2023 CMS Web Interface

PREV-12: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Measure Steward: CMS

Contents

INTRODUCTION

There are a total of 10 individual measures included in the 2023 CMS Web Interface targeting high-cost chronic conditions, preventive care, and patient safety. The measures documents are represented individually and contain measure specific information. The corresponding coding documents are posted separately in an Excel format.

The measure documents are being provided to allow organizations an opportunity to better understand each of the 10 individual measures included in the 2023 CMS Web Interface data submission method. Each measure document contains information necessary to submit data through the CMS Web Interface.

Narrative specifications, supporting submission documentation, and calculation flows are provided within each document. Please review all of the measure documentation in its entirety to ensure complete understanding of these measures.

CMS WEB INTERFACE SAMPLING INFORMATION

BENEFICIARY SAMPLING

For more information on the sampling process and methodology please refer to the 2023 CMS Web Interface Sampling Document, which will be made available during the performance year at CMS.gov.

NARRATIVE MEASURE SPECIFICATION

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 or up to two days after the date of the qualifying encounter

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL POPULATION:
All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
Patients who have been diagnosed with depression or with bipolar disorder

DENOMINATOR EXCEPTIONS:
Patient Reason(s): Patient refuses to participate

OR

Medical Reason(s): 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)

NUMERATOR:
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 or up to two days after the date of the qualifying encounter

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITIONS:
Screening: Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized.

Examples of standardized depression screening tools include but are not limited to:

Adolescent Screening Tools (12-17 years)

- Patient Health Questionnaire for Adolescents (PHQ-A)
- Beck Depression Inventory-Primary Care Version (BDI-PC)
- Mood Feeling Questionnaire (MFQ)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Patient Health Questionnaire (PHQ-9)
- Pediatric Symptom Checklist (PSC-17)
- PRIME MD-PHQ-2

Adult Screening Tools (18 years and older)

- Patient Health Questionnaire (PHQ-9)
- 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)
- Cornell Scale for Depression in Dementia (CSDD)
- PRIME MD-PHQ-2
- Hamilton Rating Scale for Depression (HAM-D)
- Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)
- Computerized Adaptive Testing Depression Inventory (CAT-DI)
- Computerized Adaptive Diagnostic Screener (CAD-MDD)

Perinatal Screening Tools

- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9 (PHQ-9)
- Beck Depression Inventory
- Beck Depression Inventory–II
- Center for Epidemiologic Studies Depression Scale
- Zung Self-rating Depression Scale

Follow-Up Plan: Documented follow-up for a positive depression screening ***must*** include one or more of the following:

- Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

GUIDANCE:

A depression screen is completed on the date of the qualifying encounter or up to 14 calendar 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 or up to two calendar days after the date of the qualifying encounter, such as referral to a provider for additional evaluation, pharmacological interventions, or other interventions for the treatment of depression. An example to illustrate the follow-up plan documentation timing: if the encounter is on a Monday from 3-4 pm (day 0) and the patient screens positive, the clinician has through anytime on Wednesday (day 2) to complete follow-up plan documentation.

This is a patient-based measure. Depression screening is required once per measurement period, not at all encounters.

This measure requires documentation that a screening was conducted with a standardized depression screening tool. It is recommended that **both** a score and clinician interpretation of the score is documented, especially when a patient screens positive. At a minimum, the medical record must contain documentation of the tool's name and results of the screening with a score **OR** clinician interpretation of positive or negative for depression. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression. A score interpreted as positive requires documentation of a follow-up plan. A score interpreted as negative does not require a follow-up plan.

The intent of the measure is to screen for new cases of depression in patients who have never had a diagnosis of depression or bipolar disorder prior to the qualifying encounter used to evaluate the numerator. Patients who have been diagnosed with depression or bipolar disorder will be excluded from the measure.

Screening Tools:

- An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance.
- The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.
- The depression screening must be reviewed and addressed by 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.The screening should occur during a qualifying encounter or up to 14 calendar days prior to the date of the qualifying encounter
- The measure assesses the most recent depression screening completed either during the qualifying encounter or within the 14 calendar 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.

Follow-Up Plan:
For a depression screen deemed positive, the follow-up plan MUST still be provided for and discussed with the patient during the qualifying encounter used to evaluate the numerator. However, documentation of the follow-up plan can occur up to two calendar days after the qualifying encounter, in accordance with the policies of an eligible clinician or provider's practice or health system. All services should be documented during, or as soon as practicable, after the qualifying encounter in order to maintain an accurate medical record.

The follow-up plan must be related to a positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening."

