



## Highlight of a Leading Practice

### Group Health Cooperative: Integrating Patient-Reported Outcomes Across the Continuum of Depression Care

Produced by Kaiser Permanente's Care Management Institute  
in partnership with Group Health Cooperative, Seattle, Washington



The purpose of this case study is to support acceleration of spread of leading practices in health care.

Kaiser Permanente produces case studies by rigorously reviewing performance data to identify leading practices addressing critical health care issues. A multidisciplinary team captures elements of patient and family experiences, culture, clinical practices and processes, and operations through a rapid mixed methods approach, synthesizing insights from leaders, health care providers, staff, patients, and family members.

The result is a detailed picture of the context and components of leading practices—and how they can be applied in other settings.

## Contents

- Depression Care At Group Health Cooperative At A Glance.....3
- Comparative Performance Data.....4
- The Path to Leading Performance.....5
- Key Components of the Leading Practice.....6-14
- Acknowledgements and Contact Information.....15
- Appendix.....16

# Group Health Cooperative Depression Care



Location: Seattle, WA

Goals: To improve the overall effectiveness of depression care through routine evaluation and ongoing reassessment using the Patient Health Questionnaire (PHQ-9).

Start date: 1994

Scale: Approximately 350 primary care providers care for approximately 365,000 Group Health Cooperative patients.

Specialty Behavioral Health Services (BHS) staff includes psychiatrists, psychologists, psychotherapists, and nurses.

## The Opportunity

Depression affects 9.5% of all U.S. adults and costs employers an estimated \$17-44 billion per year in lost productivity.<sup>1</sup> Depression is a relapsing and recurrent condition. Early identification and treatment improve long-term treatment success, but only 50% of U.S. adults with depressive symptoms receive any treatment and just 21% receive treatment consistent with clinical guidelines.<sup>2,3</sup>

## The Leading Practice

Group Health Cooperative optimizes depression care by using patient-reported outcomes and population care management strategies. Behavioral Health Services and primary care providers consistently use the PHQ-9, a well-validated, multipurpose questionnaire for assessing, diagnosing, monitoring, and measuring the severity of depression, across the continuum of care.<sup>4</sup>

- Care teams use proactive case identification strategies involving all team members to ensure the PHQ-9 is administered.
- Clearly defined care pathways across the continuum of care support routine depression assessment and follow-up using the PHQ-9 in populations and identified cases.
- Physician extenders administer the PHQ-9 via the phone and secure electronic messaging.
- Routine data sharing at multiple organizational levels identifies care gaps and enables action planning to address them.

## Results

Group Health Cooperative outperforms external benchmarks for six-month remission rates in adults after a new diagnosis of depression.

<sup>1</sup> Centers for Disease Control and Prevention. Workplace health promotion: depression. [www.cdc.gov/workplacehealthpromotion/implementation/topics/depression.html](http://www.cdc.gov/workplacehealthpromotion/implementation/topics/depression.html) Accessed January 12, 2015.

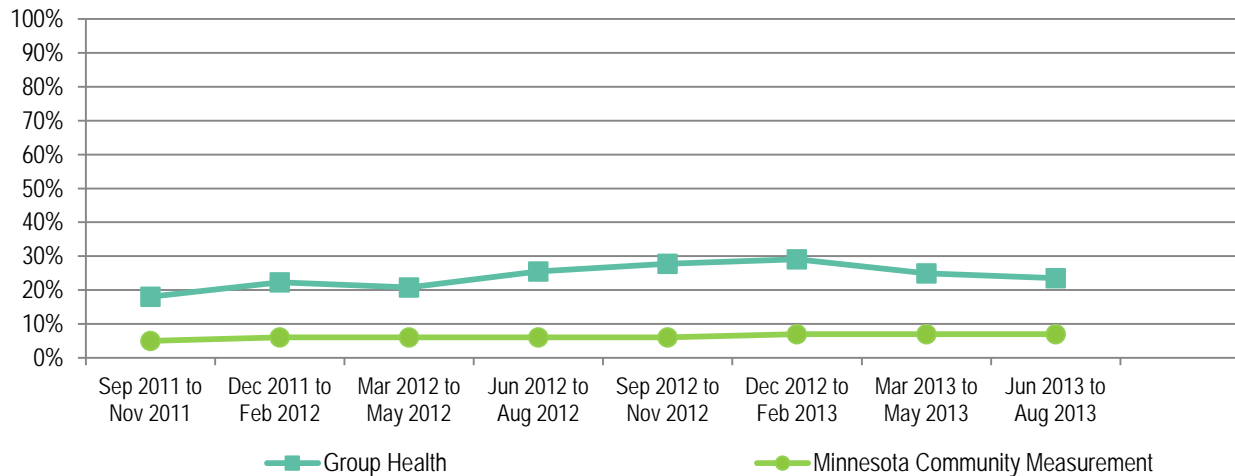
<sup>2</sup> Gonzalez H et al. Depression care in the United States: too little for too few. *JAMA Psychiatry* 2010; 67(1):37-46

