HEAT MAP QUALITY METRICS GUIDE

FY 2024

Updated December 2023

Introduction

The MaineHealth ACO (MHACO) has 16 value-based care contracts with over 115 different quality performance measures. The MHACO Quality Heat Map highlights the 10 highest-priority measures. The selected measures are reviewed and approved by the Quality Workgroup of the ACO and the Value Oversight Committee, comprised of physicians, MaineHealth System leadership, and other leaders from local health systems. In Fiscal Year 2024, the MHACO Quality Heat Map measures are:

- **Colorectal Cancer Screening**
- **Depression Screening and Follow-Up**
- **Diabetes: Eye Exam**
- **Diabetes: HbA1c Poor Control >9%**
- **Diabetes: HbA1c Disparities Gap**
- **Diabetes: Kidney Health Evaluation**
- **Diabetes: Statin Therapy**
- **HPV Vaccination**
- **Hypertension Control**
- **Patient Experience: Would Recommend**

The ACO's performance in these measures impacts the eligibility to earn shared savings in value-based contracts or can result in financial penalties in downside risk arrangements, particularly in Medicare Advantage.

Heat Map targets are set based on national benchmarks from NCQA HEDIS and the Centers for Medicare & Medicaid Services (CMS) and are weighted to represent the MaineHealth ACO patient population mix. Patient's medical history, provider's clinical expertise, and shared decision-making supersede the recommended guidelines. Details on each measure definition are included on the measure's summary page below. For more specific information about documenting these and other measures in Epic, please reference the **CQM Guide**[1]. The CQM Guide can be found within MH Epic and via SeHR on MaineHealth's Intranet.

Performance on the Heat Map quality metrics is based on panel data pulled from Epic by the MaineHealth Medical Group Analytics team and are the same metrics used to populate medical group aggregate and operational reports as well as the new MH Strategic Plan FY24 Scorecard. Care teams can utilize Epic's Analytics Catalog to easily find and favorite quality performance dashboards and gap lists. Data for St. Mary's are self-reported from a separate Epic EMR instance.

The MaineHealth Medical Group has a subcommittee to focus on Adult Quality Improvement efforts and create standards of care across the system. The initial focus of this group was Hypertension, Diabetes, and cancer screenings. For more information on this work and the toolkits under development, contact Lauren Atkinson, Director of Quality for MaineHealth Medical Group at Lauren.Atkinson@mainehealth.org.

General questions about this guide can be directed to Melissa Montimurro, Program Coordinator, MaineHealth ACO at Melissa.Montimurro@mainehealth.org.

Colorectal Cancer Screening

Significance

- U.S. Preventative Services Task Force (USPSTF) Grade A Recommendation: Screening for colorectal cancer in all adults aged 50 years to 75 years.[2]
- U.S. Preventative Services Task Force (USPSTF) Grade B Recommendation: Screening for colorectal cancer in all adults aged 45 to 49 years.[3]
- Of cancers that affect both men and women, colon cancer is the third leading cause of cancer mortality in the United States. Estimates for 2023 note 153,000 new cases of colon cancer, with 52,500 deaths.[4]

Measure Description

Numerator: Number of patients with one or more screenings documented for colorectal cancer: colonoscopy in the last 10 years; flexible sigmoidoscopy in the last 5 years; computed tomography colonography in the last 5 years; multi-target stool DNA test/Cologuard in the last 3 years; or a fecal immunochemical test (FIT) or fecal occult blood test (FOBT) in the past 12 months.

Denominator: Number of patients **ages 45-75** at the beginning of the measurement period, with an office visit in the last 12 months.

Exclusions: A diagnosis or past history of total colectomy or colorectal cancer.

Strategies and Resources for Improvement

- Schedule colonoscopy visits while patients are on the phone or in the office to increase the likelihood of completion.
- Outreach to patients via phone calls instead of letters, as this method yields better results.
- Encourage patients who are averse to having a colonoscopy to complete a stool test in the privacy of their own home (FOBT, FIT-Non-DNA, and FIT-DNA).
- Educate, order and/or distribute FOBT, FIT-Non-DNA or FIT-DNA kits to patients who need a colorectal cancer screening.
- A toolkit for colorectal cancer screening is in development and on target for publication in FY24.

