

A New Direction in Depression Treatment in Minnesota

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The problem with clinical depression is that treatment often is ineffective. Only 5.8% of patients with clinical depression have symptom remission within six months of treatment, according to a Minnesota study of 184 primary care and behavioral health clinics conducted by MN Community Measurement, the state's public reporting agency. The DIAMOND program (Depression Improvement Across Minnesota, Offering a New Direction) leverages the expertise of psychiatrists through the support of care managers, thereby offering primary care physicians a more effective way to treat depression. Outcomes for patients in this program are roughly 4.5 times better than usual treatment. Two years of data, collected since the program's inception, indicate that 45% of reassessed DIAMOND patients achieve remission after six months of treatment.

DIAMOND was developed and implemented through a collaborative arrangement facilitated by the Institute for Clinical Systems Improvement (ICSI), a nonprofit organization representing more than 60 medical groups, hospitals, and health plans in the Upper Midwest. ICSI's mission is to initiate health care redesign based on evidence-based practices, collaboration, and innovation. To develop DIAMOND, the group convened psychiatrists, primary care physicians, health plan leaders, employers, and patients as collaborators.

DIAMOND was launched in March 2008 in ten primary care clinics in Minnesota. Clinics have been added every six months; 80 primary care clinics now deliver DIAMOND in 23 medical groups in the state. Care systems include rural and urban areas, large integrated systems, and small

independent sites. DIAMOND has served over 5,000 patients.

DIAMOND is a unique delivery model that fosters teamwork between primary care and behavioral health. Founded on the IMPACT model (Improving Mood—Promoting Access to Collaborative Treatment), which was proven effective in geriatrics research trials, DIAMOND is the first to apply the model in a primary care setting for adults of all ages and to innovate payment systems to provide reimbursement for a bundled set of care management services.

In recognition of its innovative, evidence-based collaborative treatment model, which integrates psychiatric consultation and care management into the treatment of clinical depression in primary care clinics, the DIAMOND program was selected for an APA Gold Achievement Award in the category of community-based programs. In the category of academic or institutionally based programs, the program selected for a Gold Award is described on page 1039. Each Gold Award recipient receives a plaque and a \$10,000 prize made possible by a grant from Pfizer, Inc.

The DIAMOND model of collaborative care

DIAMOND is available to adults aged 18 and older with a diagnosis of major depression or dysthymia according to *DSM-IV-TR* criteria and a score ≥ 10 on the nine-item Patient Health Questionnaire (PHQ-9) at their primary care visit. The PHQ-9 is a basic validated instrument that gives providers and patients a starting point to discuss this chronic illness.

Use of a validated instrument is one of six key components adapted from the IMPACT model. Additional components are use of a care manager, a

consulting psychiatrist, evidence-based guidelines and a stepped-care approach to treatment, a patient registry, and a relapse prevention plan.

DIAMOND has clearly defined roles for all program participants. The primary care physician reviews the PHQ-9 results and symptoms with the patient and makes a diagnosis. Patients with a score ≥ 10 and a depression diagnosis are eligible for the program. DIAMOND does not replace specialty mental health services, and patients who need more specialized care than this program can provide are referred.

The care manager meets the patient for enrollment, intake, and follow-up. Patients are screened for other mental problems, including substance abuse, anxiety, and bipolar symptoms. At each weekly follow-up contact, by phone or in the clinic, patients complete the PHQ-9 and talk with their care manager about adherence or barriers to their treatment plans. Frequent contact helps to keep the patient engaged in treatment and improves the likelihood of adherence and remission. For example, care managers notice when a patient does not make a follow-up appointment and troubleshoot with the patient accordingly.

DIAMOND care managers are certified medical assistants or nurses or have backgrounds in social work or psychology. Interpersonal skills are critical, as indicated in a sampling of patients' testimonials (www.icsi.org/health_care_redesign_/diamond_35953): "The most important element of the program is [my] care coordinator. . . . For the patient to have that advocate—it's huge." "My DIAMOND care manager gained my trust and made me feel like someone was there for any reason."

