444971000124105; 446301000124108; 446381000124104; 669251000168104; 669261000168102; 669271000168108; 669281000168106 |
| **Rate 1** | The numerator statement. |
| **Rate 2** | The numerator statement, stratified by race. |
| **Rate 3** | The numerator statement, stratified by ethnicity. |
| **Rate 4** | The numerator statement, stratified by language. |

## Measure #2: Comprehensive Diabetes Care: HbA1c Control (CMS122v10)[5]

### Measure #2 – Description

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c <8.0% during the measurement year.

### Measure #2 – Denominator

| | |
|---|---|
| **Initial Population** | Patients 18-75 years of age with diabetes with a visit during the measurement period.<br><br>Services delivered via telehealth are eligible encounters. |
| **Denominator Statement** | Equals Initial Population |
| **Denominator Exclusions** | • Patients who are in hospice care for any part of the measurement period.<br>• Patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period.<br>• Patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria:<br>  ○ Advanced illness with two outpatient encounters during the measurement period or the year prior OR<br>  ○ Advanced illness with one inpatient encounter during the measurement period or the year prior OR<br>  ○ Taking dementia medications during the measurement period or the year prior.<br>• Patients receiving palliative care during the measurement period. |
| **Denominator Exceptions** | None |
| **Rate 1** | The denominator statement. |
| **Rate 2** | The denominator statement, stratified by race. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data. |
| **Rate 3** | The denominator statement, stratified by ethnicity. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data. |
| **Rate 4** | The denominator statement, stratified by language. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data. |
| **Rate 5** | The denominator statement, stratified by disability status. Separately report the percentage of patients in the denominator statement for which the provider organization has complete disability status data. |

[5] Source: Modified from CMS 2022 eCQM specifications for Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%). https://ecqi.healthit.gov/ecqm/ep/2022/cms122v10.

## Measure #2 – Numerator

| | |
|---|---|
| **Numerator Statement** | Patients whose most recent HbA1c level (performed during the measurement period) is <8.0% |
| **Numerator Exclusions** | Not applicable |
| **Guidance** | If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance.<br><br>Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included. |
| **Rate 1** | The numerator statement. |
| **Rate 2** | The numerator statement, stratified by race. |
| **Rate 3** | The numerator statement, stratified by ethnicity. |
| **Rate 4** | The numerator statement, stratified by language. |
| **Rate 5** | The numerator statement, stratified by disability status. |

## Measure #3: Controlling High Blood Pressure (CMS165v10)[6]

### Measure #3 – Description

Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, , and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

### Measure #3 – Denominator

| | |
|---|---|
| **Initial Population** | Patients 18-85 years of age who had a visit and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period.<br><br>Services delivered via telehealth are eligible encounters. |
| **Denominator Statement** | Equals Initial Population |
| **Denominator Exclusions** | • Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.<br>• Exclude patients who are in hospice care for any part of the measurement period.<br>• Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period.<br>• Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria:<br>  ○ Advanced illness with two outpatient encounters during the measurement period or the year prior OR<br>  ○ Advanced illness with one inpatient encounter during the measurement period or the year prior OR<br>  ○ Taking dementia medications during the measurement period or the year prior.<br>• Patients 81 and older with an indication of frailty for any part of the measurement period.<br>• Patients receiving palliative care during the measurement period. |
| **Denominator Exceptions** | None |
| **Rate 1** | The denominator statement. |
| **Rate 2** | The denominator statement, stratified by race. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data. |
| **Rate 3** | The denominator statement, stratified by ethnicity. Separately report the percentage of patients in the denominator statement for which the provider organization has |

[6] Source: CMS 2022 eCQM specifications. https://ecqi.healthit.gov/ecqm/ep/2022/cms165v10.

| | |
|---|---|
| | complete ethnicity data. |
| **Rate 4** | The denominator statement, stratified by language. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data. |
| **Rate 5** | The denominator statement, stratified by disability status. Separately report the percentage of patients in the denominator statement for which the provider organization has complete disability status data. |

