



Help *and* Healing

Depression resources for care and recovery

Developed by

Minnesota Community
Measurement

Minnesota Health Action Group

Institute for Clinical Systems
Improvement

Help and Healing:

Resources for Depression Care and Recovery

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Help and Healing:

Resources for Depression Care and Recovery

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Help and Healing: *Depression resources for care and recovery*

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Partners:



Introduction

Introduction to *Help and Healing: Resources for depression care and recovery*

In 2008, an initiative called DIAMOND – Depression Improvement Across Minnesota, Offering a New Direction – was implemented by ICSI (the Institute for Clinical Systems Improvement). DIAMOND helps primary care clinics to be more proactive and effective in caring for adult patients with depression. The DIAMOND initiative introduced new tools for clinics to use in managing care and in implementing the concept of “collaborative care”.

Research has proven that this new collaborative care approach results in improved outcomes, improved quality of life and greater productivity, and long-term health care cost savings for patients with depression.¹ As part of the DIAMOND initiative, several process and outcome measures were developed to monitor progress, performance and outcomes. A number of these measures were incorporated into the work of Minnesota Community Measurement (MNCM) who was instrumental in the measure development. It should be noted however, that the MNCM measure not only applies to DIAMOND clinics but all primary care and behavioral health clinics providing care to patients diagnosed with Major Depression.

Measure implementation

Minnesota Health Action Group (formerly known as Buyers Health Care Action Group) implemented one of the MNCM depression care measures – **Depression Remission at Six Months**– into the Minnesota Bridges to Excellence (MNBTE) program in 2009. MNBTE is a purchaser-led pay-for-performance program. Performance rewards are funded by eleven participating purchasers, including several large employers, the University of Minnesota, and the State of Minnesota Employee Group Insurance Plan. Clinics that voluntarily submitted data on Remission at Six Months were eligible for a performance reward if they met or exceeded the performance threshold. One hundred and thirty-two clinics voluntarily reported in 2009 and 151 clinics in 2010, going well beyond the 86 clinics certified to offer DIAMOND.

Toolkit Partners

MN Community Measurement
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MN Health Action Group
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Improvement
ICSI.org

Toolkit development

In 2011, the State of Minnesota added **Depression Remission at Six Months** to the slate of measures covered by the Statewide Quality and Reporting Measurement System (SQRMS). All primary care and behavioral health

clinics with a physician on staff and providing care for patients diagnosed with Major Depression are now required to submit data on this measure to MNMCM, and publicly reported clinic data became available in June of 2011 for 592 clinics.

Minnesota Health Action Group and MNMCM entered into a jointly managed project with assistance from ICSI in late 2011 to develop a Depression Care Toolkit that ultimately became **Help and Healing: Resources for depression care and recovery**. The goal of **Help and Healing** is to provide clinics across the State of Minnesota with tools and resources to assist them in the identification of patients with depression, treatment planning, self-management techniques for patients to use and systems implementation activities geared to making follow-up and data collection easier.

The ultimate goal is for patients with depression to get better faster. We know Minnesota clinicians are up to the challenge. In 2011, the highest performing clinic had 30% of their patients with depression in remission at six months. While clinics not participating in DIAMOND do not have access to all the resources available through DIAMOND, many clinics are making great strides to improve the care for their patients with depression. Just as we have seen impressive improvement in Optimal Diabetes Care in prior years, we know Minnesota clinics can do the same with depression care.

Opportunities to collaborate

We hope **Help and Healing** is a useful resource for clinics looking to improve the outcomes for their patients with depression. We acknowledge the limitation that tools, by themselves, provide only a level of technical support. Any substantial improvement effort also requires attention to adaptive changes affecting the culture and values of health care systems and stakeholders. Our three organizations of MN Community Measurement, Minnesota Health Action Group and the Institute for Clinical Systems Improvement encourage your involvement in our ongoing collaborative opportunities.

You can view and download the entire **Help and Healing** toolkit at www.MNHealthScores.org.

For reference:

¹[DIAMOND Fact Sheet, ICSI
http://www.icsi.org/health_care_redesign_/diamond_35953/what_is_diamond_/diamond_fact_sheet/](http://www.icsi.org/health_care_redesign_/diamond_35953/what_is_diamond_/diamond_fact_sheet/)

Acknowledgements and Contributions

Partners

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Help and Healing:

Resources for Depression Care and Recovery

Section 1: Identification, Education and Talking Points

PHQ-9

Talking Points

Strategies for Patient and Family Education

Patient Education - Depression Fact Sheet

Example Suicidality Screening Flow

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered
by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your
work, take care of things at home, or get along with other people?

