Perfect Depression Care

M. Justin Coffey, MD
Henry Ford Health System
IBHI Webinar Series 2011

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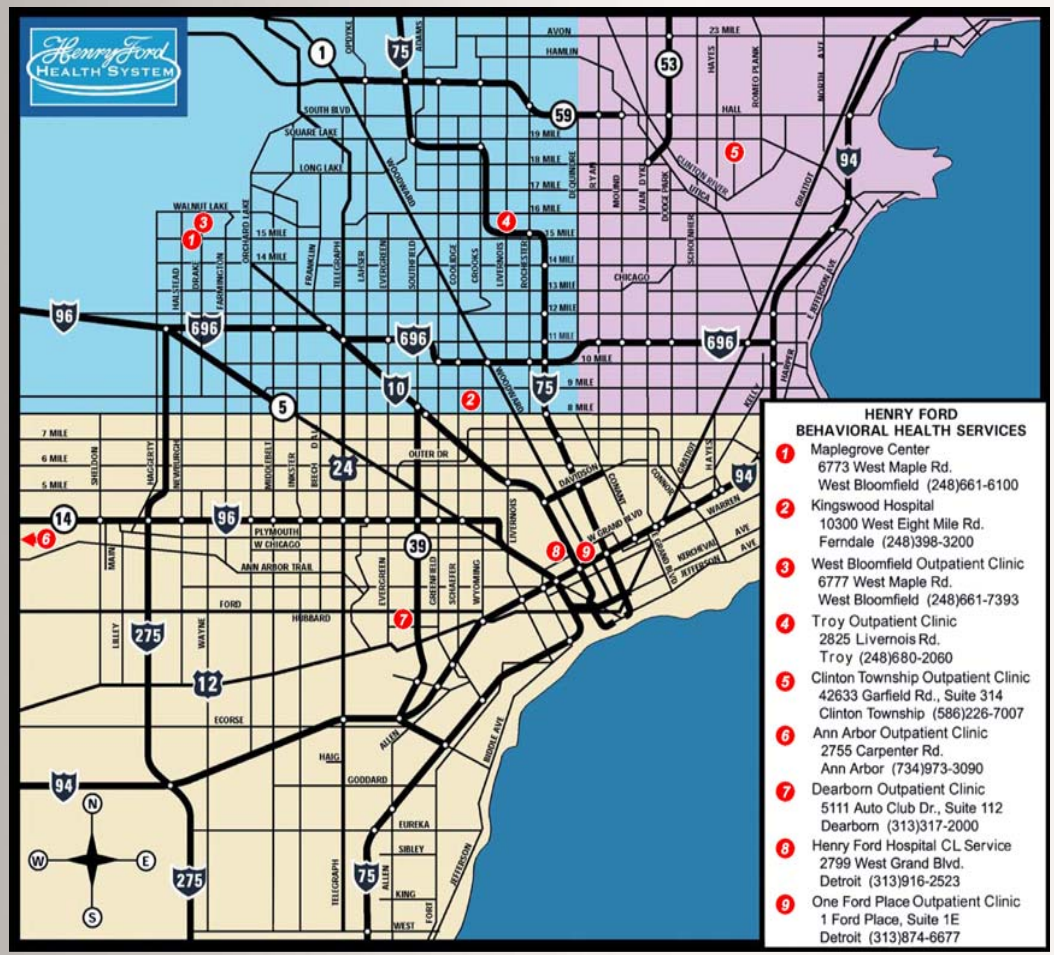
Webinar Objectives

- 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

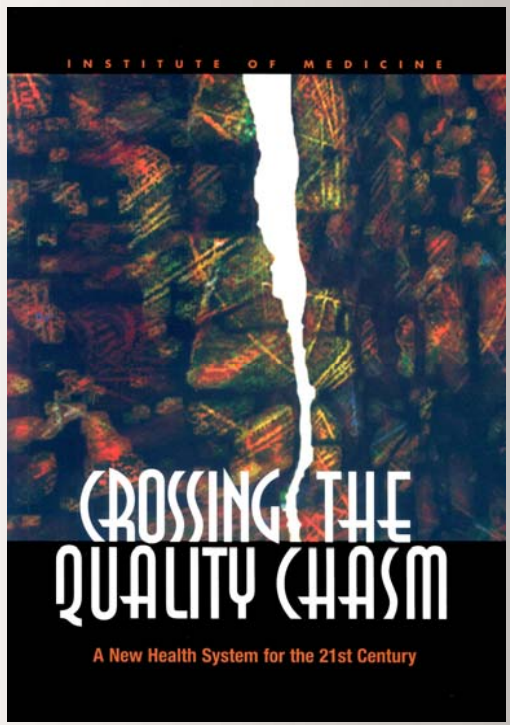
Behavioral Health Services



- 2 hospitals
- 8 clinics
- 325 employees
- $40M GPR
- Education programs
- Research programs
- A “system” within a “system”

Pursuing Perfect Care

"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."



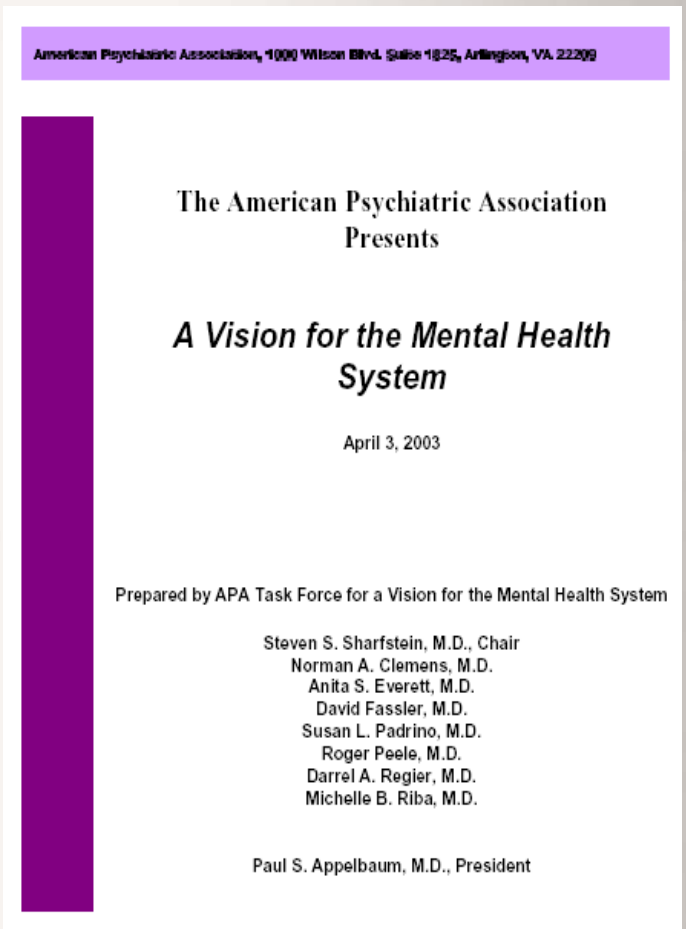
There Are No Toyotas

"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.



American Psychiatric Association, 1000 Wilson Blvd. Suite 1825, Arlington, VA 22209

The American Psychiatric Association Presents

A Vision for the Mental Health System

April 3, 2003

Prepared by APA Task Force for a Vision for the Mental Health System

Steven S. Sharfstein, M.D., Chair
Norman A. Clemens, M.D.
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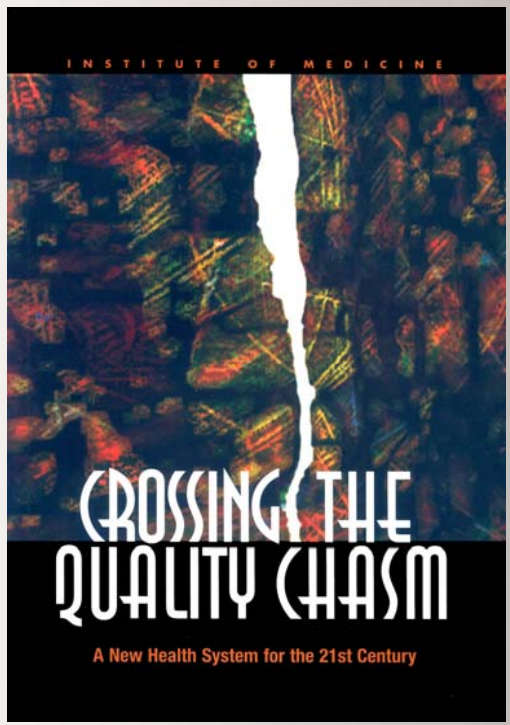
Roger Peele, M.D.
Darrel A. Regier, M.D.
Michelle B. Riba, M.D.

