Improving Depression Screening and Follow Up Data Exchange and Patient Adherence

Connecting for Better Health

Advancing data sharing to improve the health of all Californians

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Improving Depression Screening and Follow Up (DSF-E) Measure Data Submission: Implementation Playbook

About this Playbook

The Depression Screening and Follow-Up (DSF-E) measure is central to advancing integrated behavioral health, preventive care, and improved mental health outcomes in California. While routine screening and follow-up are widely implemented across primary care settings, performance challenges, like low compliance rates, often stem not from lack of clinical activity, but from how screening results and follow-up actions are **captured, coded, exchanged, and reported.**

Variability in EHR configuration, limited interoperability between physical and behavioral health systems, inconsistent coding practices, and fragmented data submission pathways can all contribute to underreporting. As a result, depression screenings and follow up care that are conducted are often not reflected in quality measures—leading to missed opportunities for care coordination, performance improvement, and appropriate reimbursement.

Design Studio

The Depression Screening and Follow-Up Design Studio, convened by the Population Health Learning Center (PHLC) and Connecting for Better Health (C4BH) and funded by Covered California (CCA), brought together health plans, providers, and data exchange partners to address these challenges.

Key Participant Activities in the Six Week Design Studio Process

- Mapping real world workflows
- Identifying breakdowns in data exchange
- Co-developing practical solutions

This playbook translates Design Studio insights into practical guidance that organizations can use to **improve data accuracy and completeness**, **streamline workflows**, **reduce manual burden**, and i**ncrease DSF-E measure performance**.

To learn more about the Design Studio approach and how Connecting for Better Health uses user-centered design to convene stakeholders and address data sharing challenges in health and social care, visit our website.

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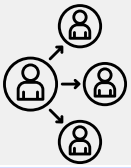
Who is Involved in Depression Screening and Follow Up Data Exchange

Accurate DSF-E performance relies on coordination across multiple stakeholders

Stakeholder	Teams	Role
Clinical Care Teams 	• Front Desk Staff • Medical Assistants • Primary Care Providers • Behavioral Health Clinicians	• Administering screenings • Documenting results • Initiating follow up care
Practice Operations and Quality Teams 	• Health IT • EHR teams	• Monitoring performance • Validating documentation and coding • Outreach to patients with care gaps
Health Plans 	• HEDIS specialist	• Receive and process submitted data • Calculate performance • Generate gap reports for providers
Intermediaries 	• Independent Practice Associations (IPAs) • Managed Services Organizations (MSOs) • Health Information Exchanges (HIEs)	• Data aggregation • Support reporting and reocnciliation
External Partners 	• Pharmacies • Behavioral Health Providers	• Provide essential data and information for follow-up closure ◦ Often through claims

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Why Does Accurate and Timely Submission of Depression Screening Data Matter

High-quality depression screening data leads to:

- Appropriate follow-up care
- Improved care coordination for patients
- Less time spent with manual reconcilation processes
- Reliable performance tracking
- Efficient resource allocation

When data is incomplete or delayed, screenings and follow-up care may not be recognized, leading to **underreported performance** and **missed opportunities** for intervention.

Strengthening data capture and **exchange** is therefore critical to improving care coordination, accountability, and overall outcomes.

Key Issues Identified in the DSF-E Design Studio

1. **Required depression screening results not supported in standard claim files:** California Health Plans require practices to submit depression screening scores rather than indicating whether result were negative or positive. Current claims structure does not support inclusion of actual result values. [1]

2. **Lack of Visibility on Follow-Up Care Status:** When follow-up services occur outside the organization, practices often lack visibility into the care patients receive, making it difficult to accurately document and code those services,

3. **EHR Limitations**: Limited reporting capabilities and inconsistent use of structured fields for Depression Screening and Follow-Up data hinder workflow automation and standardization.

4. **Variability Between EHR Data and Health Plan Reports:** Discrepancies between EHR data and health plan reports, often driven by claims processing delays or inconsistencies in data submission.

