Collaborative Care for Depression in the Primary Care Setting

A Primer on VA's Translating Initiatives for Depression into Effective Solutions (TIDES) Project

Veterans Health Administration
Research & Development
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Health Services Research and Development Service

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Purpose of Primer series:

The Primer series is part of several research dissemination initiatives developed by VHA's Office of Research and Development through its Health Services Research and Development Service (HSR&D). The purpose of the Primer series is to share evidence from health services research and to foster collaboration between researchers, policymakers, managers, and clinicians in an effort to improve the quality and cost-effectiveness of health care for veterans.

Purpose of the "Collaborative Care for Depression in the Primary Care Setting: A Primer on VA's Translating Initiatives for Depression into Effective Solutions (TIDES)" Project:

The purpose of this Primer is to provide information about collaborative care for depression, particularly in the primary care setting. The Primer discusses several collaborative care models, but specifically focuses on VA's TIDES project—an evidence-based collaborative approach to depression management that has proven successful in the VA healthcare system. In addition, appendices provide a glossary of terms and a list of resources for further information about depression and treatment.

Suggested audience:
VA managers, policymakers, clinicians, front-line supervisors, researchers, nurse care managers, and staff involved in the delivery of care for depression, in particular healthcare providers working in primary care and mental health.

Suggested uses:
Individual study and education for professional staff and healthcare providers and healthcare teams involved in the management of depression, a tool for medical and health professional training programs addressing the treatment and management of depression, as well as other continuing medical education courses.

July 2008

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Preface: Implementing collaborative care for depression into the primary care setting

This Primer is intended to help practices and facilities who are interested in implementing new collaborative models for caring for veterans with depression. Depression is a major problem for veterans seen in primary care. About one out of every three veterans visiting primary care have some symptoms of depression; one in five have serious symptoms that suggest the need for further evaluation for major depression; and one in eight to ten have major depression requiring treatment with psychotherapy or antidepressants. Without treatment, symptoms of depressive disorders can last for an extended period of time and can cause significant disability. Most VA patients with depression are cared for principally in primary care clinics, thus collaboration between primary care and mental health care providers is essential to enhancing treatment for depression and improving outcomes.

About one out of every three veterans visiting primary care have some symptoms of depression; one in five have serious symptoms that suggest the need for further evaluation for major depression; and one in eight to ten have major depression requiring treatment with psychotherapy or antidepressants.

VA/HSR&D's Mental Health Quality Enhancement Research Initiative (MH-QUERI) works to improve the quality of care and health outcomes of veterans with major depressive disorder and schizophrenia—two highly prevalent conditions among veterans. Mental Health QUERI has been a key part of VA's efforts to incorporate collaborative care for depression in the primary care setting through its Translating Initiatives for Depression into Effective Solutions (TIDES) project. The TIDES project was designed to:

- adapt depression collaborative care models to VA settings through Evidence-Based Quality Improvement for Depression (EBQID);
- implement VA depression collaborative care models in selected medical centers;
- support and evaluate the implementation of collaborative care for depression; and
- prepare quality improvement methods and materials to support implementation throughout the VA.

A key feature of TIDES is collaboration between primary care providers and mental health specialists, supported by a depression care manager. The care manager, under supervision of a mental health specialist, assists the primary care provider in the assessment and ongoing management of depressed patients.

This Primer discusses details of the TIDES model, in addition to other successful collaborative care models for depression treatment, to assist clinicians and managers who are interested in implementing these successful models in their setting. VA is at the forefront of this important work. Researchers within VA are working in collaboration with VA leaders toward a systematic integration of collaborative care for depression into the primary care setting. Together we can provide the best possible care to veterans living with this chronic mental illness.

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Introduction

Major depression is currently the leading cause of disability in the United States, and by 2020 it is projected to be the leading cause of disability worldwide. The annual societal costs of depression are currently estimated at $66 billion, which includes costs for providing treatment for the condition and lack of productivity. Nationally, fewer than one-fourth of persons experiencing an episode of depression during a 12-month period receive appropriate treatment.[1] Moreover, depression is the second most prevalent, chronic, disabling, and costly illness in VA healthcare settings and also is prevalent among veterans with other chronic mental and physical illnesses. Approximately 7% of VA patients meet criteria for major depression, and veterans with depression account for 14.3% of total VA healthcare costs.[2]

Most patients with depression are detected in primary care settings, with studies showing that about 20% of primary care patients screen positive for depressive symptoms. About half of these patients are being treated for mental health issues within the VA healthcare system.[3] In 2002, VA's National Registry for Depression—a comprehensive database of patients with diagnosed depressive disorders in VHA primary care and mental health specialty settings—showed that while 56% of veterans had the majority of their depression visits in specialty settings, 44% had their depression visits in primary care.[4]

Approximately 7% of VA patients meet criteria for major depression, and veterans with depression account for 14.3% of total VA healthcare costs.

