

Depression in primary care: linking clinical and systems strategies

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Abstract

Depression is a serious, often chronic disease that can be managed effectively with a chronic care model in primary care settings. Depressed persons are likely to be seen by a primary care physician, but their condition often goes unrecognized and untreated. There are effective treatment models that consist of efficacious psychotherapeutic and pharmacological interventions, use of evidence-based guidelines for primary care treatment of depression, development of explicit plans and protocols, reorganization of practice, longitudinal follow-up, patient self-management, decision-making support, access to community resources and leadership commitment. Moving these models into everyday practice requires overcoming both clinical and system barriers. Barriers consist of issues surrounding patients, providers, practices, plans, and purchasers. An understanding of these barriers at each level helps to provide a framework for the changes required to overcome them. The Robert Wood Johnson Foundation National Program on Depression in Primary Care will seek to apply simultaneously both clinical and system strategies in a new five-year initiative to overcome these barriers. © 2001 Elsevier Science Inc. All rights reserved.

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1. Introduction

Depression is a serious, highly prevalent, often chronic medical condition that can be managed effectively in primary care settings using well developed practice guidelines and models for chronic care treatment. This paper provides evidence for considering depression as a chronic disease and an analysis of the barriers that have limited the broader application and dissemination of improved clinical care models in depression treatment. We discuss conceptual issues related to the complexity of the problem and multi-system interactions and barriers (e.g., between primary and specialty care and at the patient, provider, practice, plan, and purchaser levels). Finally, we discuss a national initiative on depression management in primary care that links both clinical and system strategies.

The approach we discuss presents a set of thematically focused activities that are expected to have substantial impact on improving treatment and outcomes for individuals with depression. Such an approach can serve as a model for

other chronic diseases, many of which have depression as a significant co-morbidity.

2. Background

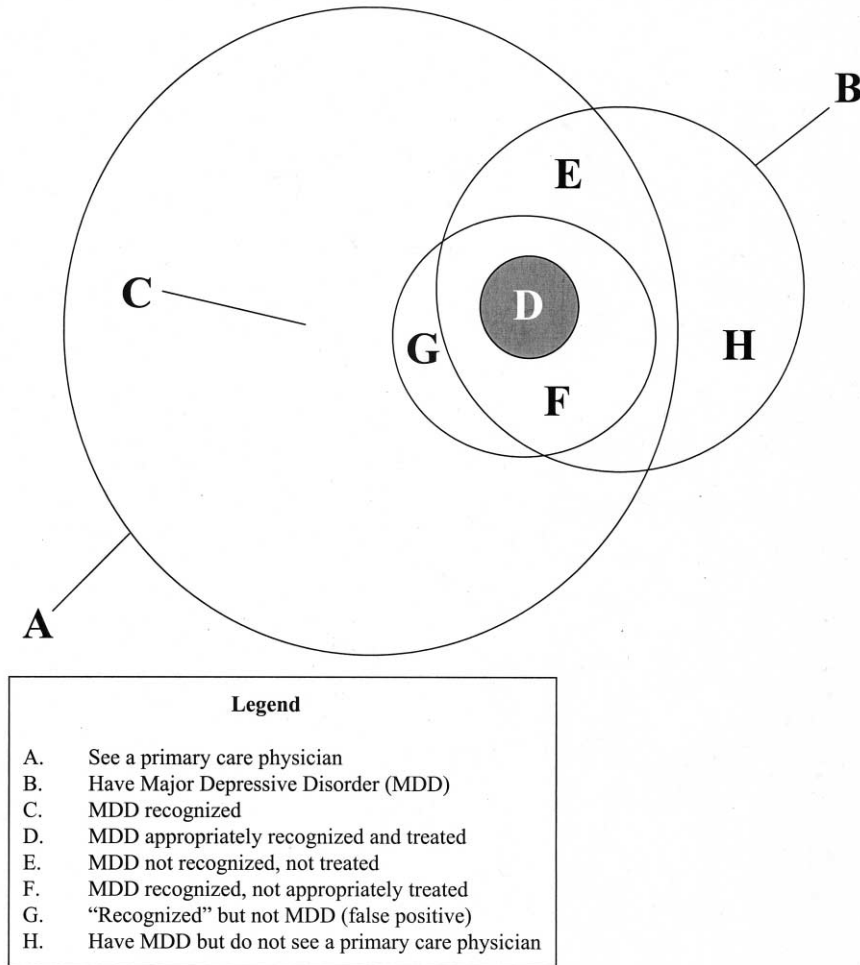
An estimated 5% to 25% of individuals in the United States will experience major depressive disorder (MDD) in their lifetime, with women suffering at rates two to three times those of men [1]. Furthermore, since many depressive episodes do not fully remit and symptoms may last for years, and with recurrence rates estimated at 60% or higher [1], major depression is a chronic illness for most individuals suffering from the condition.

