Approaches to Depression Screening

Capital District Physicians’ Health Plan (CDPHP)

Program Overview
Under a program called Improving Mood–Promoting Access to Collaborative Treatment (IMPACT), older adults with major and/or chronic depression receive evidence-based integrated care delivered by a collaborative team. The IMPACT model has two key processes. The first involves screening and tracking of depression outcomes using the PHQ-9 questionnaire. The second is the repeated use of the PHQ-9, with adjustments to interventions as needed. The IMPACT model includes a case manager who works with the primary care provider. The case manager educates patients about depression, supports antidepressants prescribed by the primary care provider and refers patients to psychiatric treatment as necessary. Supervision by a psychiatrist is also part of the model.

CDPHP launched its IMPACT program in January 2013. The program seeks to help members who suffer from depression with a co-morbid diagnosis of diabetes. CDPHP behavioral health case managers work with Enhanced Primary Care (EPC) practices to screen adult patients for depression who have diabetes. CDPHP’s EPC program supports providers in a transition toward teamwork, efficiency, coordination of care and treating “the whole patient.”

Diabetic Population
A bidirectional association has been found between depression and diabetes. Depression is a risk factor for diabetes, and diabetes increases risk for the onset of depression. Data from the Centers for Disease Control and Prevention (CDC) indicate 28 percent of people with diabetes have undiagnosed major depression. Not only is depression common in patients with diabetes, but it also contributes to poor adherence to medication and dietary regimens, physical inactivity, poor glycemic control, reduced quality of life, disability, increased risk for morbidity and mortality and increased health care expenditures.

Screening Process
The screens are done annually. The goal is to identify patients with depression so they get the treatment and support they need to reach remission of depression and to increase adherence with their diabetic care.

Adult patients with diabetes are screened for depression with the PHQ-9 during an appointment with their primary care provider (PCP). A CDPHP behavioral health case manager reaches out to patients who screen positive for depression on the PHQ-9. The behavioral health case manager makes guideline-based treatment recommendations and encourages adherence if there is an already existing treatment plan. Through in-person sessions and telephone conversations, the behavioral health case manager provides education about depression and diabetes, emphasizing the importance of controlling depression to manage diabetes; helps identify target symptoms; explains the rationale for antidepressant and oral hypoglycemic agent use; and assesses for side
effects. The behavioral health case manager re-administers the PHQ-9 at four-week intervals to assess if treatment is effective. Failure to improve leads to increased intensity of treatment. Significant improvement leads to disengagement from the active protocol into maintenance care. All information is reported back to the patient’s treating providers.

The behavioral health case manager follows the patient throughout their course of treatment to provide education, support, encouragement and empowerment. Patients and their levels of progress are tracked in a database. All outcomes are monitored. The behavioral health case manager works collaboratively with the CDPHP medical case manager who assists the patient with diabetes self-management. The behavioral health case manager is responsible for coordinating care between the relevant providers.

Outcomes
The IMPACT-based programs for treating depression in primary care settings have consistently shown positive or neutral return on investment (ROI) when deployed with the 60 years or older population and the population with chronic disease, particularly those with diabetes.

Dean Health Plan

Dean Clinic uses the PHQ-9 to assess for depression. Staff members have taught primary care physicians how to use this tool and how to use the PHQ-2 as an initial screen. The tool is incorporated into Dean members’ electronic medical records (EMR). Currently, the department of psychiatry is discussing whether it would be wise to include the PHQ-9 as a monitoring tool for depressed patients. No decision has been made as of this date.

The only specific group screened for depression is post-partum mothers. These mothers are screened with the Edinburgh Postnatal Depression Scale (EPDS). This is an initiative started within the past year (2013).

Fallon Health

Fallon Health uses the PHQ-9. A licensed nurse or social worker, employed by FTC, administers the test to every new member, during an initial in-home, comprehensive assessment of health and social service needs and goals.

Geisinger Health Plan

Program Overview
As part of an integrated health system, Geisinger Health Plan has had two depression screening programs in place: one on the clinical side and a similar model enacted by the health plan. Geisinger Health System’s ClinicalEnterprise began using PHQ-2 and PHQ-9 in 2012. The program began at a few select primary care clinics among patients over age 65. Geisinger ultimately expanded the program to all Community Practice Service Line (CPSL) sites and to the 18 to 25-year-old
population. In October 2013 the program expanded to all adults over age 18 and today the program operates in 42 PCP sites. In July 2013, Geisinger Health Plan began a similar program with Proven Health Navigator medical home case managers and adult health plan members.