As treatments for mental disorders have become more effective and acceptable to patients, the case for screening and early recognition of these disorders is strengthened, particularly in the primary care setting. Not only can early treatment improve depression outcomes, it raises the possibility of preventing the development of other mental and substance use disorders which so often are co-occuring.[5] However, treatments shown to be effective in research are not automatically successful in actual practice. For example, the assessment process by which patients with possible depression are evaluated takes time and training. Just as a diagnosis of diabetes cannot be made without a visit to the lab for a blood-draw, a diagnosis of depression depends on an analogous "test" involving the administration of a diagnostic instrument and a tailored medical and social history. In addition, once treatment is initiated, symptom improvement is usually not immediate, and initial courses of antidepressants are often accompanied by temporary side effects. Sufficient monitoring is required to support medication tolerance and compliance. Also, depression treatment can require adjustment of dosages and multiple medication trials that may require specialty mental health consultation.

Studies show that collaborative models for depression care delivery can bridge the gap between treatment efficacy reported in carefully controlled research trials and the effectiveness actually achieved in typical primary care practice. One type of collaborative care model—the model on which VA's TIDES Project is based—links primary care and mental health via a depression care manager. The care manager assesses and educates patients, and follows up with patients and providers between primary care visits to optimize treatment. TIDES can also be combined with another collaborative care model involving co-located mental health providers.[6]

In co-located models, a mental health specialist has an office and sees patients in the primary care setting (or via telehealth when supporting a patient at a location without an on-site

mental health provider). The co-located model has been used most extensively at the White River Junction VA. It emphasizes changing how mental health and primary care interact, and provides methods for doing so. Blending co-location with TIDES allows both the flexibility and improved efficiency offered by structured care management, while strengthening the overall program by better integrating mental health and primary care.

This Primer focuses on VA's Translating Initiatives for Depression into Effective Solutions (TIDES) Project—an evidence-based collaborative approach to depression management that has proven successful in the VA healthcare system. TIDES is similar in concept to another model also being implemented in VA—the Behavioral Health Laboratory (BHL) model, which will be discussed later in this Primer.[7]

Most patients with depression are detected in primary care settings, with studies showing that about 20% of primary care patients screen positive for major depression symptoms.

What are the elements of effective depression treatment in the primary care setting?

Effective models of care for depression involve collaboration between mental health and primary care specialists with support for:

- assessment and triage,
- patient education and activation, and
- proactive follow-up of patients with depressive symptoms.

Evidence-based depression guidelines, including those of VHA, recognize that collaborative care is effective and cost-effective for improving symptoms of depression and promoting treatment adherence. Multiple studies have demonstrated the effectiveness of collaborative care in improving treatment and outcomes for primary care patients with depression. Nurse care management and collaborative care can improve the detection of suicidal ideation and reduce suicidal ideation or attempts.[8,9]

VHA and other evidence-based depression guidelines recognize the effectiveness and cost-effectiveness of collaborative care with regard to improving symptoms of depression and treatment adherence.

What is the evidence that collaborative care improves outcomes for depressed patients?

Meta-analysis of more than 35 randomized trials shows that collaborative care models are effective.[10] This type of depression care improves quality of care and outcomes for men and women of all ages, from diverse ethnic backgrounds, and in a broad range of rural and urban practice settings, including VA and managed care settings.

Studies also show that clinical outcomes remain improved for two to five years after participation in care management[11] . Cost-effectiveness studies demonstrate that collaborative care can be cost-effective or cost-saving in diverse settings, including VA.[12,13,21] A long-term cost analysis for the Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) model shows a $3,300 cost-savings in overall healthcare costs over a 4-year follow-up period of elderly patients who received care management for depression for 12 months. While overall costs were up a little in year 1, there were substantial savings in later years. At 4 years, costs in every category examined (and the total) were lower in the intervention group than in the group treated in primary care with usual care.[13] Recent studies also show that total costs for care for elderly diabetic patients with depression under depression care management may be less than those for usual care after one year.[12]

Studies of collaborative care have varied in how care was structured or delivered. While most studies used registered nurses as care managers, others employed social workers, psychologists, or pharmacists who received special training to provide depression care support. Collaborative care models also vary in their decision support methods (e.g., paper and pencil versus computer), their training styles and intensity, and the degree to which care managers assume care for more complex patients. While the specifics of these models vary,

they consistently show improvement in satisfaction with care, recovery from depression, and, in some cases, possible reduction in deaths.[14]

Key collaborative care model studies, projects, and initiatives

Several of the studies and projects contributing to the literature on collaborative care are of particular relevance to the VA and are highlighted below.