With the care manager's weekly administration of the PHQ-9 and entry of the scores into a patient registry, intensity of depressive symptoms is closely monitored. The registry also contains information on each patient's medication, treatment adjustments, and behavioral activation. With a typical caseload of 90–120 patients, the care manager depends on the registry to follow patients and guide weekly case discussions with the consulting psychiatrist, and it is a critical means for the care team to monitor progress and alter treatment as needed.

A consulting psychiatrist meets weekly with the care manager to review the caseload. The two discuss diagnoses, comorbidities, and any key psychodynamic issues and needs. Other foci include patient response after a change in psychotropic medications or after psychotherapy, non-adherence to medication or treatment plans, and problems with concurrent substance use disorders or psychiatric problems that interfere with patients' progress. The two periodically review all patients in the registry to ensure ongoing involvement with care and to modify treatment plans.

The consulting psychiatrist and primary care physicians are encouraged to make regular direct contact with each other. The primary care physician is the medication prescriber. When patients do not progress, the psychiatrist may recommend treatment changes, including using a different approach to improve patient engagement; starting, modifying, or augmenting a psychotropic medication; adding or switching types of psychotherapy; or recognizing psychiatric comorbidities and coordinating with other mental health resources. The psychiatrist may provide additional training to primary care staff and physicians about psychiatric disorders, assessments, and treatments.

DIAMOND patients' services are covered for a maximum of 12 consecutive months. When they are ready to move out of care management, patients complete a relapse prevention plan, which includes their maintenance plan and helps them recognize symptoms that might signal a relapse or recurrence of their depression.

Should those symptoms occur, they have an action plan on how to respond and reengage in treatment if needed.

Patients participate in DIAMOND's planning and oversight activities. Several patients are members of the DIAMOND steering committee and provide input and guidance on program development and maintenance issues. Since its inception, DIAMOND has fostered relationships with several state mental health care consumer groups, including Guild Incorporated and the Minnesota chapter of the National Alliance on Mental Illness.

Obstacles overcome

Many obstacles and barriers were overcome to launch DIAMOND. A major cultural shift in health care systems was necessary to deliver team-based care and to reimburse for bundled services. All stakeholders had their own concerns and were persuaded to recognize the value of the partnership between the provider, consulting psychiatrist, and care manager. For example, primary care physicians became less hesitant to deal with depressed patients after receiving psychiatric guidance on recognizing clinical depression and on working with this population. Physicians' concerns that a team approach would be cumbersome were eased once it was clear that care managers' support and caseload would allow earlier intervention for patients with mental health problems.

Psychiatrists' concerns about the potential liability of providing consultation to care managers and primary care physicians were laid to rest when ICSI found that the issues were similar to other types of curbside medical consultations. Some psychiatrists worried about reduced referrals. In fact, referrals to mental health specialists did not decrease; they have become fully triaged and targeted, thus facilitating treatment.

Health plan administrators were initially reluctant to provide additional reimbursement for this more comprehensive treatment model. However, the health plans agreed to pay for the services once the research-based and outcome-based model demonstrated its cost-effectiveness.

DIAMOND program leaders also persuaded employers and the Minnesota Department of Health that behavioral health measures are important and should be reported in a way that integrates behavioral health and primary care. Concerns that the PHQ-9 was too simple to work effectively with a depression treatment program were quelled when program planners presented research that supported its validity in assessing and managing depression. Physicians still make the diagnosis; the PHQ-9 simply verifies symptom intensity.

A sustainable payment model

The collaborative care models on which DIAMOND is based were all funded through grants or research monies. DIAMOND has obtained payment support from all major health plans in the state, unlike any other program for depression in the nation. To develop this sustainable payment model, the ICSI DIAMOND steering committee analyzed costs of staffing for care manager (80% of costs) and consulting psychiatrist (10% of costs) positions, secured health plan and employer participation in discussions on how to provide reimbursement, established a single billing code that the health plans agreed to use, identified a bundle of services for reimbursement (weekly psychiatric consultation and case review, care manager contact, and tracking of patients; use of the registry and the PHQ-9 tool; communication between the psychiatrist, care manager, and primary care physician; and relapse prevention visits with the patient), and recommended a payment process for the bundle. As a result, medical groups participating in DIAMOND receive a monthly fee for each enrolled patient. The specific fee is determined by each health plan working individually with each participating clinic. The primary care physician visit continues to be billed separately.