The societal costs of depression, which have been discussed in detail elsewhere [2–4], consist of morbidity, mortality from suicide and accidents due to impaired concentration, failure to advance in career and school, loss of employment, and increased risk of substance abuse. Furthermore, the United States loses between \$30 and \$53 billion in productivity and direct medical costs related to depression each year [5,6].

There are strong arguments for identifying and treating depression in a primary care setting [7–9]. Major depression

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* Adapted from Goldberg & Huxley, 1980.

Fig. 1. Scope of the problem: recognition and treatment of depression in primary care settings.*

is two to three times more common in general medical settings than in community samples and is one of the most common health problems seen in primary care [10–13].

Furthermore, persons who are depressed are likely to seek or be receiving care from a primary care provider (PCP) for other reasons [14]. Compared to nondepressed patients, depressed patients use health care services three times as frequently [14], visit the emergency room seven times more frequently [15], and have twice the overall medical costs, even after controlling for severity of comorbid general medical conditions [16].

Most patients with depression are initially seen (although not necessarily recognized and properly treated) by primary care professionals [17,18] (Fig. 1) [19], irrespective of the patients' health plan characteristics [20]. Even for those whose depression is recognized, treatment in the primary care sector is often suboptimal [20,21], and inadequate follow-up and long term monitoring are also a problem [22,23].

A proliferation of effective treatments for depression, including both proven psychotherapeutic approaches and an

arsenal of improved (though highly expensive) pharmacological interventions, have been developed, tested, and incorporated into widely accepted evidence-based guidelines for primary care treatment of depression [24,25]. In addition, chronic care models of effective treatment in primary care also have been developed and tested [26–29].

These models contain several components necessary for high quality treatment of chronic health conditions, including use of explicit plans and protocols, reorganization of practice (e.g., time and resources), longitudinal follow-up, patient self-management, decision-making support, access to community resources (e.g., specialty expertise), and leadership commitment. The use of these models, along with efficacious medication and psychotherapies has made the prognosis for depression among the best of any major medical illness [3].

On the other hand, direct pharmaceutical company marketing to consumers and aggressive marketing to nonpsychiatric physicians risk the serious complication of over-treatment with medication. As many as 40% of the population may manifest subsyndromal symptoms of de-

pression, and there is little evidence to support (and some evidence against) the use of medications (rather than watchful waiting) in this population [30–32].

3. Barriers to solutions

While the need for improved primary care treatment of depression is well-documented and opportunities for making a difference are clear and well-timed, there exist significant barriers to effective implementation of evidence-based chronic care models [33]. These barriers relate to the disease itself and also concern issues related to patients, providers, health practices, health plans, and purchasers.

3.1. Conceptual barriers

Depression involves the complex interaction of multiple systems, both within the body, as well as within the health care system and society. Yet, health care providers, as well as the public, continue to make a distinction between physical and mental illness. Besides being counterproductive from a treatment perspective, such a distinction also impacts on billing codes, information systems, and the financing of health care. Moreover, although the development of standardized, operationalized criteria for major depressive disorders, as reflected in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) [1], represents a breakthrough in establishing a reliable diagnostic framework, most of the literature on depression comes from specialty and tertiary care settings, and there are questions as to the generalizability of these data to primary care. Furthermore, commonly used diagnostic systems such as DSM-IV are often seen by primary care providers as too complex and specialty focused.

