

Behavioral Health Clinics Improve Depression Care

Abstract

From its inception in March 2008, the DIAMOND program (Depression Improvement Across Minnesota, Offering a New Direction) has demonstrated that a new approach to delivering and paying for depression care in the primary care setting yields substantially better patient outcomes than standard approaches. Psychiatric leaders in the community began to explore ways to use some of the DIAMOND program elements—especially the standardized use of the Patient Health Questionnaire (PHQ-9) tool and the collaborative process—within behavioral health. From an initial workgroup, a Minnesota Behavioral Health Depression Collaborative (BHDC) was formed in 2009 to establish and implement best practices for depression care in behavioral health clinics. Collecting data in order to measure processes and outcomes was added in the second year of the BHDC. A new state mandate requiring all clinics with physicians on staff to publicly report their depression care performance this year has generated interest among behavioral health groups in this collaborative work. This article describes what the BHDCs have achieved in standardization, process improvement, data collection, measurement and ongoing education to date. Key lessons learned by participating groups are highlighted.

All behavioral health specialists are trained to recognize and treat depression. However, most do not work in settings where measurement-enhanced care is practiced, i.e., many do not use standardized processes and tools to measure their patients' progress to modify treatment plans and improve outcomes. Measuring outcomes has become more critical in 2011 as quality reporting rules established through the Minnesota Department of Health will require all Minnesota clinics with physicians on staff, including behavioral health groups, to report to MN Community Measurement (MNCM) how many of their patients with depression are in remission six months after treatment starts.

These performance numbers are based on scores from the PHQ-9, a questionnaire that quantifies symptoms of depression such as changes in eating and sleeping patterns and feelings of hopelessness. When administered before treatment begins and at regular intervals thereafter, the PHQ-9 enables providers to monitor the status of patients with depression, adjust therapy and medications as warranted, and quantify improvement.^(1,2)

Genesis of the BHDC

Even before the current measurement mandates were implemented for behavioral health clinics, leading psychiatrists became convinced of the value of using the DIAMOND program elements.⁽³⁾ The 70+ clinics participating in the DIAMOND program use the PHQ-9 as a tool for initial documentation and quantifying symptom severity of depression. Systematic

patient follow-up through additional PHQ-9 scoring and the use of a patient registry, along with regular contact by a care manager between appointments, improve the ability to monitor each patient's status. Care managers also educate, coordinate and troubleshoot services for patients. A consulting psychiatrist works with each DIAMOND clinic to review and provide recommendations.

The DIAMOND program's results have been dramatic. The DIAMOND clinics collectively have achieved a six-month remission rate of 26 percent for their patients, with some sites achieving remission rates as high as 46 percent.

Seeing this significant improvement in patient outcomes in primary care served as a catalyst to form a Behavioral Health Depression Collaborative (BHDC) in 2009. Initially funded by the Minnesota Department of Human Services (DHS) and the Minnesota Association of Community Mental Health Programs (MACMHP), the collaborative was facilitated by ICSI. Its goals were to implement and share best practice methods, get the 18 participating behavioral health organizations to routinely use the PHQ-9 to engage patients in discussions about their progress and clinical decisions, and develop action plans for building processes and measurement into daily workflow.

Provider participation ranged from large systems such as HealthPartners Medical Group to smaller, rural groups such as South Central Human Relations Center.

Eleven behavioral health groups joined or continued in the 2010 BHDC. Representatives from the Minnesota Psychological Association and Minnesota Psychiatric Society joined the planning committee, and health

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By Michael Trangle, M.D.
and Pam Pietruszewski, MA

plans BlueCross and BlueShield of Minnesota, HealthPartners and Medica joined DHS and MACMHP in providing funding. Goals were extended to include:

1. Routine use of the PHQ-9 for initial assessments and to monitor treatment, and reliable tracking of patients' progress via a patient registry;
2. Use of the rapid cycle change model to standardize and improve PHQ-9 administration, workflow efficiency and patient follow-up;
3. Team-based care that is efficient, eliminates gaps in care, and optimizes the role of each team member; and
4. Data collection for process and outcomes measurement.

Initial actions included completing readiness assessments to determine a participating clinic's quality improvement infrastructure, identifying a provider champion and team members, and evaluating organizational priorities and resources committed to the project. Participants then conducted team exercises to modify roles and key tasks and eliminate redundancies, as well as develop and implement clinical process workflows to align with best practices.

The participating BHDC groups also began collecting data and measuring depression care effectiveness for adults with major depression and dysthymia. Measurement was based on sample data from 50 random patients per group (roughly 750 total patients) who were evaluated using the PHQ-9. Results showed that behavioral health clinicians administered the PHQ-9 to nearly 83 percent of patients during their first visit, a high level of standardization. More than half of those patients had at least one follow-up PHQ-9. Of that group, 28 percent achieved treatment response (50 percent reduction in the severity of their depression) and nearly 7 percent were in remission upon follow-up (using the standard definition of < 5 on the PHQ-9 for remission).

The Minnesota collaborative may be one of the first large-scale attempts to utilize this approach and transparently share results. Also, the work has been done with very limited resources. The 2009 MNMCM report revealed that two out of the top 10 performing clinics

for treating patients with depression were behavioral health clinics that had participated in the BHDC (seven out of the other eight top performing clinics were DIAMOND primary care clinics).

Implementation/ Lessons Learned

Two groups that have changed their approach to depression care stemming from their BHDC involvement are St. Cloud Hospital and Owatonna-based South Central Human Relations Center (SCHRC). St. Cloud Hospital is part of the CentraCare system and is the largest health care provider in a 12- to 15-county referral area. Its outpatient Behavioral Health Services staff of more than 50 people, including 10 psychiatrists, coordinates care with seven CentraCare primary care clinics that offer the DIAMOND program. The 13-clinician SCHRC group provides behavioral health services to residents of Dodge, Steele and Waseca counties. These two groups emphasize the following key lessons from BHDC.