**Screening Process**

In the CPSL program, nurses give patients tablet computers with PHQ-2 loaded. If the patient scores a 3 or higher, the remaining seven PHQ-9 questions load. The results are then immediately available to the primary care physician (PCP) when the PCP accesses the patient’s electronic medical record (EMR). A smart set loads in the EMR offering the PCP options regarding course of action, ranging from monitor to hospitalization.

Under the Geisinger Health Plan program, a nurse case manager administers the PHQ-2 and moves on to PHQ-9 if positive. Nurse case managers share the results with the PCP.

**Outcomes**

The system has completed close to 40,000 screens with 70 percent of patients showing no depression, 27 percent mild depression, two percent moderate depression and one percent severe depression. To date there has been no effort to examine preferred treatment modalities or their effectiveness. The Community Practice Service Line program initially encountered some anxieties among PCP office staff over lack of training. In response, the program was rolled out slowly and Geisinger’s Center for Best Practices provided staff members with education on incidence of depression, workflow and referral resources.

**Group Health Cooperative**

**Program Overview**

Group Health Cooperative’s Behavioral Health Services (BHS) department is accountable for the entire segment of Group Health’s membership experiencing mental health and chemical dependency problems. BHS is responsible across the full continuum of services, in both the provision of care as well as behavioral health benefit management of Group Health’s insurance products.

The BHS delivery system consists of:

- Seven BHS staff model specialty clinics statewide;
- A network of 1500+ contracted outpatient community providers for mental health (MH) and chemical dependency (CD) services;
- Network-based inpatient services for MH and CD; and
- Three pilot Primary Care Medical Homes with integrated behavioral medicine specialists (out of 26 Primary Care Medical Centers statewide).

The BHS Health Plan Operations includes care management services that are multidisciplinary in scope. The BHS care management teams provide coordination with Complex Medical Care Management for members with complex co-morbid physical and behavioral health conditions that
are being treated both within the integrated group practice and contracted, network primary care providers.

**Screening Process**

In specialty BHS, the PHQ-9, is administered at each intake, along with Audit & Dast and other screening questions. The patient fills out the assessment packet in the waiting area of the clinic. It is scored and discussed with the patient in the exam room. If Question #9 on the PHQ-9 scores 2 or 3, a Columbia Suicide Risk Assessment (CSRA) is performed and a crisis plan is developed. PHQ-9 results are entered into a flow sheet while the crisis plan is input into the problem list within the patient’s electronic medical record (EMR). The PHQ-9 can also be sent in a secure patient e-mail as a follow-up measurement. Specialty BHS is in the early stage of developing a pilot for a team-based “Treat-to-Target” model using its progress monitoring tool. If the PHQ-9 score is less than 10, the BHS clinician may consider the patient for discharge. In Group Health’s PCMH, the PHQ-2, and if indicated, PHQ-9 is used as a screening tool in both well & routine visits. A PHQ-9 is used during chronic disease management care visits.

If the member in a network primary care setting receives a high PHQ-9 score in the Health Risk Assessment (HRA), their case is addressed by Complex Medical Care Management. If a member receives a moderate to low score, the member is contacted and asked if they would like to be contacted by a coach from an outside vendor.

In Specialty Behavioral Health, Group Health uses a team-based visual system to track the gap in utilization of the PHQ-9 to the target. If there is a gap, teams discuss the causes and problem-solve to close it. Solutions are shared through regular training and collaboration sessions. In addition to ongoing training, BHS provides psychiatric consultation to both internal and contracted primary care providers for tackling medication issues and other treatment recommendations. Psychiatric consultants also support primary care providers in suicide risk assessment when applicable. Group Health is expanding the use of the CSRA to integrated group practice social workers during the first quarter of 2014.

**Lessons Learned**

Group Health’s longstanding focus on depression care management has created a common culture across service lines in the use of the PHQ-9, making the evidence-based tool part of the “standard work” for both screening and monitoring. Creating guidelines for PHQ-9 use and synching scores with the EMR flow sheets for each line of service have improved internal consistency for use of the tool. Entering the results in the EMR allows for communication between providers in the delivery system and supports them in measuring progress in treatment with the member across departments.