3.2. Patient barriers

Societal stigma is also a barrier to treatment of depression and may impact the health care decisions of individuals with depression [34,35] and their physicians [36]. A recent survey of PCPs found that more than one third of their patients with depression were reluctant to accept such a diagnosis, and more than half were hesitant to see a mental health specialist (MHS) [34]. This may be related to concern about confidentiality and may deter individuals from seeking or receiving help, particularly when using employer-based health plans to pay for services. Some patients may worry that awareness of their psychiatric condition will have a detrimental effect on their relationships with family or friends, and others are simply unaware of modern conceptions of depression as a medical condition with highly effective treatments. In many cases, the illness itself causes feelings of pessimism, nihilism, and low energy that interfere with help-seeking behaviors or result in unemployment and loss of insurance coverage.

3.3. Provider barriers

Primary care professionals have a unique opportunity to detect depressive symptoms early and either to provide adequate care or timely referral for their patients [34]. However, limited time, as well as the PCP's own interests, background, and training may also act as barriers to appropriate depression treatment in primary care settings [34]. Patient resistance to diagnosis, as well as somatic presentations, also act as barriers to recognition and treatment of depression in the primary care setting.

With regard to training, there is no clear consensus concerning what primary care providers should know about depression or how this information should be taught, since there are specialty differences in training approaches. In addition, physicians obtain considerable information on new medications from pharmaceutical representatives and promotional activities [37,38], and this information may not be optimally balanced between pharmacological and psychotherapeutic treatments. Moreover, while various models for mental health training of PCPs have been identified and implemented [39,40], there remains significant variation across different primary care specialties (i.e., family practice, internal medicine, obstetrics/gynecology and pediatrics) in the content of these training programs, the focus on specific diagnostic and treatment issues at various levels of complexity, and the degree to which the curriculum is structured (e.g., whether structure is formal and specified versus informal and case-based).

3.4. Practice barriers

The practice arrangements of health care also create barriers to effective depression treatment. Most clinical practices and delivery systems are set up to deliver health care for acute conditions [28]. Chronic conditions such as depression, however, require different strategies (e.g., increased patient-provider interactions, long-term follow-up, patient involvement, and effective linkages to specialists for consultation and follow-up) [26,28].

There is wide variation in how primary care practices are organized to care for people with behavioral health problems and how clinical practices are linked to mental health specialty support (Fig. 2) [41]. A fully integrated team approach (A), in which both the PCP and MHS are involved in patient care and have frequent communication, is most suited to deliver health care for chronic disease patients. A totally autonomous approach of primary care providers (E) or mental health specialists (F) is less suitable because of the lack of interaction between primary care providers and specialists. In between are the consultative care approach (B), referral (C), and independent care (D). In the consultative care approach the PCP provides health care services while maintaining contact through consultation from the MHS. In referral care the patient is referred to the MHS, and communication between the PCP and MHS is both limited