Quick Tip: Be sure to scan and document external lab results appropriately. For MaineHealth Epic practices, refer to the Clinical Quality Measures guide for more details on documentation.

Depression Screening and Follow-Up

Significance

- Major depressive disorder (MDD) is the second leading cause of disability worldwide, affecting an estimated 120 million people.[5] The lifelong prevalence is estimated to range from 10%–15%.[6]
- In the United States, 16% of people report that at some point in their lifetime they were told by a health care professional that they had depression.[7]
- In adolescents, depression can also result in serious long-term morbidities such as generalized anxiety disorder and panic disorder or lead to engagement in risky behaviors such as substance use.[89] Adolescent-onset depression increases the risk of attempted suicide five-fold in comparison with non-depressed adolescents. Most adolescents who commit suicide, the third leading cause of death among 15–24-year-olds, have a history of depression.[10,11,12]
- Studies have found that patient outcomes improve when there is collaboration between a primary care provider, a case manager, and a mental health specialist to screen for depression, monitor symptoms, provide treatment, and refer to specialty care as needed.[13,14,15]
- Depression Screening and Follow-Up is included as a measure in the CMS Universal Foundation Measures for the pediatric and adult Behavioral Health domain.[16]

Measure Description

Numerator: 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 tool AND if positive, a **follow-up plan** is documented on the date of the eligible encounter or up to two days after the qualifying encounter.

What counts as documentation of a **follow-up plan**:

- **Referral for additional evaluation/assessment**
    1. Referral orders for behavioral health services entered in Epic (see Appendix 4)
    2. Depression Treatment/Follow-up Flowsheet
    3. QM Depression Follow-up Plan (NQF0418) SmartList
- **Pharmacological interventions**
    1. Medication orders recorded in Epic, based on adolescent vs. adult depression medication value sets listed for CMS2v13 metric. Counted if:
        a. Ordering date within 2 days of positive screening, or
        b. Medication already active as of positive screening and medication was reviewed during the visit

2. Depression Treatment/Follow-up Flowsheet
3. QM Depression Follow-up Plan (NQF0418) SmartList

- **Other ("Watchful waiting," "Medication & Counseling not appropriate")**
    1. Depression Treatment/Follow-up Flowsheet
    2. QM Depression Follow-up Plan (NQF0418) SmartList

Denominator: Number of patients ages 12 and older at the beginning of the measurement period, with an office visit in the last 12 months.

Exclusions: Patients who have been diagnosed with bipolar disorder, refuse, or there is a documented medical reason for not screening the 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).

Note: A score of 10 or above is considered positive.[17,18] This can be overridden by the provider.

More details regarding depression screening tools and referral orders counted for documentation of follow up plan for positive depression screen can be found in the 'sources' section of the guide (pages 21 – 22).

Strategies and Resources for Improvement

- Consider patient-administered screening up to 14 days prior to patient appointments, either electronic or paper.[19]
- Embed depression screening into the patient check in process.
- NAMI: **The Ripple Effect of Mental Illness**
- **NAMI Maine Fact Sheet**

Quick Tip: Be sure to document external screening results appropriately. For MaineHealth Epic practices, refer to the Clinical Quality Measures guide for more details on documentation.

Diabetes: Eye Exam

Significance

Eye diseases affecting people with diabetes can lead to blindness. Diabetic retinopathy has an insidious onset and progression which can be managed with effective treatment when detected early. Early detection by screening for diabetic retinopathy can protect eyesight and significantly decrease future morbidity.[20] Studies suggest patients with diabetes have a 25 times increased risk of developing blindness, than those patient who do not.[21] It is estimated that 21% of patients with type 2 diabetes have retinopathy at the time of their diabetes diagnosis.[22]

- Studies suggest that screening for retinopathy in patients with type 1 diabetes would save 70,000 years of sight. For patients with type 2 diabetes, screening would save an estimated 94,000 years of sight.[23]

Measure Description

Numerator: Number of patients in the denominator with documentation of a retinal or dilated eye exam in the last 24 months or last 12 months for patients with retinopathy.