- VA's Behavioral Health Laboratory
- MacArthur Initiative on Depression and Primary Care
- Partners in Care
- Improving Mood-Promoting Access to Collaborative Treatment Program (IMPACT)
- Prevention of Suicide in Primary Care Elderly: Collaborative Trial
- Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISMe)
- VA's Translating Initiatives for Depression into Effective Solutions (TIDES)

VA's Behavioral Health Laboratory (BHL) project is a flexible and dynamic clinical service designed to help manage the behavioral health needs of patients seen in primary care. The core of the BHL is a brief, structured interview that provides primary care providers with comprehensive assessments of veterans' mental health and substance abuse symptoms, along with the option of structured follow-up assessments, as needed or requested. The program was designed to be:

- cross-cutting, in that it provides support for depression, alcohol, and anxiety problems; and
- multi-modal, for example, assessments can be conducted by telephone or in-person and can be conducted at individual clinics or medical centers.

The BHL also was designed to provide targeted interventions, such as early intervention, disease management, and referral management.[24]

The *MacArthur Initiative on Depression and Primary Care* is based on the Three Component Model (3CM™)—a specific clinical model for depression that incorporates tools, routines, and a team approach to patient care. The three components include: 1) training the primary care clinician and practice to deliver collaborative care, 2) depression care managers, and 3) collaborating mental health specialists. Telephone support for the patient from a care manager is a central element, as is a close relationship between the primary care clinician and mental health specialists that includes informal psychiatric advice from a psychiatrist, as needed.[25]

The *Partners in Care* project involved six managed care organizations and 48 of their practices in a randomized trial of two care manager-based interventions. One arm of the study emphasized nurse care management, with emphasis on follow-up of antidepressant treatment in primary care (enhanced medication). In the other arm, nurse care managers provided assessment and early education to depressed patients, but then referred them

directly to group cognitive behavioral therapy without an intervening mental health specialty visit if appropriate (enhanced therapy). Compared to a group receiving usual care, both groups significantly improved treatment adherence and reported reduced symptoms; the largest impact was on ethnic minority patients.[15, 16] In studies carried out over the succeeding nine years, positive effects of the psychotherapy-enhanced intervention (but not the antidepressant-enhanced group) were seen at two,[17] five,[18] and nine years.[19,20]

The *Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)* project is a collaborative care program for late-life depression that includes four essential elements: 1) a depression care manager, 2) a designated psychiatrist, 3) collaborative care, and 4) stepped care. The IMPACT program was tested in the largest treatment trial for late-life depression to date. It included 18 diverse primary care clinics within eight health care organizations across the United States, including one VA. At one year, about half of the patients receiving IMPACT care reported a reduction in depression symptoms of at least 50%, compared with only a 19% reduction for those in usual care. While physical functioning steadily declined in usual care patients, it improved in patients receiving IMPACT care.[26]

TIDES' goals are to improve treatment adherence, promote symptom resolution, and prevent patient relapse.

The *Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISMe)* study was carried out in a multi-site trial including VA sites[21] to foster collaboration between mental health and primary care in taking care of a range of mental disorders in the elderly. The study resulted in substantial new knowledge about the collaboration process.

The *Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT)* was a practice-based randomized controlled trial to test whether a collaborative care intervention for depression could modify risk for death. Depression care managers (social workers, nurses or master's level psychologists) worked with primary care physicians to provide algorithm-based care in 20 primary care practices. The risk for death was reduced in patients with major depression who received collaborative care.[14] In addition, collaborative care reduced suicidal ideation and produced larger and faster improvements in symptoms than usual care.

VA's Translating Initiatives for Depression into Effective Solutions (TIDES) project is an effort to bring evidence-based, depression collaborative care models into routine care in the VA. The project provided three demonstration VISNs with information and tools from previous high-quality collaborative care studies, and assisted them in adapting the published models to VA outpatient practices. The resulting collaborative care methods are integrated into VA Employee Education System training packages, Office of Information & Technology development, and standard VA policies and procedures. The program is thus intended to continue to evolve through the ongoing activities of VA program participants, and in response to new developments in the mental health and primary care evidence bases upon which it rests.