[1] This Design Studio focused on submission of data per California's Equity Practice Transformation (EPT) and Medi-Cal Managed Care Accountability Set (MCAS) programs and should be verified for applicability to other quality program requirements.

Current Workflow

Screening and Follow Up Workflows: Closing DSF-E Measure Gaps

Why This Matters

Patients are screened for depression using validated tools, and those with positive results must receive timely follow-up care. Health plans monitor compliance using standardized systems and share gap reports with providers to support performance improvement.

Who Is This For

Clinical Care Teams, MCPs, Quality Teams, Intermediaries, External Partners

Depression Screenings Completed

Denominator (reported by age group)

People 12 years of age and older at the start of the measurement period

Numerator (reported by age group)

Those in the denominator who had a depression screening result using a standard screening tool for depression:

- Patient Health Questionnaire (PHQ-9, PHQ9M, PHQ-2)
  - DHCS recommended screening tool
- Beck Depression Inventory (BDI-II) adults only
- Beck Depression Inventory-Fast Screen (BDI-FS)
- Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)
- Edinburgh Postnatal Depression Scale (EPDS)
- PROMIS Depression
- Duke Anxiety-Depression Scale (DUKE-AD) adults only
- Geriatric Depression Scale-Short Form & Long Form (GDS) adults only
- My Mood Monitor (M-3) adults only
- Clinically Useful Depression Outcome Scale (CUDOS) adults only

Follow up After Positive Screen

Denominator

All patients from the Depression Screening Numerator (previous slide) with a positive depression result.

Numerator

Those in the denominator who had one of the following within 30 days:

- Outpatient, telephone or e-visit for follow-up for depression/behavioral health
- Depression case management encounter
- Behavioral health encounter (assessment, therapy, collaborative care, medication management)
- A diagnosis of encounter for exercise counseling
- Dispensed antidepressant medication
- Documentation of a negative full-length depression screening on the same day as a positive screen on a brief screening tool (i.e., a negative PHQ-9 as a follow-up to a positive PHQ-2).

This Design Studio focused on submission of data per California's Equity Practice Transformation (EPT) and Medi-Cal Managed Care Accountability Set (MCAS) programs and may not be applicable to other agencies or programs.

Things to Consider

- Patients should be screened using validated tools such as PHQ-2 or PHQ-9
- Documentation must include the screening tool used, score, and date of completion
- Positive screenings require follow-up within 30 days
- Follow-up may include behavioral health visits, primary care visits with a depression diagnosis, case management, exercise counseling, or medication treatment
- Health plans combine clinical and claims data within HEDIS-certified systems to assess compliance

Suggested Workflow Improvements

Improving Data Capture and Coding

Improving DSF-E performance requires alignment between clinical workflows and the processes used to capture and code the data for accurate submission to health plans.

EHR Screening Data Capture

Screening results should be captured as **structured data** within the **EHR**, including **LOINC codes** corresponding with the screening assessment used.

- Some EHR templates start with the PHQ-2 and transition to the PHQ-9 if the score of the PHQ-2 is 3 or higher. Ensure the LOINC code reflects the PHQ-9 when this occurs.
- Use EHR screening templates when possible, as they capture data in discrete fields that support accurate reporting and measure tracking.

Coding Suggestions for Follow Up Care

Practices must ensure their **procedure** and **diagnosis codes** align with health plan requirements.

For example, one practice used CPT code 96127 for behavioral health case management, but it was not accepted by plans for closing the DSF-E follow-up gap.

- After switching to HCPCS code T1016, follow-up rates improved.

Things to Consider

- Always confirm coding requirements with your health plan, as guidance may vary
- Ensure the accurate LOINC Code is being captured and reported.

Improving Data Submission

Lower closure rates stem from claims limitations and manual reporting, making supplemental data submission the most reliable approach.

Claims Cannot be Used to Submit Depression Screening Data to Managed Care Plans [2]

Practices assumed depression screening data was being submitted to managed care plans through claims. **However**, the **California Health Plans** we worked with **require the actual screening score** or **result**, and the claims format does not include a field to transmit this information—making claims an unusable submission method.