Not difficult at all <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
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Section 1

Identification,
Education &
Talking Points

Talking Points

Team Care for Depression

About the Team Approach:

I would like to tell you about how we care for clients/patients with depression here. We use a team approach, which means you (the client/patient), the clinician and the care coordinator are a team. It is important that you are actively involved in the process.

About the Care Coordinator:

The care coordinator is part of the treatment team. I want you to work with her/him.

The care coordinator helps us keep in touch and monitor your progress in between visits. He/she is the physician's eyes and ears since the visit time with him/her is limited.

He/she supports you in making sure the treatment is well tolerated and effective and lets us know when it is time to change treatment.

Your first visit with the care coordinator will give you a chance to meet and ask any question you may have about what will happen/occur moving forward.

To Describe the PHQ-9:

Each time you and I touch base, I'll ask you some questions that will help us to see how you are doing and where you and I need to focus our efforts to improve your symptoms and daily functioning.

The tool I will be using is called a PHQ-9. It is an objective way to determine the main symptoms you are having that relate to your depression. It is very much like when your clinician checks your blood pressure. Instead of asking you, "How does your blood pressure seem today?" an actual measurement is taken that gives the clinician accurate information to help in determining your treatment. The same is true when assessing depression. Instead of only asking you "How are you feeling today?" we ask you a set of questions that assists us when making treatment decisions.

This tool cannot summarize everything about you. Yet it serves as a way to gather additional information so we can make treatment decisions.

If you've already taken the PHQ-9 in the last 2 weeks, has anything changed since then? If not, let's take that one out and use it again today.

The road to recovery
has a new map.

Help and Healing connects you to quality
resources for depression care and recovery.
Get better, faster.

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Talking Points

Internal Communication/Questions to Implement the PHQ-9:

Who will give out the tool?

Will the tool be in paper or electronic form?

Who will score the tool?

Who will document the score and where will the full tool's responses be documented and filed?

Who will trigger the need for a repeat PHQ-9?

About Depression Treatment:

In depression treatment, the first thing we try is often helpful, but if it is not we have to be systematic about making adjustments. This can take time and this is where the care coordinator comes in. The care coordinator will work with you on some other aspects of your care such as goal setting and establishing healthy behaviors.

Care Coordinator/Manager First Contact with Patient:

Hello, my name is _____, we met on (state the day) when Dr. _____ introduced us. He/she asked that I follow-up with you regarding your depression care.

Hello, my name is _____, I am a depression care manager/coordinator here at _____ clinic. I work with Dr. _____. He/she asked that I follow-up with you.

What is a Care Manager/Coordinator and what to they do?

I am responsible for overall coordination of your depression care. I'll follow-up with you on your treatment plan, work with you on setting goals, and update your physician/therapist/clinician on your progress.

Will I still be able to see my Care Provider?

Yes. I stay in close contact with your doctor/therapist/provider, keeping him/her current on your treatment and how you are doing. If either you or I feel at any time you should see your Care Provider, we'll arrange an appointment. He/she may also request to see you for a follow up.

Talking Points

Next Steps:

You may not know a lot about your condition now, however, we will teach and work with you so you can be actively involved in your care.

Will you ask questions, communicate problems or issues, and share good things that happen along the way? (Wait for response.)

Will you come with me to meet the care coordinator (or other staff person for warm hand off)? (Wait for response.)

To improve likelihood of follow-up (commitment influences behavior):

Your next appointment with me is (date/time). Will you call if you need to reschedule?

What barriers do you anticipate could get in the way of making our next scheduled appointment?

What is a back-up phone number you would like me to call if I can't reach you at this number?



Section 1

Identification,
Education &
Talking Points

Strategies for Patient and Family Education

It is important to remember that no one makes it through a serious illness by himself or herself. This is true for depression as well. People need the support and help of family and friends who provide practical assistance, comfort and hope. When asked, families reported their most-valued provider attributes included compassion, respect, flexibility, accessibility, candor, hopefulness, and commitment.

Helpful strategies

Refrain from imposing a “therapeutic agenda” on families who are in crisis or pain.

Ask “what can we do today that would be most helpful?”

Provide a “no fault” explanation – relieve the family of the burden of guilt and shame.

Share information about depression, treatment, medications and side effects, and dealing with practical issues.

Remember that families go through stages of coping and may be facing a number of burdens including emotional and financial.

Seek information from families about the history, background and day-to-day progress.

Encourage the patient to sign a privacy release, or the family involvement privacy release so that basic information can be shared. (Remember: families don’t want access to the medical records, they want to know what is going on and how to help their loved one.)

