Pursuing Perfect Depression Care

Perfect Depression Program, Henry Ford Health System, Detroit

Can suicide be eliminated? Doing so is the goal of the Perfect Depression Care program, initiated by the Department of Psychiatry at the Henry Ford Health System. Using a framework proposed by the Institute of Medicine to dramatically improve health care, the team set out to examine its department's existing practices and develop new systems of care. To encourage high-quality care for chronic illnesses, the new system addresses the community, the health system, patient self-management support, delivery system design, decision support, and clinical information systems. A key improvement from this model was a new evidence-based approach to suicide prevention, which consists of a three-tiered system of care based on an individualized and continuous risk assessment of each patient.

As a result of these innovations, the Henry Ford Department of Psychiatry has reduced the suicide rate among its patients by 75 percent, to 22 per 100,000 patients, compared with the expected rate in the literature of 1,000 per 100,000. This success has been sustained in each follow-up year since the program's inception in 2001, and the approach used has become a model for new programs within the Henry Ford Health System and across the country.

In recognition of its success in reengineering depression care and significantly reducing suicide rates, the Perfect Depression Program of the Henry Ford Health System was selected to receive APA's Gold Achievement Award in the category of academic or institutionally based programs for 2006. The winning program in the category of community-based programs is described on page 1521. Each Gold Award winner will receive a plaque and a $10,000 prize, made possible by a grant from Pfizer, Inc., on October 5 at the Institute on Psychiatric Services in New York City.

The challenge

Annually, depression affects about 10 percent of adults in the United States. The leading cause of disability in developed countries, depression results in substantial medical care expenditures, lost productivity, and absenteeism. Untreated or poorly treated, depression can be deadly—each year up to 10 percent of patients with major depression die from suicide.

In its 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century,* the Institute of Medicine identified depression as a priority condition for immediate national attention. That same year the Robert Wood Johnson Foundation issued a challenge to American health care leaders to "pursue perfect care" by embracing the Institute of Medicine's framework as an approach to program redesign.

The Department of Psychiatry at the Henry Ford Health System accepted the foundation's challenge, choosing as its overall goal the pursuit of a system of perfect care for persons with depression. Through a competitive process the program won funding from the foundation, and in 2002 the Perfect Depression Care initiative began its start-up phase.

Goal: no suicides

The overall goal of the initiative was to eliminate suicide. More broadly, the aim of the program was to completely redesign depression care delivery to achieve breakthrough improvement in quality and safety by using the structure articulated in the *Quality Chasm* report. The redesign would focus on six aims: effectiveness, safety, patient centeredness, timeliness, efficiency, and equity among patients. The program developed concrete measures to assess progress on each of these aims. For example, effectiveness in eliminating suicides would be measured in terms of the number per 100,000 network members. Patients' satisfaction with remaining aims would be measured with a standardized national survey.

The targeted sample was all patients with depression and other mood disorders (about half the clinical volume) being cared for by the Henry Ford Department of Psychiatry, a large regional integrated delivery system serving southeastern Michigan and the entire Midwest. The department owns and operates a comprehensive behavioral health care delivery system that includes ten outpatient centers, a 100-bed psychiatric hospital, a 64-bed residential and outpatient substance abuse program, and numerous specialty care and service programs, all staffed by a workforce of 515 employees. The department receives approximately 70,000 outpatient visits and provides 46,000 inpatient days of care annually.

Blues Busters team

To launch the initiative, the department chair formed and led a 15-member team to set the vision and strategic goals for the Perfect Depression Care initiative. Dubbed the Blues Busters, the team conceptualized, planned, and launched the initiative and provided initial leadership direction and oversight during implementation. The team included the chief operations officer, medical directors of inpatient and outpatient services, director of quality management, and other key clinicians and managers, such as the inpatient nursing leader, several key physicians, therapists, and clinical managers.

Perhaps the largest obstacle to implementing the Perfect Depression Care initiative was the team's acceptance of "no suicides" as the goal. Some Blues Busters eagerly embraced the goal. Others challenged it, viewing it as unrealistic for a network of 200,000 members, most of whom were outpatients. The debate was finally resolved when the question was asked, "If zero is not the right number of suicides, then what number is? One? Four?