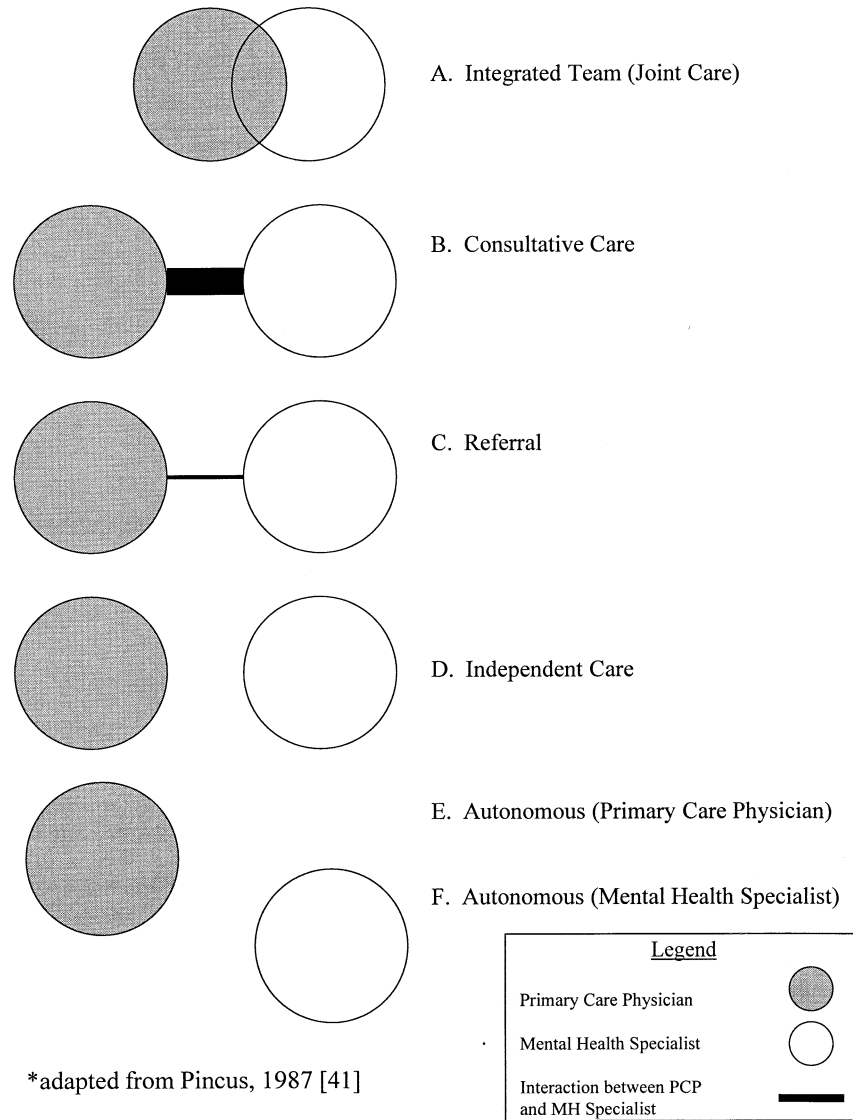


Fig. 2. Practice delivery system.*

and rare. Both types of providers provide services in the independent care approach. Such care is entirely separate, however, and communication is almost nonexistent between the PCP and MHS.

At the practice level there is often ambiguity about *who* is responsible for care (i.e., primary care or mental health practice), and limited communication and teamwork between primary care and mental health practices (i.e., a tendency for the practices to be like those toward the lower half of Fig. 2) [41,42].

Systematic structures for orchestrating care along a longitudinal perspective of a chronic illness are also rare. Moreover, it is hard to find other components of a chronic care treatment model such as use of patient registries and chronic care managers, application of sophisticated yet available information system technology, and decision support.

3.5. Health plan barriers

Infrequent use of a chronic care treatment model is not surprising when one considers modern day health care financing and organization in the United States, particularly with regard to mental health. Not only is the majority of U.S. health care financed by managed care organizations [43], but managed behavioral health has evolved into a \$4.4 billion dollar industry, with approximately 78% of Americans with public or private insurance enrolled in some form of managed behavioral health care [44]. Although it can be argued that managed behavioral health organizations (MBHOs) were originally intended to manage the risk of the most resource intensive mental health cases, one unintended result has been a shift in incentive structures for coordination and communication between primary care and specialty practices and providers.