Validate the family’s early warning signs of relapse.

Refer the families to resources and support groups.

Remember that a family’s desire to remain connected is normal - an expression of loyalty and support - not their trying to keep their family member “dependent.”

Families need help with subjective burden, objective burden; help with management of symptoms and family education.

Avoid the words such as enabling, co-dependency, denial, rock bottom, dysfunctional and hopeless.

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Section 1

Identification,

Education &

Talking Points

Depression Fact Sheet

Major Depression

What is major depression?

Major depression is a serious medical illness affecting 15 million American adults, or approximately 5 to 8 percent of the adult population in a given year. Unlike normal emotional experiences of sadness, loss, or passing mood states, major depression is persistent and can significantly interfere with an individual's thoughts, behavior, mood, activity, and physical health. Among all medical illnesses, major depression is the leading cause of disability in the U.S. and many other developed countries.

Depression occurs twice as frequently in women as in men, for reasons that are not fully understood. More than half of those who experience a single episode of depression will continue to have episodes that occur as frequently as once or even twice a year. Without treatment, the frequency of depressive illness as well as the severity of symptoms tends to increase over time. Left untreated, depression can lead to suicide.

Major depression, also known as clinical depression or unipolar depression, is only one type of depressive disorder. Other depressive disorders include dysthymia (chronic, less severe depression) and bipolar depression (the depressed phase of bipolar disorder or manic depression). People who have bipolar disorder experience both depression and mania. Mania involves unusually and persistently elevated mood or irritability, elevated self-esteem, and excessive energy, thoughts, and talking.

What are the symptoms of major depression?

The onset of the first episode of major depression may not be obvious if it is gradual or mild. The symptoms of major depression characteristically represent a significant change from how a person functioned before the illness. The symptoms of depression include:

- persistently sad or irritable mood
- pronounced changes in sleep, appetite, and energy
- difficulty thinking, concentrating, and remembering
- physical slowing or agitation
- lack of interest in or pleasure from activities that were once enjoyed
- feelings of guilt, worthlessness, hopelessness, and emptiness
- recurrent thoughts of death or suicide
- persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

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Depression Fact Sheet

When several of these symptoms of depressive illness occur at the same time, last longer than two weeks, and interfere with ordinary functioning, professional treatment is needed.

What are the causes of major depression?

There is no single cause of major depression. Psychological, biological, and environmental factors may all contribute to its development. Whatever the specific causes of depression, scientific research has firmly established that major depression is a biological, medical illness.

Norepinephrine, serotonin, and dopamine are three neurotransmitters (chemical messengers that transmit electrical signals between brain cells) thought to be involved with major depression. Scientists believe that if there is a chemical imbalance in these neurotransmitters, then clinical states of depression result. Antidepressant medications work by increasing the availability of neurotransmitters or by changing the sensitivity of the receptors for these chemical messengers.

Scientists have also found evidence of a genetic predisposition to major depression. There is an increased risk for developing depression when there is a family history of the illness. Not everyone with a genetic predisposition develops depression, but some people probably have a biological make-up that leaves them particularly vulnerable to developing depression. Life events, such as the death of a loved one, a major loss or change, chronic stress, and alcohol and drug abuse, may trigger episodes of depression. Some illnesses such as heart disease and cancer and some medications may also trigger depressive episodes. It is also important to note that many depressive episodes occur spontaneously and are not triggered by a life crisis, physical illness, or other risks.

How is major depression treated?

Although major depression can be a devastating illness, it is highly treatable. Between 80 and 90 percent of those diagnosed with major depression can be effectively treated and return to their usual daily activities and feelings. Many types of treatment are available, and the type chosen depends on the individual and the severity and patterns of his or her illness. There are three well-established types of treatment for depression: medications, psychotherapy, and electroconvulsive therapy (ECT). For some people who have a seasonal component to their depression, light therapy may be useful. These treatments may be used alone or in combination. Additionally, peer education and support can promote recovery. Attention to lifestyle, including diet, exercise, and smoking cessation, can result in better health, including mental health.

Medication. It often takes two to four weeks for antidepressants to start having an effect, and 6-12 weeks for antidepressants to have their full effect. The first antidepressant medications were introduced in the 1950s. Research has shown that imbalances in neurotransmitters like serotonin, dopamine, and norepinephrine can be corrected with antidepressants. Four groups of antidepressant medications are most often prescribed for depression:

Depression Fact Sheet

Selective serotonin reuptake inhibitors (SSRIs) act specifically on the neurotransmitter serotonin. They are the most common agents prescribed for depression worldwide. These agents block the reuptake of serotonin from the synapse to the nerve, thus artificially increasing the serotonin that is available in the synapse (this is functional serotonin, since it can become involved in signal transmission, the cardinal function of neurotransmitters). SSRIs include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), escitalopram (Lexapro), and fluvoxamine (Luvox).