In Specialty Behavioral Health, Group Health is developing a pilot to test a “treat-to-target” depression care model with the anticipated outcome of shortening an outpatient episode of care. The same “treat-to-target” depression care model was used in Primary Care for members with co-morbid chronic health conditions such as diabetes and coronary heart disease and the program was
shown to improve health outcomes as measured by HbA1C, LDL, total cholesterol & systolic blood pressure with effective depression care.

**Group Health Cooperative of South Central Wisconsin (GHC-SCW)**

**Program Overview**
Group Health Cooperative of South Central Wisconsin (GHC-SCW) understands that depressive disorders are common, costly and treatable, but that they often go unrecognized. GHC-SCW provides screening for depression in primary care settings and couples the screening with primary care behavioral health services to ensure adequate treatment and follow-up. The focus on screening for depression in primary care comes from the fact that almost two thirds of patients with depression receive care in that setting.

GHC-SCW promotes the use of the PHQ-2 and PHQ-9 by primary care providers and behavioral health providers. The use of these instruments is recommended in GHC-SCW’s clinical guideline *Diagnosing and Treating Depression – Adult Primary Care*. The use of the instruments provides a consistent measure of depression across the organization. This consistency improves communication, data analysis and reporting. Additionally, the PHQ-2 and PHQ-9 are available in many languages. All patients ages 12 and older are screened annually with the PHQ-2. Patients who screen positive on the PHQ-2 are administered PHQ-9 for further diagnosis.

**Screening Process**
The PHQ-9 is currently being used primarily in ambulatory provider settings. It is used in both primary care settings and specialty behavioral health settings. Some additional specialties use it spontaneously. The PHQ-9 is used by health plan staff such as embedded nurse case managers and behavioral health care managers, but this is not a routine or standardized practice at this point. An upcoming project will pilot administration of the PHQ-2 by health plan case management staff during the “on-boarding” process for new members with chronic conditions such as diabetes, chronic pain, and cardiovascular disease.

Mental health providers use the PHQ-9 in initial intake appointments and diagnostic assessment sessions, as well as during treatment to measure of symptom reduction. GHC-SCW’s primary care behavioral health specialists use the PHQ-9 in primary care when members have chronic illnesses such as diabetes, chronic pain, and cardiovascular disease.

The PHQ-9 is available within the patient’s Electronic Medical Record (EMR). Each administration is stored by date so scores can be reviewed and trended over time. PCPs, behavioral health specialists, nurses and case managers have access to the flow sheets portion of the record and can view the PHQ-9 scores. Through the use of “dot-phrases,” specific elements of the PHQ-9 and historical trends can be brought into progress notes.

The majority of the PHQ-9 tests are administered and completed in the outpatient clinic setting. The PHQ-9 is sent out to members and returned directly into EMR flow sheet via secure MyChart messaging. Furthermore, a provider can “post-date” a MyChart message with PHQ-9 attached to be delivered to a member at a later date. For example, when initiating antidepressant therapy the provider can post-date a MyChart PHQ-9 message to be delivered to member four to six weeks after prescription date. In some situations the PHQ-9 is administered over the phone as a follow-up measure or as part of a triage process. Regular U.S. mail has been used with members who do not have a MyChart account.
Lessons Learned
Providers and other staff report satisfaction with PHQ-9 as a consistent, easy-to-use method for assessing and monitoring depressive symptoms across the organization. Primary care physicians in particular appreciate the assistance the PHQ-9 provides in diagnosing, establishing a baseline severity of symptoms, assessing symptoms over time and a basis for identifying a stepped care approach to adapt treatment. Providers note, mainly through verbal feedback, great value in having the PHQ-9 in EMR and available to members via secure messaging.

In establishing use of screening in primary care it is important to obtain buy-in and develop champions across primary care, behavioral health and nursing. The use of clear, evidenced-based rationale and guidelines are helpful in this regard.

It is important to provide assistance with workflow development for administration. While the instrument is relatively simple to administer and score, it is important to provide training on the use of measure, how to introduce it to members, scoring, and clinical implications. GHC-SCW is in the process of developing specific measures regarding the use of PHQ-9.

GHC-SCW is working toward including an age-appropriate instrument such as the Center for Epidemiological Studies Depression Scale for Children (CES-DC) for younger children.

HealthPartners

Program Overview
HealthPartners has a long history of leadership in supporting improved health care outcomes by setting stretch goals, defining measurement parameters and partnering with health care systems on best practices. Our Partners for Better Health program targets selected conditions for collaborative, multi-year quality improvement efforts. In 1999, Partners for Better Health added depression to the list of conditions. Health plan and care delivery system leaders teamed up to launch depression screening and treatment efforts.