## Measure #3 – Numerator

| | |
|---|---|
| **Numerator Statement** | Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period. |
| **Numerator Exclusions** | Not applicable |
| **Guidance** | In reference to the numerator element, only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure. This includes blood pressures taken in person by a clinician and blood pressures measured remotely by electronic monitoring devices capable of transmitting the blood pressure data to the clinician. Blood pressure readings taken by a remote monitoring device and conveyed by the patient to the clinician are also acceptable. It is the clinician's responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's medical record.<br><br>Do not include BP readings:<br>• Taken during an acute inpatient stay or an ED visit.<br>• Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.<br>• Taken by the patient using a non-digital device such as a manual blood pressure cuff and stethoscope.<br><br>If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled."<br><br>If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading. |
| **Rate 1** | The numerator statement. |
| **Rate 2** | The numerator statement, stratified by race. |
| **Rate 3** | The numerator statement, stratified by ethnicity. |
| **Rate 4** | The numerator statement, stratified by language. |
| **Rate 5** | The numerator statement, stratified by disability status. |

## Measure #4: Prenatal and Postpartum Care (Adapted HEDIS Specifications)[7]

### Measure #4 – Description

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care*. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
- *Postpartum Care*. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

### Measure #4 – Denominator

| | |
|---|---|
| **Initial Population** | Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include women who delivered in any setting.<br><br>Multiple births. Women who had two separate deliveries (different dates of service) between October 8 of the year prior to the measurement year and October 7 of the measurement year count twice. Women who had multiple live births during one pregnancy count once.<br><br>Follow the steps below to identify the initial population, which is the denominator for both rates:[8]<br>1. Identify deliveries. Identify all women with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.<br>a. Note: The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.<br>2. Exclude non-live births (Non-live Births Value Set). |
| **Denominator Statement** | Equals Initial Population |
| **Denominator Exclusions** | Patients in hospice or using hospice services anytime during the measurement year. |
| **Denominator Exceptions** | None |
| **Guidance** | This measure requires use of administrative data to identify well-care visits. ANs should leverage payer-provided data for measure performance. For example, payers |

[7] Source: Adapted from NCQA HEDIS MY 2022 specifications.

[8] Visit https://store.ncqa.org/my-2022-quality-rating-system-qrs-hedis-value-set-directory.html to obtain the codes associated with each Value Set.

| | |
|---|---|
| | could share a spreadsheet with information on which patients meet the numerator for the measure. ANs could use this information to update data in their EHRs and report performance on the measure.<br><br>Alternatively, ANs could report performance for this measure using data from their EHRs if it includes information on whether a patient had a well-care visit. The limitation of this approach, however, is that EHR data likely would not contain information on whether a patient received a well-care visit from another AN. |
| **Rate 1** | The denominator statement. |
| **Rate 2** | The denominator statement, stratified by race. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data. |
| **Rate 3** | The denominator statement, stratified by ethnicity. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data. |
| **Rate 4** | The denominator statement, stratified by language. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data. |
| **Rate 5** | The denominator statement, stratified by disability status. Separately report the percentage of patients in the denominator statement for which the provider organization has complete disability status data. |

**Measure #4 – *Timeliness of Prenatal Care* Numerator**

| | |
|---|---|
| **Numerator Statement** | A prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP during the required time frame. Follow the steps below to identify numerator compliance:<br>1. Identify women attributed to the AN with a delivery during the measurement year.<br>2. Identify prenatal visits that occurred during the required timeframe. The practitioner type must be an OB/GYN or other prenatal care practitioner or PCP to meet criteria for a prenatal visit. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following:<br>a. Documentation indicating the woman is pregnant or references to the pregnancy; for example:<br>i. Documentation in a standardized prenatal flow sheet, or<br>ii. Documentation of LMP, EDD or gestational age, or<br>iii. A positive pregnancy test result, or<br>iv. Documentation of gravidity and parity, or<br>v. Documentation of complete obstetrical history, or<br>vi. Documentation of prenatal risk assessment and counseling/education.<br>b. A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used). |

| | |
|---|---|
| | c. Evidence that a prenatal care procedure was performed, such as:<br>i. Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), or<br>ii. TORCH antibody panel alone, or<br>iii. A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or<br>iv. Ultrasound of a pregnant uterus. |
| **Numerator Exclusions** | Not applicable |
| **Guidance** | Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.<br><br>For each patient, the organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, the member is excluded as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester.<br><br>The organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.<br><br>A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.<br><br>The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.<br><br>The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.<br><br>Services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting. |
| **Rate 1** | The numerator statement. |
| **Rate 2** | The numerator statement, stratified by race. |
| **Rate 3** | The numerator statement, stratified by ethnicity. |

| | |
|---|---|
| **Rate 4** | The numerator statement, stratified by language. |
| **Rate 5** | The numerator statement, stratified by disability status. |