Examples of a follow-up plan include but are not limited to:

- Referral to a provider, practioner, or program for further evaluation for depression, for example, referral to a psychiatrist, psychiatric nurse practitioner, psychologist, clinical 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
- Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options.

Should a patient screen positive for depression a clinician should:

- 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.
- 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.

SUBMISSION GUIDANCE

PATIENT CONFIRMATION

Establishing patient eligibility for submission requires the following:

- Determine if the patient's medical record can be found
  - If you can locate the medical record select "Yes"

  OR

  - If you cannot locate the medical record select "No - Medical Record Not Found"

  OR

  - Determine if the patient is qualified for the sample
    - If the patient is deceased, in hospice, moved out of the country, or did not have Fee-for-Service (FFS) Medicare as their primary payer select "Not Qualified for Sample", select the applicable reason from the provided drop-down menu, and enter the date the patient became ineligible

Guidance ***Patient Confirmation***

If "No – Medical Record Not Found" or "Not Qualified for Sample" is selected, *the patient is completed but not confirmed. The patient will be "skipped" and another patient must be reported in their place, if available. The CMS Web Interface will automatically skip any patient for whom "No – Medical Record Not Found" or "Not Qualified for Sample" is selected in all other measures into which they have been sampled.*

If "Not Qualified for Sample" is selected and the date is unknown, *you may enter the last date of the measurement period (i.e., 12/31/2023).*

The Measurement Period is defined *as January 1 – December 31, 2023.*

NOTE:

- ***In Hospice:*** *Select this option if the patient is not qualified for sample due to being in hospice care at any time during the measurement period (this includes non-hospice patients receiving palliative goals or comfort care)*
- ***Moved out of Country:*** *Select this option if the patient is not qualified for sample because they moved out of the country any time during the measurement period*
- ***Deceased:*** *Select this option if the patient died during the measurement period*
- ***Non-FFS Medicare:*** *Select this option if the patient was enrolled in Non-FFS Medicare at any time during the measurement period (i.e., commercial payers, Medicare Advantage, Non-FFS Medicare, HMOs, etc.) This exclusion is intended to remove beneficiaries for whom Fee-for-Service Medicare is not the primary payer.*

SUBMISSION GUIDANCE

DENOMINATOR CONFIRMATION

- Determine if the patient is qualified for the measure
  - If the patient is qualified for this measure select "Yes"

  OR

  - If there is a denominator exclusion for patient disqualification from the measure select "Denominator Exclusion"

  OR

  - If there is an "other" CMS approved reason for patient disqualification from the measure select "No - Other CMS Approved Reason"

Denominator Exclusion codes can be found in the 2023 CMS Web Interface PREV-12 Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Denominator

Denominator Exclusion Timing - *prior to any encounter during the measurement period. To implement this guidance, the qualifying encounter is the equivalent to the most recent depression screening. A patient should be excluded if they have* ***ever*** *been diagnosed with depression or bipolar disorder prior to the qualifying encounter used to evaluate the numerator.*

If "Denominator Exclusion" or "No – Other CMS Approved Reason" is selected, *the patient will be "skipped" and another patient must be reported in their place, if available. The patient will only be removed from the measure for which one of these options was selected, not all CMS Web Interface measures.*

Other CMS Approved Reason *is reserved for unique cases that are not covered by any of the above stated skip reasons. To gain CMS approval, submit a skip request by selecting Request Other CMS Approved Reason in the patient qualification question for the measure. Note that skip requests can only be submitted manually through the CMS Web Interface.*

To submit a skip request, follow these steps:

1. *After confirming the beneficiary for the sample, scroll to the measure you would like to skip.*
2. *When confirming if the beneficiary is qualified for the measure, select Request Other CMS Approved Reason.*
3. *In the skip request modal, review the organization you are reporting for and provide the submitter's email address. CMS uses this email to send status updates and/or reach out if further information is needed to resolve the skip request. You also need to provide specific information about the beneficiary's condition and why it disqualifies the beneficiary from this measure. Never include Personally Identifiable Information (PII) or Protected Health Information (PHI) in the case.*

Beneficiaries remain incomplete until CMS resolves the skip request. The CMS Web Interface automatically updates the resolution of a skip request, either approved or denied. Beneficiaries for whom a CMS Approved Reason is approved are marked as Skipped and another beneficiary must be reported in their place, if available.