Denominator: Number of patients with diabetes (type 1 or type 2), ages 18-75 at the beginning of the measurement period diagnosed and having an office visit during the measurement period.

Strategies and Resources for Improvement

- Educate patients with diabetes on the importance of annual eye exams, even when asymptomatic for vision changes. Communicate to patients that they use their medical benefits for a retinal eye exam, not their vision benefits.
- Explore expansion of digital and artificial intelligence solutions for collecting and interpreting retinal images. Care teams have had great success with in-office retinal scanners for patients who have a new diabetes diagnosis or who have had past normal eye exams.
- Assist patients with scheduling their retinal eye exam.

Quick Tip: Scan and document external eye exam results appropriately. For MaineHealth Epic practices, refer to the Clinical Quality Measures guide for more details on documentation.

Diabetes: HbA1c >9% Poor Control

Significance

- Better glycemic control is associated with 50–76% reductions in rates of development and progression of microvascular (retinopathy, neuropathy, and diabetic kidney disease) complications.[24] Achieving HbA1c targets of <7% (53 mmol/mol) has been shown to reduce microvascular complications of type 1 and type 2 diabetes when instituted early in the course of disease. In type 2 diabetes, there is evidence that more intensive treatment of glycemia in newly diagnosed patients may reduce long-term cardiovascular disease rates.[25]
- Poor glycemic control is associated with increased healthcare costs related to hospitalization & medications.[26]

Measure Description

Numerator: Number of patients in the denominator with either: the most recent HbA1c (within the last 12 months) that is > 9% OR no HbA1c test was completed.

Denominator: Number of patients with diabetes (type 1 or type 2), ages 18-75 at the beginning of the measurement period diagnosed and having an office visit during the measurement period.

Exclusions: Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness with two outpatient encounters during the measurement period or the year prior- OR advanced illness with one inpatient encounter during the measurement period or the year prior- OR taking dementia medications during the measurement period or the year prior.

Note: This is an inverse measure, so a lower rate is better.

Strategies and Resources for Improvement

- The Primary Care Specialty Council subcommittee for Adult Quality Improvement is developing a standard care pathway for diabetes on target for publication in FY 24. For more information, contact Lauren Atkinson, Director of Quality for MaineHealth Medical Group at Lauren.Atkinson@mainehealth.org.
- The MaineHealth Living Well with Diabetes Self-Management Program helps adult patients learn how to better manage their type 2 diabetes. Patients should be referred to Living Well with Diabetes through **Epic REF216**.
- **MaineHealth Diabetes Podcast: Shared Decision Making in Diabetes Care**: This podcast discusses ways to have an open conversation, identifies important questions to ask your patients, and how to help your patients set HbA1c and self-care goals.

- **MaineHealth Project ECHO – Endocrinology**: Meet on the second Tuesday of each month, 7:30-8:30 a.m. Endo ECHO sessions provide primary care physicians and other clinicians an opportunity to learn about & discuss a broad range of disorders related endocrinology and diabetes.
- Implement Point-of-Care testing or order HbA1c test before patients come in for their visit.

Quick Tip: Scan and document external HbA1c results appropriately. For MaineHealth Epic practices, refer to the Clinical Quality Measures guide for more details on documentation.

Diabetes: HbA1c Disparities Gap

Significance

This measure supports MaineHealth's overall strategy to advance and embed health equity into every aspect of care models, while increasing the focus on underserved populations. The ACO brought this innovative measure into the Heat Map in FY23 to begin conversations related to health equity and identify opportunities to build systems for reducing disparities in our communities. Recognizing the limitations of quality measurement and acknowledging that quality measures alone cannot solve for equity, clinical leadership across the system voiced strong support for examining data on disparities within clinical quality measures and beginning work to identify and address systems that create health inequities. Additional rationale for the inclusion of the health disparities measure in the Heat Map include:

