By Diane Fraser

The Depression Initiative: An Alliance to Improve Treatment

The Depression Initiative is a national alliance of Kaiser Permanente (KP) researchers, clinicians and external agencies that establishes a mechanism for soliciting and funding innovative research that can be used to influence clinical practice and improve how depression is diagnosed, treated, and prevented. With funding from the Garfield Memorial Fund and external sources, the Depression Initiative will support research into new models of care, assessment and outcomes measurement, access to care, special populations, member satisfaction, and cost-effectiveness. The Care Management Institute (CMI) will facilitate national dissemination of project results that have the potential to distinguish KP as a leading provider of mental health care.

The Issue and the Potential

Research and clinical practice could be called two sides of the same coin, both important aspects of medicine. Too often, however, rigorous and valuable research does not have an appreciable effect on clinical practice. Outcomes measurements and screening information do not always influence the delivery of care. The promise of scientific research to inform the practice of medicine has not fully materialized. Grayson Norquist, MD, MSPH, Deputy Division Director and Associate Director of Services and Research at the National Institute of Mental Health, Division of Epidemiology, has noted that "managed care needs to build a strong research infrastructure inside its own organizations. Without the interface between researcher and provider, research findings can't be used effectively to improve clinical practice."

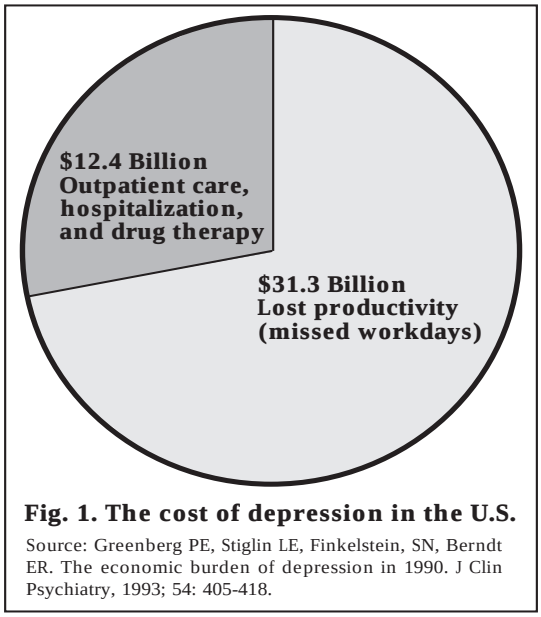

Fig. 1. The cost of depression in the U.S.

Source: Greenberg PE, Stiglin LE, Finkelstein, SN, Berndt ER. The economic burden of depression in 1990. J Clin Psychiatry, 1993; 54: 405-418.

The Depression Initiative, a national alliance of Kaiser Permanente (KP) researchers, clinicians and external agencies, is a model that seeks to build that infrastructure. KP is in a unique position to create a model whereby research is used effectively to inform clinical practice and management decisions. In a single organization, KP brings together the discipline of research, clinical practice, and the expertise of mental health specialists. Directed by Enid M. Hunkeler, Senior Investigator in the Division of Research and codirected by Arne Beck, PhD, Research and Development Director in the Rocky Mountain Division, the Depression Initiative establishes a mechanism for soliciting and funding innovative research that will have an impact on the recognition, treatment, and prevention of depression.

The artwork in this article was taken from The Depression Initiative informational pamphlet; copyright 1998, Kaiser Permanente

Depression was selected as the focus of the alliance because it is eminently treatable. It also is prevalent and carries a high cost to individuals and to society. Nationwide, 18 million people have depression, with a prevalence of three to five percent in the general population.[1] In addition to the cost in human pain and suffering, the economic toll is significant. Of the total estimated cost of $43 billion, $31.3 billion is attributed to lost productivity; another $12.4 billion is direct treatment cost.[2]

These costs are influenced by how depression care is delivered. Increasingly, patients with depression and other mental health problems are being treated by primary care providers. Estimates are that only 20% of depressed patients are treated in the mental health care setting. (Dea, R MD, personal communication, 1998.)* While this approach produces savings in health care costs, it also has led to a decline in the quality of outcomes,[3] and therefore has had little positive impact on the broader social, economic, and personal cost of depression.