Paul S. Appelbaum, M.D., President

The Institue of Medicine Chasm Report

Six Dimensions of Perfect Care

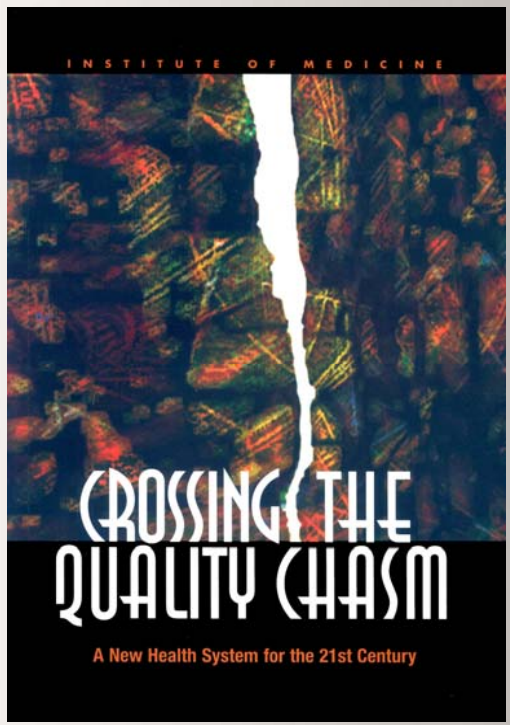
- Safe
- Effective
- Patient centered
- Timely
- Efficient
- Equitable



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?

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THE WALL STREET JOURNAL. — WEDNESDAY, JUNE 13, 2001

Internet: *An anonymous-source database leaks onto the Web* Page B8.

Technology: *Lucent's troubles deepen, its debt rating cut to junk status* Page B10.

MARKETPLACE

Advertising: *Wendy's new TV spots target midnight snackers* Page

Property Report: *Pyramid megamall to proceed despite loan worries* Page

WORK & FAMILY

By Sue Shellenbarger

A Colleague's Suicide Has a Lasting Impact On Fellow Employees

LISABETH OTTO ROSE from her seat during a Hewlett-Packard corporate shuttle flight last ember, wrenched open the emergency exit at 0 feet and stepped out the door.

The tragic death of Ms. Otto, 31 years old, a anager in H-P's purchasing unit, ended her de- ression, her talk of stress and her plans to see a unselor later that week, investigators found.

For Ms. Otto's stunned co-workers at H-P, how- er, the pain was only beginning. From the shut- tle passenger seated in front of Ms. Otto who yelled and reached out to save her, to many of her 6,000 co-workers at H-P's Roseville, Calif., offices, months of an- guish would follow.

Suicide-survivor pro- grams tend, for good rea- son, to focus on family and friends of the vic- tim. But suicide is a workplace problem as well.

The workplace is the last crucible of agitated th tragedies pose challenges no one covered in nagement school.

CiniPsych, Chicago, a provider of employee-as- tance programs, estimates its crisis calls on sui- e-related worries at work have risen 5% to 10% er last year. LifeCare, a work-life resource-and- erral organization in Westport, Conn., says nthly Web-site hits from employees seeking p with depression, which afflicts most suicidal gle, have nearly tripled since October. And at Didi Hirsch Community Mental Health Center, Culver City, Calif., calls from employers about idal workers roll in to a hot line every week.

AFTER THE SHUTTLE landed in San Jose, Ca- if., the employee who had tried to save Ms. s sat riveted to his seat, unable to move. Later, word spread at H-P, stunned co-workers talked little else. "Everyone was shocked and torn," s Marilù Rogers, an H-P spokeswoman.

A common error is to assume co-workers' trau- a end there—with shock and a flurry of water- er talk. In fact, many co-workers experience es of anger, grief and guilt. Little research been done to shed light on workplace effects. Many suicides come without warning because ple in despair can become adept at hiding their ings. Co-workers are inclined to look in the work- e for a cause, such as a poor performance re- e or a job loss. In fact, such factors are typi- y not causes but symptoms of the far deeper blems linked to suicide, such as depression, aniphrenia or substance abuse, says Herbert Hen- of the American Foundation for Suicide Preven- . "The person may have had difficulty with the for the same reasons he was suicidal, rather the other way around," Dr. Hendin says.

Co-workers may become angry at the victim. ne oft-cited article, Colleen Glair-Gajewski de- bed how she turned her desk away from the ty workstation after her partner on a hospital e-training assignment committed suicide. In a interview in the Journal of Psychosocial Nurs- she said, "She'd left me alone, in a position hich we'd been supportive of each other." anger can taint other relationships.

Mental Illness: A Rising Workplace Cost

One Form, Depression, Takes $70 Billion Toll Annually; Bank One Intervenes Early

By Elyse Tanouye

Staff Reporter of The Wall Street Journal

IN A TYPICAL OFFICE of 20 people, chances are that four will suffer from a mental illness this year. Depression, one of the most common, primarily hits workers in their most productive years: the 20s through 40s. Its annual toll on U.S. businesses amounts to about $70 billion in medical expenditures, lost productivity and other costs.

And yet most employers don't have a clue.

Even though Prozac has become a household word, few individual companies know the true cost of depression to their business, says Paul Greenberg, a health care economist at the Cambridge, Mass., consulting firm Analysis Group/Economics. That's because many of the indirect costs—such as reduced productivity and related illnesses like alcoholism—aren't readily apparent. And unlike those with allergies or appendicitis, people with mental or emotional problems rarely file big medical bills to treat psychiatric illnesses among employees. U.S. antidepressant sales alone have risen more than 800% to $10.2 billion, since 1990, according to IMS Health. Public awareness of depression has also increased, as have the cost of interventions such as hospital stays and psychiatrist visits.

Steady Growth

Antidepressant* prescriptions given to Americans aged 18 to 65, in millions

*Selective serotonin reuptake inhibitors

Source: IMS Health

Seventy percent of large employers said they were concerned about rising psychiatric claims in a survey conducted last year by consulting firm Watson Wyatt Worldwide and the Washington Business Group on Health, an employer group. And companies tend to respond to that rise by trying to control costs. "Companies view health care, and specifically psychiatric claims, as a cost to be minimized," Mr. Greenberg says.

But depression is a tough disease to manage because its symptoms are largely invisible and subjective—even as it affects a person's moods, thoughts and energy levels.

Please Turn to Page B6, Column 1

Knowing Your Rights and Responsibilities

The Americans With Disabilities Act helps protect workers with mental illness from employment discrimination. Some rights and responsibilities under the act:

Employees with a psychiatric disability

- Qualify for protection under the act only if their disability substantially limits a major life activity, such as sleeping or interacting with others
- Must disclose their disability to their employer to be eligible for protection under the act
- Can request reasonable accommodations, such as flexible work schedules, adjustments to their physical workspace, and adjustments to supervisory methods
- Can file a lawsuit or charges with state or federal agencies if they feel their rights are being violated

Employers

- Can't ask a job applicant about any mental disabilities before making a job offer
- Can require a pre-employment medical examination or inquiry after making a job offer, as long as it is required of all entering employees
- Can request an employee who is seeking accommodations to provide medical documentation of the disability
- Must keep all information concerning an employee's psychiatric condition or history confidential; the information must be kept separately from personnel records

Source: Equal Employment Opportunity Commission

What Happens When It's the Boss Who's Suffering?