Manual Entry into Population Health Platforms Is Time-Consuming and Error-Prone

Many managed care plans offer **population health portals** for practices to submit measure closure data, but the process is **largely manual**.

Staff must search for each patient, enter assessment details (date, LOINC code, score), and upload supporting documentation.

- This process is time-consuming—often requiring several days of staff time—and prone to errors.

Things to Consider

- Additional workflows may be needed to submit structured screening data
- Data accuracy and completeness are critical for reflecting true performance
- Aligning submission methods with health plan requirements is essential for success

[2]: This statement is regarding claims submitted to Managed Care Plans in California for purposes of satisfying the DHCS requirements for the Depression Screening and Follow-up measure. See footnote [1] on page 3 for more information.

Suggested Workflow Example

Automated Submission of Depression Screening Data

In working with the Health Plans that participated in the Design Studio, we determined that standard supplemental data submission is more consistent and reliable than using other more manual processes for reporting depression screenings.

Why This Matters

Below is a workflow diagram that compares the steps needed to submit Depression Screening results by uploading them to a population health management solution (pink) to the more automated workflow where practices submit the results directly to their Health Plans using the plan's standard supplemental data submission processes (yellow).

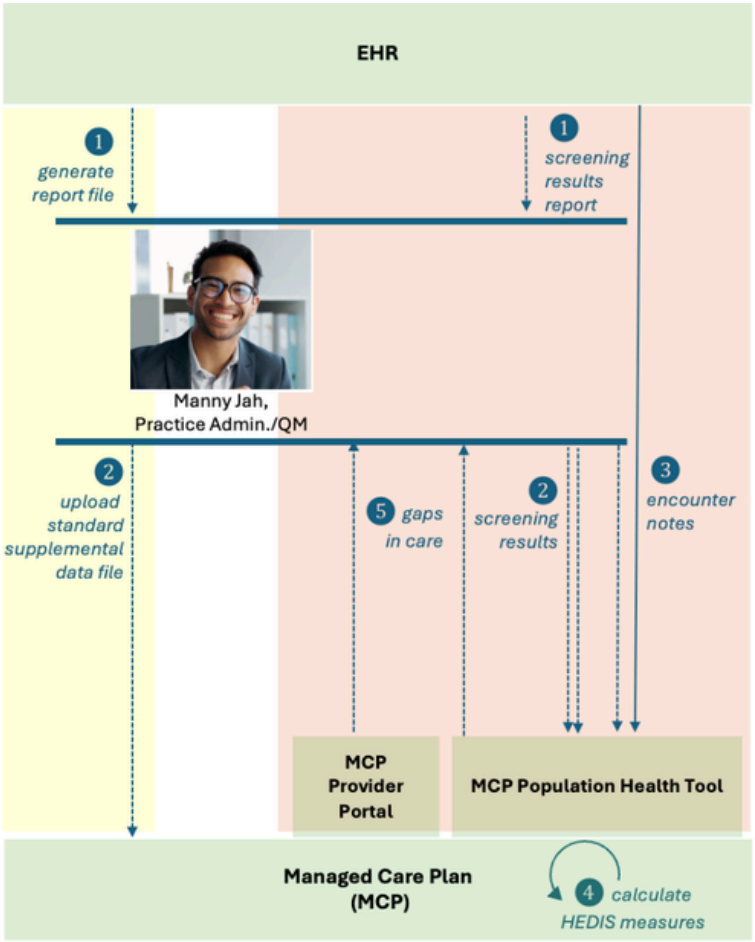
Who Is This For

Clinical Care Teams, MCPs, Quality Teams, Intermediaries, External Partners

Moving from Manual to automated data submission can save $35,000/year per 1,000 patients:

Current workflow: Practices manually upload completed screening and total score for each patient into Population Health Management Tool (ie. Cozeva) as non-standard supplemental data; this can be very time consuming.

New proposed workflow: practices can use each health plans' standard supplemental data file submission process to upload depression screening results for all patients on a monthly basis. This report can be automatically generated in most EHRs using standard reporting tools.