From 2001 through 2003, HealthPartners was one of seven organizations which participated in a RWJ funded national initiative Pursuing Perfection. This catalyzed a redesign and standardization of a care model process that incorporated best practices and outcomes which were integrated into and EMR that was utilized by the medical group and health plan. Depression was one of the prioritized diseases. The PHQ-9 began being used as a management and outcome tool and aligned perfectly with our Partners for Better Health Depression Goal.

On Your Way Program
HealthPartners created a project called “On Your Way” in 2000 to provide depression health education and treatment adherence support. Members and patients starting on antidepressants are mailed monthly newsletters and prescription refill reminders. Prescribers are alerted when patients are overdue for medication refills. This program continues to achieve strong results at HealthPartners.
Outcomes
By engaging both patient and provider, the On Your Way initiative had a tremendous impact. Between 1999 and 2004, HealthPartners’ HEDIS rates jumped 180 percent, from 35 percent acute adherence to 62 percent acute adherence. This demonstrates the power of a health plan working in partnership with care delivery and supporting members toward better outcomes.

ICSI Depression Guideline
The national health care improvement organization Institute for Clinical Systems Integration (ICSI) facilitates evidence-based guidelines and collaborative quality improvement initiatives. With ICSI guidance, health plans, behavioral health and primary care clinics partnered to create consensual approaches and protocols and to build effective strategies to tackle depression. Many of these strategies are now considered “usual care” for depression in Minnesota.

In 2001, HealthPartners health plan used the ICSI Depression Guideline to create the first Optimal Depression measurement in Minnesota. HealthPartners Optimal Depression Clinical Indicator showed comparative results in accomplishing three elements of depression care. HealthPartners presented data by care system to encourage quality innovation and competition.

HealthPartners’ Medical Group (HPMG) members have led or co-led the ICSI Depression Guideline, a well-recognized vehicle to continually update best practices. From 2003 through 2007, HealthPartners and ICSI facilitated a state-wide Depression Action Group that involved three different collaborative improvement cycles. Much of the initial work in primary care clinics involved teaching physician leaders and quality improvement leaders to teach primary care physicians and embed reliable systems to screen, identify, and document major depression, single episode, recurrent and dysthymia. The action group made significant progress in documenting symptoms of depression, getting symptom intensity scores and measuring outcomes by using the PHQ-9.

Outcomes
Over the course of the collaborative, the percentage of patients newly diagnosed with depression that met DSM-IV criteria improved from approximately 15 to 80 percent.

Initial strong improvement was noted with the initiation of the HealthPartners Depression Clinical Indicator. Additional significant improvement was noted with the initiation of the On Your Way Program. Highest results were achieved when these two initiatives were combined with the ICSI DIAMOND program. The percentage of patients newly diagnosed with depression – where the PHQ-9 score was also documented – improved from close to 0 to 79 percent. The group’s initiative did not make improvement in reliably following up with patients. The follow-up rate at three months ranged from 39 to 57 percent and only 33 to 47 percent of patients filled out a PHQ-9 at the follow-up visit. The percentage of patients who were seen at six months was only 42 percent and 29 percent of those patients filled out a PHQ-9. Only 18 percent were in remission.
DIAMOND Model
A coalition of care delivery systems, health plans, primary care clinics and behavioral clinics agreed that improvement had stalled and jointly created a new model called Depression Improvement Across Minnesota Offering a New Direction (DIAMOND). DIAMOND is based on the collaborative care model designed by Wayne Katon and implemented by Jurgen Unitzer through his IMPACT initiative.

The DIAMOND care manager is an integral part of the prepared practice team in each DIAMOND clinic. He or she typically receives warm handoffs as well as real-time telephonic introductions from primary care. Care managers also reach out to patients that meet the criteria but are not coming in for appointments. HPMG learned over time that certified medical assistants were best suited for this job because they are less expensive than registered nurses and more efficient than social workers. Each DIAMOND care manager receives direction from a psychiatrist two hours per week and reviews every new patient. Care managers also review patients that have had a medication change within the past four to six weeks. Patients receive direction about co-morbidities, lack of compliance, engagement issues, problems with self-management/behavioral activation, safety issues or other urgent problems from the consulting psychiatrist. All patients are reviewed at the 5-month and 11-month mark.