Paul Gottlieb's Story Shows Upper Ranks Get Hit Too; Screaming Atop the Cliffs

By Elyse Tanouye

Staff Reporter of The Wall Street Journal

Paul Gottlieb was a 40-something rising star in the publishing world, sought after for top positions at major book publishers in New York City. In meetings with authors, business associates and employees, he was a take-

Paul Gottlieb

had to get better or I had to end my life," he says. He got up from his desk one day and walked across Central Park to his analyst, who called his wife and urged immediate hospitalization.

Coping with employee depression is increasingly on the minds of workplace managers. But what happens when the boss is the one with a mental illness?

It isn't clear how prevalent mental illnesses are in the corporate upper echelons. Executives rarely reveal having any impairment. Some people argue that mental illness isn't common in executive suites because managers with problems are weeded out at lower levels. Still, depression, anxiety, and other psychiatric conditions plague one in five

New Medicines, Protective Laws Cut Dismissals

By Elyse Tanouye

Staff Reporter of The Wall Street Journal

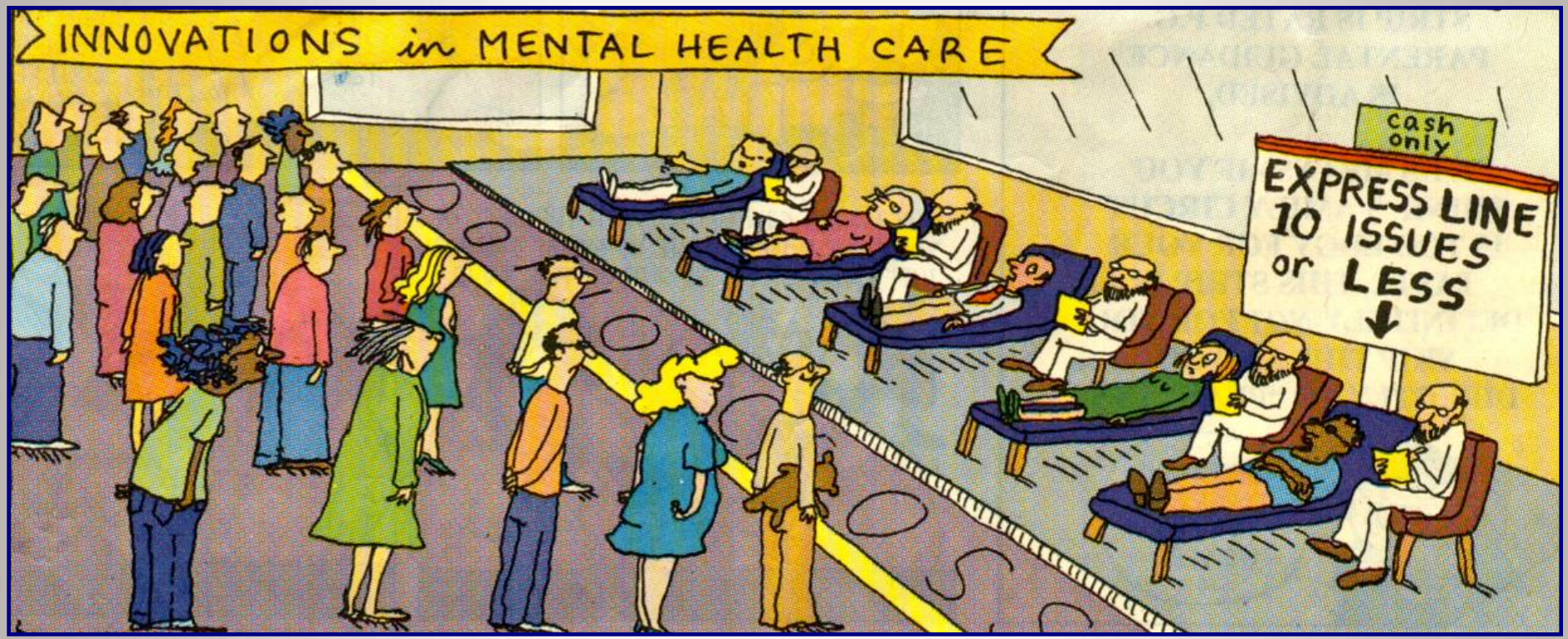
At age 34, Gerald Matusiewicz was ridi- high. He had a doctorate in metallurgical en- neering, a leading career as an engineer at IBM, and a family. But his life began to u- ravel one day when a wave of intense anxie- swept over him. His mental illness was flari- up.

No one he worked with at International Business Machines Corp. knew he suffer- from schizoaffective disorder, which falls som- where between schizophrenia and bipolar di- der and causes him periods of overwhelmi- anxiety. He tried to keep working as if nothi- were wrong. But then, uncharacteristically, h- had an angry dispute with his immediate supe- visor. When another manager, John Kelly, o- ered to mediate, Mr. Matusiewicz told him h- had suffered a psychiatric problem in the pa- and thought it was happening again.

Mr. Kelly gently suggested that Mr. M- tusiewicz meet with the company's medical d- partment for counseling. And the next day, af- the medication his psychiatrist had prescrib- made Mr. Matusiewicz drowsy, Mr. Kelly dro- him home. During the 20-minute ride, Mr. M- tusiewicz spoke openly about his problems. "- gets to a point where you can't hide it," says M- Matusiewicz, now 50 years old.

It was a crisis that could have derailed m- careers. But sympathetic IBM managers a- accommodating company policies helped hi- get back on track. Now, after nearly two d-

What Might Perfect Depression Care Look Like?