Importance of Champions

Process improvements, standardization and measurement represent major culture change for many behavior health specialists. Because a push for change usually meets some resistance, ICSI helped identify and support respected champions within each BHDC organization. At St. Cloud Hospital, the champions are psychiatrist John Schmitz, M.D., who has advocated for the PHQ-9 after using it in his practice for five years, and psychologist Steve Vincent, Ph.D., director of Behavioral Health Services and the Minnesota Psychological Association's liaison to BHDC.

"Screening is underutilized in both primary care and mental health, even though our professional associations recommend these tools and people are aware of them," Schmitz said. "Primary care physicians feel they don't have time for it and mental health practitioners feel they are the experts and don't need it. But the latter are interested when I explain the DIAMOND clinics' experience and how the PHQ-9 has made me less likely to miss symptoms, how it helps me manage my time and how it can help achieve better outcomes."

Effective Rapid Cycle Change

Collaborative members have discovered that

incremental change achieved through ICSI's teaching of the Plan-Do-Study-Act (PDSA) rapid cycle change process is an effective way to introduce new tools and processes into their practices. The PDSA model involves trying a small change, and then evaluating the results. In the next cycle, modifications can be made or another change can be added.

At SCHRC, the staff worked with ICSI to complete 14 PDSA cycles. The group is preparing to switch from paper charts to an electronic health record (EHR). Through the rapid cycle change process they have:

- Introduced stickers to flag the charts of patients identified with depression based on their PHQ-9 score;
- Established a protocol for administering the PHQ-9 to all of these patients at least once a month;
- Expanded use of the PHQ-9 to established patients who had never been screened, asking clinicians to do this with three patients per month; and
- Rolled out concurrent documentation, which involves discussing progress notes with patients during appointments, to four to five clinicians at a time so that all will be ready to use it with the new EHR.

"We've done quite a few QI projects but weren't familiar with PDSA," said psychologist Mark Skrien, SCHRC's clinical director. "We have been able to make a lot of progress and achieve continuous quality improvement. We're all more accountable for the progress we make with patients, and the staff has not resisted. We ask, 'In what way can we make this happen?'"

Value of the PHQ-9

The mental health practitioners at SCHRC and St. Cloud Hospital have found that standardized use of the PHQ-9 has not only prepared them for measurement requirements but has improved the depression treatment process.

"The PHQ-9 has become a conversation starter with patients about the changes they are experiencing during the course of treatment," Schmitz said. "It's quick to administer, helps me provide a more thorough consult and makes the evaluation more objective and evidence-based for patients. We have patients who are on medications for a long period of time, and we need a way to see how they are doing."

Vincent, who sees patients one day a week, said the PHQ-9 can reinforce patients' progress.

He recalled a case where the patient's PHQ-9 score dropped from 19 to 17 in a month—not a big improvement—with his primary symptom being a sense of hopelessness. Vincent increased treatment to two consecutive weekly visits. After the patient's PHQ-9 score dropped to 5, Vincent said, the patient could visibly note the impact of the change in treatment, and was pleased and a little surprised.

Skrien said a PHQ-9 sticker on a chart is a motivator and gets him focused on making progress with that patient. He said the PHQ-9 “makes us more accountable. We can watch the numbers and change the course of therapy more quickly.”

Value of Team-Based Care

The BHDC also is focusing on stepped care and team-based care that optimizes the role of each team member. Some SCHRC clients see a therapist through outpatient services and also see a hospital-based psychiatrist. Skrien said the patient registry record is very helpful in tracking these types of cases. He also noted that peer reviews and multidisciplinary staff meetings, both required for Rule 29 licensure for mental health clinics, have fit nicely with the workflow that was developed for PHQ-9 use. The SCHRC plans to use this as an opportunity to “Trace the Case,” bringing in PHQ-9 administered cases for the entire team to discuss.

“We would not have made nearly as much progress on our own,” said St. Cloud Hospital's Vincent. “We look forward to starting to share symptom-specific and (PHQ-9) score-specific treatment ideas. The BHDC is helping us support, reinforce and sustain the new workflow processes and measures we have adopted.”

Paradigm Change

Although primary care has long performed measurement-based care (e.g., using a lipid level to decide whether to adjust a patient's statin), this has not been the case in behavioral health. It is only very recently that there has been enough evidence for practitioners to begin matching quantitative numbers and timelines to recommendations for depression improvement.^(4,5)

Measuring and transparently sharing results and using this data to analyze impacts of using PDSA's, and then repeating these cycles to improve systems of care and patient outcomes is another big cultural shift. It is rarely seen in

the behavioral health world where resources are scarce and no budgets exist for this.

Plans for the Future

In 2011, the BHDC is focused on increasing the reliable usage of the PHQ-9, the stepped-care approach, measuring patient outcomes, and connecting BHDC members with DIAMOND primary care clinics. As the MDH depression care reporting requirements kick in and BHDC clinics show better outcomes, a large number of behavioral health groups are showing interest in this collaborative. Current members have indicated strong support for continuing with the effort, and further integrating primary and behavioral health clinics' treatment of patients with depression. New clinics have also joined the collaborative this year. ♦

References

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Michael Trangle, M.D. is the associate medical director of Behavioral Health for HealthPartners Medical Group/Regions Hospital.

Pam Pietruszewski, MA is the education program lead at the Institute for Clinical Systems Improvement. She is a trainer and facilitator for the DIAMOND depression initiative, and serves as a consultant for the Behavioral Health Depression Collaborative.

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