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# Overview of the Kit and the *Partners in Care* Study

## Organization of the Kit

**T**he kit, *Partners in Care: Improving Quality of Care for Depression in Primary Care*, is organized in five units. The components in each unit are priced separately and can be ordered separately. In addition to the materials in the kit, other materials are available as indicated on the price list. The units and their components are listed below.

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### Unit 1: Introductory Materials

- *Improving Depression Outcomes in Primary Care: A User's Guide to Implementing the Partners in Care Approach*, Lisa Rubenstein, MR-1198/15-AHRQ, 2000.
- Research Highlight: “*Partners in Care: Hope for Those Who Struggle with Hope*,” RB-4528, 2000.
- “Quality of Health Care for Primary Care Patients with Depression in Managed Care” (article describing the quality-improvement programs, reprinted with permission from *Health Affairs*).

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### Unit 2: Training Materials

*Training Agendas and Materials for Expert Leaders, Depression Nurse Specialists, and Psychotherapists*, Lisa Rubenstein, Jürgen Unützer, Jeanne Miranda, Maga Jackson-Triche, Katherine Minnium, and Kenneth Wells, MR-1198/13-AHRQ, 2000.

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### Unit 3: Materials for Primary Care Physicians and Nurses

- *Clinician Guide to Depression Assessment and Management in Primary Care*, Lisa Rubenstein, Jürgen Unützer, Jeanne Miranda, Wayne Katon, Manhal Wieland, Maga Jackson-Triche, Katherine Minnium, Cynthia Mulrow, and Kenneth Wells, MR-1198/1-AHRQ, 2000.
- Quick Reference Cards, MR-1198/8-AHRQ, 2000.
- *Guidelines and Resources for the Depression Nurse Specialist*, Lisa Rubenstein, Jürgen Unützer, Jeanne Miranda, Barbara Simon, Wayne Katon, Maga Jackson-Triche, Katherine Minnium, and Kenneth Wells, MR-1198/2-AHRQ, 2000.

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#### Unit 4: Psychotherapist Materials

- *Guidelines for the Study Therapist*, Lisa Rubenstein, Jürgen Unützer, Katherine Minnium, Kenneth Wells, and Christy Klein, MR-1198/3-AHRQ, 2000.

- Group Therapy Manuals

*Group Therapy Manual for Cognitive-Behavioral Treatment of Depression*, Ricardo F. Muñoz, Ph.D., Jeanne Miranda, Ph.D., MR-1198/4-AHRQ, 2000.

*Manual de Terapia de Grupo para el Tratamiento Cognitivo-Conductual de Depresión*, Ricardo F. Muñoz, Ph.D., Sergio Aguilar-Gaxiola, M.D., Ph.D., John Guzmán, Ph.D., MR-1198/5-AHRQ, 2000.

- Individual Therapy Manuals

*Individual Therapy Manual for Cognitive-Behavioral Treatment of Depression*, Ricardo F. Muñoz, Ph.D., Jeanne Miranda, Ph.D., MR-1198/6-AHRQ, 2000.

*Manual de Terapia Individual para el Tratamiento Cognitivo-Conductual de Depresión*, Ricardo F. Muñoz, Ph.D., Sergio Aguilar-Gaxiola, M.D., Ph.D., John Guzmán, Ph.D., MR-1198/7-AHRQ, 2000.

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#### Unit 5: Materials for Patients

- Patient-Education Brochures

*Are you feeling... Tired, Sad, Angry, Irritable, Hopeless?* MR-1198/11-AHRQ, 2000.

*¿Se siente usted... Cansado, Triste, Enojado, Enfadado, Irritable, Sin Esperanza?* MR-1198/12-AHRQ, 2000.

- Videotapes

*Beyond Depression—Partners in Care*, MR-1198/9-AHRQ, 2000 (based on a script by Maga Jackson-Triche, M.D.).

*Más allá de la Depresión*, MR-1198/10-AHRQ, 2000 (based on a script by Maga Jackson-Triche, M.D.).

A number of components in the kit, such as the manuals for primary care clinicians and for the psychotherapists, include placeholders for the Beck Depression Inventory (BDI).<sup>[5]</sup> The BDI was used in *Partners in Care* to monitor patients because it provides a sensitive indicator of change in depression symptoms over time. We used the actual BDI in the study, but it is copyrighted. Users are required to pay a small charge for each copy used. The insert pages in the manuals indicate where users can obtain the BDI.

## **Overview of the *Partners in Care* Study**

PIC was a real-world trial, conducted from 1995 to 2000. Designed to improve the quality of care for depression in managed, primary care practices, PIC was carried out in 46 primary care clinics within six diverse, nonacademic managed care plans in five states in the western, midwestern, and eastern United States. The study evaluated two quality-improvement (QI) programs based on previous successful collaborative care interventions,[6–9] each of which cost about the same amount to implement. The two programs shared many common materials, but had different supplemental resources. One program directed QI resources toward supporting medication treatment; the other directed resources toward supporting psychotherapy.