- Payers initiating the inclusion of health equity in value-based contracts, including screening for Social Determinants of Health and reviewing disparities on health outcomes measures.
- The CMS Innovation Center has committed to embedding health equity into every aspect of the CMS Innovation Center models, increasing the focus on underserved populations.[27]
- The HbA1c Poor Control (>9%) measure assesses management of populations with chronic disease and is noted to be disparities-sensitive by the National Quality Forum.[28]

Note: Insurance status is currently used to stratify patient populations. Several investigators have used insurance status as a proxy for individual socioeconomic status[29] and Medicaid coverage, with the exception of limited medical conditions, is only provided to patients below the federal poverty level. Thus, in the absence of other socioeconomic status information, Medicaid coverage is a reasonable surrogate for low socioeconomic status and may be related to the receipt of evidence-based therapies.[30]

Measure Description

Disparities Gap: The delta between the rate of control for patients with commercial insurance coverage compared to the rate of control for an aggregate rate of patients with MaineCare and no insurance coverage.

Numerator from HbA1c >9% Poor Control: Number of patients in the denominator whose most recent HbA1c (within the last 12 months) is > 9% or no HbA1c test was completed.

Denominator from HbA1c >9% Poor Control: Number of patients with diabetes (type 1 or type 2), ages 18-75 at the beginning of the measurement period diagnosed and having an office visit during the measurement period.

Strategies and Resources for Improvement

- The MaineHealth Primary Care Specialty Council Subcommittee for Adult Quality Improvement is developing a standard care pathway for diabetes (on target for publication in FY 24) which will be a basis for tracking and improving care for all patients with diabetes. For more information, contact Lauren Atkinson, Director of Quality for MaineHealth Medical Group at Lauren.Atkinson@mainehealth.org.
- The MHMG is developing a standard process to increase the rate at which providers, care teams and care coordination staff assess and document Social Determinants of Health (SDOH)-related information with patients to assist in connecting patients with needed resources. For more information, contact Malindi Thompson, Manager of SDOH – Population Health Management team for MaineHealth Medical Group at Malindi.Thompson@mainehealth.org.
- The MaineHealth Living Well with Diabetes Self-Management Program helps adult patients learn how to better manage their type 2 diabetes. Patients should be referred to Living Well with Diabetes through **Epic REF216**.
- **MaineHealth Diabetes Podcast: Shared Decision Making in Diabetes Care**: This podcast discusses ways to have an open conversation, identifies important questions to ask your patients, and how to help your patients set HbA1c and self-care goals.
- **MaineHealth Project ECHO – Endocrinology**: Meets on the second Tuesday of each month, 7:30-8:30 a.m. Endo ECHO sessions provide primary care physicians and other clinicians with the opportunity to learn about and discuss a broad range of disorders in the fields of endocrinology and diabetes.
- To address cost barriers:
    - Refer patients to the Patient Assistance Line in Epic using **REF155** or PAL (also available by emailing PatientAssistLine@mainehealth.org or 1-833-644-3571)
        - The Patient Assistance Line helps patients with needs beyond medical care, such as housing, transportation, food insecurity, and much more.
    - Refer patients to **MedAccess Program** in Epic using **REF155** or PAL (also available by emailing MedAccessProgram@mainehealth.org or 1-877-275-1787)
        - The MedAccess Prescription Assistance Program is a statewide program to assist anyone struggling to pay for medications apply for free prescription assistance programs through pharmaceutical companies, find less expensive generic alternatives and price check medications at different pharmacies for a lower cost.
    - Refer patients to a Lend-a-Hand Care Manager by sending a request to your local Lend a Hand team's clinical pool or to the Population Health care coordination pool (pool# 940900).
    - **FindHelp** (formerly known as Aunt Bertha) offers resources related to Diabetes and SDOH-related needs. Care Teams can access FindHelp through Epic, and patients have access to FindHelp through MyChart or online.

- Refer to insurance-specific formulary coverage:
  - MaineCare Preferred Drug List: http://mainecarepdl.org/pdl
  - VA National Formulary - Pharmacy Benefits Management Services: https://www.pbm.va.gov/nationalformulary.asp
- If patients are unable to afford or need assistance with insulin: Consider ReliOn Novolin Regular vial, ReliOn Novolin NPH vial, ReliOn Novolin 70/30 mix vial, ReliOn Novolin 70/30 mix pens provided at low cost at Walmart.