NOTE:

- *The intent of the measure is to screen for new cases of depression in patients who have never had a diagnosis of depression or bipolar disorder prior to the qualifying encounter used to evaluate the numerator. Patients who have been diagnosed with depression or bipolar disorder will be excluded from the measure.*

SUBMISSION GUIDANCE

NUMERATOR SUBMISSION

- Determine if the patient was screened for depression using an age-appropriate standardized tool on the date of the qualifying encounter or up to 14 days prior to the date of the encounter
  - If the patient was screened for depression using a standardized tool select "Yes"

  OR

  - If the patient was not screened for depression using a standardized tool select "No"

  OR

  - If the patient was not screened for depression using a standardized tool due to a medical reason select "No - Denominator Exception – Medical Reasons"

  OR

  - If the patient was not screened for depression using a standardized tool due to a patient reason select "No - Denominator Exception – Patient Reasons"

Numerator and Denominator Exception codes can be found in the 2023 CMS Web Interface PREV-12 Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Numerator

NOTE:

- ***Use most recent screening*** *for depression which occurred either during the qualifying encounter or up to 14 days prior to the encounter*
- ***Although the patient may have access to the depression screening tool in advance*** *of the encounter, the depression screening results must be documented on the date of the qualifying encounter. The results must be reviewed/verified and documented by the eligible professional in the medical record on the date of the encounter to meet the screening portion of this measure*
- ***Screening for depression*** *may be completed during a telehealth encounter*
- ***Denominator Exception timing*** *is during the encounter during the measurement period*

SUBMISSION GUIDANCE

NUMERATOR SUBMISSION

- Determine if the screen was positive for depression on the date of the encounter or up to 14 days prior to the date of the encounter
  - If the patient's screen was positive for depression using a standardized tool select "Yes"

    IF YES

    - Determine if a follow-up plan for depression was documented on the date of or up to two days after the date of the qualifying encounter
      - If a follow-up plan for depression was documented select "Yes"

      OR

      - If a follow-up plan for depression was not documented select "No"

  OR

  - If the patient's screen was not positive for depression using a standardized tool select "No"

Numerator and Numerator Drug codes can be found in the 2023 CMS Web Interface PREV-12 Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Numerator

NOTE:

- ***If screening for depression is documented as negative,*** *a follow-up plan not required*
- ***Documentation of recommended follow-up plan for a positive depression screen*** *may be completed during a telehealth encounter*
- ***Positive or negative****-Whether or not a standardized screening tool score is considered positive or negative would be determined by the eligible professional administering and reviewing the standardized tool. If the result is positive, documentation of a recommended follow-up is required.*
- ***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.*

DOCUMENTATION REQUIREMENTS

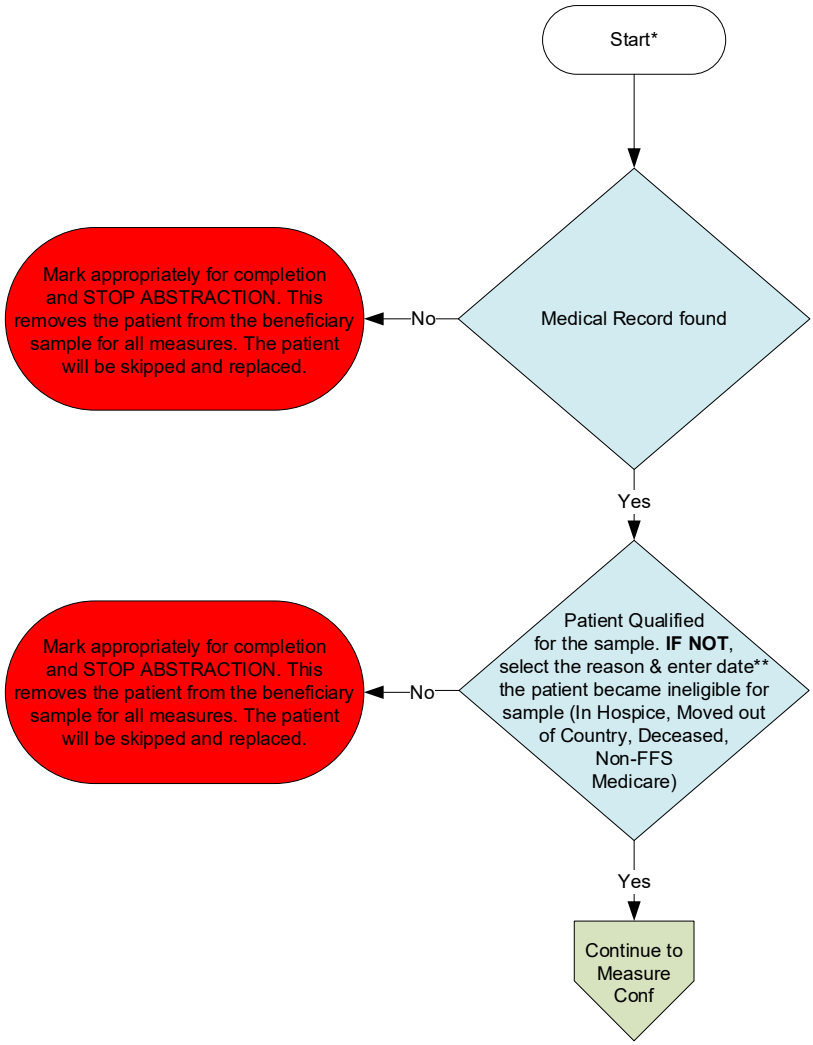
When submitting data through the CMS Web Interface, the expectation is that medical record documentation is available that supports the action reported in the CMS Web Interface i.e., medical record documentation is necessary to support the information that has been submitted.