Outcomes and Lessons Learned
ICSI has collected data from up to 93 DIAMOND-certified clinics on over 10,000 patients. For over eight years, the DIAMOND Steering Committee has provided guidance and support for the project, the clinics and the clinicians. One of the practical learnings from DIAMOND has been that care delivery systems need to gear up for dealing with alcohol misuse, once they implement enhanced care using a case management approach. Behavioral Health Centralized Services receive referrals from primary care and behavioral health providers as part of the HPMG’s extended treatment team to complete telephonic SBIRT and documentation of the outcome in EPIC.

HPMG data shows that the six-month remission rate for DIAMOND patients is four to six times better than for non-DIAMOND patients.

The majority of the patients participating in an ICSI certified DIAMOND clinic are located in Minnesota and western Wisconsin. Between 20 and 30 percent of depressed patients in an ICSI certified DIAMOND clinic, get into a DIAMOND program. Some of this lack of engagement results from payment issues. Medicaid and Medicare do not have a payment source, whereas commercial patients and prepaid medical assistance program (PMAP) patients covered by regional health plans are covered by a bundled monthly fee.

As an organization with both health care financing and health care delivery roles, HealthPartners is ideally situated to work in an integrated manner. With DIAMOND care managers in clinics and working alongside Depression Disease Management from the health plan, there are few missed opportunities for supporting patients and members to better depression outcomes. Primary care providers, behavioral health providers and centralized behavioral health services each have roles in
screening, diagnosing, treating, monitoring and supporting patients toward better depression outcomes. This interwoven system of diagnosis and treatment, along with monitoring and supports, has allowed HealthPartners to maintain HEDIS Depression Band 1 performance for the past nine years and to steadily improve performance.

Parallel to this, HealthPartners has participated in three cycles of a state-wide behavioral health clinic depression collaborative, which had an equally significant impact. Members of this collaborative included community mental health centers, free-standing psychiatric or behavioral health clinics and behavioral health departments in multi-specialty groups. Most of these groups had never reliably collected quality data before let alone engaged front-line clinicians, receptionists and nurses, administrators and patients/families in care improvement. In addition to involving behavioral health staff at all levels, the collaborative engaged them in standardizing protocols, processes and using quantitative outcomes to improve care. Before their involvement, some clinicians and staff felt passive, powerless and skeptical of the measurement process being used to evaluate care. After being involved, they felt empowered and optimistic about improving care and were more motivated to actively engage patients and families in self-management and behavioral activation. The groups quickly mastered documenting depression symptoms and getting initial PHQ-9 scores. They saw some improvement in getting patients back regularly and measuring outcomes at six months. The mental health clinics in this initiative struggled to use existing resources to achieve the same good care, outreach and activities that a DIAMOND care manager produces.

Since late 2011, HealthPartners health plan and care delivery systems have partnered closely to better manage patients for whom the enterprise has total responsibility for cost of care, quality and patient satisfaction; HealthPartners calls this group Population Health. This group of patients/members is disproportionately made up of members on prepaid medical assistance program (PMAP) and Minnesota Care. The group tends to have high incidences of depression, substance abuse and various chronic medical problems. In order to manage this population, the health plan has centralized behavioral health services. The health plan encourages appointment attendance by helping to arrange transportation and applying telephonic case management resources when patients do not show up. The health plan provides this support for patients of both behavioral health clinics and primary clinics.

In behavioral health care delivery, a special clinic for these patients was created. This clinic reserves significant time for walk-in clinics, provides telephonic and electronic medical records curbside consults and offers tele-video psychotherapy and tele-psychiatry to all primary care sites. In a similar fashion, a chemical dependency treatment/facility program provides verbal and electronic advice to primary care.
**Independent Health**

**Program Overview**
Independent Health expects screening by all providers for all individuals. Independent Health encourages its providers to use the PHQ-9 in addition to tools each provider uses independently. The PHQ-9 is available on the provider portal. Independent Health also includes the PHQ-2 questions on its health risk assessment for new Medicare and Medicaid enrollees.

**Screening Process**
Independent Health employs behavioral health and medical case and disease managers who incorporate the PHQ-2 questions into all clinical assessments. The PHQ-9 is in the system for follow-up if the patient scores positive on the PHQ-2.

The health plan utilized the PHQ screening questionnaire in a small IMPACT pilot conducted for the Patient-Centered Medical Home project in 2012. There were five primary care practices that participated in this one year initiative. One of the incentives for participation was the new 2011 NCQA standards for medical home recognition.