<sup>3</sup> Bukh, JD et al. The effect of prolonged duration of untreated depression on antidepressant treatment outcomes. *J Affect Disord* 2013; 145(1):42-8.

<sup>4</sup> Kroenke K et al. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med* 2001;16(9):606-13.

# Data

Percentage of patients with a new diagnosis of depression who showed symptom remission within six months of the beginning of the episode of depression



## Group Health and external performance data

**Initial assessment:** Group Health administers and records an initial PHQ-9 at the time of diagnosis in 80-90% of adults with a new episode of depression. The initial PHQ-9 establishes baseline symptom severity and is used to calculate remission and improvement rates.

**6-month follow-up reassessment:** Group Health records at least one PHQ-9 at reassessment within 6 months after initial assessment and diagnosis in approximately 50% of adults with a new episode of depression.

**6-month follow-up symptom improvement or remission:** Improvement and remission rates are more meaningful when initial and 6-month PHQ-9 capture rates are high. Group Health outcomes are consistent and sustained. Nearly 70% of adults with a new episode of depression who are initially screened and then reassessed with the PHQ-9 experience symptom improvement or remission within 6 months.

**6-month follow-up symptom remission:** External benchmarks for depression outcomes are available from Minnesota Community Measurement (mncm.org), combining data from more than 600 multispecialty medical groups and clinics in Minnesota. The Group Health 6-month symptom remission rate is substantially better than the MNCM-reported rate.

# The Path to Leading Performance at Group Health

## Stakeholder investment

- Senior leaders became invested as they understood the opportunity to relieve the burden of depression for patients and support primary care providers (PCPs), the effectiveness of the PHQ-9, and the evidence for population care strategies.
- Primary care leaders recognized an opportunity to improve performance on HEDIS depression measures and increase the impact of depression care on the lives of patients.
- Providers felt supported to provide better depression care and transparent data facilitated performance improvement.
- Clinical and support staff became invested as depression care was integrated into standard work, as regional leaders visited each clinic to explain care pathways, and after testimonials from clinics that had successfully implemented PHQ-9 use.
- Patients became invested as PHQ-9 use was normalized and they began to perceive its value.

## Implementation

### Building processes in real-time

- Multidisciplinary teams of patients and care team members tested processes real-time until they were satisfied.

### Identifying optimal points for standardizing work

- A Behavioral Health Services goal was to use the PHQ-9 for every patient age 13 and up. The reception desk was the optimal point in the care process for introducing this as standard work.

### Involving clinical and support staff

- Unclear roles and responsibilities initially led to variable PHQ-9 use. Care processes became reliable after PHQ-9 use was integrated into standard workflows of clinical and support staff.

## Implementation (continued)

Providing structured decision-making support for primary care.

- A clear care pathway for interpreting PHQ-9 scores, monitoring, escalating treatment, or referring to Behavioral Health Services helped support PCPs in managing patients with depression.

## Sustaining leading performance

Systematically tracking goals and ensuring transparency

- Structured daily team huddles include current performance, ensure tracking and transparency, and facilitate real-time problem solving.

Driving PHQ-9 use at the level of clinic staff, not providers

- Integrating the PHQ-9 into clinical and support staff workflows created provider confidence that a PHQ-9 was completed when they saw a patient with depression.

Viewing standard work as a foundation for personalized care.

- Organizational goals and targets allow for personalized care, distinguishing between intentional personalized care and unintentional variation. Room for mindful deviation from standard work to accommodate clinical judgment and patient preferences, combined with accountability to carry out standard work through tracking and data transparency.

Leveraging the idea of opportunistic care

- If a Behavioral Health Services patient is seen in primary care, this is seen as an opportunity to provide a PHQ-9.

Continually integrating research.

- Partnerships with research and feeding data and recommendations into practice keeps care delivery current and evolving.

# Key Components of the Group Health Depression Care Program

A key component is an essential program element. A consensus of individuals administering and/or receiving program activities consider key components to be indispensable to leading performance, although case studies cannot establish causal relationships.