"Across all of our Divisions, researchers are doing important work on all aspects of depression, and clinicians encounter a steady flow of depressed patients in their practices," Enid Hunkeler said. "We need to ensure that the research findings reach clinicians in ways that will inform their practices and improve the quality and effectiveness of the care they deliver. The Depression Initiative has the potential to bridge that gap."

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Speaking as a mental health care practitioner, Howard Gould, MD, Chief of Mental Health in Georgia, noted that clinicians in all disciplines are more aware of depression and of the shortcomings in how it is treated. "Increasingly, clinicians are coming to realize just how often they treat a patient's somatic complaints without fully probing for underlying depression. This leads to misdiagnosis and often, inappropriate treatment and use of medical services. The Depression Initiative is an exciting opportunity to work with our colleagues nationally and across disciplines to improve how we detect and treat depression."

According to Dr. Norquist, "The Depression Initiative brings together researchers, clinicians, employers, consumers and advocates in a collaborative arrangement that will benefit all stakeholders."

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Creating the Depression Initiative

In May 1997, during the HMO Research Network meeting in Boston, a group of researchers, psychiatrists, psychologists, social workers, primary care physicians and administrators from all KP Divisions and Regions met to discuss the current state of diagnosis, treatment, outcomes measurement, and research on depression in the Kaiser Permanente Medical Care Program. Participants from throughout the Program made presentations and discussed issues related to depression care, current goals, successes and failures, and what they hoped would result from future interdivisional collaboration.

"From the very beginning, there was a clear desire to construct a national platform from both the research and implementation perspectives," said Dr. Beck.

The meeting was planned to coincide with the establishment of The Permanente Federation, unifying all of the Permanente Medical Groups in a single national governance entity. "The Depression Initiative is one of the first manifestations of our new national approach to research and clinical practice," said Jed Weissberg, MD, Federation Associate Executive Director, Quality and Performance Improvement. "We have tremendous talent, influential research centers, and pockets of clinical practice scattered across the organization. What we can offer now is a coherent strategy and sense of purpose to these individual efforts. The Depression Initiative is one example of how much more effective we can be when we think and act in pursuit of a shared goal."

Attendees of the Boston meeting crafted a research agenda centered on common themes. They agreed that the Depression Initiative, as funding allowed, would seek to support innovative projects that maximized opportunities for interdivisional collaboration. The Initiative would encourage proposals from Divisions with developing research capabilities, and from less-experienced researchers and clinicians, as well as those from seasoned researchers in Divisions with well-established research centers.

Developmentally, the backers of the Depression Initiative were ready to take the next step—securing financial support and a way to coordinate the effort on a national level. Their first stop was the Garfield Memorial Fund.

The Role of the Garfield Memorial Fund

The Garfield Memorial Fund (GMF), established in 1986, honors the memory of Sidney Garfield, MD, the physician cofounder of KP. Its mission is to support research that has system-wide implications for improving the quality of care, enhancing efficiency, and reinforcing member loyalty.

The GMF had previous success in focusing its resources on a single topic. Over a three-year period in the early 1990s, in collaboration with the Interregional Committee on Aging, a collection of nine research projects on health care for the elderly were funded and supported by GMF. The $2.5 million effort also included funding from five participating KP Divisions. Examples of practice innovations generated from the Elderly Initiative include the Medicare II Screening Form and the introduction of a team approach to geriatric care in the Rocky Mountain Division. The Elderly Initiative also was the catalyst for the Geriatrics Institutes, a forum where geriatricians, clinicians, and researchers meet annually to share best practices and to further their understanding of how best to care for this growing segment of the population.

Edward Thomas, RN, MBA, Director of the fund, participated in the Depression Initiative organiza-

tional meetings. He called the Depression Initiative "almost tailor-made" for GMF's new strategic direction—to integrate research directly into the clinical and health services needs of the organization. "Our relationships with researchers and clinicians across all Divisions give us a good grasp of what the issues are," he noted. "The majority of the research we fund originates with front line clinicians, who might not otherwise have an opportunity to participate directly in research. We examine their ideas from an objective perspective, taking into consideration KP's mission and strategic direction. Then we provide funding, administrative support, and coordinate with groups like the CMI to disseminate and implement the results." As evidence of its enthusiasm for the project, the GMF committed $575,000 to get the Depression Initiative's research grant effort underway.

