DEPRESSION CARE
Opportunities to move the needle

BY ANGELINE CARLSON, RPH, PHD, AND DEBRA KRAUSE, MBA

Depression care has been a focus in Minnesota for more than a decade. Past substantive efforts have included Minnesota Bridges to Excellence, a purchaser-led pay-for-performance program; the DIAMOND and COMPASS Projects, quality improvement efforts directed at clinic performance; and other purposeful efforts. However, despite good intentions and thoughtful collaboration, patient outcomes have failed to improve significantly and practices known to deliver improved outcomes such as Measurement-Based Care and the Collaborative Care Model have not been widely adopted by clinics and care systems in the state.

A 2019-2021 project funded by a Eugene B. Washington Community Engagement Award from the Patient-Centered Outcomes Research Institute (PCORI) used a mixed-methods approach (semi-structured interviews, surveys, and stakeholder and community convenings) to understand opportunities for "Improving Together: Advancing Mental Health Outcomes in Minnesota."

What the data tell us

In Minnesota, we are fortunate to have publicly reported data regarding patient care and outcomes available from MN Community Measurement (MNCM). The Depression Care Measures Suite includes Adult Depression: PHQ-9/PHQ-9M Utilization; Follow-up, Response, and Remission at Six Months; and Follow-up, Response, and Remission at Twelve Months. A comparable suite of measures is available for adolescent depression but was not part of this project.

From the 2020 data reporting for 2019 dates of service, we know that while use of screening tools is high (77.6 percent for adults who have depression), performance rates drop for follow-up (48.5 percent), six-month response (19.4 percent), and six-month remission (11.3 percent). In addition, there is wide variation in performance. The top-performing clinic has a six-month remission rate of 41.2 percent and a dozen clinics have a 0-percent six-month remission rate. There is also geographic variation by county. MNCM calculates the expected rate of performance, which adjusts for patient demographics. There are high-performing clinics that achieve two to three times the expected rate, while average and low-performing clinics fall well short of expected outcomes. While patient outcomes for all Minnesotans are unacceptable, outcomes for patients of color and ethnic and culturally diverse communities are even lower (remission rates less than half the rate for White patients), and in the case of depression remission at six months, the needle has been "stuck." We wanted to better understand "why?" and learn how we could make progress together.

Key findings

We talked with clinicians and administrators at randomly selected clinics in both urban and rural communities. The clinics were system and non-system affiliated, of different sizes and with a wide range of performance rates. We supplemented the individual clinic interviews with interviews at a system-wide level to better understand the role system policies and support played in the care processes at individual clinics. We also conducted an online quantitative survey of clinics to validate our findings. There were six overall themes that emerged regarding strategies for improving depression care. Some are new; others are not.

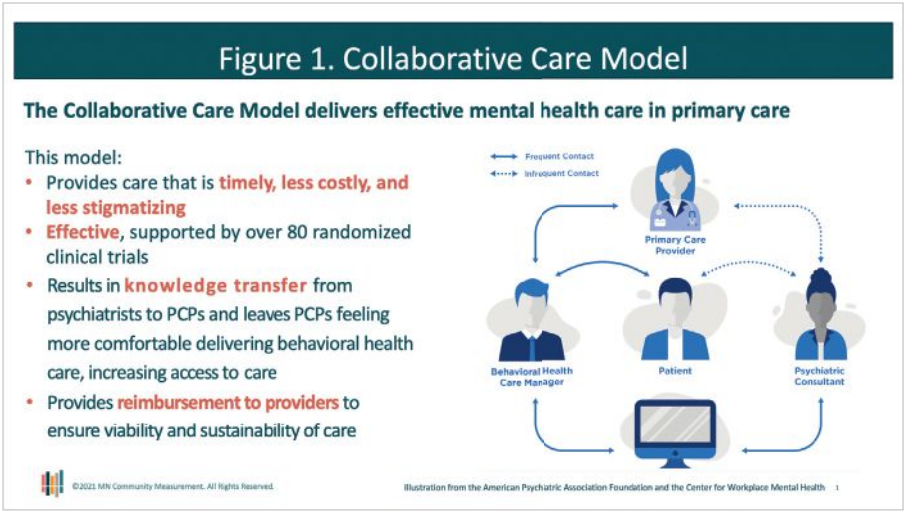
> If outcomes improve 1 percent per year, that is improvement. But at that rate, it would take decades to get mental health outcomes to a level on par with physical health conditions. Incremental change is insufficient. Transformation with a sense of urgency is needed.

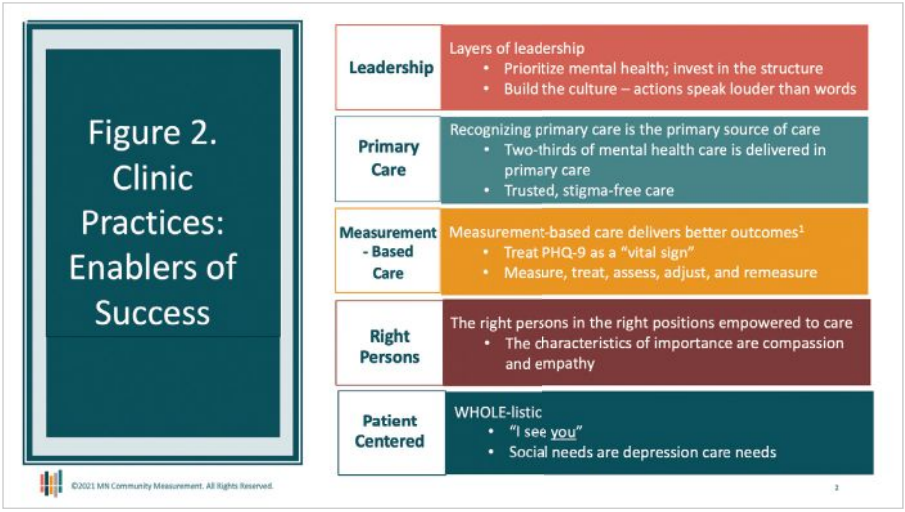
The PHQ-9 is only the beginning in caring for patients. Screening rates for depression are high, but clinic-reported performance rates decline at each successive Minnesota Community Measure—follow-up, response and finally remission. Even low performers on response and remission have high screening rates. Clinics with higher remission performance use the PHQ-9 as a vital sign, every bit as important as taking blood pressure readings for hypertension patients and HbA1c measures for persons with diabetes.