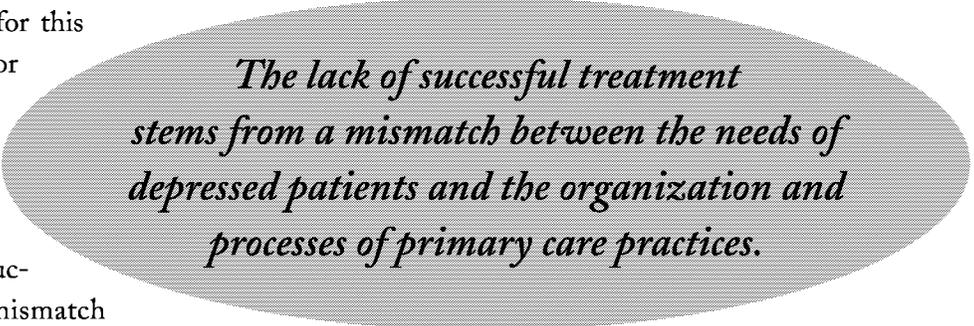
No one told the clinics, clinicians, or patients what to do. They were encouraged to follow their own goals. Physicians and patients were informed about both medication and therapy, but they were free to make their own choice. In effect, the practices were trained to improve themselves.

The medication and therapy programs were about equally successful over the first year. Practices can thus choose either model and, if they wish, can add elements of the one not chosen. However, we note that a fairly complete program may be needed to achieve a good result.

## **Rationale for the PIC Collaborative Care Model**

Most patients with symptoms of depression are seen in primary care settings, rather than in specialty mental health care. And most are not treated effectively. This lack of successful treatment is not because patients, insurance purchasers, or clinicians think depression is unimportant: Research shows that patients and their families want help for this condition; employers want better care for depression because it is a common cause of poor work performance; and primary care clinicians see depression as an important illness that they should be treating.[10] The lack of successful treatment stems from a mismatch between the needs of depressed patients and the organization and processes of primary care practices.

Primary care practices depend on general medical clinicians, who often have fairly few support staff. To ensure that physicians can see all the patients seeking care, patient visits are kept brief—usually to 15 minutes. Mechanisms for ensuring provider and patient education, guideline-adherent assessment and follow-up care for chronic illnesses, and linkages to specialists are variable in their quality and availability. Under these circumstances, care for depression poses special challenges. The PIC collaborative care QI programs are intended to address the following challenges.



*The lack of successful treatment stems from a mismatch between the needs of depressed patients and the organization and processes of primary care practices.*

- **Need for Proactive Case Detection**

Fatigue, hopelessness, and passivity are part of the illness of depression. In addition, depressed patients often feel shame for having a mental condition and may not expect primary care providers to care for their depression symptoms. Unlike chronic illnesses such as diabetes, depression waxes and wanes. As a consequence, database information that a patient had depression last year is of limited help for treatment decisions this year. Active, ongoing practice-wide strategies for detecting current major depression are needed.

- **Need for Proactive Case Management and Patient Activation**

Medications take time to improve depression symptoms, and they must be continued long after the symptoms have subsided. Medications also have side effects, and require monitoring, change, and adjustment. Brief psychotherapy requires 8 to 12 sessions for adequate improvement. Depressed patients often know little about depression and its treatments. They often find it hard to get out of bed in the morning, let alone to deal with medications or psychotherapy. Therefore, primary care practices must take an active role in ensuring that patients are knowledgeable about their condition, that they are motivated to follow treatment regimes, and that therapy is successfully completed.

- **Need for Time to Conduct a Thorough Clinical Assessment**

In order not to overuse depression treatments, clinicians must assess patients in some depth to identify the approximately 6% requiring full treatment from among the approximately 20% of patients with some symptoms of depression. Most of the 20% require neither psychotherapy nor medications, although some will need education, further monitoring, or low-intensity psychological support (e.g., a support group). In addition, treatment guidelines stipulate the need to assess depressed patients for important common conditions, such as alcoholism, mania, or anxiety, that may affect depression treatment. Primary care practices must find ways to ensure that appropriate assessment is done.

- **Need for Collaboration with Mental Health Specialists**

Primary care clinicians need access to psychotherapists for their patients, for consultation on difficult cases, and for ongoing education about depression. Standards of care for depression need periodic review and updating by specialists. However, mental health specialists often have less interaction with primary care providers than do medical subspecialists. Therefore, primary care practices need to develop mechanisms for ongoing, effective interaction with mental health specialists, both at the practice level and around individual patient cases.

The *Partners in Care* approach directly addresses these challenges through a collaborative care model.[6, 7, 9, 11] Key characteristics of this approach include collaboration between specialists and generalists, active case management, and patient empowerment.