Research Grants and Other Efforts

As approved by the Depression Initiative Working Group[4], a Request for Applications was issued to attract applications "aimed at developing new, innovative practices, outcomes data acquisition techniques, or patient screening and assessment methods in depression care." The Working Group also hoped that this RFA would "encourage the development of research capabilities in mental health services among emerging Divisions." Dr. Beck explained that "we hoped to elicit proposals that, if successful, will be appropriate for dissemination across the Divisions. We wanted projects that have the potential to make KP a leader in depression care."

Although important, the research grants are only a part of the Depression Initiative. Other projects include KP partnerships with industry, a Quality Improvement Project conducted jointly by The HMO Group and six KP Divisions, and support for National Depression Screening Day. Separate projects are funded by the KFHP Eldercare Initiative, targeting special populations, including women, seniors, and disabled people.

In January, the RFA was distributed to 1,000 clinicians and researchers and was put up on the CMI Internet site (www.kpexchange.org). Forty-five preliminary proposals were submitted within the one month allowed for responses. As hoped, each Division was represented.

Twenty-seven reviewers—17 scientists and 10 clinicians—reviewed the preliminary proposals. External reviewers included professors from the University of California San Francisco Medical School and the University of Washington, among others. Internal reviewers included researchers and clinicians, the six KP Divisions and members of the Depression Initiative Working Group.

"I was impressed with the variety of topics presented, as well as with the thought and preparation that went into the proposals in a relatively tight time period," said Dr. Beck. "I can foresee a lot of difficult choices ahead of us."

The first of those decisions was made by the Depression Initiative Steering Committee and the GMF Board in April, when they selected 25 preliminary proposals to be developed into full proposals for the initial funding cycle (See Table One). Funding decisions will be made when the Board meets again in July. The number of projects funded will depend on individual budgets and the amount of matching funding available.

Six Areas of Focus

Proposals are being developed in all six of the Depression Initiative areas of focus:

New Models of Care

The proposals submitted investigate integrating behavioral health with adult primary care; targeting patients at risk for relapse; matching treatment intensity with patient severity; and employing primary care nurses and/or peer support in depression treatment. "We need to know more about how to recognize depression in situations other than the psychiatrist's office," said Robin Dea, MD, Regional Chief of Psychiatry Chiefs in Northern California. "The primary care setting is one obvious place, since that's where the vast majority of our members receive care. But we need to widen our scope to look at the workplace and community settings, as well."

Several proposals in this area focus on integrating depression care into ongoing disease management treatment programs for other conditions, such as diabetes and coronary artery disease. Dr. Beck uses the analogy of a physician taking "social and emotional vital signs" along with blood pressure level and heart

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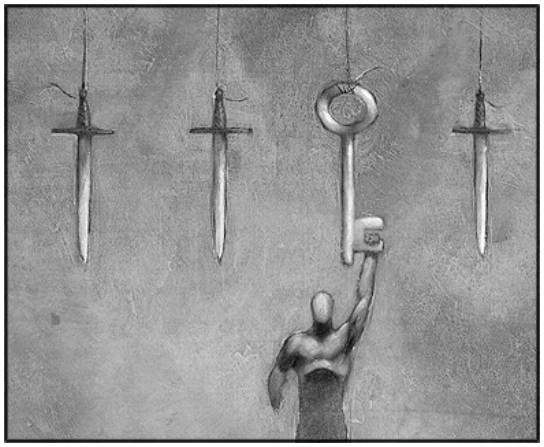

rate, as an example of what might become standard practice in this area.

Access to Care

Projects in this area might examine how to identify and remove barriers to care, encourage patients to seek treatment, and facilitate adherence to treatment plans.

Assessment and Outcomes Measurement

Screening procedures; the efficacy and feasibility of systems of outcomes measurement; innovative assessment tools and methods; and new measures of health plan performance in treating depression are examples of the type of research that could be done in this area.

Medicine is moving into a new era of mental health care, according to Dr. Dea. "In the past, we've been something of an unwanted stepchild, in part because physicians weren't convinced that psychotherapy was efficacious. Three developments are changing that perception. The first is the switch to more cognitive and transpersonal treatment options. Second is the explosive improvement in medications that work better with fewer side effects. The third development, which underlies the first two, is the existence of research that measures our outcomes in terms of clinical and functional improvement," she said.