## 1 Depression care is part of primary care

Primary care providers (PCPs) initiate and manage much of depression care with Behavioral Health Services (BHS) consultation for mild to moderate depression or management of refractory or more severe depression symptoms.

## 2 PHQ-9 is consistently used across the continuum of care

Consistent use of the PHQ-9 across primary care and BHS allows for a common language and sharing of data and clinical information. Clear clinical pathways exist for referral and care gaps.

## 3 Depression care includes population care strategies across the continuum

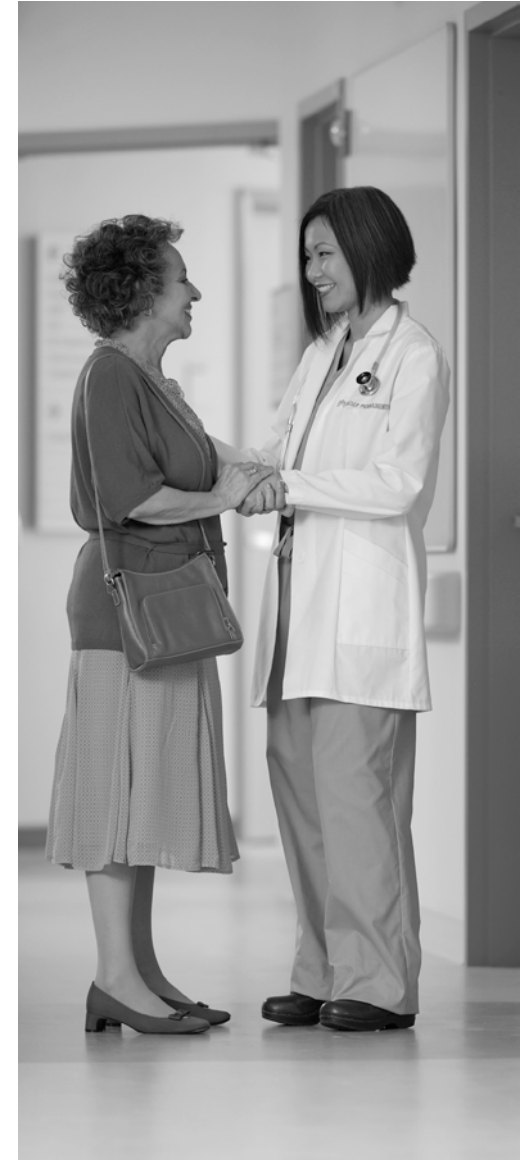
Organizational culture creates an expectation among providers and patients that assessment and treatment of depression is a routine process, important to achieving overall health.

## 4 Resources, tools, and training support primary care providers

Group Health empowers PCPs with training, tools, and BHS consultation resources.

## 5 Performance data is transparent across the organization

Process and outcome measures for depression are reported regularly and shared openly, drilling down to medical center, team, and individual providers. Team daily huddles reinforce depression care goals as a top priority, and clinicians having trouble meeting goals receive support.





“You are in the medical environment and filling out a structured questionnaire. It unburdens you.”

-Patient

## Key Component

### 1 Depression care is part of primary care

Primary care providers (PCPs) initiate and manage much of depression care with Behavioral Health Services (BHS) consultation for mild to moderate depression or management of refractory or more severe depression symptoms.

#### Benefits

- Patients are encouraged to talk to PCPs about their mental health and anticipate routine assessment of depression symptoms.
- PCPs address mental health concerns and manage uncomplicated depression and anxiety.
- Total health management includes depression assessment and monitoring.
- Patients are identified and treated for depression regardless of the reason for care; for example, if a patient with depression presents with a sore throat, the PCP also addresses depression care as needed.

#### Process

- At every well visit, every patient completes the PHQ-2 (short form). A high score triggers PHQ-9 use.
- Medical assistants (MAs) play a key role in consistent use of the PHQ-9 in primary care by reviewing care gaps for patients (Figure 1) during pre-work before scheduled visits, and while rooming patients. MAs enter scores into electronic health record (EHR) after visit.
- PCPs also give the PHQ-9 during visit as needed, using it to monitor and adjust treatment.
- PHQ-9 use is incorporated into follow up: in person, by phone, or by secure message.
- New patients complete a Health Risk Assessment (HRA) on the patient EHR portal, repeated annually. The HRA includes the PHQ-2. An elevated score triggers a message to the PCP team for follow-up outreach to the patient and an outreach call from a contracted health coaching vendor to give the PHQ-9 and motivate the patient to see the PCP for complete evaluation and to explore treatment options.
- Registered nurse (RN) screens patients with newly diagnosed or uncontrolled chronic disease referred by PCP for active management with the PHQ-2, giving the PHQ-9 as indicated.