Resource proximity does not equal high performance. Clinics that have internal resources—care coordinators, social workers and consultant connections—are not always high performers. Clinics in areas lacking a large number of proximally located mental health resources are not always low performers. Identifying and then innovatively using the resources available in the clinic's geographic area is key. Referrals to distant resources may not be comfortable for patients.

Health information technology is necessary but not sufficient. This is an old truth. A computer in every examination room isn't enough—it has never been enough. Higher-performing clinics have integrated evidence-based care alerts into the EMR for depression just as alerts have been integrated for diabetes and cardiovascular care. Clinicians also ask more questions and find creative ways to help; clinic staff make warm handoffs, not just EMR notes, and compassionately help the patient take the first step, or the next step, in getting where they want to be, feeling better. As one high-performing clinician told us, "The patient knows that we're on their side. There isn't anything we're not going to do to help them."

Incentives and recognition of staff efforts play an important role. The incentives to increase performance do not need to be monetary. Nurses and care coordinators at higher-performing clinics appreciate being recognized for their contributions in aid of patient care. They are pleased and proud to know that they are an integral part of the team, with opportunities to air concerns about patients and to offer suggestions that are valued. The importance of recognition can be summed up in three words: staff need to feel connected, appreciated and supported.





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There are disconnects and gaps in care. This is another old truth in the healthcare system and it remains true, despite years of admiring the problem and attempts to deploy technology to facilitate record-sharing and information exchange. The disconnects and gaps are especially troublesome for mental health care. Connections between inpatient hospital care and return to primary care are significantly hampered. Connections between the community resources providing services to patients that can complement and enhance clinic care are even more difficult. Health plans and employers offer resources as well, but these resources generally are not well known or utilized.

The Collaborative Care Model has not been widely adopted, despite efforts to increase awareness at the state level and nationally about the evidence supporting this model and the opportunity to receive reimbursement for services delivered under this model. This model provides care that is timely, less costly, and less stigmatizing and is supported by over 80 randomized clinical trials published in clinical journals. (Figure 1)

Collectively, these key findings offer insight regarding the unacceptably low performance levels and the lack of meaningful progress in improving outcomes. Even so, there are bright spots—clinics across the state that are delivering wonderful care and achieving remarkable levels of perfor-

mance. These clinics serve as evidence of what is possible. Keys to success are shown in Figure 2.

Challenges

We couldn't help but develop a deeper appreciation of the challenges that clinics face and need to overcome. Conversations with both high- and low-performing clinics identified four key challenges, each with multiple facets that were reinforced by responses to the quantitative survey conducted as part of this project.

The first three (prioritization, investments and talent) are connected and speak to resources. If we are to improve mental health care and outcomes, it must be prioritized. As one clinic told us, "We want brain health to be like heart health." Words alone will not make this a reality. It needs to be considered an investment, not a cost that can be trimmed when budgets are tight. We heard about positions and technology being eliminated, but "doing more with less" will not facilitate improved outcomes. Clinics are spread thin, care is time-consuming and the needs are great. Talent is essential—more people are needed in all roles and they are hard to find, especially the top talent. One of the outstanding clinicians at a high-performing clinic confided in us, "I am exhausted."

The final challenge is connecting the dots. Many hard-working and well-intentioned individuals and organizations want to help and are doing things large and small, but they are working in silos. We will only optimize the impact if we connect the dots within and between primary care and specialist resources and between healthcare providers and employer and community resources.

Looking forward

Based on interviews with clinics and health system administrators and the input from healthcare purchasers, stakeholders and communities, three key recommendations emerge for advancing mental health outcomes in Minnesota:

- Fully implement the Collaborative Care Model. This is proven, high-value care that will accelerate improved patient outcomes. High-performing clinics will be able to do even better if they have the missing pieces of the model added. Average to low-performing clinics will get on the path to success. This model can be, and has been, successfully implemented in other states. Investment is needed in clinic staff and processes to accelerate adoption in Minnesota.
- Create community linkages to close gaps. The roles of each stakeholder group, as well as collaboration opportunities, were identified and documented in this project. If all stakeholders come together with their unique perspectives and capabilities, and if they work together, hold each other accountable and focus on outcomes, progress is possible.
- Drive improvement by investing in, reimbursing and rewarding clinics and clinicians providing exceptional evidence-based care. This must become the norm and not the exception.

Given the realities of our world today—the coronavirus pandemic and Delta variant, increasing prevalence of depression, recent MNCM performance data and health disparities—we are at a crisis point. If outcomes improve 1 percent per year, that is improvement. But at that rate, it would take decades to get mental health outcomes to a level on par with physical health conditions. Incremental change is insufficient. Transformation with a sense of urgency is needed. **MM**

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For further information

This article focuses primarily on clinic practices. More information on project methods, community perspectives and collaborative opportunities to transform care were shared in MN Community Measurement's February 2021 Mental Health Summit and May 2021 Mental Health Awareness webinar. The recordings and slides from these events are available at https://mncm.org/past-events-webinars/.

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