Forty?" This debate was a milestone in the initiative. The team united in its commitment to pursuing perfection. These critical first steps gave the project an identity within the department and the larger health system.

The department's board of trustees provided leadership and support to the team by reviewing progress quarterly, encouraging leaders and staff, and recognizing accomplishments in written communications.

Pursuing perfection

Strategy

The approach to achieving perfect depression care included six major tactics: commit to "perfection" (zero care processes defects, or zero suicides) as a goal; map the current care processes and develop a clear vision of how patient care must change; partner with patients to ensure their voice in care redesign; conceptualize, design, and test strategies for improvement in four areas identified in the mapping of current care—patient partnership, clinical practice, access to care, and information systems; implement relevant measures of care quality, continually assess progress, and adjust the plan as needed; and communicate the results and celebrate the victories.

Key activities

Multiple changes were made from 2001 to 2005 to redesign depression care. First, the team envisioned how each patient's care would need to change to achieve optimal care that provided a continuous healing relationship. The team operated on the principle that perfect depression care must be barrier free and consistently provide timely and accurate recognition of suicide risk.

After carefully examining the existing care processes and benchmarking processes in exemplary organizations across the country, the team improved care in four principal areas.

Partnership with patients. A consumer advisory panel was established to help redesign the treatment planning process. With the panel's input, the new plan involves each patient as an active partner in treatment. At each key juncture of program development, the team held focus groups with patients and families to solicit feedback. The team also developed a survey to measure patient satisfaction.

Clinical care. A key change was the development and implementation of a suicide prevention protocol across outpatient and inpatient facilities. This protocol is the core of revised evidence-based depression care guidelines. The protocol stratifies patients on the basis of risk—acute, moderate, and low—and requires specific actions within specific time frames for each risk level. Such actions include assessing whether the patient has access to weapons and, if so, developing a plan for removal; conducting a psychiatric evaluation, providing individual and group psychotherapy appropriate to the patient, involving the patient's family, and providing additional resources to the patient and family. The risk assessment looks beyond suicidal ideation for predictors of acute and chronic suicidal risk. Mood disorders, as well as severe anxiety, severe insomnia, global insomnia, and severe anhedonia, have been found in recent literature to be predictors of suicide risk, so all are considered in the risk assessment.

The depression care guidelines were revised to ensure a systematic and evidenced-based approach to coordinating an array of somatic and psychotherapeutic treatments, including psychotherapy, psychopharmacology, and brain stimulation techniques, such as electroconvulsive therapy. The Department of Psychiatry also partnered with the Beck Institute of Philadelphia to establish and maintain departmentwide competency in cognitive-behavioral therapy and provided training for 30 clinicians to achieve certification. Also, the department implemented evidence-based clinical protocols to reduce the risk of falls and medication errors in the inpatient facilities.

Access. Three innovations to improve access were implemented: drop-in group medication appointments, advanced (same-day) access, and e-mail "visits." Each outpatient site offers one or more 90-minute drop-in group appointments weekly, led by a psychiatrist and a social worker. This approach provides temporary additional access and group support on short notice. A secure e-mail system was established for patients who prefer to use it for some interactions with their behavioral health care providers. Also, several stand-alone behavioral health outpatient clinics were physically reintegrated into the medical group's outpatient clinic buildings to ease access and continuity of care.

Information flow. Several technological changes improved the flow of information within the health care system and to patients. First, electronic medical records were updated to comply with confidentiality policies and to enable sharing of information between health care sites. For example, complete behavioral health information (including suicide risk) is now immediately available to behavioral health clinicians at any site at which the patient is seen.

Second, a comprehensive and secure "Living With Depression" Web site was developed for patients and family members. In addition to providing treatment information, the Web site features video clips of evidence-based information, "ask the expert" forums, and secure chat rooms for information and support. The secure e-mail communication system was established within this context.

Third, an Intranet was created for the health system to disseminate the depression guidelines to all clinicians and to provide access to a patient registry and other electronic tools to improve the quality and efficiency of care.

Funding the initiative

The Perfect Depression Care initiative was launched at a time of financial challenge for the Henry Ford Health System. One-time financial support was required in three areas: project management support equivalent to one full-time manager for one year, training in cognitive-behavioral therapy for 30 clinicians, and Web site development and the other electronic enhancements. Support was provided by the grant from the Robert Wood Johnson Foundation and by the health system and Department of Psychiatry board of trustees. The trustees raised substantial sums of money to support the development of critical information technology, including the Web site.