#### Staff

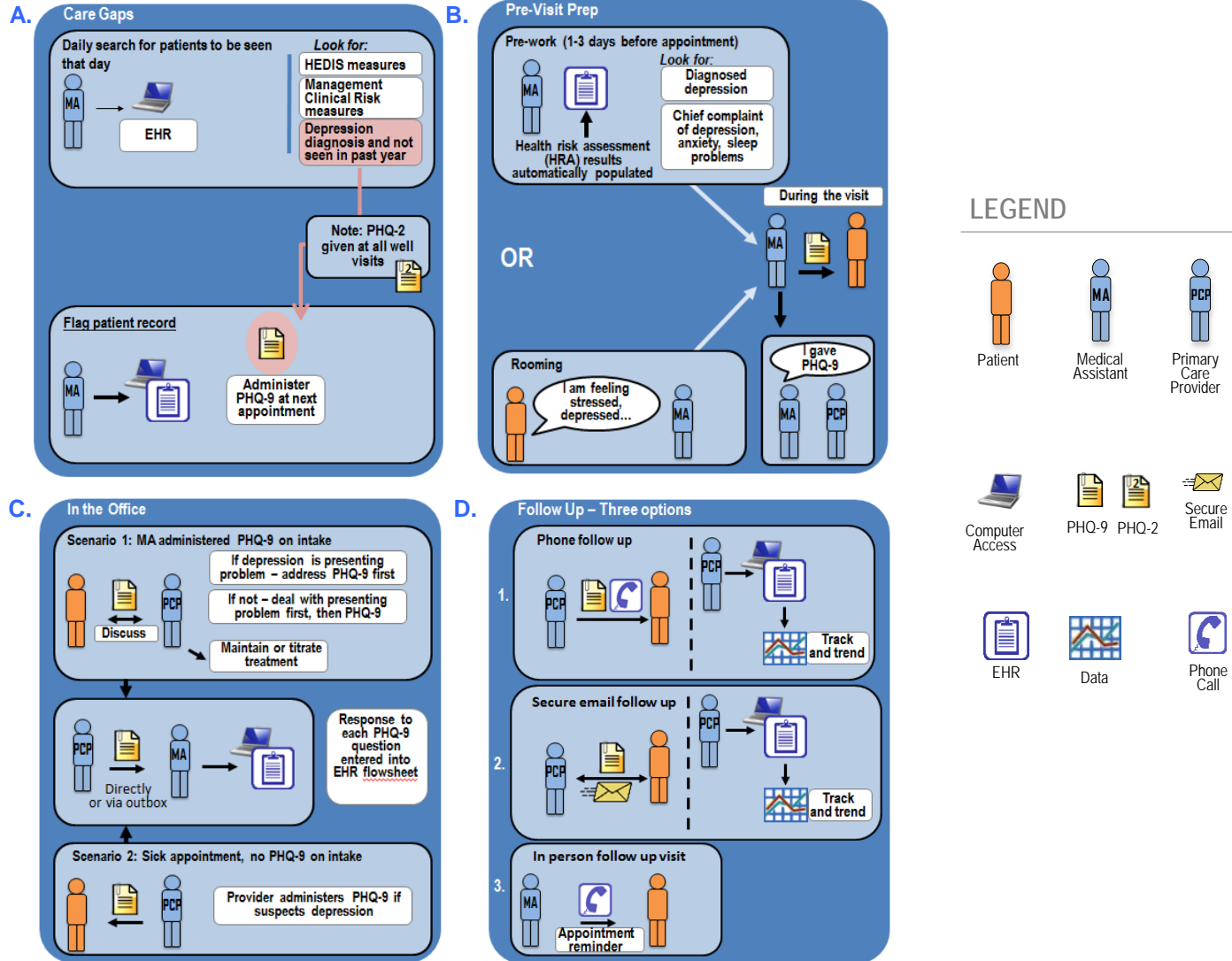
- MA, RN, PCP, contracted health coaching vendor

#### Cultural Enablers

- A strong culture of assessing and treating depression exists at Group Health.
- PCP training (primarily family medicine at Group Health) embraces mental health as part of a whole-person orientation to health. PCPs view depression as a chronic condition similar to heart disease and diabetes.
- Clinical and support staff are empowered to act within scope of practice to support PCPs in managing depression.