What is the TIDES Care Model?

TIDES is an evidence-based quality improvement program that aims to improve depression outcomes across the VA primary care patient population. The program builds on the evidence supporting nurse care management for depression.[11, 12, 13]

TIDES' goals are to improve treatment adherence, promote symptom resolution, and prevent patient relapse. TIDES continues to gather and evaluate new evidence about what works and does not work for improving depression outcomes. Through its Collaboration Workgroup[14] (a national group of participating mental health specialists, nurse care managers, and primary care clinician leaders) and its link to VA's Mental Health Quality Enhancement Research Initiative (MH-QUERI), TIDES incorporates new evidence from the literature and from field investigation. A key TIDES objective is to capitalize on the VA's computerized patient record system (CPRS), to improve adherence to effective collaborative care within participating VISNs.

TIDES uses a population-based and patient-centered approach to care to increase the number of veterans with depression who receive optimal depression care in primary care. TIDES does this by educating primary care clinicians and by giving them access to comprehensive assessment by a trained nurse care manager.

TIDES also works to bring primary care providers and mental health specialists together.

The comprehensive assessment is critical to identifying those patients who can benefit from nurse care management. Although one in every three veterans visiting primary care has some symptoms of depression, only two-thirds of them meet criteria for possible major depression (persistent depressed mood and/or loss of pleasure); the remainder may be experiencing grief, stress, adjustment, or other transient problems affecting their mood. Others may have a distinct mental health problem, such as substance abuse or post-traumatic stress disorder. Of those patients with possible major depression, only one-half to three-quarters have depression that requires antidepressants or psychotherapy. In addition, some depressed patients in primary care are complex, with suicidality (e.g., suicide attempt, suicidal ideation), substance abuse, psychosis, post-traumatic stress disorder (PTSD), and/or anxiety disorders, which require more specialized care.

TIDES is designed to assess patients with symptoms of depression—and to distinguish from among this group those with major depression, dysthymia (less severe, persistent depression), and other psychiatric disorders, including suicidality. [Patients already known to be suicidal or otherwise in acute danger should be not referred to TIDES]. The TIDES program follows patients with major depression or dysthymia for six months after their assessment, and assures that all referred patients receive care according to their needs and preferences.

TIDES also works to bring primary care providers and mental health specialists together. Patients with major depression who do not need mental health specialty care (e.g., due to major psychiatric comorbidities, suicidality, or patient preference) are followed in primary care with support from mental health specialists and RN Depression Care Managers. Mental health specialists gain efficiency by working through the care manager to monitor and adjust treatment for an entire panel of 100 to 150 patients, using the initial and ongoing assessment of depression symptoms and treatment adherence to identify and address problems as they occur.

Developed by MH-QUERI, TIDES was designed to increase appropriate and effective mental health specialty care for veterans with major depressive disorder by:

- adapting and implementing depression collaborative care models to VA settings through evidence-based quality improvement for depression (EBQID),
- participating in the intervention,
- supporting and evaluating depression collaborative care implementation, and
- preparing EBQID methods and materials for dissemination to support further implementation throughout the VA healthcare system.

How does TIDES work?

Collaborative care begins when the primary care physician refers veterans with symptoms of depression to the Depression Care Manager, using the CPRS (computerized patient record system) electronic consultation mechanism. If the primary care physician considers the patient to be a psychiatric emergency, or if the patient is in active treatment with a mental health specialist, the patient would not be referred to the Depression Care Manager.

TIDES results show that most depressed patients without major comorbidities can be effectively treated in primary care.

Upon receiving the consult, the Depression Care Manager contacts the patient by telephone for an assessment and education session, and then mails appropriate education materials to the veteran. The assessment focuses on diagnosing major depression, measuring symptom severity and past depression history, and assessing any mental health comorbidities (i.e., anxiety disorder, substance abuse, suicidality, or PTSD). The Depression Care Manager also identifies the patient's preferences and questions about depression treatment.

The Depression Care Manager communicates the assessment to the primary care physician, who reviews the suggestions and initiates either a referral or medications, if needed. The Depression Care Manager also communicates weekly with a mental health specialist supervisor to review problematic cases and confers with TIDES faculty consultants (working through MH-QUERI) who have extensive expertise in evidence-based care for depression. For each patient's treatment plan (i.e., watchful waiting, drug therapy, or referral to a mental health specialist), the Depression Care Manager provides follow-up and assistance for the veteran, periodically assessing symptom severity, medication adherence and side-effects, as well as relapse prevention.

