

Detection and Treatment of Depression in Primary Care*

CONFERENCE REPORT

Reporter, Susan B. Yox, RN, EDD
Executive Editor

Effective Clinical Practice.
1998;1:39-42.

A companion conference, sponsored by The HMO Group, was integrated with the third national “Primary Care Behavioral Healthcare Summit,” presented by the Institute for Behavioral Healthcare in joint sponsorship with the Primary Care/Behavioral Healthcare Partnership and CentraLink, on 10 to 12 November 1997 in Chicago, Illinois. The HMO Group’s meeting was a follow-up to a series of conference calls designed to initiate shared improvement projects with the goal of better detection and treatment of depression in the primary care setting.

The HMO Group, a national alliance of 25 integrated, nonprofit, and provider-sponsored health plans, has a long history of nurturing collaborative projects between member organizations. (The name of the organization has since been changed to the Alliance of Community Health Plans.) To accelerate the improvement process, participants came to the meeting having already identified improvement teams and specific goals for collaborative projects. Using goal-setting, evidence and effective interventions, and data on baseline performance, conference attendees devised specific plans to improve clinical practice in their own settings.

Guidelines for Care

Presenters from Group Health Cooperative (GHC) of Puget Sound and the National Institute of Mental Health began the conference by describing evidence-based models for the detection and treatment of depression in integrated systems.

Neil Baker, MD, regional chief of Central Mental Health Services at GHC, began by making a compelling case for the use of *evidence-driven* clinical guidelines. That means that guidelines are based on published, peer-reviewed evidence, not on expert opinion or, in Baker’s words, “an unsystematic gestalt of the literature.” Pointing out that the mental health culture has traditionally been driven by “expert opinion,” Baker made the point that guidelines need to be data-driven, whereas the job of the expert practitioner is to *translate* guidelines into clinical practice.

The process at GHC for guideline development is rigorous. The resulting guideline for depression includes the following phases:

- acute assessment (weekly contacts for the first 4 weeks, in person or by telephone)
- continuation (8 months)
- maintenance (more than 8 months, instituted only if a patient has had three or more episodes of major depression).

A key portion of GHC’s program has been the use of diagnostic and severity tools as well as a patient pamphlet and a relapse prevention plan.

Kathryn Magruder, PhD, MPH, assistant chief of Services Research and Clinical Epidemiology at the National Institute of Mental Health, discussed various types of guidelines and the structural changes needed in primary care to facilitate guideline implementation. Magruder pointed out that the shared improvement ini-

*Conference supported by an unrestricted educational grant from Wyeth-Ayerst.

Change Concepts

- Change concepts are ideas for change that are based on rational theory, expert opinion, successful demonstration in another setting, or research.
- Change concepts are only the “germ” of an idea; they can then be tailored to fit local conditions.
- Change concepts are used to “jump-start” the improvement process by offering a quick way to begin a cycle of implementing and testing change.

tiative can be seen as a way to begin working collaboratively in providing answers to some of the practical questions of primary care practitioners.

Collaborative Care

David Sobel, MD, MPH, regional director of Patient Education and Health Promotion Program at Kaiser Permanente in Northern California, encouraged the group to improve collaborative care by looking for “out-of-the-box” health care strategies.

Sobel pinpointed the key questions facing conference participants: First, how can the full range of psychosocial needs of patients in primary care be assessed; second, how can behavioral health knowledge and skills be shared with primary care providers and patients?

The traditional, inside-the-box approach was for the mental health professional to manage mental illness and drug and alcohol addiction. However, in the paradigm Sobel described, the scope is much wider. Behavioral health can affect many areas, such as psychosocial distress, utilization and demand management, compliance, coping, and health behavior change. To make a real difference in these areas, primary care providers need to become extensively involved.