## Measure #4 – *Postpartum Care* Numerator

| | |
|---|---|
| **Numerator Statement** | A postpartum visit to an OB/GYN or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following:<br>• Pelvic exam.<br>• Evaluation of weight, BP, breasts and abdomen.<br>  ○ Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.<br>• Notation of postpartum care, including, but not limited to:<br>  ○ Notation of "postpartum care," "PP care," "PP check," "6-week check."<br>  ○ A preprinted "Postpartum Care" form in which information was documented during the visit.<br>• Perineal or cesarean incision/wound check.<br>• Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.<br>• Glucose screening for women with gestational diabetes.<br>• Documentation of any of the following topics:<br>  ○ Infant care or breastfeeding.<br>  ○ Resumption of intercourse, birth spacing or family planning.<br>  ○ Sleep/fatigue.<br>  ○ Resumption of physical activity.<br>  ○ Attainment of healthy weight. |
| **Numerator Exclusions** | Services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set). |
| **Guidance** | Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.<br><br>For each patient, the organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, the member is excluded as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester.<br><br>The organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate. |

| | |
|---|---|
| | A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.<br><br>Services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting. |
| **Rate 1** | The numerator statement. |
| **Rate 2** | The numerator statement, stratified by race. |
| **Rate 3** | The numerator statement, stratified by ethnicity. |
| **Rate 4** | The numerator statement, stratified by language. |
| **Rate 5** | The numerator statement, stratified by disability status. |

## Measure #5: Screening for Depression and Follow-up Plan (CMS2v11)[9]

### Measure #5 – Description

Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.

### Measure #5 – Denominator

| | |
|---|---|
| **Initial Population** | All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.<br><br>Services delivered via telehealth are eligible encounters. |
| **Denominator Statement** | Equals Initial Population |
| **Denominator Exclusions** | Patients who have been diagnosed with depression or with bipolar disorder, |
| **Denominator Exceptions** | • Patient Reason(s)<br>• Patient refuses to participate<br>OR<br>• Medical Reason(s)<br>*Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; 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).* |
| **Rate 1** | The denominator statement. |
| **Rate 2** | The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data. |
| **Rate 3** | The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data. |
| **Rate 4** | The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data. |

### Measure #5 – Numerator

| | |
|---|---|
| **Numerator Statement** | Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter. |
| **Numerator** | None |

[9] Source: CMS 2022 eCQM specifications. https://ecqi.healthit.gov/ecqm/ep/2022/cms002v11.

| | |
|---|---|
| **Exclusions** | |
| **Guidance** | The intent of the measure is to screen for depression in patients who have never had a diagnosis of depression or bipolar disorder prior to the eligible encounter used to evaluate the numerator. Patients who have ever been diagnosed with depression or bipolar disorder will be excluded from the measure.<br><br>A depression screen is completed on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan must be documented on the date of the encounter, such as referral to a practitioner who is qualified to treat depression, pharmacological interventions or other interventions for the treatment of depression.<br><br>This measure does not require documentation of a specific score, just whether results of the normalized and validated depression screening tool used are considered positive or negative. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression.<br><br>This eCQM is a patient-based measure. Depression screening is required once per measurement period, not at all encounters.<br><br>Screening Tools:<br>• An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance.<br>• The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.<br>• The depression screening must be reviewed and addressed in the office of the provider, filing the code, on the date of the encounter. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider practice.<br>• The screening should occur during a qualifying encounter or up to 14 days prior to the date of the qualifying encounter.<br>• The measure assesses the most recent depression screening completed either during the eligible encounter or within the 14 days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count towards a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a patient screening positively, the eligible clinician would need to provide one of the aforementioned follow-up actions, which does not include use of a standardized depression screening tool.<br><br>Follow-Up Plan: The follow-up plan must be related to a positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening."<br><br>Examples of a follow-up plan include but are not limited to: |

| | |
|---|---|
| | • 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.<br>• Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options.<br><br>Should a patient screen positive for depression, a clinician should:<br>• Only order pharmacological intervention when appropriate and after sufficient diagnostic evaluation. However, for the purposes of this measure, additional screening and assessment during the qualifying encounter will not qualify as a follow-up plan.<br>• Opt to complete a suicide risk assessment when appropriate and based on individual patient characteristics. However, for the purposes of this measure, a suicide risk assessment or additional screening using a standardized tool will not qualify as a follow-up plan. |
| **Rate 1** | The numerator statement. |
| **Rate 2** | The numerator statement, stratified by race. |
| **Rate 3** | The numerator statement, stratified by ethnicity. |
| **Rate 4** | The numerator statement, stratified by language. |