

CBE ID

0109

Title

Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors

Project

Behavioral Health

Endorsement Status

Endorsement Removed

Is Under Review

No

Previous Endorsement Cycle

Full Year 2013

Removal Date

Thu, 09/18/2014 - 20:00

Initial Endorsement

Sun, 08/09/2009 - 20:00

Steward

Center for Quality Assessment and Improvement in Mental Health

1.0 New or Maintenance

Maintenance

1.1 Measure Structure

Single Measure

1.3 Electronic Clinical Quality Measure (eCQM)

No

1.6 Measure Description

Percentage of patients treated for depression who were assessed, prior to treatment, for the presence of current and/or prior manic or hypomanic behaviors.

1.7 Measure Type

Process

1.8 Level of Analysis

Clinician: Group/Practice, Clinician: Individual

1.9 Care Setting

Ambulatory Care: Clinician Office, Outpatient Services

1.14 Numerator

Documentation of an assessment that considers the presence or absence of current and/or prior symptoms or behaviors of mania or hypomania. Sources of documentation may include the following: Documentation of presence or absence of the symptoms/behaviors associated with mania/hypomania (Reference List of Symptoms/Behaviors of Mania or Hypomania included in data collection form-will be available to TAP review) Or Use of a bipolar disorder screening or assessment tool : Clinical Global Impression - Bipolar MDQ: Mood Disorder Questionnaire BSDS: Bipolar Spectrum Diagnostic Scale YMRS: Young Mania Rating Scale BDSS: Brief Bipolar disorder Symptom Scale Hypomanic Personality Scale Self Report Mania Inventory Altman Self Report Mania Scale Bech-Rafaelsen Mania Rating Scale Or, Other scale used & documented at site AND Timeframe for chart documentation of the assessment for mania/hypomania must be present prior to, or concurrent with, the visit where the treatment plan is documented as being initiated

1.15 Denominator

Patients 18 years of age or older with an initial diagnosis or new presentation/episode of depression AND Documentation of a diagnosis of depression; to include at least one of the following: • Codes 296.2x; 296.3x. 300.4 or 311 (ICD9CM or DSM-IV-TR) documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms • Diagnosis or Impression or “working diagnosis” documented in chart indicating depression • Use of a screening/assessment tool for depression with a score or conclusion that patient is depressed and documentation that this information is used to establish or substantiate the diagnosis AND Documentation of treatment for depression; to include at least one of the following: Antidepressant pharmacotherapy (Reference List of Antidepressant Medications included in data collection form) AND/OR Psychotherapy for depression; provided at practice site or through referral New diagnosis” or a “new episode,” is defined as cases where the patient has not been involved in active treatment for 6 months. Active treatment includes being hospitalized or under the out-patient care of a physician.

1.20 Types of Data Sources

Claims Data, Paper Records

6.1.2 Current or Planned Use(s)

Public Reporting, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations), Regulatory and Accreditation Programs

6.1.3 Current Use(s)

Public Reporting, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations), Regulatory and Accreditation Programs

Planned Use

Public Reporting, Quality Improvement (Internal to the specific organization), Quality

Improvement with Benchmarking (external benchmarking to multiple organizations)

Risk Adjustment

No risk adjustment or risk stratification

Steward Organization

Center for Quality Assessment and Improvement in Mental Health

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