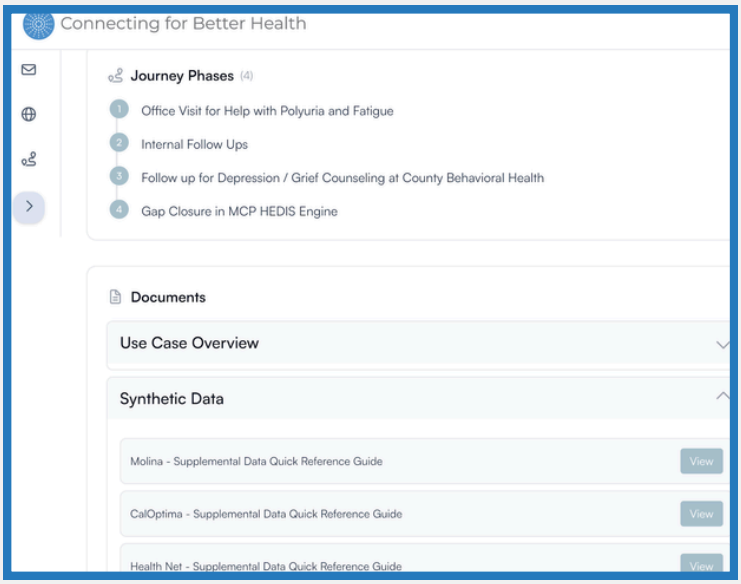


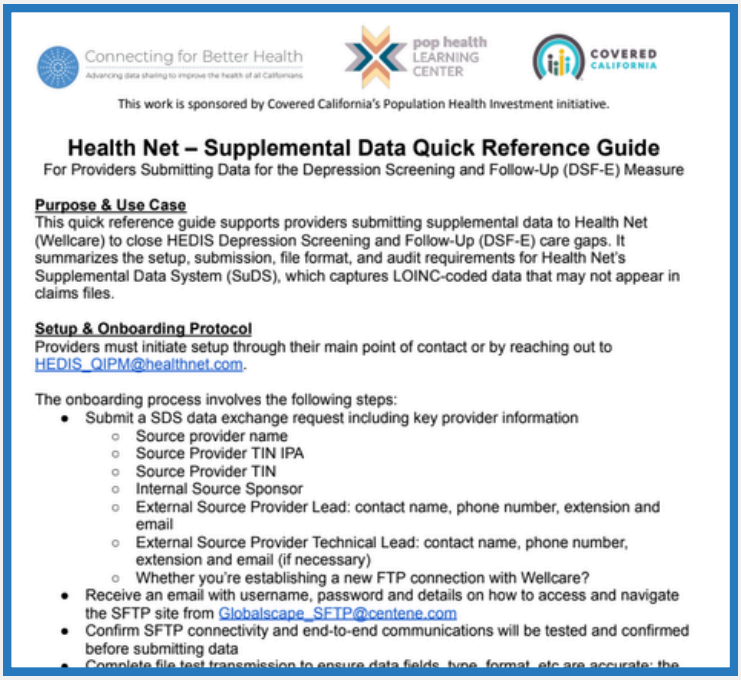
Implementation Support Resources

To support practices in transitioning to a more automated workflow, we developed implementation guides for how to submit standard supplemental data to health plans. The guides provide step-by-step instructions to establish processes, validate data, and submit depression screening information for the following six health plans:

- Blue Shield of California, CalOptima, Central California Alliance for Health, Molina, HealthNet, LA Care

They can be found in the [Connecting For Better Health (C4BH) Sandbox] Use Case Library in the "Synthetic Data" section.





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Health Net – Supplemental Data Quick Reference Guide

For Providers Submitting Data for the Depression Screening and Follow-Up (DSF-E) Measure

Purpose & Use Case

This quick reference guide supports providers submitting supplemental data to Health Net (Wellcare) to close HEDIS Depression Screening and Follow-Up (DSF-E) care gaps. It summarizes the setup, submission, file format, and audit requirements for Health Net's Supplemental Data System (SuDS), which captures LOINC-coded data that may not appear in claims files.

