



One Voice Project

Depression Screening and Treatment in Primary Care



Executive Summary

The Northeast Business Group on Health (NEBGH) multi-stakeholder Mental Health Task Force, comprised of the New York City Department of Health and Mental Hygiene (NYC DOHMH), primary care physicians, mental health professionals, commercial health plans, employers and consumers, has designed a demonstration project to implement an evidence-based collaborative depression care model to improve depression screening and management in a limited number of primary care practices (PCPs) in the New York City (NYC) region. The active support and involvement of the NYC DOHMH and all the major metropolitan area commercial health plans renders the task force uniquely well positioned to design and implement such an initiative.

The clinical intervention to be implemented is an adaptation of a collaborative depression care model being implemented across the country that calls for a three-member clinical team comprised of a primary care provider, care manager, and consulting psychiatrist to work as an integrated team. In the One Voice (OV) Initiative, the care manager will be a Licensed Clinical Social Worker (LCSW). Participating clinicians will receive training on the OV collaborative care model and technical assistance for integrating this model into routine care.

Improvement in treatment and outcomes will be monitored to assess the success of the demonstration project. The pilot will also address reimbursement mechanisms for making the model a sustainable one for providers, patients, purchasers and payers.

One Voice Goal

The goal of the One Voice Initiative is to catalyze regional uptake of the evidence-based Three Component Model¹ to diagnose and treat depression in primary care settings in New York City (NYC). While there has been regional adoption of the Three Component Model in other parts of the country, its successful implementation in New York City NYC's complex, fragmented environment has not been demonstrated.

Sustaining and scaling up the proposed intervention has been a core consideration throughout the development of the One Voice Initiative. The intervention is intentionally structured to fit within existing reimbursement structures, so that the majority of the costs will be absorbed by health plans as part of routine care.

Background

The burden of underdiagnosed and undertreated mental illness is a substantial concern for New York residents and the companies where they work. An estimated 380,000 New Yorkers suffer from depression, but only 54.6% of adults have ever been diagnosed with depression, and only 36.7% of adults are treated². Among those treated, the quality of care is often insufficient, with poor patient tracking and follow-up. According to America's Health Rankings, the average number of poor mental health days is 3.2 per month in New York State³; however, in New York City, 7.8% of residents reported frequent mental distress (mental health "not good" on more than 13 of the last 30 days)⁴.

Responding to this burden has been challenging given the complexity of NYC's health care environment. The array of players in the health care landscape includes more than seven major commercial health plans and nearly 10,000 primary care practice locations. New York also has a high proportion of solo practices (34%), compounding the complexity of the landscape, as well as low psychiatric participation in health plans, making mental health care provision particularly challenging.

The Three Component Model (Collaborative Care Model)

The Three Component Model is characterized by the following key components:

- A three-member clinical team comprised of a primary care provider (PCP), licensed clinical social worker (LCSW), and consulting psychiatrist, working as an integrated team within the primary care practice
- Routine depression screening using the PHQ-2, followed up with the PHQ-9 for positive results on the PHQ-2
- Depression management by the PCP and subsequent differential diagnosis by the LCSW
- Consistent care management, using a patient registry to track patients' progress throughout diagnosis, treatment, and relapse prevention
- Adherence to well-accepted stepped care guidelines to inform treatment methods

Evaluations of the model have demonstrated strong results. The RESPECT program, by the MacArthur Initiative, tested its implementation of the care model in a cluster randomized controlled trial. At six months, 60% of patients in the intervention group had responded to treatment and 37% were in remission, compared to 47% response and 27% remission in practices assigned to usual care⁵. In a

¹ Oxman TE, Deitrich AJ, Williams JW Jr, Kroenke K., A three-component model for reengineering systems for the treatment of depression in primary care. *Psychosomatics*. 2002 Nov-Dec; 43(6):441-50.

² NYC Health and Nutrition Examination Survey (HANES), 2004.

³ America's Health Rankings (2009). Measure: Poor Mental Health Days. State: New York. Online at <http://www.americashealthrankings.org/>. Referenced March 18, 2010.

⁴ Community Health Survey, New York City Department of Health and Mental Hygiene, 2008. Accessed via EpiQuery on March 19, 2010 at <https://a816-healthpsi.nyc.gov/epiquery/EpiQuery/CHS/index2008.html>.

⁵ Dietrich, A. et al., Re-engineering systems for the treatment of depression in primary care: Cluster randomised controlled trial. *British Medical Journal*, 2004. doi: 10.1136/bmj.38219.481250.55.

randomized clinical trial of a collaborative care intervention for elderly patients, the IMPACT study showed significant improvements in both symptoms and functionality in the intervention group at 6 month, 12 month, and 2 year measurements⁶. Finally, the DIAMOND Initiative, an adaptation of the IMPACT study for the general population, showed a 64% response to treatment and 44% remission at 6 months, and 72% response and 52% remission at 12 months⁷.

The NEBGH Mental Health Task Force has studied the elements that drove success in these cases, and has combined this evidence with the group's understanding of the health care landscape in New York City to structure the One Voice Initiative.