Serotonin and norepinephrine reuptake inhibitors (SNRIs) are the second-most popular antidepressants worldwide. These agents block the reuptake of both serotonin and norepinephrine from the synapse into the nerve (thus increasing the amounts of these chemicals that can participate in signal transmission). SNRIs include venlafaxine (Effexor) and duloxetine (Cymbalta).

Bupropion (Wellbutrin) is a very popular antidepressant medication classified as a norepinephrine-dopamine reuptake inhibitor (NDRI). It acts by blocking the reuptake of dopamine and norepinephrine.

Mirtazapine (Remeron) works differently from the compounds discussed above. Mirtazapine targets specific serotonin and norepinephrine receptors in the brain, thus indirectly increasing the activity of several brain circuits.

Tricyclic antidepressants (TCAs) are older agents seldom used now as first-line treatment. They work similarly to the SNRIs, but have other neurochemical properties which result in very high side effect rates, as compared to almost all other antidepressants. They are sometimes used in cases where other antidepressants have not worked. TCAs include amitriptyline (Elavil, Limbitrol), desipramine (Norpramin), doxepin (Sinequan), imipramine (Norpramin, Tofranil), nortriptyline (Pamelor, Aventyl), and protriptyline (Vivactil).

Monoamine oxidase inhibitors (MAOIs) are also seldom used now. They work by inactivating enzymes in the brain which catabolize (chew up) serotonin, norepinephrine, and dopamine from the synapse, thus increasing the levels of these chemicals in the brain. They can sometimes be effective for people who do not respond to other medications or who have “atypical” depression with marked anxiety, excessive sleeping, irritability, hypochondria, or phobic characteristics. However, they are the least safe antidepressants to use, as they have important medication interactions and require adherence to a particular diet. MAOIs include phenelzine (Nardil), isocarboxazid (Marplan), and tranylcypromine sulfate (Parnate).

Non-antidepressant adjunctive agents. Often psychiatrists will combine the antidepressants mentioned above with each other (we call this a “combination”) or with agents which are not antidepressants themselves (we call this “augmentation”). These latter agents can include the atypical antipsychotic agents [aripiprazole (Abilify), olanzapine (Zyprexa), quetiapine (Seroquel), ziprasidone (Geodon), risperidone (Risperdal)], buspirone (Buspar), thyroid hormone (triiodothyronine, or “T3”), the stimulants [methylphenidate (Ritalin), dextroamphetamine (Aderall)], dopamine receptor agonists [pramipexole (Mirapex), ropinirole (Requip)], lithium, lamotrigine (Lamictal), s-adenosyl methionine (SAME), pindolol, and steroid hormones (testosterone, estrogen, DHEA).

Consumers and their families must be cautious during the early stages of medication treatment because normal energy levels and the ability to take action often return before mood improves. At this time - when decisions are easier to make, but depression is still severe - the risk of suicide may temporarily increase.

Depression Fact Sheet

Psychotherapy. There are several types of psychotherapy that have been shown to be effective for depression including cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT). Research has shown that mild to moderate depression can often be treated successfully with either of these therapies used alone. However, severe depression appears more likely to respond to a combination of psychotherapy and medication.

Cognitive-behavioral therapy (CBT) – helps to change the negative thinking and unsatisfying behavior associated with depression, while teaching people how to unlearn the behavioral patterns that contribute to their illness.

Interpersonal therapy (IPT) – focuses on improving troubled personal relationships and on adapting to new life roles that may have been associated with a person's depression.

Electroconvulsive therapy (ECT). ECT is a highly effective treatment for severe depressive episodes. In situations where medication, psychotherapy, and a combination of the two prove ineffective, or work too slowly to relieve severe symptoms such as psychosis or thoughts of suicide, ECT may be considered. ECT may also be considered for those who for one reason or another cannot take antidepressant medications.