Setup & Onboarding Protocol

Providers must initiate setup through their main point of contact or by reaching out to HEDIS_QIPM@healthnet.com.

The onboarding process involves the following steps:

- Submit a SDS data exchange request including key provider information
  - Source provider name
  - Source Provider TIN IPA
  - Source Provider TIN
  - Internal Source Sponsor
  - External Source Provider Lead: contact name, phone number, extension and email
  - External Source Provider Technical Lead: contact name, phone number, extension and email (if necessary)
  - Whether you're establishing a new FTP connection with Wellcare?
- Receive an email with username, password and details on how to access and navigate the SFTP site from Globalscape_SFTP@centene.com
- Confirm SFTP connectivity and end-to-end communications will be tested and confirmed before submitting data
- Complete file test transmission to ensure data fields, type, format, etc are accurate; the

Generating Standard Supplemental Files For Submission to Health Plans

After obtaining submission requirements from your health plan, **confirm whether your EHR can generate the file**, and work with your EHR vendor or internal IT team if needed.

athenahealth

athenaOne has a standard reporting tool that can be customized by practices. **However**, the full set of clinical data is not available through this reporting tool. Practices will need to work with athenahealth to determine if the needed data for health plan submission are avaialble.

- athenaOne has an add-on product called Data View that the practice can purchase.
- athenahealth's athenaPayer platform automatically extracts clinical quality data from provider charts and is provided free to athenaOne practices through health plans.

eClinicalWorks (eCW)

eCW has the capability within their core EHR to build a report that contains the data needed to close the Depression Screening measure.

- **However**, if practices do not have a data analyst on staff, they will likely want to contract with eCW to build that report for them. Additionally, eCW can set up these reports to run monthly and automatically send them to the health plan.

NextGen

NextGen includes a reporting tool that can be used to build a report of measure specific data

- NextGen also has a population health tool that has greater functionality to create these types of files.

OCHIN Epic

OCHIN Epic allows users to build custom reports using Epic's Reporting Workbench.

- Additionally, Epic has a payer platform where clinical quality data is automatically extracted and sent to health plans who have purchased the platform.

Now that you've generated a test file you are **ready to validate the file against your health plan's requirements**. You can do this directly with your health plan or use the C4BH Sandbox first to gain initial validation on the format of your files using the Data Compass feature.

Future Recommendations

Improving DSF-E performance at scale will require a shift toward more automated and standardized approaches to data exchange. Recommendations include:

1. Moving away from manual data entry toward EHR-generated file submissions can significantly reduce administrative burden and improve accuracy.
   - **Recommendation: EHR vendors should enhance existing clinical reporting tools**—rather than requiring practices to purchase additional population health or reporting modules—to generate health plan supplemental data files. In our research, minor updates, such as adding MEMBER ID, would enable automated file creation and reduce the need for separate, often costly third-party solutions.
2. Aligning data submission requirements across health plans would further simplify implementation for providers working with multiple payers.
   - **Recommendation**: Health plans currently use different formats for standard supplemental data submissions, creating significant administrative burden for practices working with multiple plans. **We recommend DHCS require a standardized submission structure to reduce this overhead.**
3. Expanding access to external data sources, such as pharmacy and behavioral health data, would improve visibility into follow-up care and reduce reliance on incomplete internal records.
   - **Recommendation**: Only three of California's nine QHIOs receive medication fill data, and those that do report delays. Because timely fill data is critical for follow-up care, **the state should prioritize providing pharmacy fill and/or claims data to QHIOs in a more timely manner**.
   - **Recommendation**: In counties where specialty mental health services are carved out to county plans, practices and managed care plans struggle to close follow-up care gaps because claims data are often not shared. **We recommend the state improve data exchange between county mental health and managed care plans** to enable automated data sharing and better care coordination.

How To Get Involved

To learn more about our work please visit

www.connectingforbetterhealth.com.

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