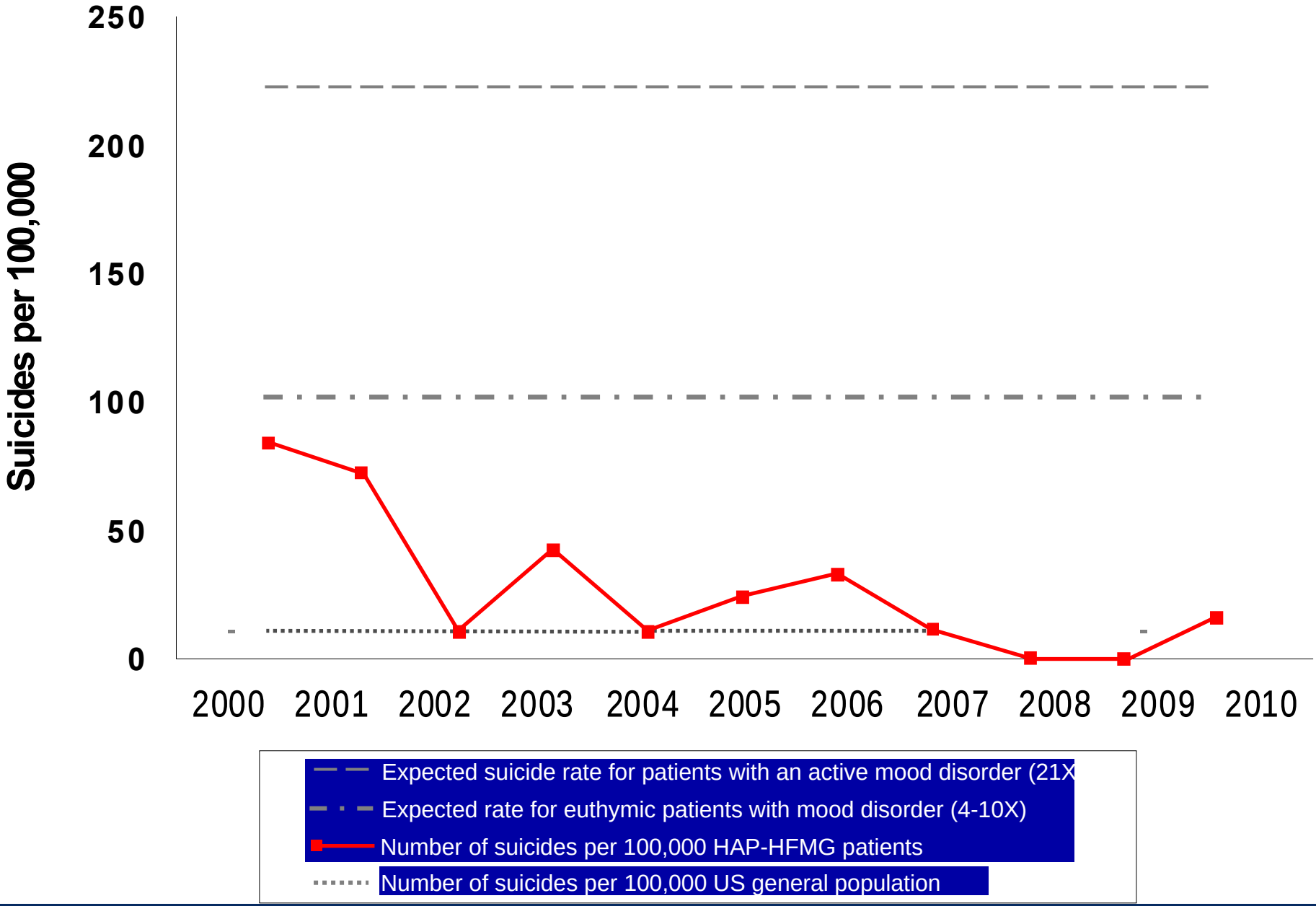
Perfection Defined

- 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



How'd They Do That?

JAMA®

Online article and related content
current as of May 19, 2010.

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 2 key approaches at once: carefully assessing patients for risk of suicide and adopt-

several awards, including the Joint Commission's Earnest Amory Codman Award and the Gold Achievement Award from the American Psychiatric Association.

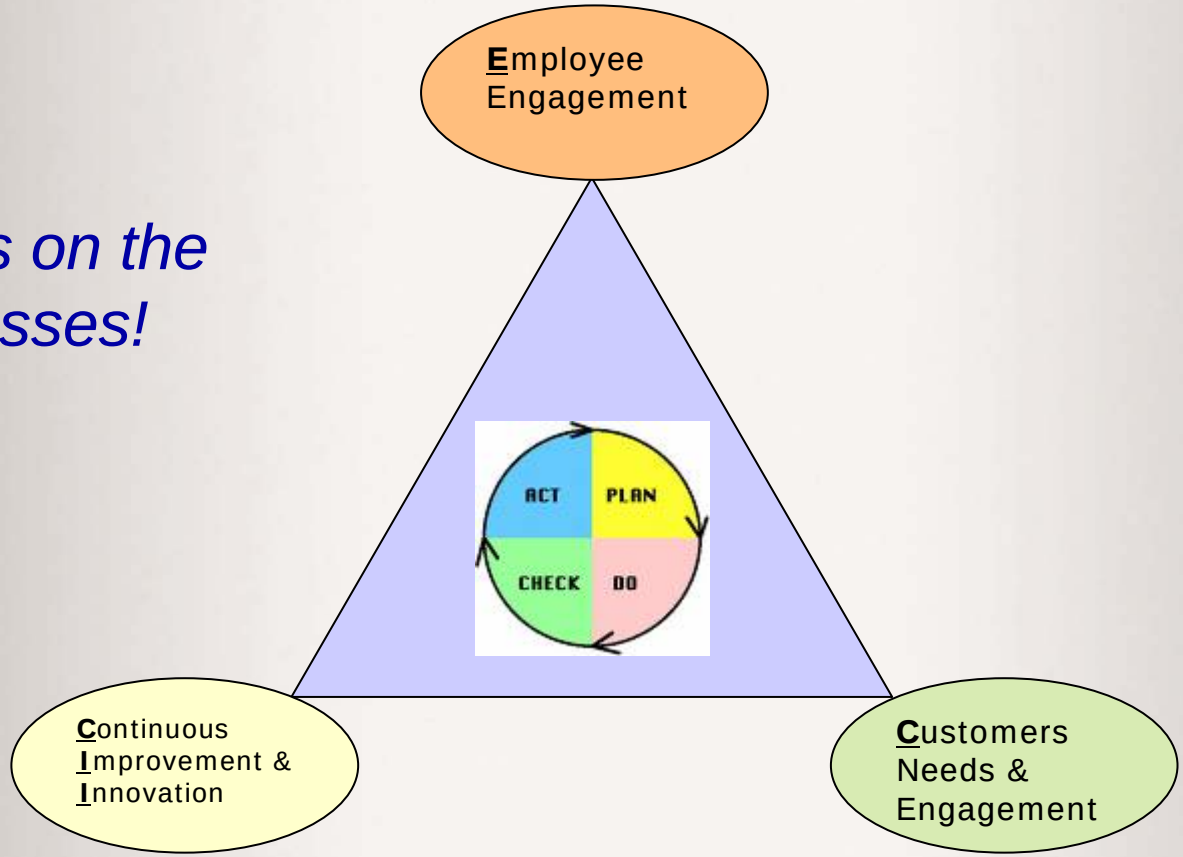
"I believe we have a model that is applicable to most health care settings and that could dramatically improve the care of patients with depression and other major mental disorders that raise the risk of suicide," said neuropsychiatrist C. Edward Coffey, MD, Henry Ford Health System vice president and 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

