Perfect Depression Care

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IBHI Webinar Series 2011
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Depression Care Team

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- Richard Dryer, MD
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- C. Edward Coffey, MD
Webinar Objectives

- Provide a brief history and operations overview of the Perfect Depression Care initiative.
- Share current work on Perfect Depression Care spread.
- Answer your questions.
Henry Ford Health System
Behavioral Health Services

- 2 hospitals
- 8 clinics
- 325 employees
- $40M GPR
- Education programs
- Research programs
- A “system” within a “system”
“In its current form, habits, and environment, the health care system is incapable of giving Americans the health care they want and deserve… The current care systems cannot do the job. Trying harder will not work. Changing systems of care will.”
There Are No Toyotas

“The current US system produces exactly what it was designed to … highly variable care, widespread failures to implement best practices, and inability to change patterns of practice.”

Molly Joel Coye, Health Affairs, 2001
“Business as Usual” Will Not Work

The current system is “in shambles ... a patchwork relic – the result of disjointed reforms and policies” that cannot be fixed by traditional reform measures.
Six Dimensions of Perfect Care

- Safe
- Effective
- Patient centered
- Timely
- Efficient
- Equitable
A Roadmap for Health Care Transformation

10 Rules for Perfect Care

- Care = relationships
- Care is customized
- Care is patient centered
- Share knowledge
- Manage by fact
- Make safety a system priority
- Embrace transparency
- Anticipate patient needs
- Continually reduce waste
- Professionals cooperate
The Perfect Depression Care Initiative

Goal: Develop a system of perfect care in 2 years

Competitive Application Process
Coordinated by IHI & RWJ

- 3000 applications downloaded
- ~300 applications submitted 2001
- 25 semifinalists
- 12 finalists
- Henry Ford Medical Group: Depression Care and Prostate Cancer Care
“Perfect, really? Perfect, perfect?”

If 99.9% quality is good enough, then …
- 2 million records will be lost by IRS
- 12 babies will be given to wrong parents
- 18,322 pieces of mail will be mishandled in the next hour
- 2 landings at Detroit Metro Airport will be unsafe today
Why Depression?
What Might Perfect Depression Care Look Like?
Perfection Defined

- **Safe**: Eliminate inpatient falls & medication errors
- **Effective**: Eliminate suicides
- **Patient-Centered**: 100% of patients will be *completely satisfied* with their care
- **Timely**: 100% complete satisfaction
- **Efficient**: 100% complete satisfaction
- **Equitable**: 100% complete satisfaction
Award Winning Care

- 2002 RWJ Foundation *Pursuing Perfection* finalist
- 2002 HFHS Quality Expo *Quality Award*
- 2003 APA Administrative Psychiatry Award
- 2003 AHRQ Nominee “National Best System Practice”
- 2004 ACMHA National Model of Care
- 2004 AMGA *Acclaim Award* Honoree
- 2006 APA Gold Achievement Award
- 2006 TJC Codman Award
- 2008 TJC National Model of Excellence
- 2009 Commonwealth Fund Case Study for Excellence
- Featured in JAMA May 19, 2010
Suicides per 100,000 HMO Patients

Expected suicide rate for patients with an active mood disorder (21X)
Expected rate for euthymic patients with mood disorder (4-10X)
Number of suicides per 100,000 HAP-HFMG patients
Number of suicides per 100,000 US general population
How’d They Do That?

Depression Care Effort Brings Dramatic Drop in Large HMO Population’s Suicide Rate

Tracy Hampton, PhD

While physicians and other health care workers may not be able to predict which of their patients will attempt suicide, they can implement preventive strategies that markedly lower the risk of such tragedies. Now, one pioneering program has demonstrated the importance of pursuing two key approaches at once: carefully assessing patients for risk of suicide and adopting several awards, including the Joint Commission’s Earnest Amory Codman Award and the Gold Achievement Award from the American Psychiatric Association.

“I believe we have a model that is applicable to most health care settings and that could dramatically improve the care of patients with depression and other major mental disorders that raise the risk of suicide,” said neuropsychiatrist C. Edward Coffey, MD, Henry Ford Health System vice president and CEO of BHS, a large integrated mental health and substance abuse system that includes 2 inpatient hospitals and 10 clinics serving southeastern Michigan and adjacent states.

ZERO SUICIDES

The Perfect Depression Care Initiative was one of 12 national demonstration projects (and the only mental health
The HFHS Culture of CQI

Focus on the processes!

Evaluate the effectiveness of the improvement methods & tools used
Strategies for Pursuing Perfection

- Form a team, and create a name and logo
- Map our care processes and identify high-leverage OFIs (Planned Care Model)
- Set specific “perfection” goals and manage by fact
- Ensure the voice of the customer in care design (the Consumer Advisory Board)
- Develop and implement rapid tests of change (PDCA Cycles)
- Continuous learning
- Celebrate successes
Our Team, Circa 2000

Our promise to each and every patient:

"We will work with you to achieve the best possible care, always respecting your individual wants and needs."
Planned Care Model

Community Resources and Policies

Health System
  Health Care Organization

Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems

Productive Interactions

Improved Outcomes

Informed, Activated Patient

Prepared, Proactive Practice Team
Transformation ≠ Intervention
Informal Focus Group Hints

- Depression website – probably not
- Drop-in group visits – maybe not
- Suicide risk assessment tool – maybe not
- CBT certification – maybe
- Treatment algorithms – maybe
- Suicide prevention protocol – yes!
Suicide Prevention Protocol