# 1 Depression care is part of primary care

Figure 1: Process of identifying and managing depression in primary care







“ Regular use of the PHQ-9 makes you realize depression is not a character flaw. It’s a medical condition.”  
-Patient

## Key Component

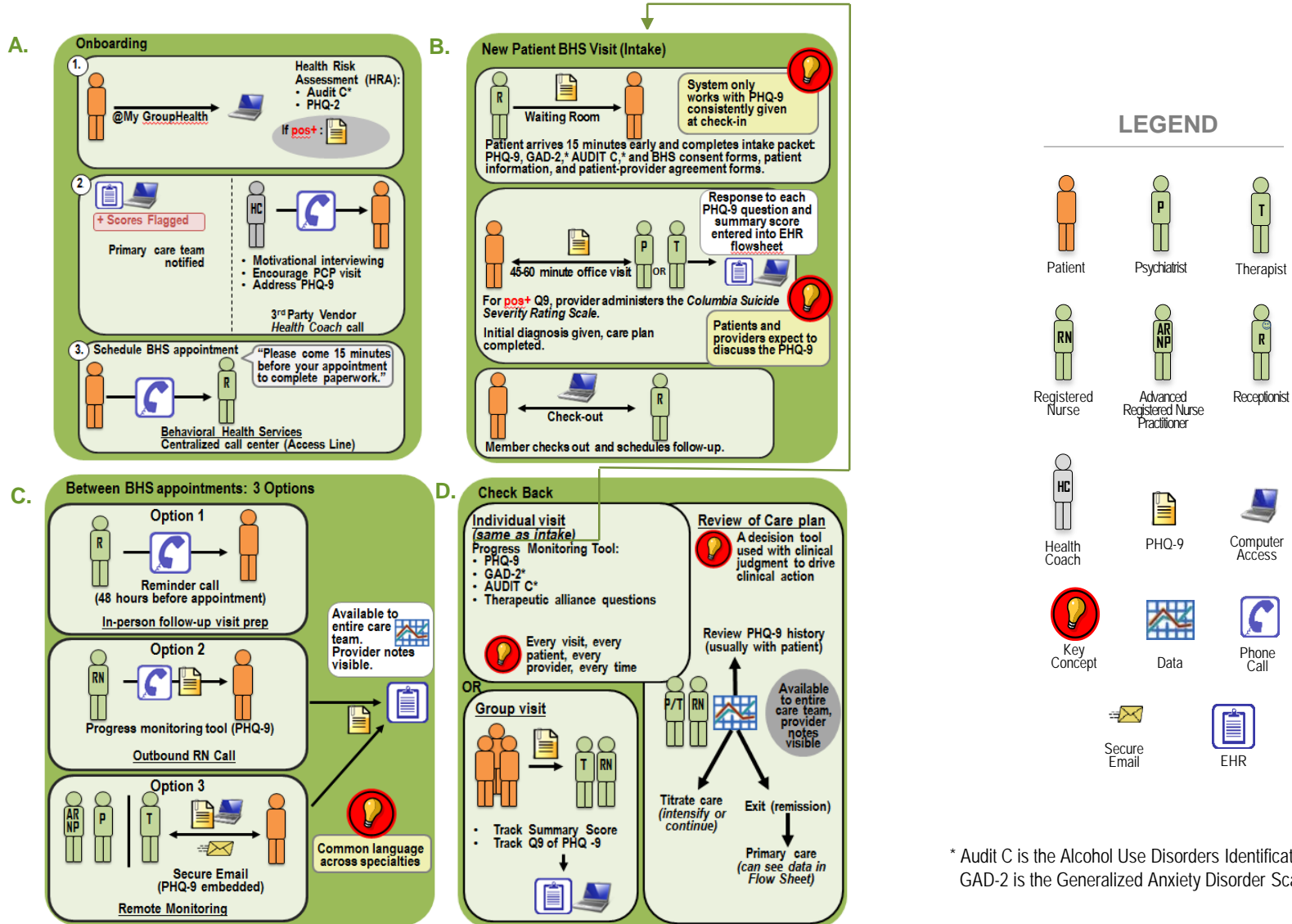
### 2 The PHQ-9 is consistently used across the continuum of care

Consistent use of the PHQ-9 across primary care and Behavioral Health Services (BHS) allows for a common language and sharing of data and clinical information. Clear clinical pathways exist for referral and care gaps.