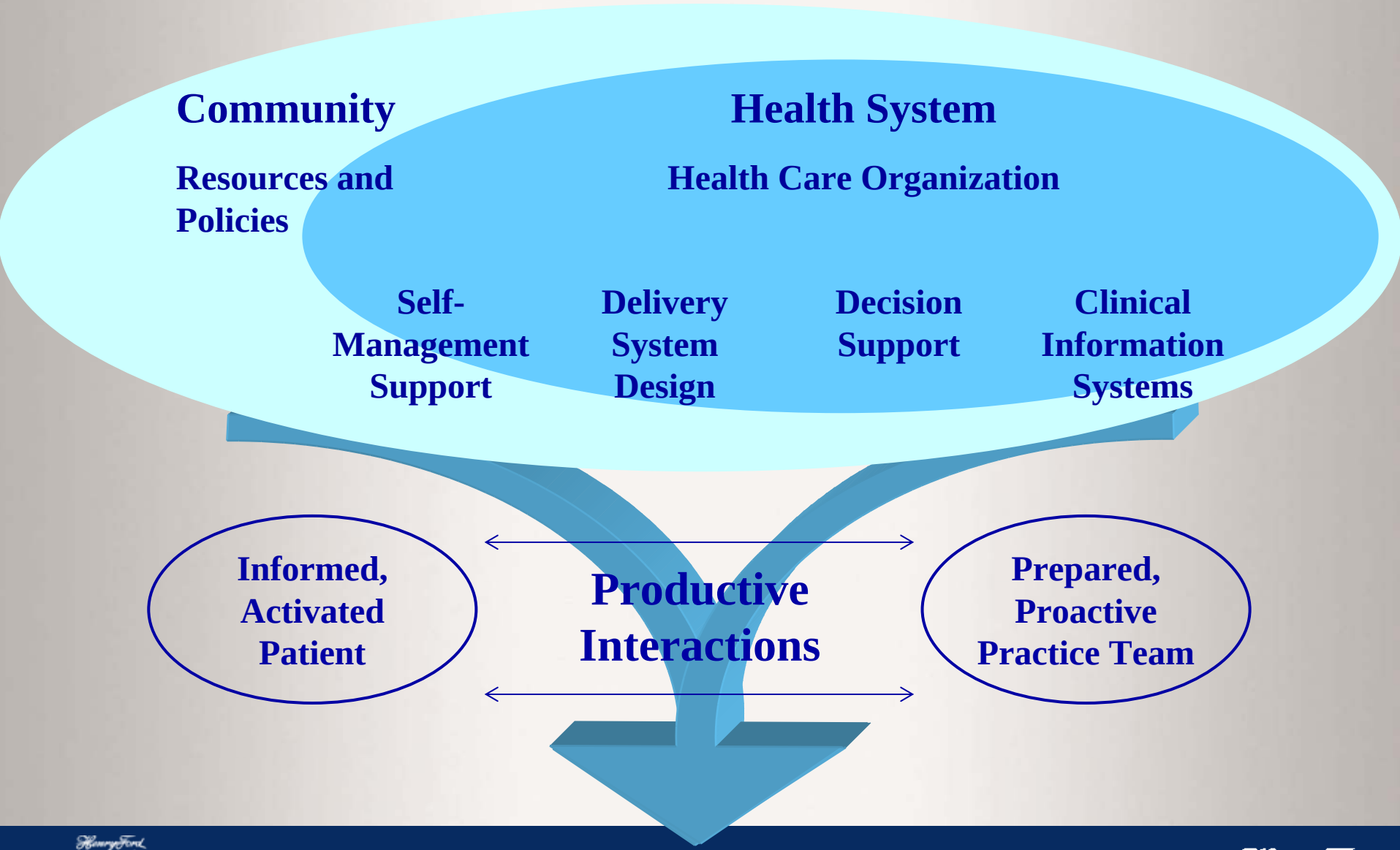
Our Team, Circa 2000

Blues Busters Team

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

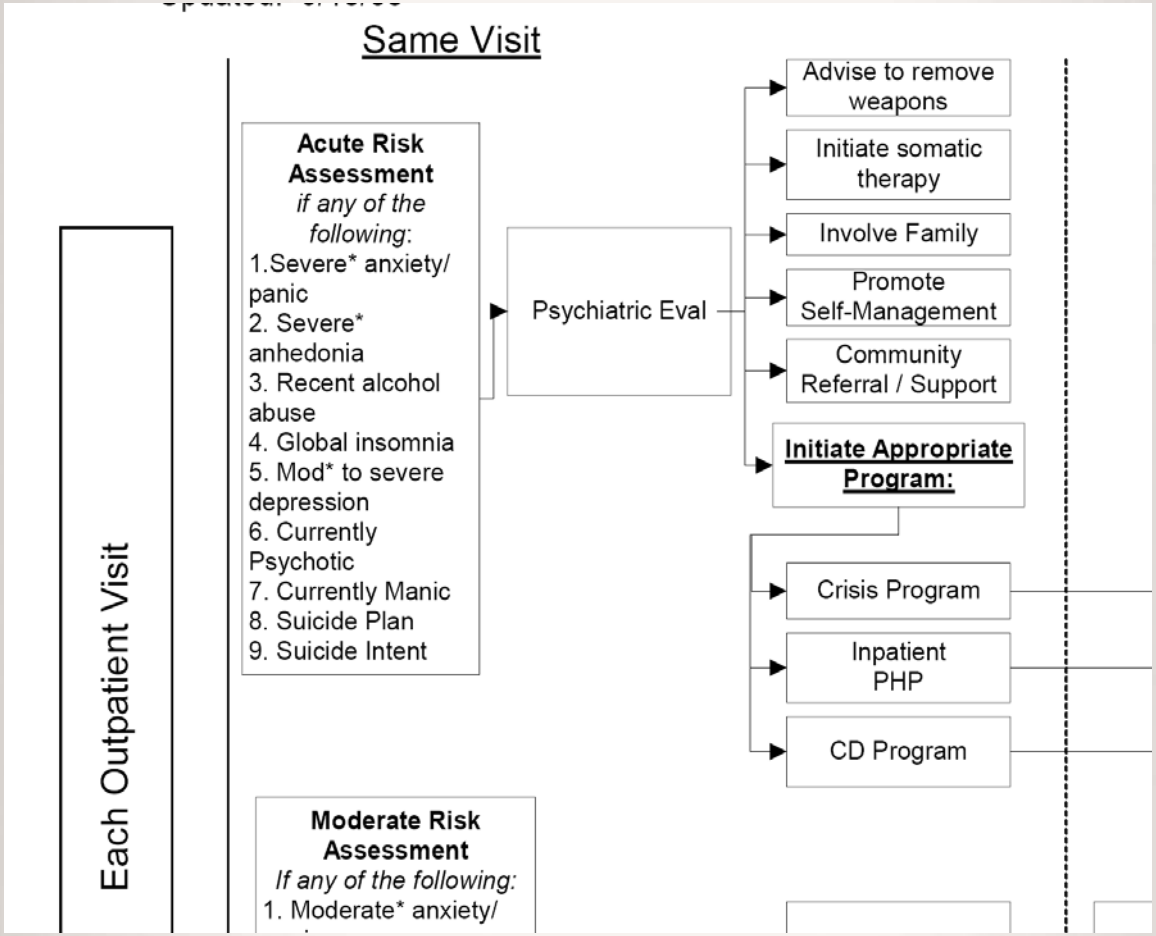


Transformation ≠ Intervention

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



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?

Perfect Care in Real Time

I. Report of Patient Status by Patient or Family/Significant Other

Please Mark Line

bad, lots of problems — 0 — 50 — 100 — perfect, no problems

- Emotional Health:
- Physical Health:
- Thoughts of Suicide:
- Thoughts of Hurting Others:
- Social Functioning:
- Occupational Functioning:
- Safety of ECT Care:
- Sense of Control Over ECT Care:
- Timeliness of ECT Care:
- Efficiency of ECT Care:
- Equity of ECT Care:
- Overall Satisfaction with ECT Care:

Please Describe

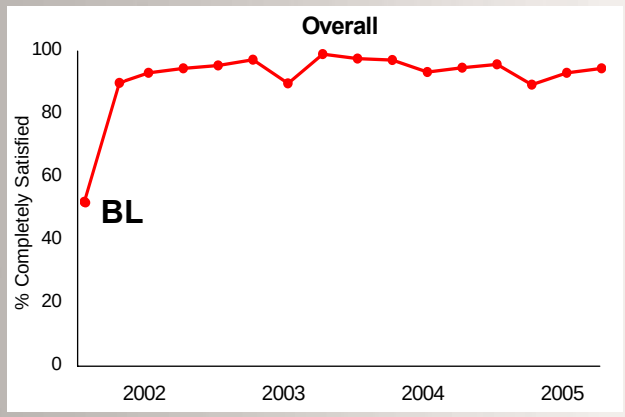
Evidence of Relapse / Signal Events: _____

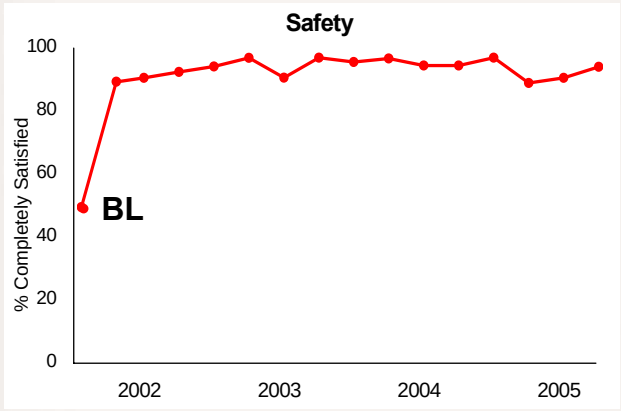
List 3 things you would like to discuss with your doctor or ECT staff: _____