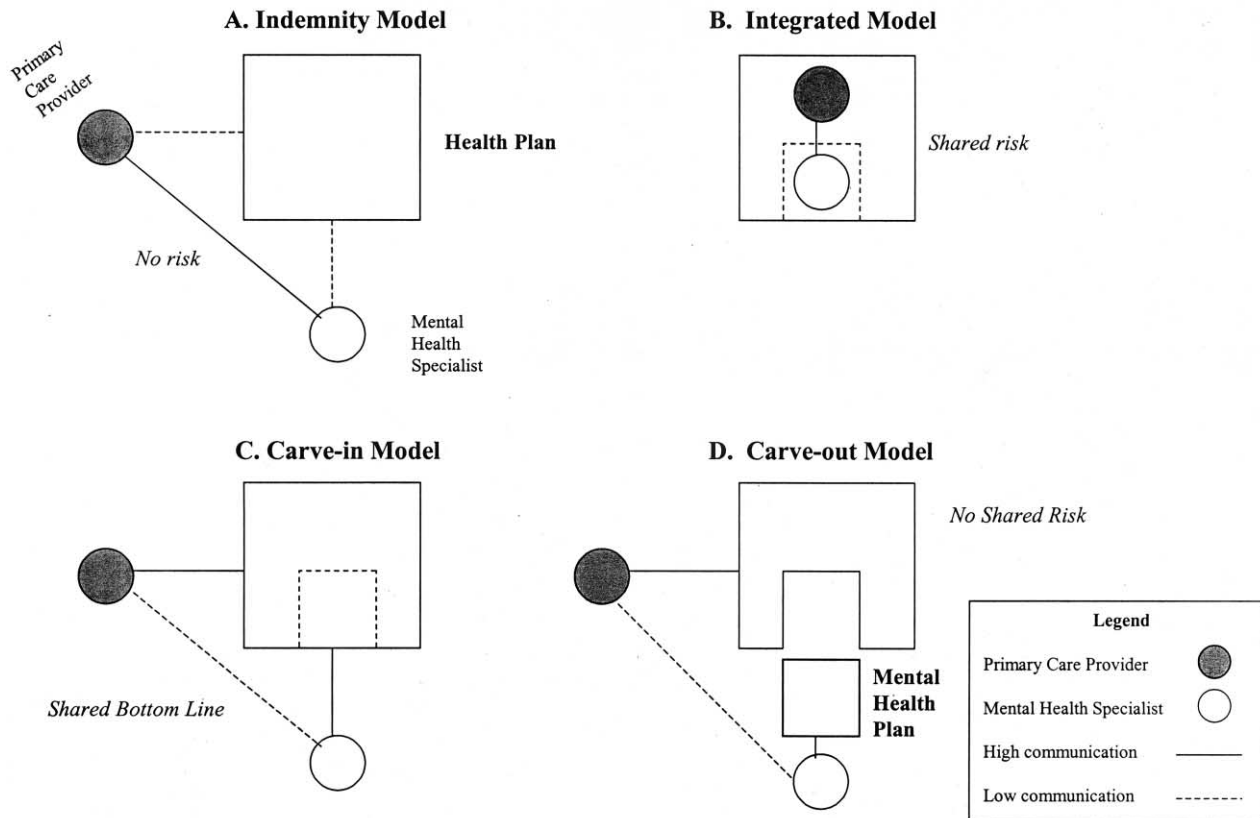


Fig. 3. Health plan structure, risk, and communication.

For example, in the idealized indemnity model (A) in Fig. 3, both sets of providers generally have established professional relationships with each other and have little connection to the financing system; nor is there any intrinsic contractual or financial relationship between providers, except that both can benefit from mutual referral. The integrated managed care system model (B), predominantly in staff model HMOs, is able to establish collaborative relationships among providers and can generally link clinical information. Financial incentives for coordination and communication between primary and specialty care are more likely to be shared across medical/surgical, behavioral, and pharmacy costs.

When behavioral health is carved in (C) or out (D), the primary care and behavioral health networks are entirely separate. To make a referral to a MHS, a PCP may only be able to offer the patient a toll-free telephone number to the managed behavioral health organization (MBHO) triage center in another state. Particularly in carve-out structures, collaboration and communication are not only limited but also discouraged with financial and structural disincentives. The primary care sector has a financial incentive to shift responsibility for direct care to the MBHO. The MBHO does not share in any rewards or risks for more efficient management and reduced costs associated with more appropriate pharmacy or medical/surgical utilization.

Approaches for improving care for depression in both integrated and network managed care plans have been de-

veloped and tested [45–47], but these collaborative arrangements are unlikely to remain in place after a demonstration is concluded unless they are tied to financial incentives.

3.6. Purchaser barriers

Ultimately, public purchasers (e.g., Medicare or Medicaid) and private purchasers (e.g., employers) wield enormous, though often indirect, power in the design of the health care system. While purchasing decisions are amenable to systematic and quantitative analysis, there is little evidence that such analysis takes place. Further, despite the publication of data on the increasing value of depression care [48–50], a persisting general view that such costs are continually rising also negatively influences purchaser decisions [48]. Purchasers may also be uninformed about the substantial indirect costs of depression from absenteeism and disability.