Participants

The One Voice Initiative will introduce the collaborative care model for depression in a minimum of 2-3 large and 5-6 small NYC primary care practices. Approximately 20 primary care providers will participate in total. Based on average caseloads of 1,000 patients per primary care provider and depression incidence of 5.3%, we expect that we will identify approximately 750 patients with depression during the first year of the project. We anticipate that not all of these patients will elect to take advantage of the enhanced services available, and when projected attrition is factored in, we estimate that approximately a quarter of these patients will receive services under the model.

The One Voice depression collaborative care model specifies that the care manager be a Licensed Clinical Social Workers (LCSW). The choice of LCSWs for the care manager role is a defining feature of this demonstration project. One of the primary barriers to introducing the collaborative care model in NYC has been the absence of appropriate mechanisms to compensate the primary care team for this enhanced mode of service delivery. We have determined that LCSWs will be able to bill for care management services under current behavioral health reimbursement guidelines and intend to demonstrate that linking LCSWs trained in care management (CM) with PCPs is a viable alternative for implementing the model. We plan to enlist 3 – 5 LCSWs to participate in the program, with each LCSW working with 1 – 2 practices.

Once Voice Initiative Protocol

Screening

Practices will be encouraged to introduce universal depression screening using the PHQ2 and 9⁸. The PHQ9 will be administered (self-administered or by practice staff or primary care provider) when patients screen positive on the PHQ2.

Diagnosis and Treatment

The PCP will review the completed PHQ9 as part of their patient assessment. If indicated, based on their clinical judgment, the PCP will make a diagnosis of depression and develop a treatment plan. The treatment plan may include psychotherapy, medication, referral for further evaluation, watchful waiting, and/or other appropriate actions in accordance with accepted clinical guidelines. The provider will also determine if this patient can reasonably be treated for their depression in primary care using the Three Component Model. Patients that require specialty care will be referred accordingly.

⁶ The IMPACT Program: A team approach to depression care that gets dramatic results. John A. Hartford Foundation.

⁷ Jaeckels, N. and Trangle, M. DIAMOND: Origin, Context & Future. ICSI presentation, Oct. 2009.

⁸ *The PHQ-9 is adapted from PRIME MD TODAY[®], developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues with an educational grant from Pfizer Inc. The names PRIME-MD[®] and PRIME MD TODAY[®] are trademarks of Pfizer, Inc.

If the PCP is uncertain about making a diagnosis of depression or has questions about the treatment plan, the PCP can obtain a consultation from the Collaborative Care team psychiatrist.

Care management referral and initial assessment

Patients with a diagnosis of depression to be managed in primary care will be asked if they would like a referral to a care manager to support them during the initial phase of their depression treatment. The PCP office staff will assist the patient with making an appointment for an initial assessment with the care manager (CM). This may be an in-person or a telephone or virtual visit, in accordance with patient and care manager preference.

The CM will conduct a thorough psychosocial assessment to confirm the diagnosis and review the treatment plan with the patient. The CM will also discuss the CM follow up plan and provide education and self management support. As needed, the CM will help to identify an appropriate professional for counseling/psychotherapy. In some instances the patient and CM may determine that the CM is the appropriate professional to provide those services. However, the counseling services will be considered as distinct from CM. The CM will maintain a registry containing limited elements, such as PHQ9 score, medication prescribed and PCP visits (scheduled and attended), to support care management as well as to assess and drive improvement.

If the CM has concerns about the diagnosis and/or treatment plan, the CM will follow up with the PCP. As indicated, the CM will also seek consultation from the third member of the team, the psychiatrist.

Care management

After the initial visit, the CM will follow up with the patient through a series of brief visits (15 minutes), most often by telephone. The planned schedule for these visits is 3 weeks after diagnosis and treatment initiation, monthly thereafter for five months (months 2 – 6) and bi-monthly for another 6 months (months 8,10 &12). The CM may change the frequency and or length of the visits based on their clinical judgment, however, it is anticipated that the total time will be relatively consistent. These visits will be used to re-administer the PHQ9, assess adherence to the treatment plan and provide self-management support and education.

The patient will be encouraged to have follow-up visits with their PCP one month after diagnosis and initiation of treatment as well as at 4, 6, and 12 months.

Care team consultation

The psychiatrist will be available to both the PCP and LCSW CM to discuss cases and provide an educational consultation re: diagnosis and treatment. The psychiatrist will not see the patients. If a patient requires evaluation by a psychiatrist, a referral will be made. The three members of the team will be encouraged to have regularly scheduled calls for a brief review of the CM's panel.

Training

Both LCSWs and participating providers will be trained in the collaborative care model.

The Depression Care Management Training Program will prepare social workers to take on a new role in a new setting. While LCSWs are skilled professionals that currently manage patients with depression, the role a care manager in a collaborative care team is different from that of the independent practitioner. The care must be closely aligned and integrated with that of the primary care provider and the focus is on brief supportive counseling rather than long term therapy. In addition, the primary care environment is much faster paced than the typical behavioral health environment.

The training, which will take place over five to seven sessions, will be both didactic and interactive. It will introduce LCWS to the specifics of both the primary care environment and the collaborative care model.