Clinic participation

Participating clinics receive training from ICSI and must be certified before accepting patients. The certification process includes an assessment of operational readiness, identifica-

tion of a care team and its physician champion, a history of appropriate depression coding and use of *DSM-IV-TR* criteria, and demonstrated success in providing high-quality health care. Each clinic works through a plan to handle mental health emergencies (such as a suicidal patient), including communication with primary care staff and the consulting psychiatrist.

DIAMOND has tracked best practices of its clinics. For example, it has refined workflows to incorporate comorbidity screening at key intake points to prevent intake for conditions such as bipolar disorder that are outside the scope of the program. Scripting tools have been developed to deliver consistent messages about patient enrollment and the value of the PHQ-9, to set goals with patients, and to improve the quality of the six- and 12-month follow-ups. DIAMOND also established separate training tracks on antidepressant medications to accommodate the different needs of care managers and prescribing providers. Clinics have fully adopted the warm handoff to transfer patients from provider to care manager; it is critical for optimal patient engagement and enrollment.

As DIAMOND expands, ICSI is conducting site visits to evaluate its clinics and continuously refine processes and bolster performance. Key success factors include provider endorsement and use of the program, identification of key tasks and roles to optimize team members' performance, and efficient workflows to allow timely patient follow-up.

Measures of success

The DIAMOND patient achieves remission in six to seven months on average. Of the patients with a PHQ-9 readministered at six months, 45% were in remission, and an additional

15% had reduced their PHQ-9 scores by at least 50%. Of the patients reassessed at 12 months, 56% were in remission, and an additional 19% responded to treatment. These year-long measures indicate that DIAMOND's relapse prevention segment and patient self-management approach are effective.

MN Community Measurement's two-year review confirmed this spring that DIAMOND significantly improves patient outcomes in primary care. Many more patients reach remission in DIAMOND than in clinics providing usual primary care for depression. Rough comparisons using intention-to-treat analyses have shown that the six-month remission rate (usual care) is 5.8% in primary care and behavioral health clinics combined and 7.8% in behavioral health clinics, compared with 26% for DIAMOND clinics.

Given the success of DIAMOND, the Minnesota Department of Health has now mandated all physicians and physician clinics to report six-month remission rates to MN Community Measurement beginning in January 2011. Also, the National Quality Forum is using Minnesota's experience and results as key evidence in their discussion about endorsing this measure nationally.

Building on DIAMOND's success

Several certified DIAMOND organizations have asked to implement DIAMOND at more clinics within their system, and many other health care organizations have requested DIAMOND certification training. An ICSI DIAMOND symposium in October 2009 attracted 100 medical group and behavioral health attendees. ICSI has also provided consultation and training in DIAMOND to other states. Partners include the Oregon Health Leadership Task Force,

the University of Washington, and the Hawaii Primary Care Association.

A parallel Minnesota Behavioral Health Depression Collaborative facilitated by ICSI adapts components of the DIAMOND model and is supported by the Minnesota Psychiatric Society, Minnesota Department of Health, Minnesota Department of Human Services, Minnesota Association of Community Mental Health Programs, Minnesota Psychological Association, and MN Community Measurement. These efforts have influenced standardization and have raised public awareness of psychiatric and mental health outcome measures and made them a priority in the state.

DIAMOND is an innovative and highly effective program that integrates psychiatric consultation into the primary care setting to provide effective treatment of patients with clinical depression. It offers a self-sustaining model that other programs can follow to implement measurement-based depression care. The program has demonstrated markedly higher remission rates than are usually seen in primary care clinics, and this success is attributed to evidence-based clinical treatment practices and intensive care management. As a result, employers, health plans, the Minnesota Department of Health, and the Minnesota Department of Human Services all support the need for better care and outcomes, recognizing that the DIAMOND project is on the forefront of outcome-based, evidence-based treatment that integrates psychiatry into primary care medicine.

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