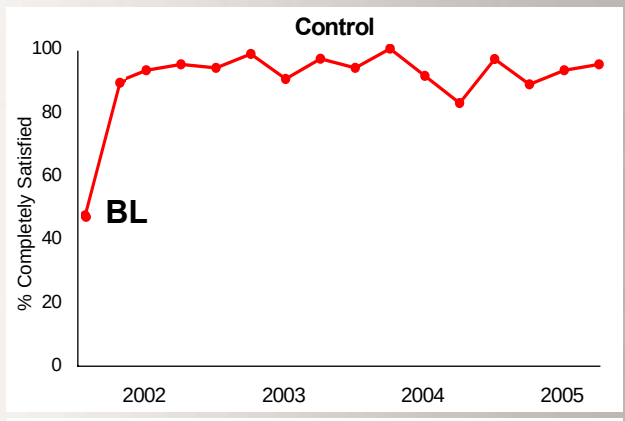
_____

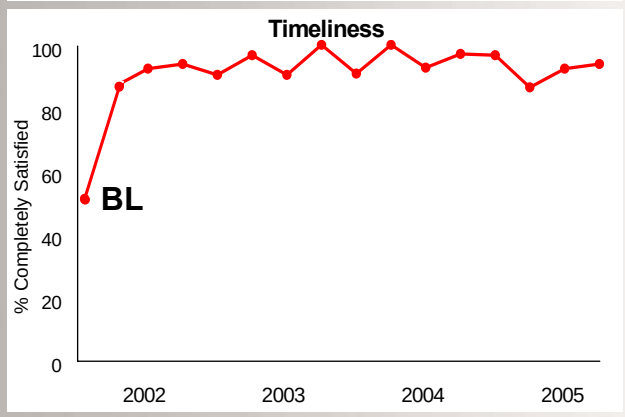
Report Given By: _____ Relationship to Patient: _____ Date: _____