Although improving financial performance was not a formal goal of the initiative, the outcome was essential to the long-term viability of the program and of the overall health system. From 2002 to 2004, the gross contribution

(total net revenue minus total direct expenses) was improved by nearly eightfold, mainly by a nearly $3.5 million reduction in expenses in that period. Expenses were reduced in part through improvements in productivity generated by the Perfect Depression Care protocols. Financial success continues for the program. With additional grants and support from affiliated partners, Perfect Depression Care programs are spreading throughout the state of Michigan and nationally.

Dramatic reduction in suicide

The goal in the Perfect Depression Care initiative was to eliminate suicide, which the program has come very close to achieving. Since implementation of the program, the rate of suicide in the patient population has declined by an impressive 75 percent, from approximately 89 deaths per 100,000 at baseline (2000) to approximately 22 per 100,000 for the follow-up interval of 2002 to 2005 (p=.007). This improvement has been sustained during each of the four outcome years. For comparison, although the expected suicide rate in the general population, per U.S. census figures, is 11 deaths per 100,000, the suicide rate among patients with an active mood disorder is estimated at 80 to 90 times the rate of the general population, and the suicide rate among patients with a history of suicide attempts is 100 times the rate of the general population. This dramatic and sustained reduction in suicide rate achieved in the Perfect Depression Care program is unprecedented in both the clinical and quality improvement literature. In fact, in two of the four follow-up years, the suicide rates dropped to levels seen in the general population.

In addition to the substantially improved suicide rate, the level of patient satisfaction has also greatly improved. The team developed a simple survey for patients to assess their care, which was piloted with the electroconvulsive therapy unit. The percentage of patients completely satisfied with all dimensions of their care increased to over 90 percent, from 55 percent on average during the baseline period. This level of satisfaction has been sustained in the unit for over four years. Although the team attempted to use the survey in the outpatient clinics and inpatient services, recording the data is too cumbersome for large, busy services.

Effective model

The encouraging results of the Perfect Depression Care Initiative are among the first to demonstrate that the *Quality Chasm* report can be a highly effective model for breakthrough quality improvement in mental health care. The successful Perfect Depression Care initiative is the prototype for a comprehensive redesign of behavioral health care across the Department of Psychiatry. Work is under way to perfect the care of persons with anxiety or psychotic disorders, and similar care systems are being developed for violence prevention and medication safety.

The program is not only a model treatment program but also a model of health systems research. An initiative was recently launched to spread perfect depression care to the primary and specialty medical care settings of the health system, in part by reintegrating behavioral health and medical outpatient clinics and redirecting information flow. The group is also collaborating with the insurance division of the health system to develop a depression care management product designed to provide major employers (in particular, the automotive manufacturers in Detroit) with a system of depression care that will improve employee productivity and lower health care costs. The creative use of information technology has drawn attention and support from Microsoft and the Flinn Foundation. The team is helping the state of Michigan develop and implement evidenced-based guidelines for the care of persons with mood disorders. Finally, the team is consulting with numerous mental health care providers, insurers, and professional organizations throughout the United States to support their efforts to improve their mental health care services.

Summary

In summary, by using the *Quality Chasm* report as a roadmap and by leveraging "pursuing perfection" as a strategic driving force, the Perfect Depression Care program has achieved unprecedented results in reducing suicide and improving the care of persons with depression. This approach is economically viable and readily applicable to other mental health care delivery systems.

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Applications Invited for the 2007 Achievement Awards

The American Psychiatric Association's (APA's) Psychiatric Services Achievement Awards, funded by Pfizer Inc., recognize programs that have made an outstanding contribution to the field of mental health, that provide a model for other programs, and that have overcome significant challenges. The winner of the first prize, or Gold Award, in each of two categories—community-based programs and institutionally sponsored programs—receives a $10,000 grant. Programs also may be selected to receive a Silver or Bronze Award.

To obtain an application form for the 2007 competition or for additional information, write to Achievement Awards, APA, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; phone: 703-907-8592; or visit www.psych.org/psychpract/awards.cfm.