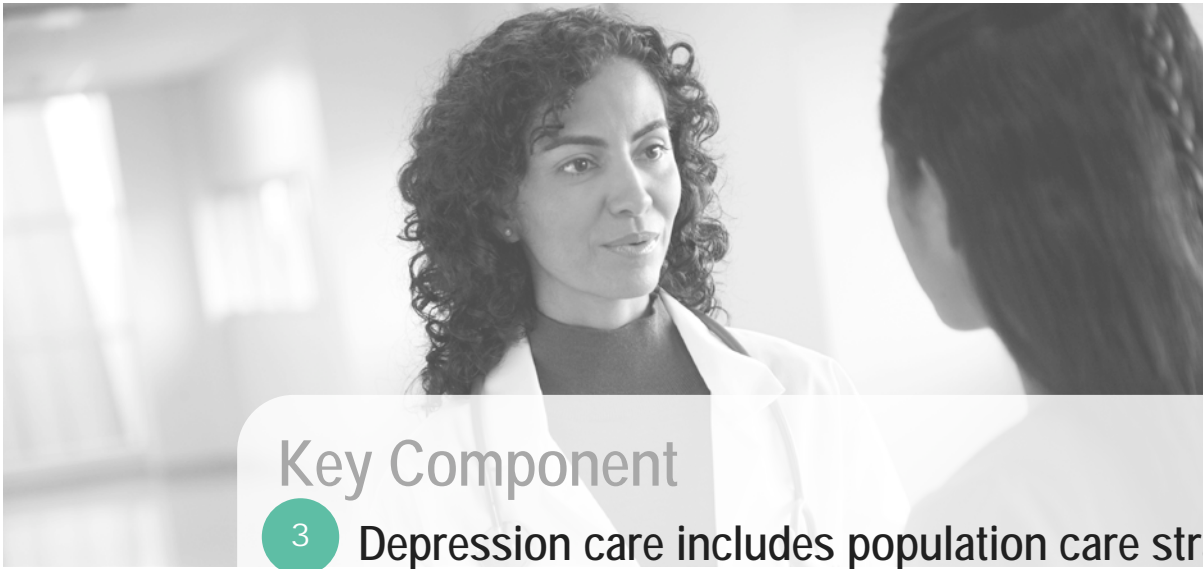
Benefits	<ul style="list-style-type: none"><li>• Consistent PHQ-9 use improves diagnostic accuracy.</li><li>• PHQ-9 scores provide a common language for describing depression severity.</li><li>• Use of a single assessment improves communication between care settings and leads to easy handoffs between BHS and primary care.</li><li>• Consistent PHQ-9 use enables treatment to a target score, typically 5 or less.</li><li>• PHQ-9 use over time facilitates tracking of treatment effectiveness.</li></ul>
Process	<p>Primary care’s integral role is described in Key Component 1. In BHS setting (Figure 2, page 11):</p> <ul style="list-style-type: none"><li>• Patients complete a PHQ-9 every visit, every time.</li><li>• At check-in, BHS receptionists ask every patient to complete a PHQ-9, collect them, and give to clinicians.</li><li>• BHS clinicians enter all PHQ-9 data into EHR.</li><li>• Elevated score on question 9 of the PHQ-9 triggers standardized suicide risk assessment.</li><li>• The PHQ-9 is used during consultation between primary care and BHS.</li></ul>
Staff	<ul style="list-style-type: none"><li>• Primary care PCPs and MAs; BHS receptionists and providers</li></ul>
Cultural Enablers	<ul style="list-style-type: none"><li>• PCPs and BHS providers highly value the PHQ-9 for assessing depression symptoms and monitoring progress.</li><li>• An overall organizational focus is on standardizing work and identifying the appropriate organizational level for standardized processes, such as BHS receptionists providing the PHQ-9 to all patients.</li><li>• Organizational focus on translating research into practical recommendations for care led to the routine use of the PHQ-2 and PHQ-9 in daily practice.</li><li>• The commitment to continuous quality improvement includes the systematic use of tools and measurement, fostering consistent and reliable PHQ-9 use.</li><li>• Reporting lines support consistent care across the continuum; the director of Behavioral Health Services reports to the medical director of primary care.</li></ul>

# 2 The PHQ-9 is consistently used across the continuum of care

Figure 2: Process of identifying and managing depression in Behavioral Health Services



\* Audit C is the Alcohol Use Disorders Identification Test; GAD-2 is the Generalized Anxiety Disorder Scale



“ *The PHQ-9 jogs your memory and cues you into what's going on and what needs to be talked about.* ”  
-Patient

## Key Component

### 3 Depression care includes population care strategies across the continuum

Organizational culture creates an expectation among providers and patients that assessment and treatment of depression is a routine process, important to achieving overall health.

