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AMGA Foundation

Acclaim Award
UW Medicine

2019 Recipient

Narrative: A Population Approach to Depression Management

UW Medicine
The Road to Care Transformation: Accomplishing Reliably Excellent Care That Is Patient-Centered and Mission-Driven

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Narrative: A Population Approach to Depression Management

In January of 2019, AMGA named University of Washington (UW) Medicine as the recipient of the 2019 Acclaim Award. The Acclaim Award, supported by AMGA Foundation, the association's nonprofit arm, is designed to recognize and celebrate the successes that medical groups and other organized systems of care have achieved in improving the value—the quality and cost of care—of the healthcare services they provide to their communities. It honors organizations that are meeting the IOM Aims for Improvement and are taking the necessary steps to become a High-Performing Health System™ as defined by the AMGA.

As part of the Acclaim Award application process, the organization was asked to highlight narratives describing the design and deployment of major components—projects, phases, or tactical plans—that were part of their plan to transform the way they deliver health care in order to more fully achieve the AMGA High-Performing Health System™ attributes, improving both the quality and cost of care. Here, we share one of their narratives.

Care Transformation Strategy

Depression remains one of the most common mental health conditions in the United States. We estimate at least one in five of our empaneled patient population has had at least one visit with a mental health diagnosis, most commonly depression or dysthymia. The historic approach in UW Medicine to depression care was visit-based and complaint-oriented: the PCP elicited signs and symptoms of depression, established the diagnosis, began medical management as appropriate, and referred to mental health professional as needed. This approach missed many patients who were less engaged in their health or unwilling to come into the clinic for symptoms. This resulted in inconsistent criteria for diagnosis, non-standard treatment, treatment inertia and poor follow-up. Our objectives in our transformation of depression care were to: (1) integrate mental health services in primary care and other clinical settings, (2) screen all patients for depression using the PHQ-2,[1] (3) standardize the diagnosis and treatment of patients with depression, and (4) routinely monitor for depression response or remission using the PHQ-9.[2]

Design

Clinicians and researchers in our organization pioneered the design of "Collaborative Care" models to integrate mental health care into primary care. The Collaborative Care model focuses on defined patient populations tracked in a registry, PHQ-9 measurement-based practice, and treatment to PHQ-9-defined response or remission of depression. Trained PCPs and mental health professionals embedded in the primary care practices provide evidence-based medication or counseling, supported by as-needed psychiatric case consultation. Treatment is adjusted for patients who are not improving as expected to avoid treatment inertia. We deployed the behavioral health "Collaborative Care" model at 19 PCP clinics and found that offering mental health treatments in primary care was convenient for patients, built existing provider-patient relationships, and helped to improve the care and outcomes for our patients.

We also found, however, that only 5% of our depressed patients truly needed the level of care provided through the "Collaborative Care" model. The vast majority of patients could be managed successfully by PCPs and care teams, perhaps requiring a brief specialist intervention. In 2016-2017, we launched a comprehensive and stratified approach to depression screening and management with four tactics:

1. Depression screening and management clinical pathway
2. Depression Population Approach to Health (PATH)
3. Collaborative Care model
4. Psychiatric specialist referral

The depression pathway is a clinical workflow to guide PCPs to screen and then to manage patients with depression, using evidence-based guidelines, in an effort to create standardization around chronic disease management. Electronic health record (EHR) decision-support tools were deployed to direct care, and clinical teams were educated about appropriate algorithms of care. The Depression PATH program employs a central team of mental health specialists and population health coordinators who monitor outlier patients (based on PHQ-9) or patients with uncontrolled symptoms over a period of time. As patients are identified, the PATH team contacts the PCP to provide guidance on medication changes or suggested behavioral interventions. Psychiatric specialist referral or inpatient treatment remain options for the most severe and difficult to treat patients.