Diabetes: Kidney Health Evaluation

Significance

- Diabetic kidney disease affects 33% of patients with diabetes and is the leading cause of end-stage renal disease in the United States.[31,32] Chronic kidney disease typically develops slowly, without signs/symptoms in the early stages, so testing is paramount for early detection and intervention.[33]
- Hypertension and diabetes are top two risk factors for developing chronic kidney disease. Studies demonstrate that a majority of patients are not receiving both a urine microalbumin/creatinine ratio (uACR) and serum creatinine to assess chronic kidney disease as recommended by clinical practice guidelines.[34]
- The 2020 HEDIS measure aims to improve kidney disease testing by assessing the percentage of adults with diabetes who have received both blood and urine kidney tests within the last 12 months.
- The combination of estimated glomerular filtration rate (eGFR) and uACR testing is a strong predictor of cardiovascular mortality and kidney failure risk.[35]

Measure Description

Numerator: Number of patients who received an annual kidney health evaluation, including both estimated glomerular filtration rate (eGFR) and urine microalbumin/creatinine ratio (uACR).

Denominator: Number of patients with diabetes (type 1 or type 2), ages 18-75 at the beginning of the measurement period diagnosed and having an office visit during the measurement period.

Exclusions: End-Stage Renal Disease, frailty and advanced illness.

Note: There are no exclusions for patients on ACEs or ARBs.

Strategies and Resources for Improvement

- The MaineHealth Living Well with Diabetes Self-Management Program helps adult patients learn how to better manage their type 2 diabetes. Patients should be referred to Living Well with Diabetes through **Epic REF216**.
- **MaineHealth Diabetes Podcast: Shared Decision Making in Diabetes Care**: This podcast discusses ways to have an open conversation, identifies important questions to ask your patients, and how to help your patients set HbA1c and self-care goals.
- **MaineHealth Project ECHO – Endocrinology**: Meets on the second Tuesday of each month, 7:30-8:30 a.m. Endo ECHO sessions provide primary care physicians and other

clinicians with the opportunity to learn about and discuss a broad range of disorders in the fields of endocrinology and diabetes.

- **NCQA Kidney Health Provider Guide**

Quick Tip: The MaineHealth Epic team has added Health Maintenance support topics to help providers order both tests needed to detect and assess chronic kidney disease.

Diabetes: Statin Therapy

Significance

- Statin therapy has been shown to be effective as both a primary and secondary prevention of cardiovascular disease and mortality for individuals with diabetes.[36]
- According to guidelines from the American Diabetes Association (ADA),[37] American Heart Association (AHA),[38] and the American College of Cardiology (ACC),[39] statin medication is recommended for all patients with diabetes between the ages of 40 to 75, regardless of LDL level, to help prevent heart disease.

Measure Description

Numerator: Patients in the denominator who were seen in the last year with an active statin medication of any intensity on their medication list.

Denominator: Number of patients with diabetes (type 1 or type 2), ages 40-75 at the beginning of the measurement period diagnosed and having an office visit during the measurement period.

Exclusions: Clinical atherosclerotic cardiovascular disease (ASCVD).

Strategies and Resources for Improvement

- Evaluate patients with diabetes to determine if a statin medication is clinically appropriate. Initiate statin therapy as appropriate for patients without contraindications.
- Prescribe low-cost generics to eliminate cost as a barrier: atorvastatin, lovastatin, pravastatin, simvastatin, and rosuvastatin are available for $0 for extended days' supply prescriptions (for example, 90-days).
- Help patients manage potential side effects. Educate patients about the long-term cardiovascular benefits and potential side effects of a statin medication (for example, myalgia). If a patient experienced statin intolerance previously, a trial of a lower dose or of a different statin medication may help reduce risk or side effects. If no contraindications, consider a short trial of statin therapy.