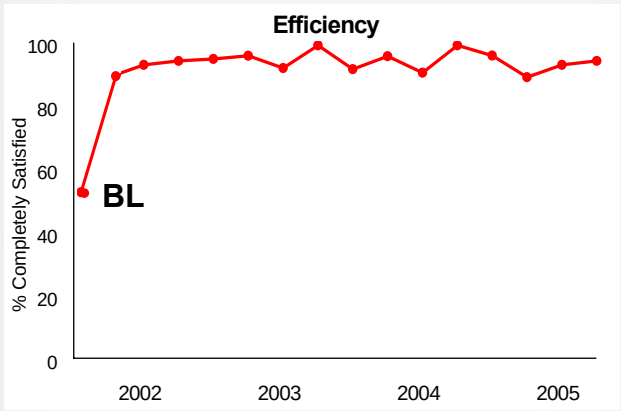
Patient Assessment of ECT Care

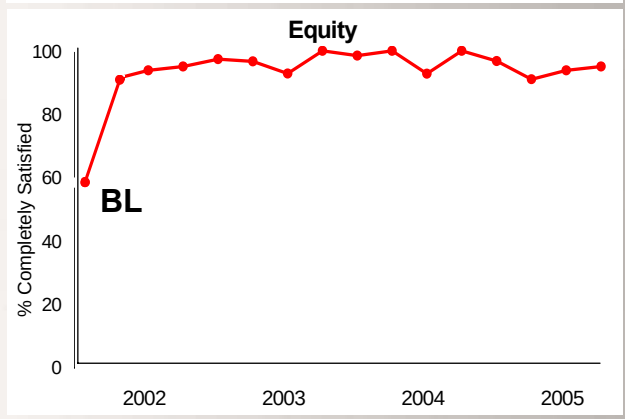




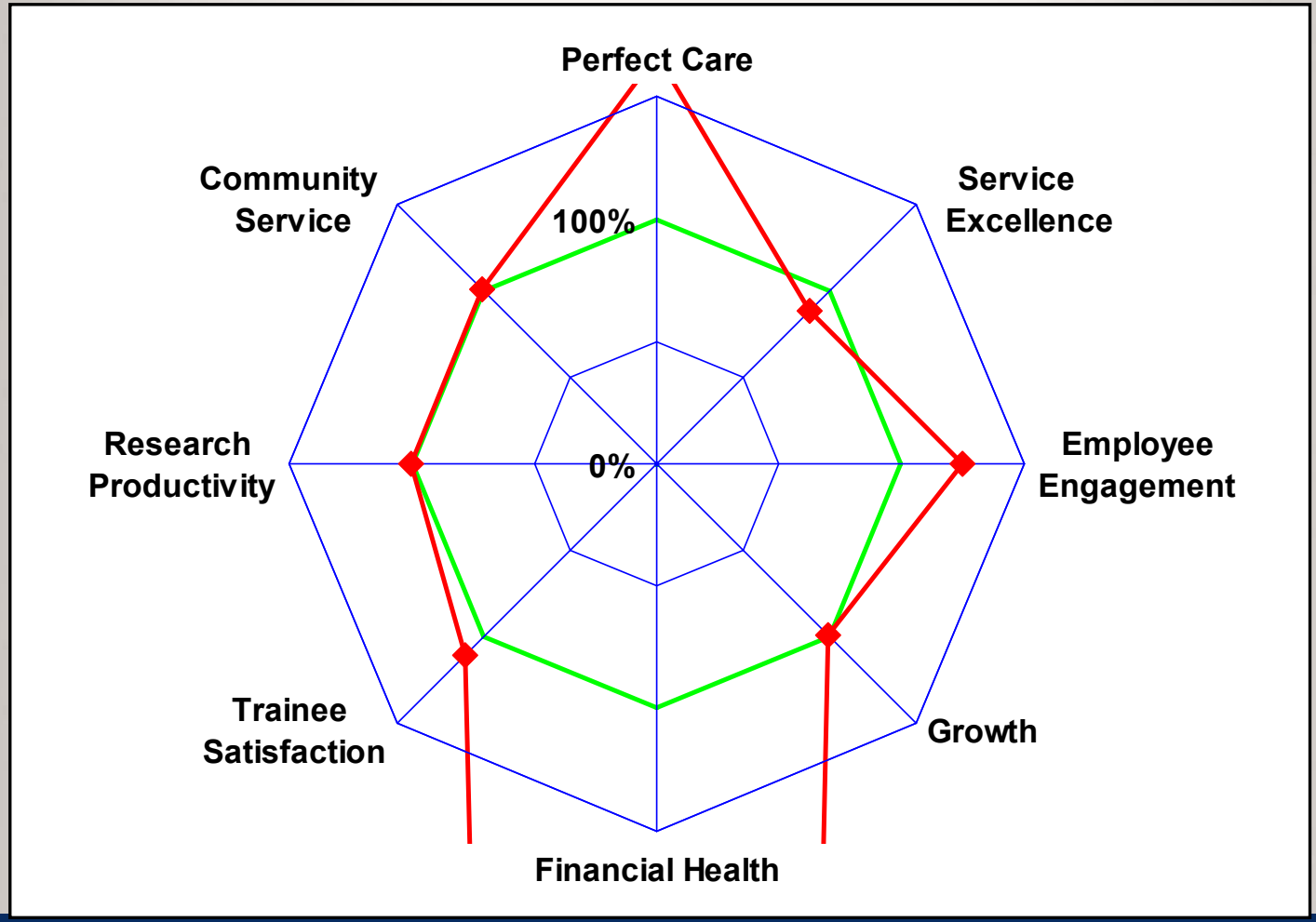








Business Viability of Perfect Care



Lessons Learned & Next Steps

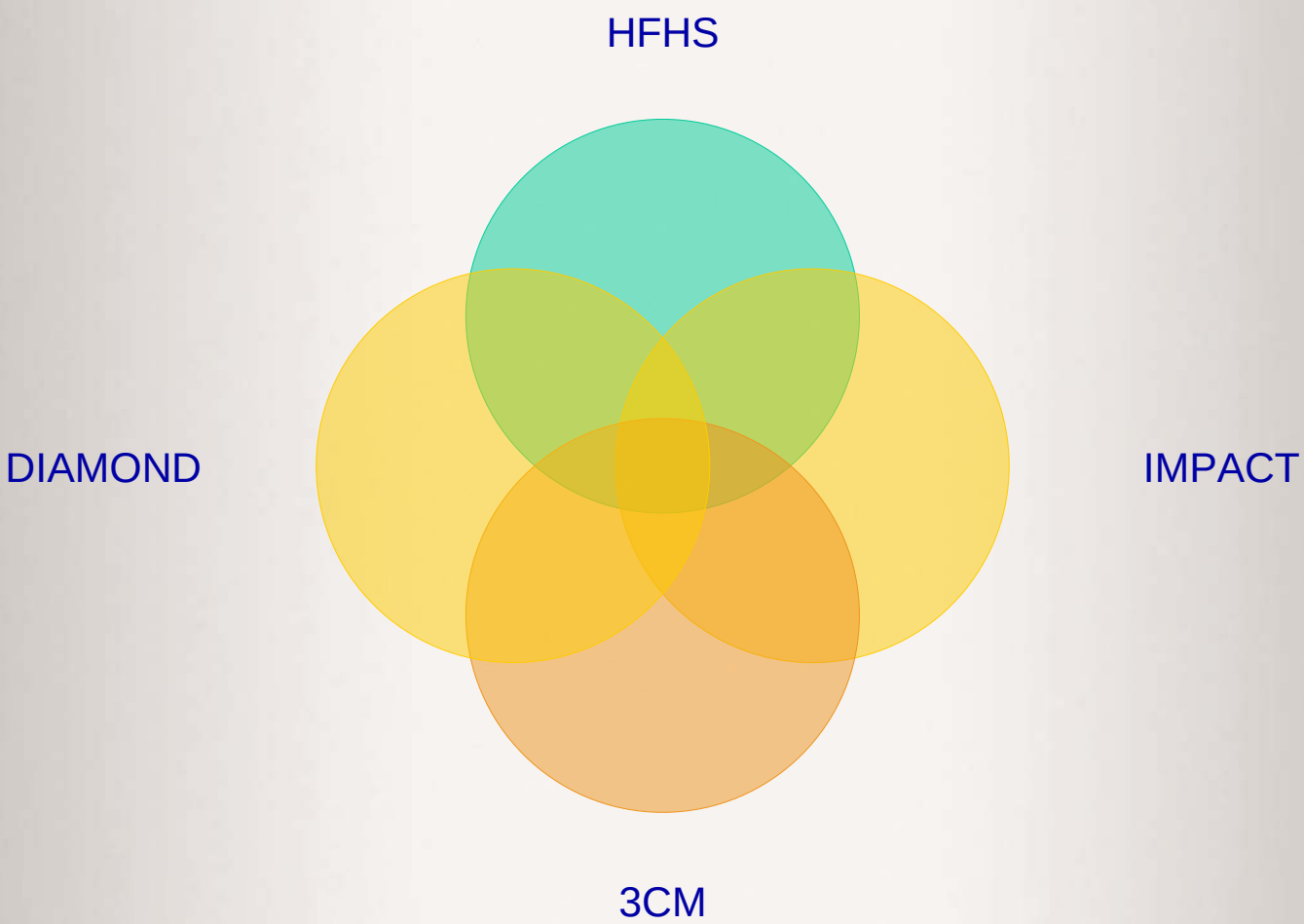
- The Chasm Report is a viable model for care
- Perfection is the goal
- Involved leadership is key
- Data are essential – manage by fact
- IT support crucial – workflow drives outcomes
- The science of spread
- The business case for perfect care
- The toxic effects of “pursuing perfection”

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 Model

Similar results on a shoestring budget.

Staffing Model

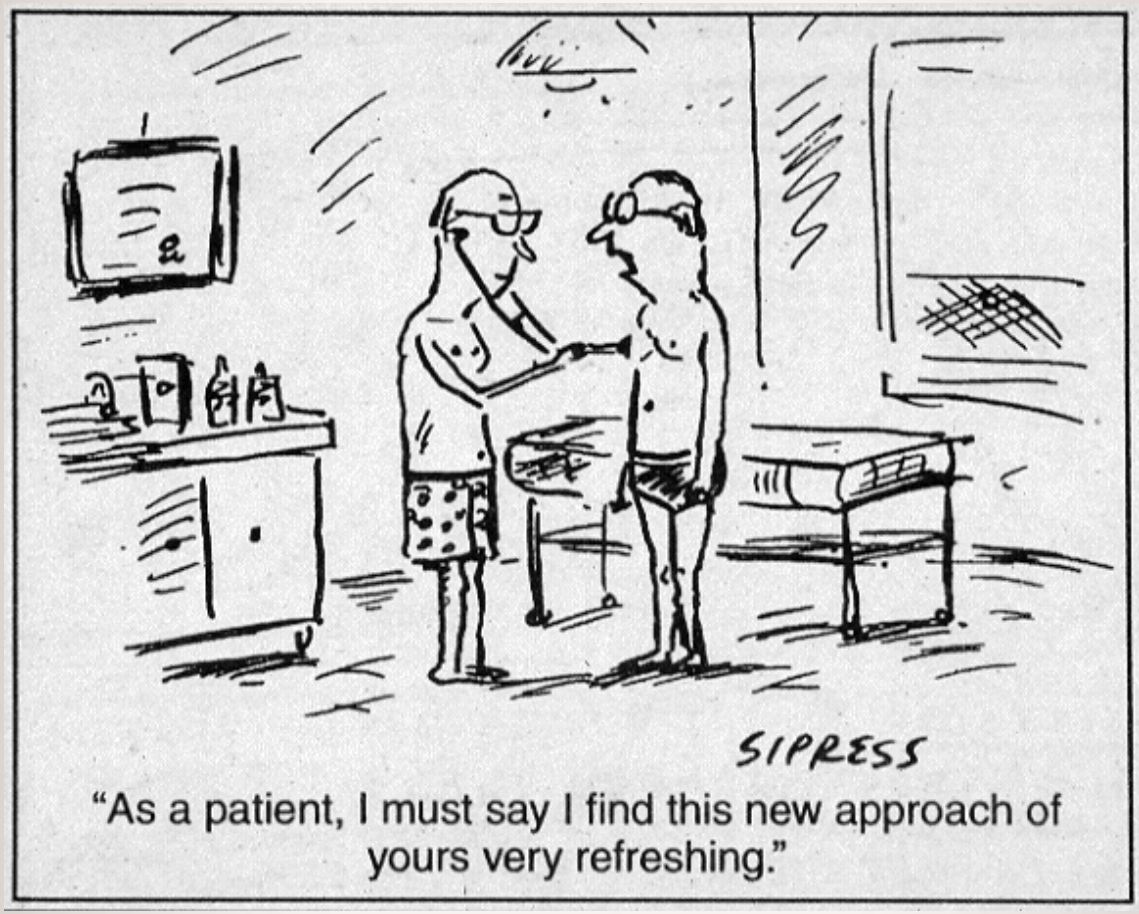
- Nurse Practitioner
  - 50% spread, 50% clinical
  - 2.0 FTE
- Clinical Psychologist
  - 0.1 FTE
- Psychiatrist Physician Champion
  - 0.2 FTE
- Program Manager
  - 1.0 FTE

- 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.



