**QUESTION (OPCA)**: In regards to the UDS depression screening and follow-up measure, we are unclear about how HRSA (or CCOs) might interpret something. If a patient has a high PHQ9 but when the PCP talks to them they find out it is an acute, resolving stressor and no follow-up is needed - resolved in the session – would a PCP noting that “no additional follow up-required” satisfy the follow-up plan?

**ANSWER**: I think that what we are dealing with is how it is documented. Sometimes an EHR can provide you an option about following up on a particular entry that is flagging for follow up (this could be a PHQ9, Columbia Suicide Screener, AUDIT, DAST, etc), but discussing further can provide clarity on the reason for that answer. From the eCQM the following is the key area:

Follow-Up Plan:

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

\*  Additional evaluation or assessment for depression

 \*  Suicide Risk Assessment

\*  Referral to a practitioner who is qualified to diagnose and treat depression

\*  Pharmacological interventions

\*  Other interventions or follow-up for the diagnosis or treatment of depression

How that is documented will differ by EHR and CCO. I would categorize that as "additional evaluation or assessment for depression" on the surface of things. You could also re-screen the patient after talking. Say I am screened and score a 12, but that is stemming from anxiety over a particular area. After talking with my provider I am more at ease and the provider does not feel I am depressed or needing further treatment. A second PHQ9 then scores a 2 for example. If both screenings are entered into the EHR in the order they were done then any EHR report should treat that patient as not needing follow up and should meet the UDS measure. The CCO may be a different story depending on what items show up in the billing to the CCO.

**QUESTION (OPCA):** Regarding your highlighted comment – would this meet the measure if PHQ-9 is no longer considered a follow up plan?

One more food for thought question… If a patient has a positive PHQ2 and then subsequently a negative PHQ9, does the clinic not get credit toward this measure? Essentially they did a screening, had a positive request but after further evaluation, no intervention was required.

**ANSWER**: The second PHQ9 isn't treated as a follow up, but a further screening. Since the metric has shifted from an encounter based measure to a patient based measure what counts is whether a screening is positive or negative. Same with the positive PHQ2 and negative PHQ9. Enter the PHQ2 first and then the PHQ9. The 9 will show that further follow up isn't needed. The last HRSA webinar on UDS I attended went over a scenario like this, but the UDS helpdesk should be able to confirm this as well.

As to the credit question. That patient should be counted as meeting the metric for the clinic.

**QUESTION (OPCA)**: One issue I see getting complicated is a positive PHQ 9 does not equal a diagnosis of depression. It seems that a standard part of the measure is follow-up to a positive screen so wouldn’t the patient need to have a diagnosis of depression to qualify for counting?

**ANSWER:** So this metric is about screening and following up to a positive screening. Diagnoses of depression are used to exclude patients from the metric population. If they have an active depression or bipolar diagnosis they aren't included in the metric population at all. So for the instance of a positive PHQ9 what matters is the follow up. This can be a referral, a discussion with a follow up screening, an RX for depression meds (usually with a Dx of depression that is after the fact - they would meet the metric at that point instead of being excluded). The only issue around the active diagnosis is what happens if a patient is seen multiple times, has a screening, is diagnosed, and has that active diagnosis on subsequent visits. The eCQM only states:

"Has Diagnosis of Bipolar Starting Before Qualifying Encounter"

        or "Has Diagnosis of Depression Starting Before Qualifying Encounter"

That can be read as "first qualifying encounter," but it's possible to read it as "most recent qualifying encounter."

**RESPONSE (OPCA)**: For what it's worth, I agree with you, Erik. A diagnosis of depression prior to the encounter we're considering should *exclude* the patient from analysis--there's no point in screening a patient who already has depression. And that's clear when there's only one visit.

But yeah, multiple visits gets really complicated, especially as I read carefully through the eCQM code itself.

I don't know why I didn't think of doing this first, but I think I'm going to explore a couple multiple-visit scenarios using Bonnie--it's a tool that implements a certified metrics engine and allows you to build test patients to see how the measure is supposed to be interpreted; it's intended for measure developers, but i'ts perfect for some of these questions.

**RESEARCH IN BONNIE (OPCA):** Okay, just couldn't help myself over the weekend, and since we're having a workshop tomorrow, thought I'd send an update.

I confirmed a suspicion I had in the 2020 spec, using Bonnie. Here's the scenario:

1. Patient seen in January, screened for depression, referred for follow-up evaluation for depression. At this point, the patient meets the measure. All is good.
2. Patient is diagnosed with depression in February as a result of the evaluation. Yay! We caught a patient who needed attention and can help them. The patient is still counted as meeting the measure.
3. But then, the patient comes back in March, and we use a PHQ-2 and/or 9, which counts as a screening tool in the measure, though it's also a good idea for monitoring a patient with depression. Now the measure marks the patient as *excluded* from the denominator because there is a depression diagnosis before their most *recent* screening, so seeing the patient back causes us to lose credit for the original screening.

So, every time you see the patient back after having successfully screened and diagnosed them, you risk getting them excluded from the measure. This is a problem because its probably a good idea to see patients recently diagnosed with depression more often, and probably administer a PHQ-9. Given the stress of Covid-19, I suspect the above scenario is occurring even more frequently in 2020.

Bonnie allows you to verify the code of the eCQM in real time; you can see the effect of each step of the process as you build a test patient to fit a scenario; Bonnie highlights and evaluatesthe eCQM code as you go, so I'm fairly confident I've got this right. As we collect more questions with the spec, Akira, I think this is a pretty good way to check it.

Bonnie lives here: <https://bonnie.healthit.gov/>

(requires registering both for it as well as for VSAC, a pain).

The 2020 version of the eCQM spec I used was this: <https://ecqi.healthit.gov/ecqm/ep/2020/cms002v9>

**RESPONSE**: I kind of expected that. The 2019 version I believe would have kept that patient as "Met." One thing to keep in mind is that it isn't so much about "credit", but about the ratio of screened with those who are adequately addressed for follow up. If you are doing what you should then that should be high. Those that then get the appropriate treatment then get tracked towards remission (which isn't a CCO metric currently).

**RESPONSE (OPCA)**: Yes, this appears to me to be new behavior of the metric in 2020. In the context of a practice doing universal PHQ-2s, which makes this a tricky measure to hit anyhow, I do think this issue has a meaningful impact. In my prior-to-OPCA-consulting work I heard about several practices whose scores are dipping substantially in 2020 even before Covid, and I've been trying to figure out why. I suspect there are multiple causes, but I think this is one of them.

**RESPONSE**: Potentially, and this might still change. I've seen that tool before and have had it change behaviors in the middle of a UDS season. A UDS helpdesk ticket might be in order to get a better answer.

**QUESTION (OPCA)**: Thank you so much! This was a really helpful explanation. Why are we seeing this behavior in 2020 and not 2019? Because of COVID? To my understanding, the only thing that changed between the 2 years was the addition that screening can occur 14 days prior to the encounter. What am I missing?

**ANSWER**: It's possible that whoever codes the tool made an assumption around the exclusions and updated the logic. That's why I'd recommend a helpdesk ticket with HRSA to verify.