Although Independent Health has used the PHQ-2 as part of a number of Practice Excellence Initiatives in the past, these initiatives are now being phased out. At this time Independent Health does not have any focused initiatives on screening for depression.

**Outcomes**
50% reductions in PHQ-9 scores over a nine (9) month period were seen in a small IMPACT based pilot. Provider and Patient satisfaction survey results were positive for this initiative.

**Looking Ahead**
Resources for depression screening have been constrained due to a large number of recent competing priorities and initiatives. Independent is also constrained by provider readiness in the community.

Future initiatives hope to address these barriers through behavioral health integration efforts. Independent is planning a larger behavioral health integration pilot in its Primary Connection practices with implementation scheduled for the third quarter of 2014. Currently, staff members are vetting screening tools for behavioral health management within the primary care practice.

**Kaiser Permanente**

**Program Overview**
Kaiser Permanente is committed to providing the highest quality care aimed at supporting the overall health of our members. With this aim, Kaiser has dedicated itself to supporting and treating the whole person. One strategy that Kaiser has developed is a program-wide depression screening
initiative as part of the National Integrated Depression Care Program. Kaiser’s Integrated Depression Care Program is comprised of five core components built upon the foundation of routine depression screening and measurement. Through the application of population and care management strategies Kaiser’s Integrated Depression Care Program has successfully expanded in its scope and now services members across all seven regions.

### Integrated Depression Care Program

| Improved Diagnosis, Screening and Assessment | • Routine use of PHQ-2 screening and PHQ-9 assessment tools in primary care, pediatrics and OB/GYN settings at the time of diagnosis and follow-up  
| | • Leveraging the use of Kaiser Permanente’s electronic medical record (EMR) and online asynchronous communication via KP.org  
| | • Medicare THA  
| Achieving Zero Suicides | • Increasing standardized suicide assessment in behavioral health services  
| | • Improving follow-up after psychiatric hospitalization  
| Improving Care Coordination | • Real-time consultation between primary and specialty care providers  
| | • Expanding transparency of behavioral health charting in EMR  
| | • Co-locating behavioral health services in Primary Care settings  
| Increased Availability of Evidence-Based Treatments | • Implementing primary care-based depression medication management programs  
| | • Embedded behavioral medicine providers in primary care settings  
| | • Expanding the application of new care delivery models  
| Monitoring Outcomes | • Application of measurement strategies aligned with HEDIS and internal quality measures |

### Target Populations

Although variation in practice patterns and clinical operations exists across the seven Kaiser Permanente regions, the PHQ-9 is used to screen for depression in specific populations, in various settings at key time intervals.

Kaiser Permanente administers depression screening on an annual basis members belonging to target populations. In the primary care setting, target populations include adults with chronic
conditions (typically those with diabetes with HBA1C ≥ 8, CVD and cancer), prenatal and postpartum women, older adults and Medicare enrollees. Adolescents and members discharged from an inpatient psychiatric hospital are also targeted in their associated settings. If an individual is diagnosed with depression, a staff member will administer a test and provide follow-up tests at six-month intervals.

Screening Process
Kaiser's National Depression Clinical Guidelines Team chose to use the PHQ-2 and the PHQ-9 as screening tools due to their simplicity and reliability. During evidence reviews and screening tool comparisons, the PHQ-2 and PHQ-9 outperformed other standardized screening tools and were shown to work well across various settings and with numerous patient populations. From an organizational standpoint, the use of a consistent depression tool is desirable to facilitate the collection of consistent depression data.

At this time, the PHQ-2 and PHQ-9 administrations are conducted by registered nurses, embedded Behavioral Medicine Specialists (psychologists and licensed clinical social workers), medical assistants, primary care providers and specialty physicians in the primary care setting. In a specialty care setting, behavioral health providers associated with psychiatry, mental and chemical dependency administer the inventory.

The key screening intervals are:
- The initial PHQ-9 administration at the time of a new diagnosis;
- Follow-up PHQ-9 administration for those with new episodes of depression at six-month and twelve-month intervals; and
- Annual PHQ-9 administration for ongoing episodes of depression.

Process and Outcomes Metrics
In 2012, Kaiser Permanente's Care Management Institute, in collaboration with the Integrated Behavioral Health Clinical Leads Group, launched a dashboard, which reports a set of metrics assessing depression outcomes. The dashboard includes three process metrics to assess depression symptoms, and an outcome metric of symptom reduction on the PHQ-9.

