AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

October 21, 2021

Primary Care Measures Workgroup

Cc: Performance Measures Coordinating Committee

Dear Primary Care Measures Workgroup Committee,

We recently learned about changes to the Multi-payer Primary Care Transformation Model Primary Care Measure Set that removed the Depression Remission and Response for Adolescents and Adults measure and would modify the Depression Screening and Follow-up for Adolescents and Adults measure. These updates are incredibly disheartening to see after having worked with primary care practices in Washington State for over 10 years on behavioral health integration in primary care.

Depression continues to be the leading cause of disability worldwide, ahead of diabetes, heart disease, cancer, and other conditions. The proven prevalence of depression in primary care is between 14.6% and 22.6% of patients. However, experts consider this a significant underrepresentation of the true prevalence because many primary care clinics do not universally screen for depression and because about 66% of depressed patients report mostly somatic symptoms when they seek care. Depression comes at a high cost, both financially and societally, and must be a priority for intervention.

In 2017, Washington State adopted the Bree Collaborative's Recommendations for Behavioral Health Integration and the Medicaid Transformation Project Toolkit was released requiring practices to work on the Bi-Directional Integration of Physical and Behavioral Health through Care Transformation. Both reports provided a roadmap for practices to improve behavioral health integration in primary care. In addition, resources, training, and technical assistance offered at various times over the last five years through the Practice Transformation Support Hub, Accountable Communities of Health, and the Bree Collaborative have given providers an opportunity to implement evidence-based models of depression care in primary care.

There are numerous examples in Washington and around the country of practices reporting and working to improve depression care quality measures. Washington State Health Center Program awardees under the Health Resources and Services Administration (HRSA) are required each year to report depression screening and follow-up and, most recently in 2021, depression remission at 12 months: https://data.hrsa.gov/tools/data-reporting/program-data/state/WA. In an initiative with the Washington State Hospital Association, critical access hospitals worked on depression screening and follow-up plan reporting and benchmarking in 2018-2019. Since 2017, UW Medicine as part its Accountable Care Network has been tracking and reporting depression remission and response data and working to improve these outcomes as part of a value-based contract.

Another example of large-scale implementation of depression outcomes reporting is the Minnesota Community Measurement project which publishes annual depression care metrics for adults and adolescents. This state reporting effort has looked at depression screening, PHQ-9 utilization, remission, and response measures since at least 2008. Public reporting at the medical group level includes all different types of practices and over the last two years they have continued to work to revise the measures they track for adolescents and adults. Additional information can be found here:

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https://mncmsecure.org/website/Reports/Spotlight%20Reports/2020%20MY%20Issue%20Brief%20-%20Depression.pdf.

Now is the time for Washington State to align the quality measures of transformation initiatives such as the Multi-payer Primary Care Transformation Model and Medicaid Transformation Project with proven depression care quality measures that can result in practice changes that improve quality of care, reduce healthcare costs, and mitigate the burden of disease. Washington has often been at the forefront of innovation in behavioral health care and including depression outcome measures as part of the Multi-payer Primary Care Transformation Model Primary Care Measure Set is an important commitment to continue as a quality leader.

As demonstrated above, we have national and local examples of providers already measuring depression screening and follow-up and depression remission or response. We understand that no quality measure is perfect and there has to be a balance with reporting burden, measure definition, and practice level implementation. However, given Washington State's practice transformation efforts on whole person care (integrated care), not aligning payment models with the right quality measures undermines the work already underway at the practice level in Washington State. Back in 2017 when the quality measures for the Medicaid Transformation Project were first proposed, they included depression screening and follow-up, which is the most basic measure. This measure was then removed because providers said it was too burdensome. As demonstrated by many healthcare organizations across the US and in Washington State, reporting this measure is feasible. To think four years later we still can't adopt this measure is disingenuous to all the great work happening across Washington State on whole person care.

Measurement and metrics matter. They communicate priorities and they lead to practice change. Depression should be a priority and we need practice changes that will reduce disability, reduce healthcare costs, and save lives.

We look forward to an opportunity to further discuss this important topic.

Sincerely,

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