Member-focused Programs

Promoting member satisfaction and loyalty is a particular interest of the GMF. In treating an illness like depression, the patient's willingness and ability to participate fully and adhere to the treatment program are critical for treatment success and for patients' ultimate satisfaction with their care. Introducing techniques like shared decision-making may have a positive impact on that experience.

Special Populations

Children, adolescents, people of color, and older members are among those with special needs. Research shows that depression occurs in approximately one percent of children prepuberty, increasing to three percent in adolescents. However, if anything, underdiagnosis is even more of a problem with children and adolescents than among adults.

"Often, very young children don't have the vocabulary to articulate how they feel emotionally or even physically in many cases," said Gregory Clarke, PhD, of the Center for Health Research. "Unless parents are exposed to the warning signs of depression, it seldom occurs to them that their child may be depressed. With older children and adolescents, their behavior is too often written of as 'just a phase.' Since we know that having an episode of depression at any age is the number one indicator of a recurrence later in life, it's worth spending the time and effort to diagnose and treat depression in this vulnerable age group."

Cost-effectiveness

Proposals would compare different treatments; examine pharmacologic and adherence studies; and determine appropriate cost offsets. Depression is costly from the health plan perspective, in terms of inpatient and outpatient care and pharmacological costs. In Northern California, the average length of stay for a depressed patient in 1996 was 4.3 days.[5] Depressed patients also are well documented for having a high rate of using outpatient services. Research and innovation in these areas, as well as the effective use of pharmacological resources, have the potential to point the way toward an effective allocation of resources for the best care.

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Alliances and Collaboration

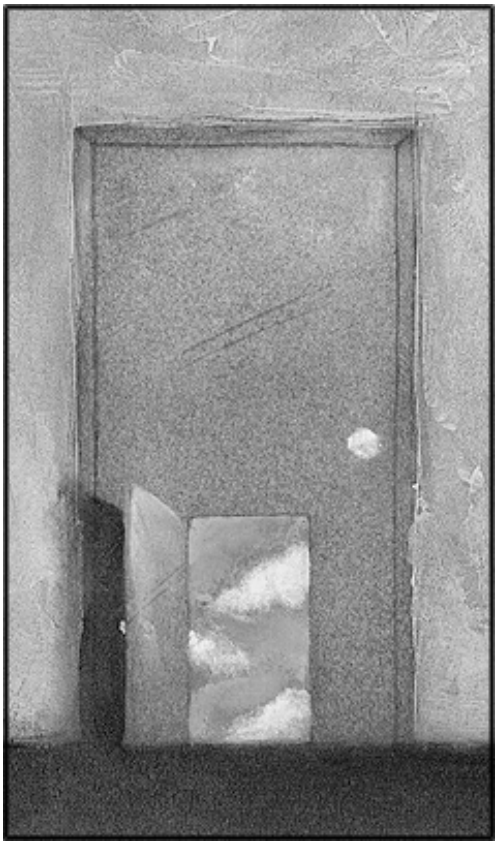
While research results are important to the Depression Initiative, influencing the process of innovation is equally important. The Depression Initiative seeks to eliminate duplicative research and to promote interdivisional cooperation. The Initiative encourages Divisions with well-established research capabilities to partner with Divisions whose research infrastructures are less well developed. These alliances strengthen both KP research capabilities and its national identity.

Other alliances will be in the academic area. In the Southeast Division, a consultant from Emory University worked with KP clinicians to develop a proposal on "Treating Depression in Primary Care: Depression and Diabetes Project." "We're excited at the prospect of enlisting the support of local university-based Mental Health Services researchers in mutually beneficial relationships," Dr. Beck said.