Metrics on the Interregional Depression Care Dashboard include:
- Initial PHQ-9 Testing for New Episodes of Depression: The percentage of members with a new episode of depression given a PHQ-9 assessment at diagnosis; Follow-up PHQ-9 Testing for New Episodes of Depression: The percentage of members with a new episode of depression and an initial PHQ-9 score greater than 9 who were re-assessed with a PHQ-9 test between 60 and 120 days after diagnosis;
- Annual PHQ-9 Testing for Ongoing Episodes of Depression: The percentage of members with an ongoing episode of depression who have had at least one PHQ-9 test administered in the prior 12 months; and
• Depression Symptom Improvement: The percentage of members with a diagnosis of depression and an initial PHQ-9 score greater than 9 who show improvement or remission, measured at 6 months and 12 months after diagnosis.

The Interregional Depression Care Dashboard is produced quarterly with a regional table and graph for each metric, in addition to an overall program rate. The intended audience for this dashboard includes Kaiser Permanente’s Clinical Leads Group and the Interregional Implementation Workgroup, as part of Kaiser Permanente’s Integrated Behavioral Health initiative to improve depression care across the program. These metrics were designed to support quality improvement, and were not proposed for use as accountability metrics.

Lessons Learned
Kaiser Permanente has learned many lessons as it relates to routine depression screening. Below is a list of specific areas of challenge and learning:

• Compiling patient reported outcome data when collected using a host of data collection modalities is difficult.
• Incorporating this data into the EMR and displaying it in a meaningful way has been a challenge.
• Variations in practice patterns and clinical operations undermine the reliability of screening.
• Charting trends over time provides opportunities to identify patterns and apply quality and clinical operations improvement strategies.
• When marketing routine depression screening to clinicians and providers, it is beneficial to position the PHQ-9 as clinician tool as opposed to a tool for monitoring.
• When attempting to spread the practice, it is useful to start with the early adopters.

Another challenge Kaiser Permanente has faced while striving for routine depression screening has been the consolidation of information from PHQ-9 tests when information is obtained from different screening modalities. Modes of data collection for depression screening include:

• Secure electronic communication
• Telephone
• Paper and pen/pencil
• In-person during ambulatory clinic visits
• U.S. Mail
• “Black Box” electronic data collection in Specialty Care

Priority Health Plan

In 2014, Priority Health will roll out a new incentive program connected to a depression screening goal. Priority will measure the percentage of members 12 years old and up who had a preventive evaluation and management visit and received a PHQ-2 or PHQ-9 within the last year. To fulfill the measure requirement, depression screening can occur at any appointment within the past 12
months. Priority’s target is 80 percent adherence. The plan primarily receives its data through its preferred method of a registry.

Additional details on the depression screening programs are available below:

<table>
<thead>
<tr>
<th>Source</th>
<th>Priority Health standard of excellence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identified measure</strong></td>
<td>The percentage of members 12 years of age and older with PHQ2 or PHQ9 conducted during a PCP preventive evaluation and management (E&amp;M) visit in 2014. The evaluation timeframe will be July 1 – December 31, 2014.</td>
</tr>
<tr>
<td><strong>Case definition</strong></td>
<td>Members must be active as of December 31, 2014.</td>
</tr>
<tr>
<td><strong>Age criteria</strong></td>
<td>12 years and older</td>
</tr>
<tr>
<td><strong>Exclusionary criteria</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>The number of members represented in a random audit with a documented PHQ2 or PHQ9 in 2014. Members included in the audit will have had a billed preventive E&amp;M visit with a PCP between July 1 and 14 as of 4.14.14.</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Fifty randomly selected members for each practice group. Member lists will be available fourth quarter 2014 by accessing monthly FileMart reports and/or Patient Profile. If a practice does not have a minimum of 50 members with a billed E&amp;M visit, the denominator will become the total number of</td>
</tr>
<tr>
<td><strong>Level of measure</strong></td>
<td>Practice group</td>
</tr>
<tr>
<td><strong>Minimum members</strong></td>
<td>100 combined members – in any month between January 1 and June 30, 2014, within all applicable product lines.</td>
</tr>
<tr>
<td><strong>Applicable product lines</strong></td>
<td>HMO/POS, ASO/PPO, Medicare and Medicaid</td>
</tr>
</tbody>
</table>