While substantial efforts have been made to expand purchaser capacity to monitor the performance of health plans in nonfinancial areas such as quality, implementation has been variable. For example, The National Committee for Quality Assurance (NCQA) has developed accreditation standards for MBHOs that include elements for coordinating with primary care as well as behavioral health and consumer satisfaction reporting elements (e.g., in The Health Plan Employer Data and Information Set [HEDIS]). Unfortunately, accreditation elements are fairly nonspecific

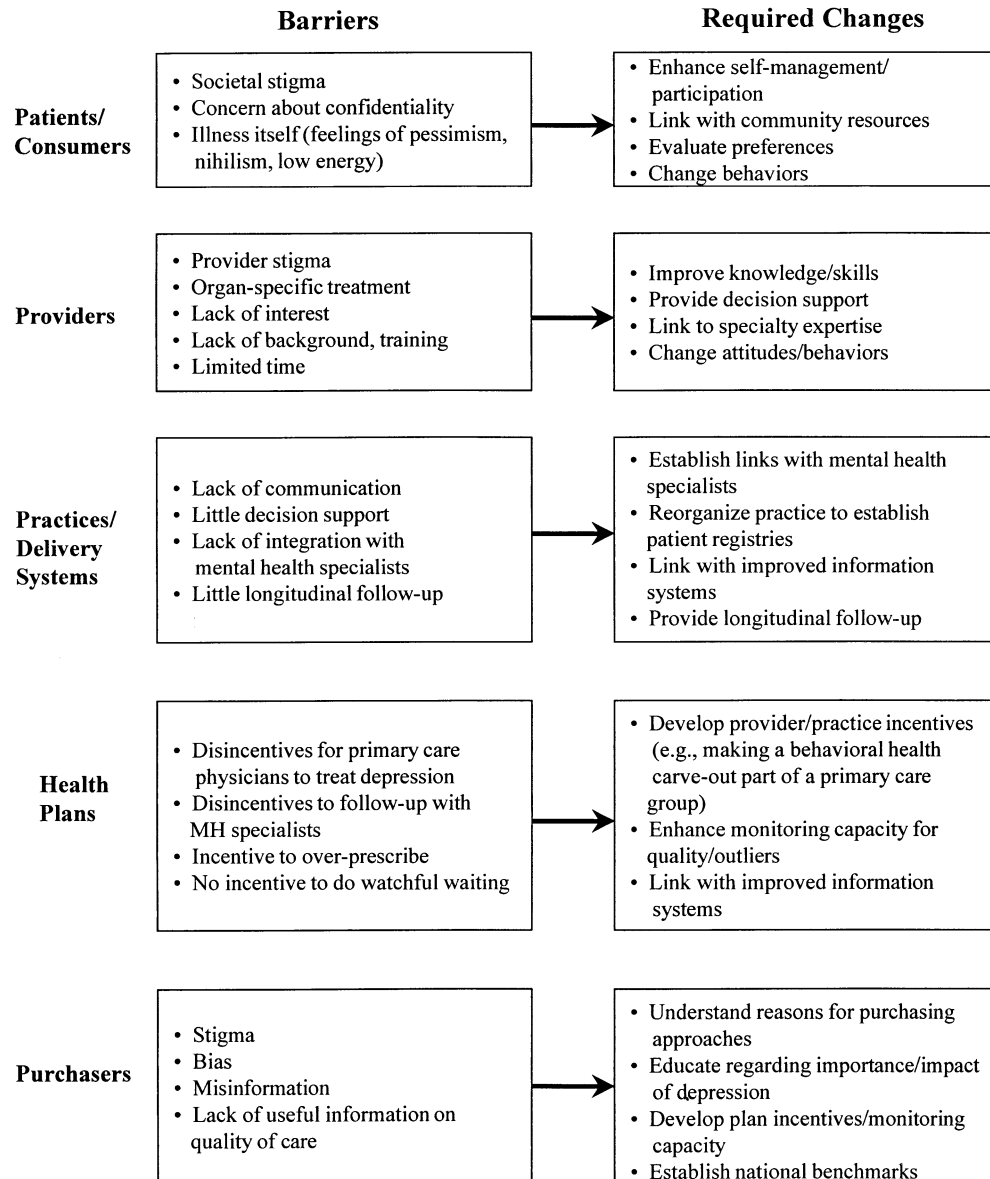


Fig. 4. Barriers and required changes for treatment of depression in primary care.

and easily met and may not capture crucial elements of the evidence-based chronic care model. Moreover, there is little evidence that purchasers have moved aggressively to incorporate mental health quality measures in their purchasing decisions [44].

4. Toward a solution—a framework for action

The clinical principles and strategies for treating depression in primary care have rarely been implemented in a fully functional and sustained manner because appropriate incentives and policy structures rarely exist. Conversely, those programs that have leaned toward a pure policy approach also do not necessarily engender clinical change [51,52].