The Depression Initiative Steering Committee, a group of distinguished researchers, clinicians, and industry experts is itself a bridge to credible and fertile external perspectives. Founding members of the Steering Committee are: Director Enid M. Hunkeler and Codirector Arne Beck, PhD; Mary Jane England, MD, President of the Washington Business Group on Health; Michael M. Faenza, MSSW, President and CEO, Na-

Preliminary proposals selected for possible funding in the Depression Initiative		
Topic	**Proposal**	**Region**
New models of care	Improving the Cost-effectiveness and Time Efficiency of Antidepressants in a Managed Care Setting	California
	Group Therapy for Patients Participating in a Congestive Heart Failure Case Management Program	
	Developing an Innovative Depression Intervention Program for Members Seen in Primary Care who Exhibit Symptoms of Depression and/or Receive Antidepressants from their Primary Care Provider	
	Team Treatment of Depression in Primary Care	
	Comparative Study of Treatments of Depression in Primary Care: Usual Care, Group Therapy Augmentation, Case Management Augmentation	Hawaii
	Primary and Secondary Prevention of Depression (pilot project)	Northeast
	Develop Telephone-based Support for Primary Care Treatment of Depression	Northwest
	A Randomized Trial of a World Wide Web	
	Treating Depression in Primary Care: Depression and Diabetes	Southeast
	Early Detection and Treatment of Depression Among Cardiac and Diabetic Populations	
	Screening for Depression in Adolescent Care	
	Cardiac Care and Depression	
Assessment and outcomes measurement	Intervention for Screening Follow-up of Postpartum Depression in Pediatrics	California
	FACCT Screening Regarding Effective Treatment of MDD in Adults	
	Improving Detection, Treatment, and Care of Depression in Cardiac and Diabetic Patients and Their Families	Northeast
Access to care	A Proposed Measure of Access to Depression Care in Kaiser Permanente	California
Member satisfaction	Impact of Shared Decision-making on Treatment of Depression	Rocky Mountain
Special populations	The Southern California Geriatric Screening Instrument Used to Identify Depressed Members	California
	Telephone Intervention to Reduce Stress and Depression in the Caregivers of Members with Dementia and Other Chronic Illness	
	Preventive Mental Health Collaboration between Managed Care and School Health Programs	
	Examining the Impact of an Integrated Service Delivery Model of Care on the Assessment and Treatment of Childhood Depression in a Pediatric Setting	
	Burden of Undiagnosed Depression on Families Served in a Pediatric Setting	
	Impact of a GrandCare Program on Depression in Mid-Atlantic States Region	Central East
Cost-effectiveness	Improve Cost/Time Efficiency of Anti-Depressants in Managed Care	California
	A Randomized Trial of Two Group Programs for Treating Depression	
These 25 proposals were selected from a pool of 45 preliminary proposals to be developed as full proposals for funding consideration by the Garfield Memorial Fund as part of the Depression Initiative.		

tional Mental Health Association; Robin Dea, MD, Regional Chief of Psychiatry Chiefs, Northern California; Neil Handelman, MD, The Permanente Medical Group, Hayward; Scott Beardsley, PhD, Georgia Permanente Medical Group; Michael Mustille, MD, Director, Employee Relations, The Permanente Federation; and Lynne DeGrande, ACSW, CEAP, General Motors Employee Assistance Program, Detroit. When complete, the Steering Committee also will include representatives from advocacy, consumer, employer, and labor groups.



These outside perspectives are important in ensuring that the Initiative's efforts will be accepted by members and purchasers. "In recent years, large employers have come to recognize both the significant impact of clinical depression on workforce health and productivity, and the high treatment effectiveness rate for depression," said Mary Jane England, MD and President of the Washington Business Group on Health. "But improvements in depression recognition and management are needed to realize the promise of depression treatment. I applaud Kaiser Permanente's leadership with the Depression Initiative and am pleased to serve on the Steering Committee."

Financial Alliances

The Depression Initiative is actively seeking outside funding. To date, Eli Lilly and Company, SmithKline Beecham, Pfizer, and Bristol Meyers have contributed substantially. Funding for research from pharmaceutical companies is not a new tactic. "Past funding from pharmaceutical companies generally has been piecemeal. Often, Divisions competed with each other for a limited pool of resources. Asking for financial support for a nationwide effort will allow us, and the pharmaceutical industry, to channel funds more effectively," said Edward Thomas. "Kaiser Permanente will be the sole judge of the research's value, safety, and appropriateness for our members and providers. The pharmaceutical companies will benefit from being acknowledged for their support in improving the quality of care for patients with depression."