Is TIDES collaborative care effective and cost-effective?

The implementation of TIDES at seven demonstration clinics in VISNs 10, 16, and 23 achieved the clinical outcomes predicted by the evidence-based quality improvement (EBQI) collaborative care model. Among the first 1000 patients cared for in TIDES, implementation of the model enabled eight out of 10 depressed patients to be treated effectively in primary care. Primary care patients achieved very high levels of compliance with medication (85%) and follow-up visits (95%). Depression severity scores and functional status scores began

showing improvement after four to six weeks, and recovery at six months was 70% among primary care patients and 50% among the more severely ill veterans referred to mental health specialty treatment. Final publications discussing these outcomes are forthcoming.[3]

Although long-term outcomes are not yet available, estimates can be projected from these short-term successes based on studies that have used similar collaborative care approaches.[15-18, 19] These projections suggest outcomes will remain improved for at least two years, including improvements in treatment adherence, recovery, social and role functioning, financial status, and patient satisfaction. Because the TIDES model is similar to other models showing long-term cost-effectiveness,[12,13] TIDES may be expected to reduce system costs by:

- reducing relapse rates,
- reducing the use of sub-therapeutic or ineffective antidepressant regimens,
- providing better patient self-management through education and psychotherapy, and
- promoting better patient overall health due to improved adherence to other treatments, better health habits, and less stress. [10]

The successful implementation of a collaborative care model for depression in primary care requires organizational effort and coordinated collaboration.

TIDES results show that most depressed patients without major comorbidities can be effectively treated in primary care with mental health specialist back-up and supervision, with the most severe cases needing to be followed in specialty settings. Based on these and other results, MH-QUERI began a TIDES follow-up project, "Expanding and Testing VA Collaborative Care Models for Depression" (ReTIDES).

What organizational changes are required to implement the TIDES approach to mental health care in primary care settings?

Although they may improve quality and costs, new care models for depression can be difficult to implement, partly because they require organizational change. A recent randomized trial assessed a specific approach to help healthcare systems design and implement evidence-based care models for depression.

Investigators compared evidence-based quality improvement (EBQI) depression care to usual depression care for 567 patients (369 EBQI and 198 usual care) with major depression at six Kaiser Permanente and three VA primary care practices. Primary care practices in the EBQI group received:

- manuals,
- key senior leader goals for depression care,
- depression care model tool kit, and
- articles on effective care models for improving depression care or changing provider behavior.

Outcomes were measured at six and 12 months among randomly selected patients. The EBQI approach had perceptible but modest effects on practice performance: Patients in EBQI practices showed a trend toward more appropriate treatment, more satisfaction with their participation in care, and better social functioning than those in usual care.[22]

The successful implementation of a collaborative care model for depression in primary care requires organizational effort and coordinated collaboration. Ongoing clinical and research partnerships are critical to ensuring long-term sustainability. Clinicians and care managers need to be educated about depression care, collaborative care, and information technology (IT) support. Depression care managers need to be instructed in the use of CPRS and VistA® (Veterans Health Information Systems and Technology Architecture) tools that can support their role as care managers, and in the clinical management of complex mental health issues, such as suicidality.

Several key elements are needed to successfully implement a collaborative care model:

- effective collaborations,
- effective depression care managers, and
- appropriate use of information technology.

Building Effective Collaborations

Collaboration between the care manager, primary care provider, mental health specialist, and patient is the key to clinical success; however, implementation of this team approach requires participation of individuals at various levels within the healthcare system. Collaboration and buy-in starts at the highest leadership levels and must take resources and priorities into account. A clear understanding between service lines regarding roles and responsibilities helps keep the project on track throughout its various implementation stages.

The TIDES project has produced tools to help anticipate the roles of different levels of the system. The TIDES Project Charter and Deliverables illustrates all of the clinical, administrative, and support services required to successfully implement TIDES. The Intervention Design Preference Questionnaire (IDPQ) identifies network and medical center leaders' preferences for initial design specifications for how the program will be implemented and with what resources. Ratings of the importance and feasibility of each possible program component and implementation option are useful starting points for a discussion among decision-makers. A sample of the TIDES Project Charter and Deliverables, and the Intervention Design Preference Questionnaire are available on a VA intranet site called SharePoint (http://vha22web6/sites/Research/HSRD/ClinicalPart/default.aspx). First-time users can learn to navigate the site by clicking on "What is SharePoint?", and "Where can I find the Site Map?"