HPV Vaccination

Significance

Every year in the United States, an estimated 37,300 individuals are diagnosed with cancer caused by HPV infection.[40] Human papillomavirus (HPV) cannot be treated, but vaccination can prevent transmission and protect against six cancers if initiated prior to exposure. HPV vaccination protects against more than 90% of HPV cancers when given at recommended ages.[41]

Initiating the HPV vaccination series at age 9 is recommended by the American Cancer Society, the American Academy of Pediatrics, and the National HPV Vaccination Roundtable. Previous guidance from the Centers for Disease Control (CDC) and Advisory Committee on Immunization Practices (ACIP) recommends routine HPV vaccination at age 11 or 12 years but notes that the HPV vaccine can be given starting at age 9.[42]

Measure Description

Numerator: Number of patients in the denominator who received 2 doses of HPV vaccine by their 13th birthday.

Denominator: Total number of patients 13 years of age at the end of the measurement period.

Strategies and Resources for Improvement

- Focus the conversation with parents or guardians on the importance of cancer prevention. Begin the discussion early, by the 9-year-old well-child visit.
- Initiate HPV #1 by age 11 and complete the series with nurse visit after HPV #1.
- Importance of scheduling:
    - Make sure patients schedule their next appointment before they leave the office. Consider scheduling the next appointment during the rooming process.
    - For patients who leave without scheduling a follow-up appointment, call them back the same day to schedule the follow-up appointment.
    - Tip: Schedule a 6-month nurse visit for HPV #2 after administering HPV #1
    - Tip: Provide scripting for schedulers to encourage patients to schedule appointments
- Consult the MaineHealth **Pediatric Primary Care Quality Toolkit** available on the MaineHealth Medical Group Intranet in the Resource Library under Quality and Safety.
- **MaineHealth Childhood Immunizations Webpage**
- CDC infographic: **https://www.cdc.gov/hpv/hcp/hpv-important/infographic-hpv-screening-508.pdf**

Hypertension Control

Significance

- Elevated blood pressure has been shown to account for 58.3% of deaths from hemorrhagic stroke and 54.5% of deaths from ischemic heart disease.[43]

Measure Description

Numerator: Number of patients in the denominator whose most recent and lowest BP reading of the day in the last 12 months is < 140/90.

Denominator: Number of patients with essential (primary) hypertension, ages 18-85 at the beginning of the measurement period diagnosed, with an office visit in the last 12 months.

Exclusions: End-Stage Renal Disease, pregnancy.

Strategies and Resources for Hypertension Improvement

- The Primary Care Specialty Council subcommittee for Adult Quality Improvement is developing a standard care pathway for hypertension and is on target for publication in FY 24. For more information, contact Lauren Atkinson, Director of Quality for MaineHealth Medical Group at Lauren.Atkinson@mainehealth.org.
- **MaineHealth Hypertension Control Toolkit**
- Other strategies and recommendations are available in the American Heart Association's **Target: BP Guidelines and Practices**
- Additional highlights from the **2017 Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults**.
- Help your patients manage their weight with **Small Steps**.

Quick Tip: If a patient's first blood pressure reading is elevated, the clinical staff can alert the provider to take a second blood pressure reading before the patient leaves and document the second result in the EMR. For quality reporting, the measure combines the lowest systolic and the lowest diastolic readings taken on the same day.

Patient Experience: Would Recommend Office

Significance

- Better patient experience of care correlates with improvements in:
    - Chronic disease management[44]
    - Adherence to medical advice and treatment plans[45,46]
    - Better health outcomes[47,48,49]
    - System issues, such as access, timeliness of test results, etc.
- Better patient experience is not associated with low-value care[50]
- Patient Experience measures are increasingly weighted in Medicare Advantage Stars.

Measure Description

Numerator: Net promoter score for email/phone survey question, "How likely would you be to recommend this office to your family and friends?" for the National Patient Experience Survey question from NRC (rolling 3 months).

- Net promoter score: % patients with a 9-10 rating minus % of patients with 0-6 rating

Denominator: Number of patients surveyed by the National Patient Experience Survey question within the past rolling 3 months.