Participants will have the opportunity to role play using CM skills and to run through CM protocols. The project team and LCSWs with expertise in the collaborative care model and brief intervention techniques will provide the training.

The training program for participating primary care providers and their care teams will be an abbreviated version of the LCSW training with additional content on best practices in depression care, with an emphasis on medication management and use of the PHQ-2 and -9, as well as an introduction to Cognitive Behavioral Therapy and Problem Solving Therapy and other behavioral health interventions

Technical Assistance

Technical assistance will be provided to support practical approaches to recognizing and treating depression in the primary care setting and to address challenges in implementing a collaborative team approach (e.g. workflow, caseload tracking, care management support and follow-up.) An experienced clinical quality improvement specialist will provide the technical assistance on site at the practices.

Assessment of demonstration project results

A core set of clinical process and patient outcome measures will be used to track improvement over the course of the project. The data for the measures will be collected by the PCPs and LCSWs in the course of care. The selected measures have been used by other similar projects in the past.

The following table outlines the main evaluation questions and measures to be used in assessing the One Voice Initiative:

	Evaluation Questions	Measures
Screening Process <i>Does the program improve frequency and accuracy of mental health screening?</i>	Screening uptake	Number of patients diagnosed with depression
	Accurate Diagnosis	Number of patients referred to specialist for complex mental health conditions
Treatment Process <i>Does the program improve the quality of care provided, as measured by treatment initiation, adherence, and follow-up?</i>	Initiation of treatment	Percent of patients on antidepressant or in therapy within 1 month of diagnosis
	Follow-up contact	Percent of patients with follow-up contact within 3 months of starting treatment
	Medication adherence (acute phase)	HEDIS antidepressant medication management indicator (84 days)
	Medication adherence (continuation phase)	HEDIS antidepressant medication management indicator (180 days)
Clinical Outcomes <i>Does the program improve patients' symptoms, achieve remission, and/or return normal functionality?</i>	Response to treatment	50% decrease in PHQ-9 score
	Remission	PHQ-9 score less than 5
	Improvement in functioning	Decreased score on Item 10 of PHQ-9
	Improvement in vocational functioning	Decreased score on vocational functioning assessment

The majority of the data collected will be gathered by the LCSW as part of the ongoing patient tracking and monitoring system. The registry will track depression diagnoses, referrals to specialist providers, PHQ-9 scores at regular intervals throughout treatment, functionality scores, treatment initiation dates and modalities, and dates of follow-up contact. These data elements will be standardized, but the application of data gathering at each site will depend on the site's current systems and will be implemented with support from the technical leads during the development phase of the project (first 2 months).

As a supplemental measure, financial information will be collected on the cost of program implementation to inform the business case for scale-up. The measures and data sources for the financial evaluation will be confirmed after further discussion with health plans and purchasers about the most persuasive evidence to make the business case.

Program Partners

Northeast Business Group on Health (NEBGH)

NEBGH is a network of employers, providers, insurers and other organizations working together to improve the quality and reduce the cost of health care in New York, New Jersey, Connecticut and Massachusetts. Since its inception in 1982 as New York Business Group on Health, the organization has spearheaded important initiatives, conducted and launched innovative programs that brought meaningful change to the healthcare marketplace for employers in the New York metropolitan area. In November 2010, the organization changed its name to Northeast Business Group on Health and expanded its mission to serve employers across the region.

The New York City Department of Health and Mental Hygiene

The New York City Department of Health and Mental Hygiene (DOHMH) is a key member of the NEBGH Mental Health Task Force. DOHMH helped the Task Force identify depression screening and management in primary care as a strategic entry point to improving treatment outcomes, and NYC DOHMH is currently sponsoring several small pilots of this model as well in practices serving low income communities.

Quality Healthcare Solutions

Quality Healthcare Solutions (QHS), founded by Jorge Petit M.D., provides consultation on behavioral health solutions to meet the challenges of the ever-changing and complex healthcare environment. The firm draws on its expertise in improving organizations from a variety of perspectives: administratively, technologically, financially, programmatically, and clinically, as well as the team's administrative and clinical experience in behavioral healthcare and public health settings to catalyze improvements and facilitate change at every level.

Joslyn Levy & Associates

Joslyn Levy & Associates, LLC (JLA) provides consulting services that support quality improvement in health care and health outcomes. The experience the firm brings in public health, health care quality improvement and program management provides for a broad and deep understanding of the challenges confronting key stakeholders seeking to achieve improved patient and population health outcomes.

Polaris Health Directions

Polaris Health Directions (Polaris) is a behavioral health research and outcomes management solutions provider. Polaris has extensive experience in both formal research projects (over 10 NIH funded Phase 1 and Phase 2 projects), in clinical quality improvement programs and in demonstration projects such as this. Polaris has also led a number of successful public-private partnership programs. Polaris has a robust, HIPAA-compliant data management and web-based application delivery platform that is used to manage data and provide web-based healthcare applications for customers such as Kaiser Permanente, Magellan Health Services and Blue Cross Blue Shield of Massachusetts. The Polaris team for One Voice will be lead by the firms Chief Operating Officer, Greg Alonzo.