Key positions for successful clinical collaboration among the care provider team include:

1) A **primary care leader** (or champion) who ensures collaboration between primary care and specialty mental health. The primary care leader monitors program productivity and outcomes. He or she ensures the education of mental health specialists and primary care

providers in the TIDES care model. PowerPoint slide presentations have been developed for provider education and can be found on the SharePoint site.

2) A **mental health leader** who ensures collaboration with primary care, as well as clinical supervision of care managers by mental health services. He or she provides the initial education and orientation of new staff, and provides clinical updates for mental health specialists and primary care physicians regarding depression care policies.

3) A **nursing leader** who ensures integration of care managers into nursing service, as well as primary care and mental health. The nursing leader administratively supervises care managers and solicits DCM performance feedback from mental health and primary care.

Effective Depression Care Managers

Depression care management can be achieved with nurses, social workers or pharmacists in the role of depression care manager. Below, nurse depression care managers and alternative approaches are discussed in greater detail.

Nurse Depression Care Managers: Nurses have been studied most frequently as care managers and are well-equipped for the role. Their backgrounds in physical health, medication management, patient education, and their collaboration with physicians and/or nurse practitioners give them broad expertise. Care managers with mental health backgrounds require less training in mental health issues, but they must be comfortable with a management as opposed to a therapy role in their patients' care. Experienced primary care nurses can be equally effective, but require more mental health training and supervision during start-up.

Effective depression care managers must be proficient at:

- working with primary care and mental health specialist clinicians,
- following patients with varying levels of depression-related symptoms, and
- educating patients toward self-management.

Care managers work within primary care, mental health, and nursing, thereby filling the gaps that exist between these services.

The target population for Depression Care Managers consists of patients in primary care with newly identified symptoms of depression, who do not have symptoms indicating a psychiatric emergency, and who have a telephone. Even depressed patients who do not fit these criteria benefit through enhanced access to mental health services, greater depression awareness in primary care, and proactive policy and educational development.

A great strength of nurse care managers is the patient education emphasis they bring to their roles. Care managers teach patients about depression, its symptoms, treatments, and treatment side effects, during the initial and follow-up assessments. They also engage patients in self-help activities to help them become activated and involved in their own care. Patient education and self-help are critical to sustaining benefits over time.

Social Workers or Pharmacists as Care Managers: There is less research on social workers or pharmacists as depression care managers, although clearly, adding the skills of each of these disciplines to the team can be very valuable. Social workers will require more training and support in medication monitoring and use than will nurses or pharmacists. On the other hand, pharmacists will require more training in mental health-specific issues (e.g., role of therapy) and may or may not have training in patient education/activation outside of medication use.

Information Technology

The information technology (IT) support needs for collaborative care among primary care providers and specialists are similar for depression care and for other chronic conditions (e.g., diabetes). An expert panel convened as part of an ongoing MH-QUERI project—Creating HealtheVet Informatics Applications for Collaborative Care (CHIACC)—cited the following important elements of effective IT support:

- the ability to track a panel of patients with specific disorders and identify next steps in clinical care for each patient in the panel.
- decision support at point-of-care for medication dosing and other clinical treatment decisions.
- context-specific prompts to help providers track and prioritize tasks during the clinical encounter.
- the ability of patients to enter patient-reported data (e.g., symptoms).
- a comprehensive treatment plan that is available through the medical record to all members of the treatment team, including the patient and family caregiver(s);
- secure messaging among team members.
- the ability to summarize in real-time the quality of depression care at the patient, provider, and practice levels.

VA VistA is currently one of the best electronic medical records (EMR) available. However, supporting collaborative care will require enhancing what is currently a documentation-oriented system to allow sophisticated methods of combining and displaying information across patients and care teams.

Different depression collaborative care models (3CM, IMPACT, BHL, and TIDES) have taken somewhat different paths to improving IT support, depending on the care model and the environment in which it was implemented. The most important distinctions include:

- whether the IT system is stand-alone or integrated within a more comprehensive EMR;
- who the intended users are, what degree of decision support is available; and
- whether provision is made for patients directly interacting with the system.

The TIDES approach has been to work to enhance existing features of VistA. Enhancement modules have been developed and are available to interested VA practices. However, these enhancements are limited by the underlying structure of VistA. Conversely, IMPACT

and BHL have developed stand-alone software that facilitates input and organization of information, at the cost of not being part of the comprehensive electronic medical record.