Appendix I: Performance Calculation Flow

Disclaimer: *Refer to the measure submission document for specific coding and instructions to submit this measure.*

Patient Confirmation Flow

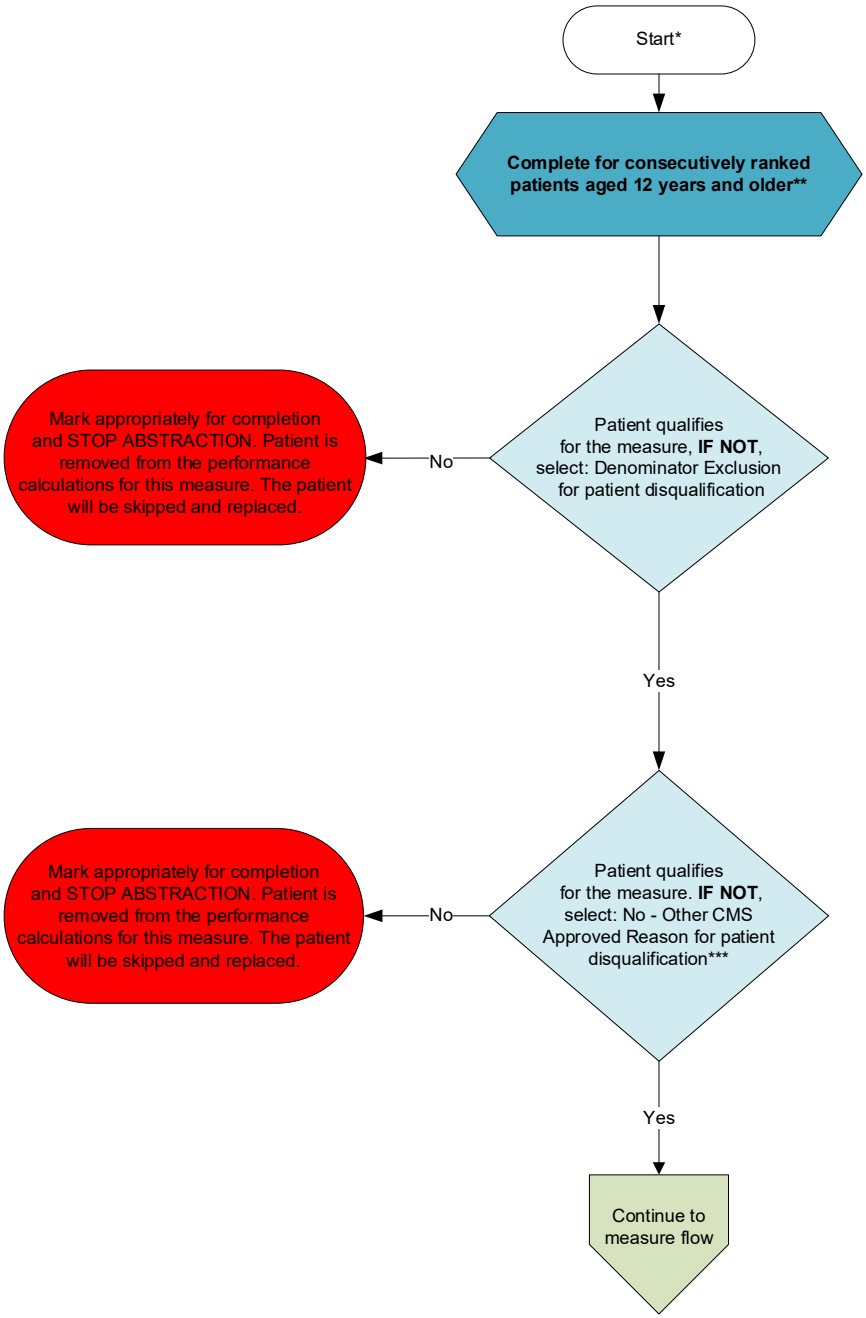
Confirmation of the "Medical Record Found", or indicating the patient is "Not Qualified for Sample" with a reason of "In Hospice", "Moved out of Country", "Deceased", or "Non-FFS Medicare", will only need to be done **once** per patient.