Data source: NRC Health Real-Time survey via the MaineHealth System Quality Dashboard *(note: St. Mary's uses the Press Ganey survey question for "Likelihood of recommending")*

Strategies and Resources for Improvement

- **Quick Tip**: For access to MaineHealth Patient Experience coaching and resources, contact Helena Ackerson, VP of Patient Experience.
- The Beryl Institute is a leadership organization focused on providing resources and research for improving patient experience. This includes:
    - **The Patient Experience Journal (PXJ)**, a peer-reviewed, open-access journal
    - To Care is Human: A Patient Experience Podcast: https://www.theberylinstitute.org/page/PXPodcast
    - A library of patient experience case studies: https://www.theberylinstitute.org/page/CASE

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More details regarding Depression Screening and Follow-Up Measure:

Scoring Criteria for Depression Screening Tools Included

Instrument	Screening Type[a]	Cutoff for Positive Screen[b]
Patient Health Questionnaire-2 (PHQ-2)	Initial	3
Pediatric Symptom Checklist-17 (PSC-17) Internalizing Subscale[c]	Initial	5
PHQ-9	Full	10
PHQ-A	Full	10
Edinburgh Postnatal Depression Scale (EPDS)	Full	10

[a]Workflow at MaineHealth is to administer a full depression screening for patients who are positive on an initial screening tool. However, if a subsequent full screening is not recorded in Epic, then the initial screening score will determine if a follow-up plan should have been documented for the patient.

[b]Definition of a positive screen is based on the total score only and does not take into consideration responses to individual questions.

[c]The PSC-17 is completed by the parent/guardian of the patient and, depending on the patient's age, the patient themselves. In situations where multiple individuals completed the PSC-17 and there are discrepancies in the internalizing score, the highest score recorded on a particular day is selected.

Encounter and Visit Provider Types Used to Define "Completed Visit During the Measurement Period"

Provider Types	Encounter Types
Case Manager [19]	Anti-Coag [1001]
Fellow [2521]	Appointment [50]
Licensed Nurse [107]	Clinical Support [2101]
Medical Assistant [114]	DM Nurse Visit [2107]
Midwife [5]	Facility Visit [2110]
Nurse Practitioner [9]	Home Care Visit [91]
Nutritionist [104]	IMAT [1005]
Osteopath [111]	Immunization [108]
Pharmacist [102]	Initial consult [1000]
Physician [1]	Initial Prenatal [1201]
Physician Assistant [6]	MH IMAT [0688]
Psychologist [10]	Nurse Only [201]
Registered Dietitian [116]	Nutrition [203]
Registered Nurse [3]	Office Visit [101]
Resident [113]	Offsite Visit [2509]
Resource [0]	Physical Therapy [2106]
Social Worker [112]	Postpartum [5000]
	Procedure only [121]
	Procedure visit [1003]
	Routine Prenatal [1200]
	Surgical Consult [2100]
	Survivorship [6503]
	Telemedicine [76]

Referral Orders Counted for Documentation of Follow-Up Plan for Positive Depression Screen