### Acute Risk Assessment
If any of the following:
1. Severe* anxiety/panic
2. Severe* anhedonia
3. Recent alcohol abuse
4. Global insomnia
5. Mod* to severe depression
6. Currently Psychotic
7. Currently Manic
8. Suicide Plan
9. Suicide Intent

### Moderate Risk Assessment
If any of the following:
1. Moderate* anxiety/panic

### Each Outpatient Visit
- Psychiatric Eval

### Same Visit
- Advised to remove weapons
- Initiate somatic therapy
- Involve Family
- Promote Self-Management
- Community Referral / Support
- Initiate Appropriate Program:
  - Crisis Program
  - Inpatient PHP
  - CD Program
A Social Intervention

- **Culture shift:** *Perfect* care is the goal.
- **Culture shift:** *All* patients are at increased risk for suicide.
- **Culture shift:** Focus on *process* improvement.
Questions?
I. Report of Patient Status by Patient or Family/Significant Other

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<th>Please Mark Line</th>
<th>bad, lots of problems</th>
<th>perfect, no problems</th>
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<tbody>
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<td>Thoughts of Hurting Others:</td>
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<td>Sense of Control Over ECT Care:</td>
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<td>Equity of ECT Care:</td>
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<td>Overall Satisfaction with ECT Care:</td>
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Please Describe
Evidence of Relapse / Signal Events: ____________________________________________

List 3 things you would like to discuss with your doctor or ECT staff: ____________________________________________________________________________

_____________________________________________________________________________________

Report Given By: __________________________ Relationship to Patient: __________ Date: __________
Patient Assessment of ECT Care
Business Viability of Perfect Care

- Service Excellence
- Employee Engagement
- Growth
- Financial Health
- Trainee Satisfaction
- Research Productivity
- Community Service
- Perfect Care

- 0%
- 100%
Lessons Learned & Next Steps

- The Chasm Report is a viable model for care
- Perfection is the goal
- Involved leadership is key
- Data are essential – manage by fact
- IT support crucial – workflow drives outcomes
- The science of spread
- The business case for perfect care
- The toxic effects of “pursuing perfection”
Questions?
PDC Spread

- Vision:
  - Every patient receives perfect depression care regardless of care setting or general medical comorbidities.
  - All patients with high risk chronic conditions are screened and, if indicated, treated for depression.
Family of Depression Care Models

- HFHS
- DIAMOND
- IMPACT
- 3CM
HFHS Model

Similar results on a shoestring budget.
Staffing Model

- Nurse Practitioner
  - 50% spread, 50% clinical
  - 2.0 FTE
- Clinical Psychologist
  - 0.1 FTE
- Psychiatrist Physician Champion
  - 0.2 FTE
- Program Manager
  - 1.0 FTE

- NP resides in a spread site for 2-3 months to assist staff with learning the screening tools and process
- Available for curb-side consults with physicians or to see patients for urgent consultation
- Serve as a liaison to inpatient & outpatient BHS
Preliminary Results 1

- Spread to 7 of 27 clinics in 3 years.
- Screening rate currently 50%.
- 22% of persons with chronic disease screened positive for depression.
  - Chronic disease = DM, CAD, CHF, COPD, Asthma, or Chronic Kidney Disease
Preliminary Results 2: Only 1% of patients refused to be screened.

“As a patient, I must say I find this new approach of yours very refreshing.”
Preliminary Results 3: PCP’s Can Do It!

- 90% of patients screening positive were “managed” by their PCP.
- 67% of patients screening positive received pharmacotherapy from their PCP.
Preliminary Results 3: Treatment Works!

- 53% of patients screening positive achieved a full response to antidepressant treatment.
- Of the patients with DM who screened positive & received treatment, 65% had a HbA1c reduction of 1.0 (p<0.05).
How does the HFHS model work?

HFHS

DIAMOND

IMPACT

3CM
Keys to Success

1. Embed a behavioral health clinician.
2. Use the model for improvement & focus on the processes.
3. Empower the front line staff to design the care processes.
4. Use simple, efficient tools.
5. Don’t be afraid of the “s” word – suicide.
6. Deliver regular performance feedback to front line team members.
7. Recruit & empower effective change agents.
8. Obtain & maintain leadership support.
Key 5: Don’t be afraid of the “s” word – suicide.
Suicide Can Be “Deadly”

- “The suicidal patient” is a major source of anxiety for primary care teams.
- Anxiety can lead to process breakdown.
- Without a clear process in place for managing “the suicidal patient,” depression care is “dead in the water.”
One Possible Solution?

The PHQ-8 as a measure of current depression in the general population

Kurt Kroenke a,*, Tara W. Strine b, Robert L. Spitzer c, Janet B.W. Williams c, Joyce T. Berry d, Ali H. Mokdad b
An Alternative Solution

The assessment & management of “the suicidal patient” in primary care settings demands systems work focusing on process improvement.
Spreading to Primary Care

- Our PHQ-9 is called “DST.”

- Positive screen to any of the above questions, prompts a same day psychiatric evaluation.
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Take Home Theme

Although suicide is a statistically very rare event, even within psychiatric populations, improvement efforts *focused on the processes of care* in which patients and clinicians live and work can drive successful clinical quality improvement work.
Thank You

“Mr. Osborne, may I be excused? My brain is full.”