In 2018, we piloted an expanded PATH approach using the central team to co-manage panels of depressed patients with PCP and care teams. This approach uses a team-based care framework and leveraged the mental health professionals already embedded in the primary care practices as part of Collaborative Care. Mental health professionals were assigned a panel of patients with depression diagnosed in the last three months or with a PHQ-9 greater than 9 in the last year. These professionals were responsible for proactively managing their population through chart review, direct-to-patient outreach, gathering follow-up PHQ-9 to assess impact of current treatments, referring back into PCP or Collaborative Care programs for treatment follow-up, and linking patients to community-based mental health care services.

Results

Collectively, the standardized depression pathway and Depression PATH program improved our population screening of depression from 52.1% in 2016 to 73% in 2018. We increased collection of follow-up PHQ-9s in our Depression PATH program and depression panel management pilot. We markedly improved depression remission or response for patients in Depression PATH programs compared to control patients (see Figures 1 and 2). This stratified and systematized approach

to depression population health achieved our goals to improve identification of patients with depression, to increase use of evidence-based practices in depression patients, and to improve the tracking of patient depression treatment outcomes.

Future Plans

In 2018, we launched work to electronically capture the PHQ-9 directly from patients through the EHR patient portal. This highly anticipated activity went live in September 2018, and we are applying test-and-learn principles to rapidly optimize workflows to reach more patients for screening and follow-up assessments. We also initiated work with our practice plans and IT teams to establish workflows for collaborative care billing for Depression PATH activities, which will allow us to expand our central teams and provide more services to more patients. Finally, we found a need to jointly manage patients with multiple high-risk or chronic disease management needs (e.g., patients enrolled in Diabetes PATH or high-risk care management programs) with other population health teams.

Adapted from the Acclaim Award application submitted by Carlos A. Pellegrini, M.D., FACS, chief medical officer, UW Medicine, and vice president for medical affairs, University of Washington.

References

1. The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD tool for common mental health disorders administered by healthcare professionals. The PHQ-2 inquires about the frequency of depressed mood, with a score ranging from 0 to 6.
2. The PHQ-9 is a 9-question instrument given to patients in a primary care setting to screen for the presence and severity of depression. It is the 9-question depression scale from the Patient Health Questionnaire. The results of the PHQ-9 may be used to make a depression diagnosis according to DSM-IV criteria, and it takes less than 3 minutes to complete.

Figure 1: Depression PATH – Remission of Depression (Follow-up PHQ-9 < 5)

Patients enrolled in Depression PATH demonstrated a much greater likelihood of achieving depression remission (follow-up PHQ9 < 5).

Percent remission (PHQ9 < 5), during 60-240 days, latest PHQ9
Excluded patients were removed