*See the posted measure submission document for specific coding and instructions to submit this measure.
**If date is unknown, enter 12/31/2023

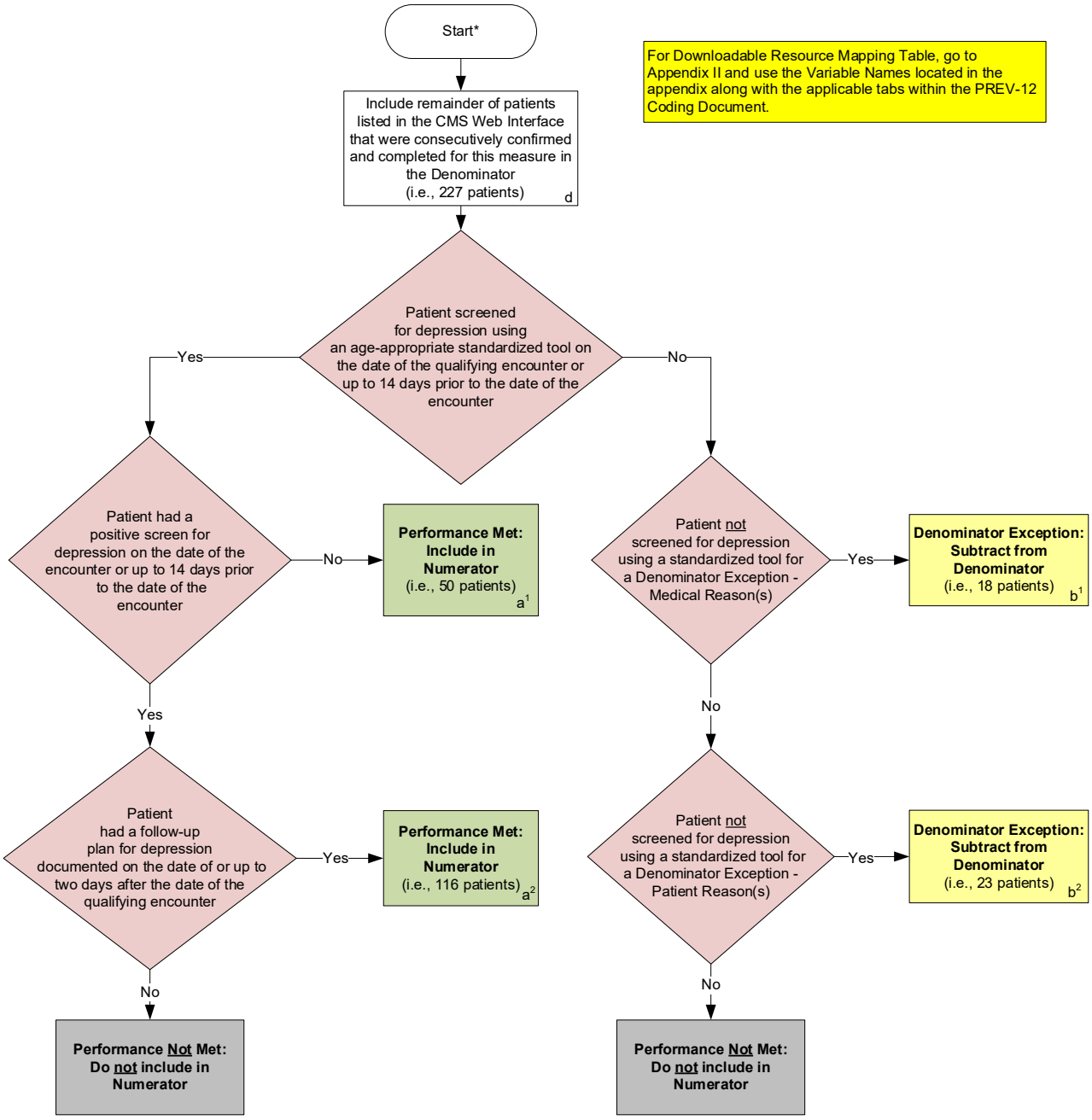
Measure Confirmation Flow for PREV-12

Measure specific reasons a patient is "Not Confirmed" or excluded for "Denominator Exclusion" or "Other CMS Approved Reason" will need to be done for each measure where the patient appears.