#### Benefits

- Addressing depression improves the overall health of patients.
- PHQ-9 use across the continuum allows for the development of clear clinical pathways based on symptom severity.
- Regular symptom assessment maintains focus on helping patient get better.

#### Process

- All BHS and primary care providers and staff have awareness, tools, and training to respond to depression.
- Depression outcomes are reported and shared across departments.
- Depression is assessed in health risk assessments (HRAs), primary care well and sick visits, and Behavioral Health Services.
- Providers and clinical and support staff look for opportunities to administer the PHQ-9 when appropriate and seek out care gaps.
- Dependencies among assessments: the PHQ-2 administered at every primary care well visit triggers a PHQ-9.

#### Staff

- Clinical and support staff and providers are trained to use the PHQ-9 within their scope of practice.
- Staff and providers are knowledgeable about depression care resources in the system and empowered to act.

#### Cultural Enablers

- Clear expectations exist for clinical and support staff roles.
- Group Health has a strong history of leadership prioritizing depression care.
- Behavioral Health Services tracks PHQ-9 entries in the EHR for provider accountability.



“ *If I’m seeing a patient with chronic depression, when I go in the room, the PHQ-9 is done.*  
-Primary care physician ”

## Key Component

4

### Resources, tools, and training support primary care providers

Group Health empowers PCPs with training, tools, and specialty Behavioral Health Service (BHS) consultation resources.

#### Benefits

- Patients in need consistently receive depression assessment and good care.
- PCPs assess for depression even in patients who don’t present with symptoms.
- Efficient assessment uses the most appropriate tool: the PHQ-2 is used at well visits with positive results triggering the PHQ-9, and patients with symptoms of depression are assessed with the PHQ-9.
- PCPs provide timely follow-up care directly or refer to BHS as needed. PCPs report that available resources make depression care much easier.

#### Process

- “Mind Phone” program provides PCPs with a real-time phone consultation with BHS providers.
- BHS uses clinics’ standardized acute care coordination process.
- Patients in crisis get appointments within 1 – 7 days, depending on need.
- Group Health invested heavily in workforce development and training for topics such as integrating tools (e.g. PHQ-9) into initial and subsequent clinical interviews.

#### Staff

- All primary care staff can reach out to BHS for support.

#### Cultural Enablers

- Group Health views the PHQ-9 as a way for patients to have a voice in their assessment and care; providers position it this way.
- Addressing depression and other mental health conditions is an organizational norm.



*“If you have an issue with having your numbers up on the wall, then this is probably not a place for you.”*  
 -Nurse manager

## Key Component

### 5 Performance data is transparent across the organization





Process and outcome measures for depression are reported regularly and shared openly, drilling down to medical center, team, and individual providers. Team daily huddles reinforce depression care goals as a top priority, and clinicians having trouble meeting goals receive support.

Benefits	<ul style="list-style-type: none"> <li>• Transparency is an opportunity for real-time problem solving, including identifying staff training opportunities.</li> <li>• Daily team huddles and accountability for performance sustain achieving care goals.</li> </ul>
Process	<p>Primary care HEDIS data is reviewed on a monthly basis at the department level and quarterly on a senior leadership level. BHS conducts regular rounding at all levels (Figure 3, page 18).</p> <ul style="list-style-type: none"> <li>• Daily huddles occur at clinics.</li> <li>• Weekly, monthly, and quarterly leadership rounds occur in clinics.</li> <li>• Monthly departmental performance checks occur at the regional level.</li> </ul>
Staff	<ul style="list-style-type: none"> <li>• Multidisciplinary care team and leaders: receptionists, medical assistants, RNs, psychotherapists, psychiatrists, clinic manager, regional manager, assistant medical director, Behavioral Health Services medical director, and medical director for primary care.</li> </ul>
Cultural Enablers	<ul style="list-style-type: none"> <li>• Providers are comfortable with transparency for performance data.</li> <li>• Individuals at all organizational levels are assessed.</li> <li>• Group Health has a long history of providing organized depression care and commitment to rigorous continuous improvement.</li> <li>• Systematic measurement and data transparency are viewed as being at the heart of good care for depression.</li> </ul>