AMB REF TO LMP FAM MED BBH BEHAVIORAL HEALTH (REF78480)
AMB REF TO LMP FAM MED WALDOBORO BEHAVIORAL HEALTH` (REF78482)
AMB REF TO LMP FAM MED WISCASSET BEHAVIORAL HEALTH (REF78481)
AMB REF TO LMP WOMENS CENTER BEHAVIORAL HEAL* (REF78483)
AMB REFERRAL TO BEHAVIORAL HEALTH (REF8)
AMB REFERRAL TO COUNSELING (REF7001)
AMB REFERRAL TO FHP BEHAVIORAL HLTH FARM (REF11012)
AMB REFERRAL TO FHP BEHAVIORAL HLTH LIV (REF11013)
AMB REFERRAL TO GERATRIC PSYCHIATRY (REF2128)
AMB REFERRAL TO LHM OCCUPATIONAL THERAPY (REF8009)
AMB REFERRAL TO LHS OCCUPATIONAL THERAPY (REF8013)
AMB REFERRAL TO LMP FAM MED DAM BEHAVIORAL HEALTH (REF78479)
AMB REFERRAL TO LMP PRIMARY CARE DAM BEHAVIORAL HEALTH (REF7891)
AMB REFERRAL TO MBH ACT CORE BRUN (REF60912)
AMB REFERRAL TO MBH COE CASE MANAGEMENT (REF15402)
AMB REFERRAL TO MBH COE EARLY INTERV (REF60926)
AMB REFERRAL TO MBH CRISIS (REF60905)
AMB REFERRAL TO MBH CRISIS BRUN (REF60906)
AMB REFERRAL TO MBH HUB BID (REF60922)
AMB REFERRAL TO MBH HUB POR (REF60904)
AMB REFERRAL TO MBH OP PROGRAMS BEL (REF60902)
AMB REFERRAL TO MBH OP PROGRAMS BID (REF60921)
AMB REFERRAL TO MBH OP PROGRAMS BRUNSWICK (REF60925)
AMB REFERRAL TO MBH OP PROGRAMS DAM (REF60911)
AMB REFERRAL TO MBH OP PROGRAMS FARM (REF60903)
AMB REFERRAL TO MBH OP PROGRAMS NOR (REF60907)
AMB REFERRAL TO MBH OP PROGRAMS PORTLAND (REF60924)
AMB REFERRAL TO MBH OP PROGRAMS ROC (REF60910)
AMB REFERRAL TO MBH OP PROGRAMS SPRG (REF60920)
AMB REFERRAL TO MCH SENIOR BEHAVIORAL (REF78901)
AMB REFERRAL TO MMC FM BEHAVIORAL HEALTH (REF1008)
AMB REFERRAL TO MMC FM PSYCHIATRY (REF1091)
AMB REFERRAL TO MMC FM SOCIAL WORK (REF1098)
AMB REFERRAL TO MMC OCCUPATIONAL THERAPY (REF9953)
AMB REFERRAL TO MMC OP PSYCH ADULT (REF60901)
AMB REFERRAL TO MMC OP PSYCH CHILD (REF60913)
AMB REFERRAL TO MMC OP PSYCH GERIATRIC (REF60909)
AMB REFERRAL TO MMC OUTPT CARE-ONC SOCIAL WORK (REF500118)
AMB REFERRAL TO MMC OUTPT CARE-ONCOLOGY PSYCHOLOGY (REF5003)
AMB REFERRAL TO MMC PSYCHIATRY (REF9101)
AMB REFERRAL TO MMP OPD PSYCHIATRY (REF2010)
AMB REFERRAL TO MMP PSC DEV & BEHAV HEALTH (REF101001)
AMB REFERRAL TO MMP SO PORTLAND PEDS BEHAVIORAL HEALTH (REF5874)
AMB REFERRAL TO MNHP BEHAVIORAL HEALTH (REF23108)
AMB REFERRAL TO OCCUPATIONAL THERAPY (REF53)
AMB REFERRAL TO PB IM THERAPY - LEDDINGTON, LCSW (REF1198)
AMB REFERRAL TO PBMC PSYCHIATRY (REF7027)
AMB REFERRAL TO PEDIATRIC PSYCHIATRY (EXTERNAL REFERRAL) (REF80)
AMB REFERRAL TO PEDIATRIC PSYCHOLOGY (REF81)
AMB REFERRAL TO PSYCHIATRY (REF91)
AMB REFERRAL TO PSYCHOLOGY (REF92)
AMB REFERRAL TO SMHC PSYCH FOR ECT (REF4040)
AMB REFERRAL TO SMHP DEV BEHAVIORAL HEALTH PEDS (REF32007)
AMB REFERRAL TO SMOKING CESSATION PROGRAM (REF100)
AMB REFERRAL TO SOCIAL WORK (REF98)
AMB REFERRAL TO SOCIAL WORK SMHP IM BID (REF2120)
AMB REFERRAL TO TRANSPLANT PSYCHIATRY (REF1607)
AMB REFERRAL TO WCGH PEDIATRICS OCCUPATIONAL THERAPY (REF31001)
AMB REFERRAL TO WCGH REHAB SERVICES OCCUPATIONAL THERAPY (REF31003)
AMB REFERRAL TO WMHS OCCUPATIONAL THERAPY (REF8004)
MMC OP PSYCH FOR ECT (REF60914)