Just as VA is undertaking comprehensive MyHealtheVet development to enhance the ability of veterans and involved family and caretakers to be full partners in their care, further enhancements of the EMR will be necessary to combine the strengths of the current depression collaborative care IT approaches.

What can VISNs do to promote evidence-based models for treating depression in primary care settings?

Research has shown that collaboration between primary care clinicians and mental health specialists is necessary for better depression care outcomes.

Research has shown that collaboration between primary care clinicians and mental health specialists is necessary for better depression care outcomes. Institutionalizing primary care/mental health collaboration across participating clinics within individual VISNs may benefit from creating a VISN leadership group that includes, for example:

- lead nurse manager
- depression care manager
- lead mental health specialists
- primary care physicians and
- representation from one or more individual medical center leaders.

The Leadership Group might meet monthly by conference call to develop strategic plans, oversee implementation of collaborative care principles, and identify and resolve implementation barriers. The VISN-level Lead Care Manager is chosen to oversee and standardize care management procedures for depression care managers working at participating VISN clinics.

The collaborative care model can be implemented in Plan-Do-See-Act (PDSA)[23] cycles within the VISN, which might start with a single medical center and clinician and rapidly cycle to include all medical centers and all clinicians over a one- or two-year period. All patients referred to care management could be entered into a database suitable for generating clinical reports, and the evaluation data managed by a designated 'data monitor.' These data could guide quality improvement (QI) decisions for modifications to be implemented in subsequent PDSA cycles until the implementation is fully achieved with optimal patient outcomes.

Steps for implementing TIDES at the VISN level

The initial steps VISNs might take in implementing TIDES include the following:

Step 1: Preparation. Identify one mental health, one primary care, one nursing, and one administrative leader within the VISN who can take leadership roles in designing

and implementing the model. This group identifies funding sources for the program and convenes a larger group (e.g., 10 leaders from sites within the VISN) as a steering committee for it.

Step 2: Design. With support from experts, the steering committee reviews the evidence base to determine and develop a summary of basic program features. The committee also identifies one to three demonstration locations and initiates PDSA cycles beginning with one and increasing to two or three clinicians per site to test and refine the program in these sites. Attention to the information technology features is critical in this phase, and should involve local information technology staff including computer applications coordinators.

Step 3: Full implementation and spread. When initial PDSA cycles have stabilized with a few clinicians, intensive efforts should be undertaken to ensure penetration throughout the primary care clinicians at the site. Moreover, the percentage of referring clinicians should be tracked regularly. This will require marketing by care managers and program leaders (champions). Spread to additional sites can begin with the initiation of regular (e.g. weekly) across-site conference calls to identify problems and begin the process of cross-training and problem-solving.

Step 4: Identify and institute the full range of data monitoring, policy changes, and program support required to maintain the program over time.

Conclusion

Major depression is currently the leading cause of disability in the United States, and by 2020 it is projected to be the leading cause of disability worldwide. Moreover, depression is the second most prevalent, chronic, disabling, and costly illness in VA healthcare settings, and also is prevalent among veterans with other chronic mental and physical illnesses. Most VA patients with depression are cared for principally in primary care clinics. Collaboration between primary care and mental health, including screening and assessment to identify the condition, symptom monitoring to guide treatment, and brief care management are essential to effective treatment and improved outcomes.

This Primer offers evidence of the success of collaborative care for depression in the primary care setting, particularly through VA's Translating Initiatives for Depression into Effective Solutions (TIDES) project. VA is working to further this effort through VA's Mental Health/ Primary Care Integration Initiative, which began in 2006 and aims to implement improved mental health care models, including TIDES, in all 22 VISNs.

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Appendix A: Glossary

Champion (or primary care leader): A technique used as a translation intervention that involves enlisting esteemed peers to encourage the desired behavior. Clinical champions often are active promoters of a best practice.

Collaborative Care for Depression: An evidence-based collaborative approach to depression management that creates linkages across primary care and mental health via a depression care manager, or other healthcare professional, who facilitates treatment between patients and providers.

Depression Care Manager: The depression care manager assesses and educates patients with depression, and follows up with patients and providers between primary care visits to optimize treatment effectiveness.

Dissemination: An active effort to communicate tailored information to target audiences with the goal of engagement and information use. Dissemination is an integral part of the process of implementing an evidence-based intervention.