*See the posted measure submission document for specific coding and instructions to submit this measure.
**Further information regarding patient selection for specific disease and patient care measures can be found in the CMS Web Interface Sampling Methodology Document. For patients who have the incorrect date of birth listed, a change of the patient date of birth by the abstractor may result in the patient no longer qualifying for the PREV-12 measure. If this is the case, the system will automatically remove the patient from the measure requirements.
***"Other CMS Approved Reason" may only be selected if the CMS Web Interface updated the resolution of the skip request to be "Approved".

Measure Flow for PREV-12



SAMPLE CALCULATION:

Performance Rate=

Performance Met (a^1=50 patients + a^2=116 patients) = 166 patients = **89.25%**

Denominator (d=227 patients) - Denominator Exception (b^1=18 patients + b^2=23 patients) = 186 patients

CALCULATION MAY CHANGE PENDING PERFORMANCES MET ABOVE

*See the posted measure submission document for specific coding and instructions to submit this measure.

Patient Confirmation Flow

For 2023, confirmation of the "Medical Record Found", or indicating the patient is "Not Qualified for Sample" with a reason of "In Hospice", "Moved out of Country", "Deceased", or "Non-FFS Medicare", will only need to be done **once** per patient.

1. Start Patient Confirmation Flow.
2. Check to determine if Medical Record can be found.
    a. If no, Medical Record not found, mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
    b. If yes, Medical Record found, continue processing.
3. Check to determine if Patient Qualified for the sample.
    a. If no, the patient does not qualify for the sample, select the reason why and enter the date (if date is unknown, enter 12/31/2023) the patient became ineligible for sample. For example; In Hospice, Moved out of Country, Deceased, Non-FFS Medicare. Mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
    b. If yes, the patient does qualify for the sample; continue to the Measure Confirmation Flow for PREV-12.

Measure Confirmation Flow for PREV-12

For 2023, measure specific reasons a patient is "Not Confirmed" or excluded for "Denominator Exclusion" or "Other CMS Approved Reason" will need to be done for each measure where the patient appears.

1. Start Measure Confirmation Flow for PREV-12. Complete for consecutively ranked patients aged 12 years and older. Further information regarding patient selection for specific disease and patient care measures can be found in the CMS Web Interface Sampling Methodology Document. For patients who have the incorrect date of birth listed, a change of the patient date of birth by the abstractor may result in the patient no longer qualifying for the PREV-12 measure. If this is the case, the system will automatically remove the patient from the measure requirements.

2. Check to determine if the patient qualifies for the measure (Denominator Exclusion).

    a. If no, the patient does not qualify for the measure select: Denominator Exclusion for patient disqualification. Mark appropriately for completion and stop abstraction. Patient is removed from the performance calculations for this measure. The patient will be skipped and replaced. Stop processing.

    b. If yes, the patient does qualify for the measure, continue processing.

3. Check to determine if the patient qualifies for the measure (Other CMS Approved Reason).

    a. If no, the patient does not qualify for the measure select: No – Other CMS Approved Reason for patient disqualification. Mark appropriately for completion and stop abstraction. Patient is removed from the performance calculations for this measure. The patient will be skipped and replaced. "Other CMS Approved Reason" may only be selected if the CMS Web Interface updated the resolution of the skip request to be "Approved". Stop processing.

    b. If yes, the patient does qualify for the measure, continue to the PREV-12 measure flow.

Measure Flow for PREV-12

For Downloadable Resource Mapping Table, go to Appendix II and use the Variable Names located in the appendix along with the applicable tabs within the PREV-12 Coding Document.

1. Start processing 2023 PREV-12 Flow for the patients that qualified for sample in the Patient Confirmation Flow and the Measure Confirmation Flow for PREV-12. **Note:** Include remainder of patients listed in the CMS Web Interface that were consecutively confirmed and completed for this measure in the denominator. For the sample calculation in the flow these patients would fall into the 'd' category (eligible denominator, i.e. 227 patients).