Our analysis of the issues and barriers described above suggests that interventions must be aligned at both the clinical and systems level to have significant and sustainable impact.

A framework to implement such a comprehensive approach is depicted in Fig. 4. This figure summarizes the barriers for the five levels of market segmentation (patients/consumers, providers, practices/delivery systems, plans, and purchasers) and the changes required to overcome those barriers. Patients/consumers and providers (practices/delivery systems) form the clinical component of this framework, while health plans and purchasers are part of the systems component. Improving treatment of depression in primary care settings requires attention at each level and between both components.

5. Depression in primary care: linking clinical and system strategies

The Robert Wood Johnson Foundation (RWJF) Program on *Depression in Primary Care: Linking Clinical and System Strategies* is an example of a program that pays attention to the five levels of market segmentation as well as the clinical and system components. The program is a five-year, \$12 million national program with the goal of increasing the use of effective treatment models for depression in primary care settings.

The program was developed to address three issues: 1) depression is a serious, often chronic disease that is commonly encountered in primary care patients but is often undetected or treated in ways that are inconsistent with evidence-based practice guidelines; 2) though models that use a chronic care approach have been shown to be effective in the treatment of depression in primary care settings, these models are not being implemented by health systems and practitioners; and 3) putting these models into place requires a combination of clinical and system strategies at multiple levels, engaging patients/consumers, providers, practices, plans, and purchasers.

The program has three components: 1) incentives; 2) value; and 3) leadership. The goal of the incentives component is to plan, implement and evaluate projects that test the feasibility and effectiveness of a combined clinical and economic/systems approach to changing the treatment of depression in primary care. This component seeks to answer two questions: 1) to what extent is it feasible to implement changes in organizational structure, systems and payment incentives? and; 2) what are the impacts on organizational and clinical processes and outcomes? The program's National Program Office has been working with leaders in the field to develop a flexible blueprint for the model to be tested. Participation in this component is limited to a small group of invitees able to develop partnerships among practices, health plans, purchasers, researchers and others.

While the incentives component of *Depression in Primary Care* seeks to determine whether depression treatment in primary care coupled with financial and nonfinancial incentives is both feasible and effective, the primary goal of the value component is to stimulate deeper levels of analysis about the outcomes and value of depression treatment in primary care. This component aims to answer the question, "What is the real value of providing quality care for depression in primary care settings, and how can that value be best achieved and documented?"

The answer to this question will vary according to the perspective of each stakeholder (e.g., patient/consumers, health care providers, health practices/delivery systems, health plans, and purchasers). A standard "call-for-proposal" strategy will be used to solicit proposals. Answers to research questions will be expected to assist in developing combined clinical and economic models that have greater relevance to these stakeholders.

The third component of the program (Leadership) is intended to advance the treatment of depression as a chronic

illness in primary care through leadership development within primary care medical specialties. Senior mentors in the field will be identified and paired with junior PCPs to conduct specific research projects relevant to the overall goals of the program. By convening these pairs of primary care specialists, the intention is to develop a cadre of future leaders in primary care with an interest in and commitment to studying and treating depression as a chronic disease.

6. Conclusions

Depression affects 10 to 14 million Americans every year, exerting a major impact on quality of life, function, and work productivity. It is both necessary and timely to improve the recognition and treatment of depression, a serious and often chronic disease. Like other chronic diseases, good models of recognition and treatment can be directed to the mainstream of primary care.

While evidence is clear and consistent that recognition and treatment models in primary care settings are effective, there are currently barriers at several levels (patients, providers, practices, plans and purchasers) that operate against implementing and sustaining these models. Overcoming these barriers requires joint ventures working at and among all levels to create change. Such a coordinated approach is currently underway with the Robert Wood Johnson Foundation National Program on *Depression in Primary Care*.

Depression in Primary Care will determine whether such a coordinated approach is feasible and effective and will provide a template of best practices for other organizations to follow in setting up similar partnerships and practice changes. At the same time, it will assist in determining and documenting the value of treating depression in primary care, as well as lay the groundwork for training a new generation of PCPs to break down the mind-body barriers in public, private, and research environments.

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