The concern about high utilizers of medical care services is a prime example. Sobel pointed out that 50% of high utilizers are psychologically distressed. He believes that high utilizers are not *inappropriate* utilizers. Rather, the crux of the problem is that *inappropriate services* are available for the psychologically distressed and people can only use what is available.

In an attempt to better meet patients’ needs, many new practice models are emerging, such as collaborative practice, group medical appointments, psychoeducation, and behavioral medicine groups. Patients themselves are increasingly being seen as primary care providers. As a result of out-of-the-box thinking, health plans may play a role in educating, equipping, and empowering the patient to be the true primary care provider.

Detection of Depression

David J. Katzelnick, MD, distinguished scientist at the Dean Foundation in Middleton, Wisconsin, described an ongoing project to identify “best practices” in the detection of depression.

Under ideal circumstances, screening and diagnosis of depression occur in the primary care setting, treatment is initiated and provided during the acute phase, the response is successful, and treatment continues for at least 6 months. In practice, many health plans have some, but not all, of these components in place.

Katzelnick pointed out that screening alone, without a follow-up treatment system, does not work. The Dean Foundation is working with three HMOs to evaluate various treatment approaches for high-utilizing patients and the outcomes in the areas of symptoms, health care utilization, occupational functioning, and quality of life.

Steve Stelovich, MD, of Harvard Pilgrim Health Care (HPHC), and Nancy Sokol, MD, of Concord Hillside Medical Associates, described a similar effort in Boston, Massachusetts. Their goal is to focus on the practical strategies to make the detection of depression in primary care feasible.

The emphasis of the HPHC initiative is to teach clinicians to screen for major depression by using a simple, three-item tool and to implement first-line treatment.

Clinicians are encouraged to screen patients who present during three or more visits with recurrent headache, low back pain, generalized pain, insomnia or fatigue, and chronic gastrointestinal symptoms, such as bloating and gas.

Other components of the program include practice and patient supports, such as clinical training and continuing education, patient education materials, follow-up and compliance support programs, and a mental health back-up system.

Treatment of Depression

Overcoming barriers to implementing depression treatment programs was the focus of the next two presentations. Steven A. Cole, MD, professor of psychiatry at Albert Einstein College of Medicine and chief medical officer at Care Management Group of Greater New York, Inc., and Wendy Levinson, MD, from the University of Chicago Medical Center, reviewed 10 barriers to integrated care for people with depression:

1. Culture of medicine: Physicians need to see the biopsychosocial model as a viable alternative.
2. Stigma: Mental disorders must be viewed as medical problems that can be effectively diagnosed and treated.

3. Fallacy of “good reasons”: Life stressors or illness may precipitate mental disorders in vulnerable individuals; mental disorders should be viewed as dread complications of stressful life events or medical conditions.

4. Time factors: Good communication skills save time, and early recognition and treatment save time and improve outcome.

5. Somatization: Physicians should recognize somatic symptoms of mental disorders; they need to be educated in persuading patients to accept alternative explanations for somatic distress.

6. Financial disincentives: Integrated, “carved-in,” behavioral health care can provide a solution.

7. Administrative and social barriers: Pharmacoeconomics, disease management, and integrated care can save money and improve outcome.

8. Overcoming knowledge deficits: Educational approaches are needed to improve knowledge, attitudes, and skills.

9. Improving skills: Educational approaches are needed to assess baseline competencies and improve skills.

10. Changing professional behavior: Several interventions are necessary to modify professional behavior.

The MacArthur Foundation Depression Education Program is an ongoing randomized, clinical trial designed to train physicians to overcome barriers in the treatment of depression. After the development and testing of a pilot program, 8-hour training workshops will begin.

Shared Improvement Projects

During the final day of the conference, The HMO Group participants developed quality-improvement strategies for screening and treatment of depression. Using many of the change concepts presented at the meeting (*see* Change Concepts), attendees analyzed what might work best in their own organizations.