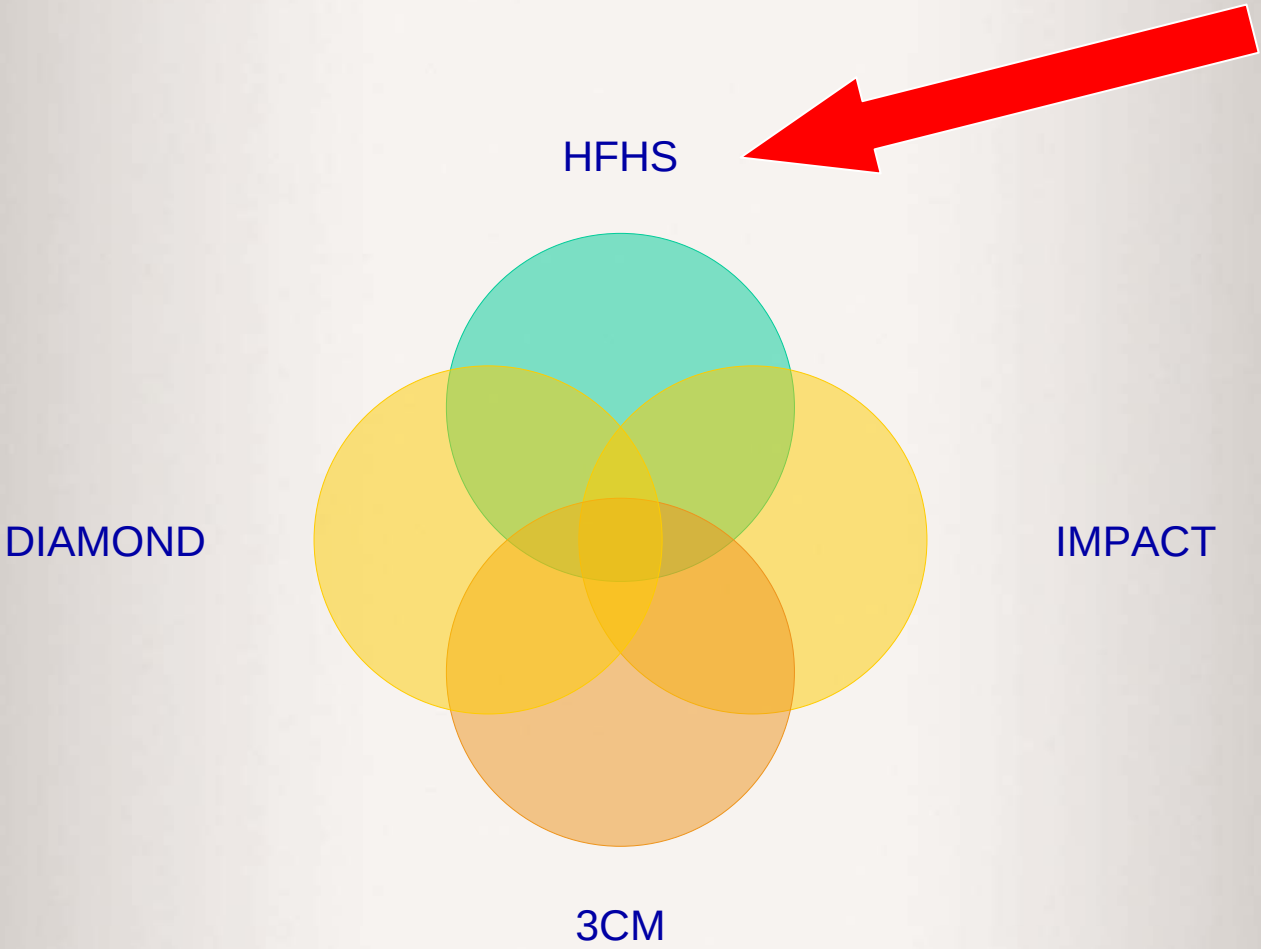
Preliminary Results 3: PCP's Can Do It!

- 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?



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.

IMPLEMENT

SUSTAIN

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?

ELSEVIER

Journal of Affective Disorders 114 (2009) 163 – 173

Journal of Affective Disorders

www.elsevier.com/locate/jad

Research report

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 the called “DST.”

3. If you checked item *1i* above as a 1 or higher:		No	Yes
a.	Do you have a plan to kill yourself?		
b.	Do you intend to kill yourself?		

		No	Yes
4. *a.*	Do you hear things that other people cannot hear, such as noises, or the voices of people whispering or talking, or do you have visions or see things that other people cannot see?		
b.	Do you feel others are talking about you, taking special notice of you, or trying to hurt you?		

	No	Yes
5. Have you ever had a period of time when you were feeling so good or hyper that other people thought you were not your normal self, or were you so hyper that you got into trouble?		

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

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.

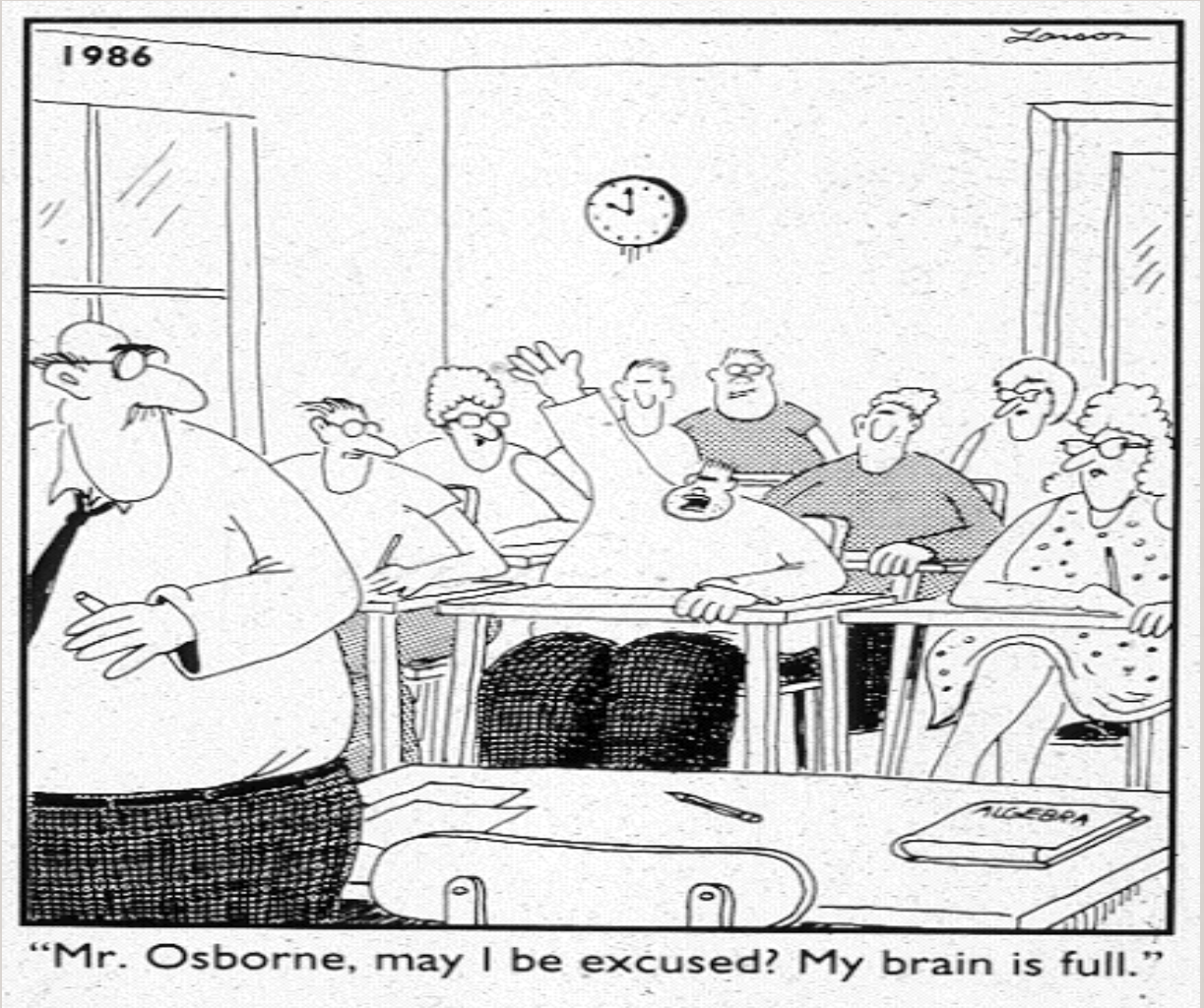
IMPLEMENT

SUSTAIN

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."