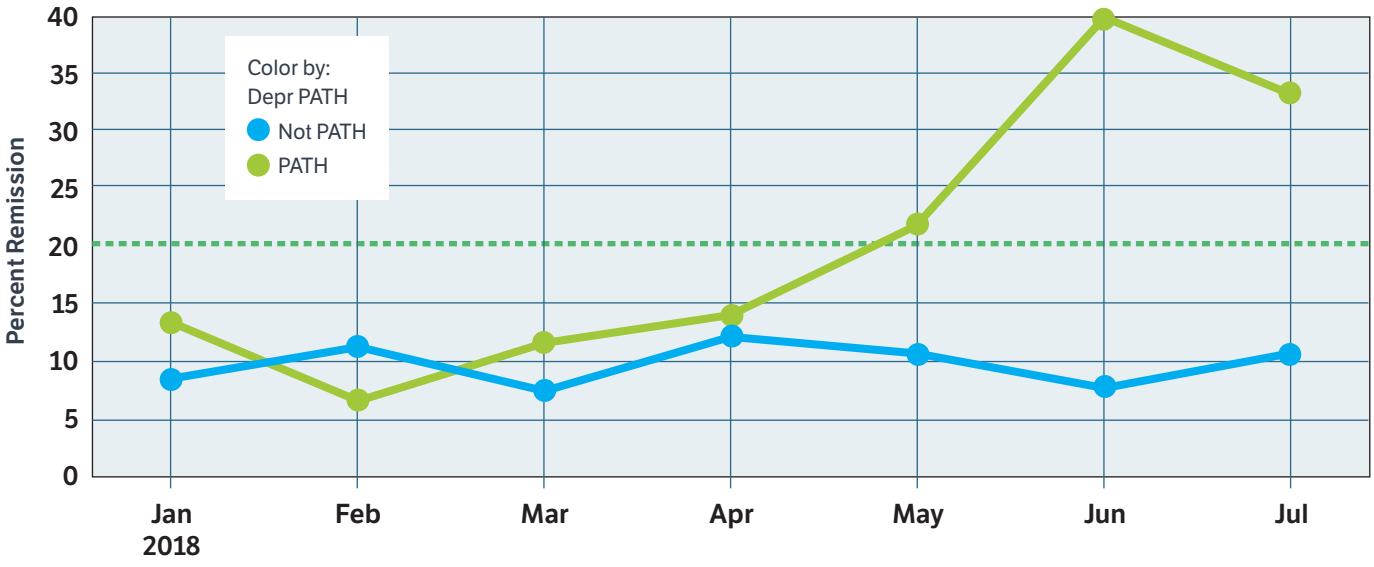
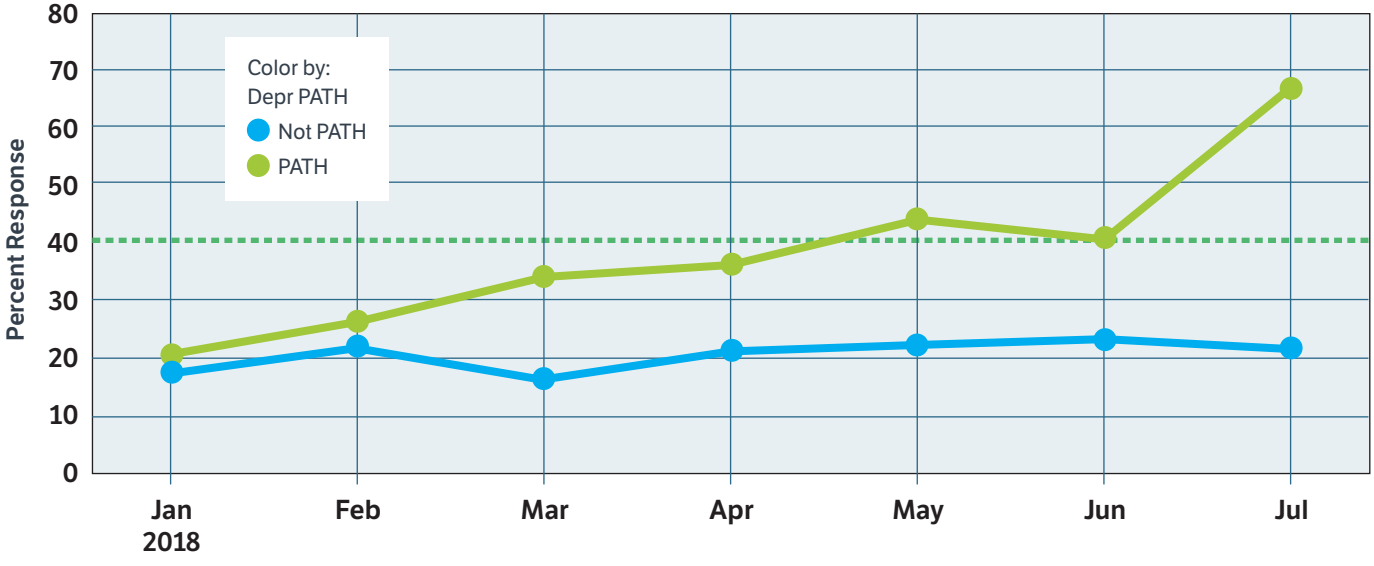


Figure 2: Depression PATH – Response to Treatment (50% improvement at follow-up PHQ-9)

Patients enrolled in Depression PATH demonstrated a much greater likelihood of achieving response to treatment (50% improvement at follow-up PHQ-9).

Percent response (PHQ9 50% of 1st or PHQ9 < 5), during 60-240 days, latest PHQ9



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