The group agreed that one of their major goals was to learn which patients could be safely treated in primary care and when referrals to mental health professionals were necessary. Facilitator Paul Plsek recommended that participants look for “leverage points” in their large systems; have clear goals; try to implement rapid, small cycles of change; and clarify (in the beginning of the process) how the interventions will be measured.

Making Change Happen

Create tension for change

- Use to convince skeptics
- Encourage employer groups to support change
- Emphasize helping primary care physicians deal with frustrating patients

Identify effective alternatives

- Start small and gradually increase the size of a project
- Encourage local adaptations of a system change

Provide social support

- Involve “superstars”
- Encourage early innovators
- Involve other health professionals, like nurses, early in the process

Plan participants had brainstorming sessions within their own groups and shared ideas with others as the day progressed. By the end of the planning process, several groups had developed detailed projects to implement at home.

Some plans are focusing on improved detection of depression in primary care, using diagnostic and severity tools that others have recommended. Other plans have screening initiatives under way and are emphasizing guidelines and improved management once depression is diagnosed. Improved adherence and compliance with medications are important goals for many of the improvement efforts.

For example, at Kaiser Permanente’s Rocky Mountain Division, a project was designed to implement and evaluate the effectiveness of a model of integrated care between mental health and primary care providers for the treatment of depressive and anxiety–panic disorders. There is an effort to improve outcomes, to more actively involve patients in treatment decisions, and to increase patient satisfaction with care for these disorders.

At Health Care Plan (HCP), the project’s goal is to improve several areas of diagnosis and treatment. Since the conference, HCP has focused on improving treatment (by the use of guidelines, a short-term group program, and the use of an assessment instrument), detection, patient education, and the development of a reminder system for primary care providers, to encourage the appropriate use of medication.

The Northeast Division of Kaiser Permanente is working to improve screening, diagnosis, and appropriate treatment of depression. Their goals have been formalized, with an effort to screen 80% of primary care patients for depression, to increase the rate of detection by 50%, and to improve compliance with clinical guidelines by 90%.

Conference calls since the meeting have indicated that many plans have had successes and have been able to learn from each other as their ideas for improvement have been continually developed, implemented, tested, and modified.

The long-term goal is to seek continual improvement in the detection and treatment of depression, and to learn from and support each other through the change process.

Acknowledgment

Thank you to Michelle Tropper of the Alliance of Community Health Plans for providing details on the shared improvement projects resulting from the work begun at this conference.

Correspondence

Susan B. Yox, *Effective Clinical Practice*, Health Care Plan, 3980 Sheridan Drive, 6th Floor, Amherst, NY 14226.

This paper is available at ecp.acponline.org.

Chronic Care in America:

A 21st Century Challenge

The Institute for Health and Aging, University of California, San Francisco, for the Robert Wood Johnson Foundation, Princeton, New Jersey. 1996; 76 pages; free.

Spiral bound for easy reference, this book describes chronic care and chronic conditions in the United States. It is an excellent overview that aims to acquaint the reader with the breadth of the issues and provides many definitions, footnotes, and graphs in a brief, easy-to-read text. The book discusses a highly complex policy area and comprises the following elements:

- An introduction to chronic conditions (an overview of illnesses and impairments, including what they are, who is at risk for them, and how much they cost)
- A description of the chronic care “system” (the source of care, how it is financed, and trends of care)

Book Review

- Stresses in the system (unmet need, potential for tradeoffs of lower-cost interventions, the demographic shift that will radically reduce the ratio of potential caregivers in the population)
- Policy challenges and 11 short profiles of groups that have had innovative responses to these challenges.

Clinicians in HMOs may want to use this book in establishing their plan’s formulation of policy for population and disease management. It pulls into one place a disparate body of information about a subject that consumes three quarters of direct medical care resources. HMOs must have creative policy responses for managed care to gain leverage in resource management.

*Robert A. Ludwig
Senior Vice President for Information Services
Health Care Plan
Buffalo, NY*