# 5 Performance data is transparent across the organization

Figure 3: Transparent performance data in Behavioral Health Services




**A. Tracking – Tier 1**  
Daily Huddle: Acute Care Coordination Patients

- 
**Visibility, on a daily basis. Daily reminder for specific interventions**
- 
**Tracking PHQ-9 scores incentivizes their collection**
- 
**Every day, Every clinic 9am 10-15 minutes**
- All attend: Receptionists, Therapists, Psychiatrists, RNs, Psychologists, Local Leaders**
- Dry-erase board**
  - 
  - Name**  
 • Provider  
 • When seen last  
 • PHQ-9 score at 1<sup>st</sup> appointment  
 • Crisis plan completed  
 • PHQ-9 at 2<sup>nd</sup> appointment
  - Red and green magnets for patient status**
  - Erase name when patient stabilized**

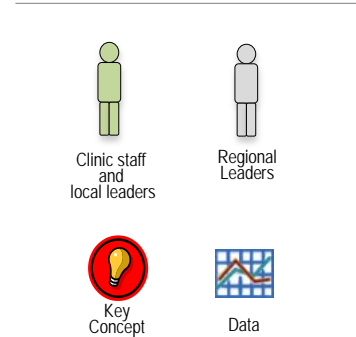
**B. Tracking – Tier 2**  
Rounding at Clinic Level

- 
  - Every clinic
  - Every patient with score 2 or 3 on Q9 of PHQ-9: how many received a completed suicide risk assessment
  - Identify opportunities for training and re-train providers and staff
- 
**Who joins:**  
**Weekly:** Regional Manager, Assistant Medical Director, local clinic manager and chief  
**Monthly:** Regional Manager, Assistant Medical Director, local clinic manager and chief, Director and Medical Director of BHS  
**Quarterly:** Regional Manager, Assistant Medical Director, local clinic manager and chief, Director and Medical Director of BHS, Primary Care V.P., and Primary Care Medical Director

**C. Tracking – Tier 3**  
Monthly Departmental Performance

- 
**What:**
  - Review performance at the department level across clinics
  - Visualize clinic performance on goals (HEDIS, quality/cost/affordability)
- 
**Who joins:**
  - All Regional Managers and Assistant Medical Director(s), Director and Medical Director of BHS
  - All BHS Regions presented to all Primary Care Leadership by Director and Medical Director of BHS
- 
**Regular checks on performance create and sustain a measurement-based culture**

## LEGEND



In primary care, HEDIS data is reviewed on a monthly basis at the department level and quarterly at the senior leadership level

# Acknowledgements and Contact Information

This case study was produced by a multidisciplinary team at the Kaiser Permanente Care Management Institute with support and guidance from Group Health Cooperative. We thank the following individuals for their contributions:

- Ioulia Kachirskaia, PhD
- Andrew Bertagnolli, PhD
- Pat deSa
- Estee Neuwirth, PhD
- Jann Dorman
- Jennifer Green

Special thanks to Annemarie Gugelmann for layout design and to Kat Darula, Dylan Ross, Eric Smallberg for supporting elements of this case study. Thanks also to the VA Leading Practice Blueprint® workgroup for developing the harvesting methodology that inspired our case studies.

Group Health is continuously improving depression care. This case study reflects practice at the time of our interviews in March 2014 and performance data available as of January 2015. GHC recognizes continuing opportunities to improve depression care.

For more information about depression care at Group Health Cooperative:

Larry Marx, MD  
Medical Director  
Behavioral Health Services  
[marx.l@ghc.org](mailto:marx.l@ghc.org)

Brad Steinfeld, PhD  
Assistant Director of  
Professional Services  
Behavioral Health Services  
[steinfeld.b@ghc.org](mailto:steinfeld.b@ghc.org)

For more information about Kaiser Permanente's Integrated Behavioral Health initiative:

Andrew Bertagnolli, PhD  
Senior Manager  
Integrated Behavioral Health  
Care Management Institute  
[andrew.bertagnolli@kp.org](mailto:andrew.bertagnolli@kp.org)



# Appendix: PHQ-9 and PHQ-2

The *PHQ-2* consists of the first two questions on the *PHQ-9*

## PHQ-9 for ADULTS Patient Health Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Over the <b>last 2 weeks</b> , how often have you been bothered by any of the following problems? (Please <b>CIRCLE</b> to indicate your answer)	<b>Not at all</b>	<b>Several days</b>	<b>More than half the days</b>	<b>Nearly every day</b>
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Note: Clinic Staff - Please file electronically in the EpicCare PHQ9 Document Flow sheet.

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc.  
Copyright © 2005 Pfizer, Inc. All rights reserved. Reproduced with permission.