2. Check to determine if the patient was screened for depression using an age-appropriate standardized tool on the date of the encounter or up to 14 days prior to the date of the encounter.

    a. If no, the patient was not screened for depression using an age appropriate standardized tool during a qualifying encounter or up to 14 days prior to the date of the encounter, continue processing and proceed to step 5.

    b. If yes, the patient was screened for depression using an age-appropriate standardized tool on the date of the encounter or up to 14 days prior to the date of the encounter, continue processing.

3. Check to determine if the patient had a positive screen for depression on the date of the encounter or up to 14 days prior to the date of the encounter.

    a. If no, the patient did not have a positive screen for depression on the date of the encounter or up to 14 days prior to the date of the encounter, performance is met and the patient will be included in the numerator. For the sample calculation in the flow these patients would fall into the 'a1' category (numerator, i.e. 50 patients). Stop processing.

    b. If yes, patient had a positive screen for depression on the date of the encounter or up to 14 days prior to the date of the encounter, continue processing.

4. Check to determine if the patient had a follow-up plan for depression documented on the date of the encounter or up to two days after the date of the encounter.

    a. If no, the patient did not have a follow-up plan for depression documented on the date of the encounter or up to two days after the date of the encounter, performance is not met and the patient should not be included in the numerator. Stop processing.

    b. If yes, the patient had a follow-up plan for depression documented on the date of the encounter or up to two days after the date of the encounter, performance is met and the patient will be included in the numerator. For the sample calculation in the flow these patients would fall into the 'a2' category (numerator, i.e. 116 patients). Stop processing.

5. Check to determine if the patient was <u>not</u> screened for depression using a standardized tool for a denominator exception, medical reason(s).

    a. If no, the patient was <u>not</u> screened for depression using a standardized tool for a denominator exception, medical reason(s), continue processing.

    b. If yes, the patient was <u>not</u> screened for depression using a standardized tool for a denominator exception, medical reason(s), this is a denominator exception and the case should be subtracted from the denominator. For the sample calculation in the flow these patients would fall into the 'b1' category (denominator exception, i.e. 18 patients). Stop processing.

6. Check to determine if the patient was not screened for depression using a standardized tool for a denominator exception, patient reason(s).

    a. If no, the patient was not screened for depression using a standardized tool for a denominator exception, patient reason(s), performance is not met and the patient should not be included in the numerator. Stop processing.

    b. If yes, the patient was not screened for depression using a standardized tool for a denominator exception, patient reason(s), this is a denominator exception and the case should be subtracted from the denominator. For the sample calculation in the flow these patients would fall into the 'b²' category (denominator exception, i.e. 23 patients). Stop processing.

Sample Calculation:

Performance Rate equals Performance Met (a^1 equals 50 patients plus a^2 equals 116 patients) divided by Denominator (d equals 227 patients) minus Denominator Exception (b^1 equals 18 patients plus b^2 equals 23 patients). All equals 166 patients divided by 186 patients. All equals 89.25 percent.

CALCULATION MAY CHANGE PENDING PERFORMANCE MET ABOVE.

Appendix II: Downloadable Resource Mapping Table

Each data element within this measure's denominator or numerator is defined as a pre-determined set of clinical codes. These codes can be found in the 2023 CMS Web Interface PREV-12 Coding Document.

***PREV-12: Preventive Care and Screening: Screening for Depression and Follow-Up Plan**

Measure Component/ Excel Tab	Data Element	Variable Name	Coding System(s)
Denominator Exclusion/ Denominator Exclusion Codes	Exclusion	BIPOLAR_DX_CODE	I9 I10 SNM
		DEPRESSION_DX_CODE	I9 I10 SNM
Numerator/Numerator Codes/Numerator Drug Codes	Depression Screen	SCREENING_CODE	LN
		NEG_SCREENING_CODE	SNM
		POS_SCREENING_CODE	SNM
	Follow-up Plan (for Positive Screen)	FOLLOW_UP_CODE	SNM
		REFERRAL_CODE	SNM
		DEP_DRUG_CODE	RxNorm (Drug EX=N)
Denominator Exception/ Denominator Exception Codes	Medical Reason	MEDICAL_REASON	SNM
	Patient Reason	PATIENT_DECLINED	SNM

** For EHR mapping, the coding within PREV-12 is considered to be all inclusive*

Appendix III: Measure Rationale and Clinical Recommendation Statements

RATIONALE:

Depression is a serious medical illness associated with higher rates of chronic disease increased health care utilization, and impaired functioning (Pratt & Brody, 2014). Results from a 2016 U.S. survey data indicate that 12.8 percent of adolescents (3.1 million adolescents) had a major depressive episode (MDE) in the past year, with nine percent of adolescents (2.2 million adolescents) having one MDE with severe impairment; (Substance Abuse and Mental Health Services Administration, 2017). The odds of a diagnosis of depression are believed to be 2.6 times greater for children and adolescents exposed to trauma as compared to those unexposed or less exposed (Vibhakar et al., 2019). Children and teens with major depressive disorder (MDD) have been found to have difficulty carrying out their daily activities, relating to others, and growing up healthy, and are at an increased risk of suicide (Siu on behalf of the U.S. Preventive Services Task Force [USPSTF], 2016).