Evaluation: The rigorous, systematic analysis of the degree to which targeted implementation goals have been met, consisting of two types:

- Summative evaluation: a systematic assessment of the degree to which the finding or product affected outcomes, the degree to which desired outcomes have been achieved, and/or an assessment of cost-effectiveness.
- Formative evaluation: an analysis of discrepancies between the implementation plan and its realization, and the monitoring of progress indicators.

Evidence: Best practice findings and/or consensus of national experts. The source, scientific basis, and thus credibility/generalizability of evidence can vary and is referred to in terms of its strength.

Evidence-Based Best Practice: Evidence-based findings regarding an appropriate diagnostic approach, therapeutic treatment/regimen, or delivery system. Findings should be well established to be "best practice."

Facilitation: A technique used as a translation intervention that involves actively promoting adoption of best practice recommendations. Facilitation roles can be both internal and external to the setting of change.

Guideline: Comprehensive evidence- or expert opinion-based guide to appropriate care for a particular condition.

Implementation: Efforts designed to get best practice findings and related products into use via effective change strategies. Implementation typically follows dissemination; multiple strategies tend to be more effective, and successful implementation includes the identification of facilitating factors as well as barriers.

Intervention: A single method or technique to facilitate change and, thereby, adoption of best practice recommendations. Interventions can be categorized as social interaction/norm/behavioral, knowledge/educational, or functional/organizational.

Major Depressive Disorder: A mood disorder characterized by the occurrence of one or more major depressive episodes and the absence of any history of manic, mixed, or hypomanic episodes. Major depression may be diagnosed when five or more symptoms of depression are present for at least two weeks. These symptoms include feeling sad, hopeless, worthless, or pessimistic, and can lead to social and occupational dysfunction.

Appendix B: Suggested reading materials

What reading materials are available to provide more information on mental health care for depression?

Depression has been the subject of numerous publications, from entire books and journals devoted to the topic to individual articles and literature reviews. The list below provides a comprehensive, but by no means complete, guide to a variety of published articles and journals on depression, including collaborative care.

Books

1. *How You Can Survive When They're Depressed* by Ann Sheffield (Harmony Books, 1998).

Ms. Sheffield describes, stage by stage, how individuals with depression affect others around them.

2. *More Than Moody* by Harold Koplewicz, M.D. (G.P. Putnam's, 2002).

The author, a leading child psychiatrist, provides advice on treating depression in the young, drawing on anecdotes from his practice.

3. *The Peace of Mind Prescription* by Dennis Charney, M.D., and Charles Nemeroff, M.D. (Houghton-Mifflin, 2004).

Physician authors dispel some of depression's mysteries and provide extensive evaluations of various drugs and therapies.

4. *Undercurrents: A Therapist's Reckoning With Her Own Depression* by Martha Manning (HarperCollins, 1994).

Martha Manning, a practicing clinical psychologist, was struck by major depression. This book describes her experience with this illness.

5. *Against Depression* by Peter D. Kramer (Viking, 2005).

Dr. Peter Kramer, the author of "Listening to Prozac," provides news from top research scientists about the causes of depression and treatment.

6. Beating Depression: The Journey to Hope by Maga Jackson-Triche, Kenneth Wells and Katherine Minnium. (UCLA, NPI Health Services Research Center, 2002).

The authors discuss treatment options and practical coping skills.

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Appendix C: Resources

What resources are available for those interested in learning about depression and/or treatment for depression?

Visit the following websites for more information about depression and various treatments for this chronic and common mental illness.

American Psychiatric Association: www.psych.org/ .

Center for Mental Health Services: http://mentalhealth.samhsa.gov/ .

Depression and Bipolar Support Alliance: www.dbsalliance.org/ .

National Institute of Mental Health: www.nimh.nih.gov/ .

National Mental Health Association: www.nmha.org/ .

To learn more about **TIDES**, visit the TIDES intranet website at vaww.gla.med.va.gov/tides (not available from outside VA). The website provides links to TIDES tools and training.

Collaborative Care for Depression in the Primary Care Setting. A Primer on VA's Translating Initiatives for Depression into Effective Solutions (TIDES) Project is available in electronic and print formats. Additional copies may be obtained from the sources listed below.

Electronic copies (PDF format) can be downloaded from the VA HSR&D web site. Point your browser to:
http://www.hsrd.research.va.gov/publications/primer/

Print copies may be requested from:
CIDER
VA Boston Healthcare System (152-C)
150 South Huntington Avenue, Building 9
Boston, MA 02130
Email: cider.boston@va.gov

Other Primers in the series include:

Primary Care in VA
Health Technology Assessment in VA
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