From Incubation to Implementation

The creators of the Depression Initiative are especially interested in projects that, in addition to innovative thinking, have the potential for quick turnaround of results and broad dissemination throughout KP. "Kaiser Permanente has two strategies for improving care. One is the Care Management Institute, which implements and disseminates evidence-based guidelines and models of care. The second is disseminating innovation. The two strategies allow us to implement both the tried and true, and to stay on the cutting edge of what is new, developing, and future-oriented," said Enid Hunkeler.

While the Garfield Memorial Fund serves as the research "incubator," the CMI is the logical source for disseminating evidence-based best practices identified through the Depression Initiative. CMI's Board of Directors targeted depression as one of the three illnesses (along with coronary artery disease and congestive heart failure) for the development of practice guidelines in 1998. These conditions were chosen, according to Neil Solomon, MD, CMI Clinical Strategies Consultant, because all "offer opportunities to improve the care we deliver by filling in gaps and developing a consistent approach. They also have high prevalence and clinically significant impacts on health status, touching the lives of a large percentage of our membership."

By participating in the review of preliminary proposals, CMI started early to lay the groundwork for later implementation of successful Depression Initiative projects. "We looked at the proposals from two perspectives: population management and the long-term prospects for implementation across the program," Dr. Solomon added. "What ultimately is implemented, of course, depends on the quality of the results received. But judging from the proposals, we will have

significant opportunities to improve how we identify patients with depression, to enhance our ability to stratify the population of depressed patients into appropriate subpopulations, and to match the best care to each." The end results could include practice guidelines and protocols, computer-based registries and other innovations to improve the quality of treatment for depression and reduce associated health care costs.

If the Depression Initiative reaches its full potential, the implications are significant. Dr. Neil Handelman, an internist at the Hayward Medical Center in California and a member of the Depression Initiative Steering Committee, hopes people one day "will automatically connect Kaiser Permanente with the best treatment for depression, the way DeBakey in Texas comes to mind when they think about heart surgery."

That vision echoes one of KP's strategic objectives. "In virtually everything we do, our goal is to differentiate Kaiser Permanente in the marketplace," Dr. Weissberg concluded. "The Depression Initiative has the potential to help us do that in a very important arena—the diagnosis and treatment of a disease that touches millions of lives. It also demonstrates a model for research and implementation—using the GMF, other funding resources, and the CMI—that we hope to use again."

Progress toward that objective will be reported in future issues of *The Permanente Journal*. For more information about the Depression Initiative, please contact Enid M. Hunkeler in the KP Northern California Division of Research at (510) 450-2151 or Arne Beck, PhD, in the Rocky Mountain Division at (303) 344-7347. ❖

* *Department of Psychiatry, Kaiser Permanente Medical Center, Redwood City, California.*

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2. Greenberg PE, Stiglin LE, Finkelstein SN, Berndt ER. The economic burden of depression in 1990. J Clin Psychiatry, 1993; 54:405-418.
3. Sturm R, Wells KB. How can care for depression become cost-effective?, JAMA 1995; 273:51-58.
4. As of April 1998, members include, from Georgia: Dennis Tolsma, MPH, Howard Gould, MD, Carole Gardner, MD; Hawaii: Wayne Levy, MD, J. Marc Rosen, MD, MPH; Mid-Atlantic: Patricia Greenfield, RN, DNSC, Timothy Sitts, MD; North Carolina: Peter Hampton, PhD, Abigail Panter, PhD; Northeast: Dierdre K. Lewin, MA, Joel Feinman, PhD, Bill Reidy, CSW; Northern California: Michael Getzell, MD, Bruce Fireman, MS, Richard Silver, MD; Southern California: Dennis Cook, MD, Anthony Radcliffe, MD; Northwest: Gregory Clarke, PhD, Mark Leveaux, MD, Kirk Strosahl, PhD; Ohio, Avtar Saran, MD, Laura Abood, PhD, Catherine Wild, PhD; Rocky Mountain: Steve Drozda, PhD, Carolee Nimmer, PhD.
5. Inpatient Utilization Statistics, January 1, 1997-June 1, 1997, Department of Quality and Utilization, Kaiser Permanente California Division- Northern, November 29, 1997.

Objects in the Rearview Mirror

If life is just a highway,
then the soul is just a car,
and objects in the rearview mirror
may appear closer than they are.

Meatloaf
Bat out of Hell 2; MCA Records