The same 2016 study indicated that 6.7 percent of adults aged 18 or older (16.2 million adults) had at least one MDE with 4.3 percent of adults (10.3 million adults) having one MDE with severe impairment in the past year (Substance Abuse and Mental Health Services Administration, 2017). Moreover, it is estimated 22.9 percent of adult patients with chronic pain (2.2 million adults) were diagnosed with comorbid depression from 2011 to 2015, with an upward trend of prevalence among Black Americans, patients aged 65 to 84 years old, Medicare and Medicaid insured patients, and patients from zip code areas with low annual household incomes (Orhurhu et al., 2020).

Depression and other mood disorders, such as bipolar disorder and anxiety disorders, especially during the perinatal period, can have devastating effects on women, infants, and families (American College of Obstetricians and Gynecologists, 2018). It's estimated that the global prevalence of antenatal (or perinatal) depression ranges from 15 to 65 percent, with current or previous exposure to abuse and violence, lack of social support, and family history of mental disorders being risk factors. Depressive symptoms measured during pregnancy have been shown to influence the quality of the postpartum mother-infant relationship (Raine et al., 2020). Additionally, the risk of low birth weight and preterm birth is higher among infants born from depressed mothers (Dadi, Miller, Bisetegn, & Mwanri, 2020).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. Data indicates that as the severity of depressive symptoms increase, rates of having difficulty with work, home, or social activities related to depressive symptoms increase. For those twelve and older with mild depressive symptoms, 45.7 percent reported difficulty with activities, and for those with severe depressive symptoms, 88 percent reported difficulty (Pratt & Brody, 2014). Depression also imposes significant economic burden through direct and indirect costs, supporting the need for regular depression screening. "In the United States, an estimated $22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated $23 billion in 2011" (Siu & USPSTF, 2016, p. 383-384).

Numerous studies have found significant disparities in depression prevalence and treatment among racial/ethnic minorities. One study revealed that Indigenous adults are at a high risk for posttraumatic stress disorder, depression, suicide, substance use disorder, and concurrent behavioral health disorders secondary to these initial health problems (Ka'apu and Burnette, 2019). Additionally, though rates of depression are lower among Blacks and Hispanics than among whites, depression among Blacks and Hispanics is likely to be more recurrent. Furthermore, 48 percent of whites receive mental health services, compared to just 31 percent of Blacks and Hispanics, and 22 percent of Asians (American Psychiatric Association, 2017). Asian Americans and Black Americans are also significantly more likely to utilize emergency rooms for depression treatment, which contributes to inconsistent follow-up care (Lee, et al., 2014).

While primary care providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 46 percent of depressed patients: (Borner et al., 2010). "In nationally representative U.S. surveys, about eight percent of adolescents reported having major depression in the past year. Only 36 percent

to 44 percent of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated" (Sui on behalf of USPSTF, 2016, p. 360 & p. 364). Furthermore, evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit, and treatment options for positive depression screening should be available for patients twelve and older including pregnant and postpartum women.

This measure seeks to align with clinical guideline recommendations as well as the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014) and makes an important contribution to the quality domain of community and population health.

CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years):

"The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui on behalf of USPSTF, 2016, p. 360).

Adult Recommendation (18 years and older):

"The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui & USPSTF, 2016, p. 380).

"The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions. (B recommendation)" (U.S. Preventive Services Task Force, 2019).

The American College of Obstetricians and Gynecologists (ACOG) provides the following recommendation: "All obstetrician–gynecologists and other obstetric care providers should complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit for each patient." (American College of Obstetricians and Gynecologists, 2018)

The Institute for Clinical Systems Improvement (ICSI) health care guideline, Adult Depression in Primary Care, provides the following recommendations:

1. "Clinicians should routinely screen all adults for depression using a standardized instrument."
2. "Clinicians should establish and maintain follow-up with patients."
3. "Clinicians should screen and monitor depression in pregnant and post-partum women." (Trangle et al., 2016, p 8-10).

Appendix IV: Use Notices, Copyrights, and Disclaimers