14 as of 4.14.14
| **Method of measurement** | PHQ2 and PHQ9 data are captured through registry data submission, HCPCS billing codes, Patient Profile and Report #70. Practices will have access to their member lists via FileMart or Patient Profile during the fourth quarter of 2014. Practices must provide PHQ2 or PHQ9 data for members selected for this measure by January 31, 2015. No member audit lists will be mailed or distributed in a manner outside of standard monthly reporting or Patient Profile. Documented PHQ2 and PHQ9 can occur during any office visit in 2014. Practices have the opportunity to conduct depression screenings within office visits scheduled after the release of their member audit list. |

**UPMC - Community Care Behavioral Health Organization**

**Program Overview**
Community Care Behavioral Health Organization, a behavioral health MCO that is part of the UPMC Insurance Division, is focused on management of behavioral health services for approximately 750,000 members in Pennsylvania. Community Care has supported teen suicide prevention grants that are being implemented in a number of counties in Pennsylvania. This project uses an on-line depression and suicide risk screening tool developed by providers in Philadelphia. There are several primary care/pediatric practices in regions served by Community Care that have implemented this practice.

In several counties in Pennsylvania, depression screening tools are used by care managers who work with families involved in early intervention (EI) programs of children aged 0-3. Care managers administer to PHQ-2 to all willing primary caregivers of children referred to EI services for possible developmental delays. If the caregiver scores positive, they are encouraged to complete the PHQ-9. This screen is usually administered in-person by a qualified health provider. Parents/caregivers are then referred to a variety of mental health treatment providers via “warm hand off” with the service coordinator to address depression within the context of the parent-child relationship.

A number of Federally Qualified Health Centers in Pennsylvania have implemented the IMPACT model for screening all individuals in their clinic for depression using the PHQ-2 and, when the PHA-2 is positive, the PHQ-9.

**Lessons Learned**
The primary issue has been funding for the screening activities. This has been addressed through grants and through fee-for-service models. Capturing data is also challenging, especially for in-
person and handwritten tests. The screening initiatives are usually measured by the number of individuals identified and, of positive screens, the number of individuals entered into treatment.

Many of the programs have had positive results. The screening associated with the early childhood intervention program has reached 70 percent of all caregivers. About 10 percent screened at-risk for depression. Over 70 percent of those identified as at-risk were referred and received mental health treatment focused on the parent-child relationship. It is too early to identify results from the teen suicide prevention program.

UPMC Health Plan

Screening Process
UPMC Health Plan’s Medicare and commercial plans employ a universal screening tool and process. All members in a physical health management program are screened for depression with the PHQ-2 by the physical health management coach, who is always a registered nurse or licensed professional. If the screen is positive, the member completes the full PHQ-9. Members with higher scores, those answering positive to question #9, or those who otherwise express a concern related to behavioral health issues are encouraged to see a behavioral health (BH) clinician. All members with a positive PHQ-9 are offered additional interventions including: outreach to the primary care physicians, help getting an appointment with a BH provider, a telephonic BH condition management program, an online cognitive behavioral therapy (CBT) program called Beating the Blues or mailings containing depression resources.

Members with a new depression diagnosis are given a health assessment and telephone support. Those members are offered the depression condition management program, which includes education as well as case management and service linkage. Besides the universal screenings, providers in UPMC’s network typically determine their own approach for addressing depression needs.

UPMC communicates with members using mail, telephone and, increasingly, through its online portal. Many members take a health risk assessment which asks about depression.

Looking Ahead
This intervention has been employed since July 1, 2013 and no outcomes data are available yet. Prior to that, health management assessments completed the PHQ-2 only and all members were encouraged to accept a call transfer to a BH clinician.

As far as measuring population data, UPMC captures descriptive data related to the members who screen positive and to which interventions they agree. It is also important to measure the initiative by how those members that are reached fare in comparison to those that didn’t have any intervention. Results can be compared (i.e. anyone who had a positive PHQ-2) with those from prior years’ interventions to determine the impact of the new approach and intervention options.
Due to the low rate of members agreeing to be transferred to a BH clinician after the positive PHQ-2 screen alone, a new approach of completing the full PHQ-9 when the PHQ-2 was positive was recently implemented to increase the positive outcomes and help depressed members receive the help they need. This also indicates that physical health providers are not properly trained on the correct protocols. UPMC plans to provide increased training and support for providers about members who complete the PHQ-9.