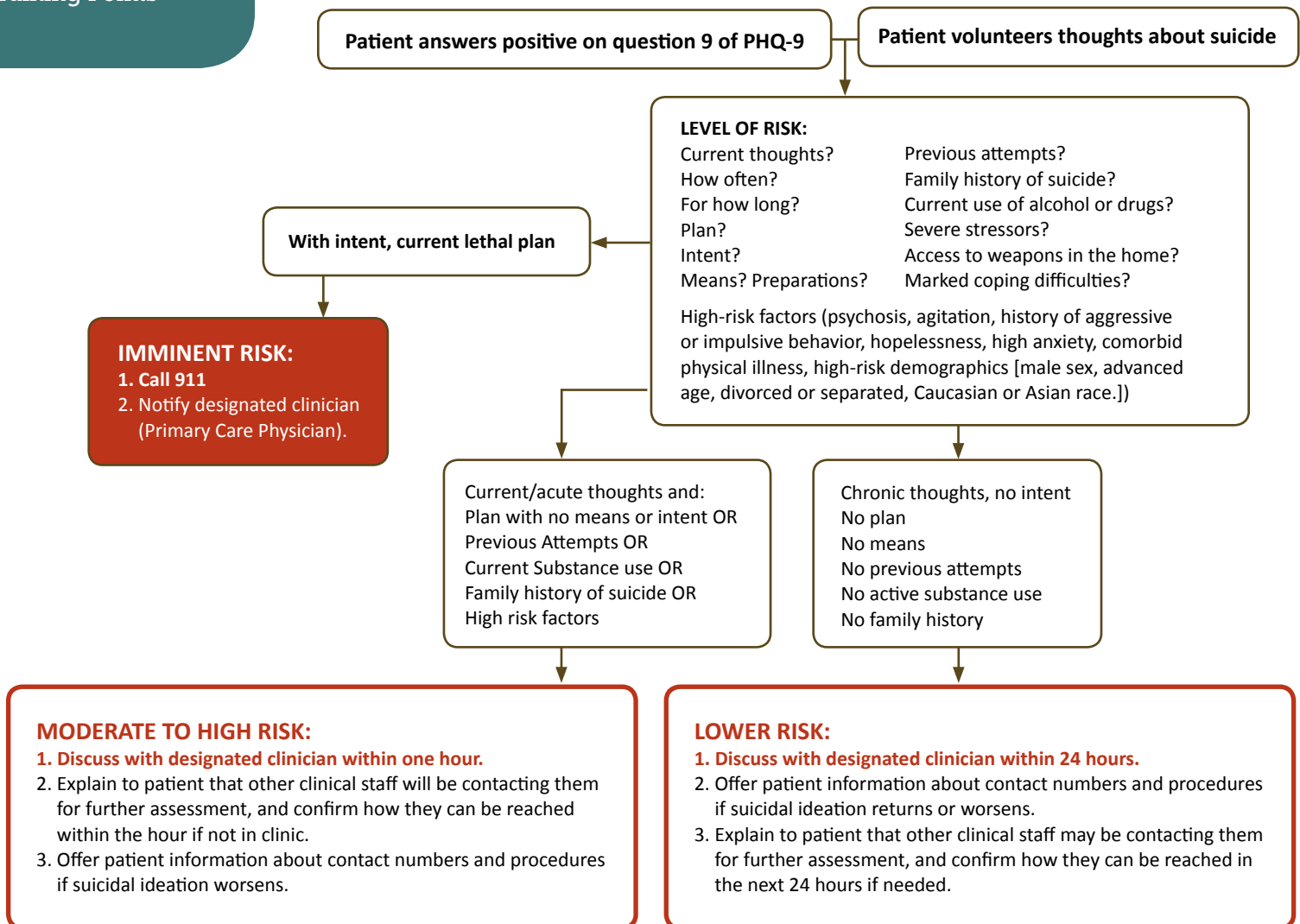
What are the side effects of the medications used to treat depression?

Different medications produce different side effects, and people differ in the type and severity of side effect they experience. About 50 percent of people who take antidepressant medications experience some side effects, particularly during the first weeks of treatment. Side effects that are particularly bothersome can often be treated by changing the dose of the medication, switching to a different medication, or treating the side effect directly with additional medications. Rarely, serious side effects such as fainting, heart problems, or seizure may occur, but they are almost always treatable.

Section 1

Identification,
Education &
Talking Points

Example Suicidality Screening Flow*



*A clear process for contacting the patient and next steps in assessing risk should be determined by the individual clinics. Many clinics may already have a protocol for the triage of suicidal patients; this is intended to guide how the Integration Specialist interfaces with that system.

A recommended resource for how to establish a clinic-based protocol to assess and minimize suicide risk is: Bonner, L., et al. Suicide Risk Response: Enhancing Patient Safety through Development of Effective Institutional Policies. Advances in Patient Safety: From Research to Implementation. 2005;3.

Help and Healing:

Resources for Depression Care and Recovery

Section 2: Treatment Planning

Treatment and Timelines

Depression Treatment Reference

Care Team Communication

Provider Education Tool - Questions to ask your clinician

Provider Education Tool – What is ECT

Your Depression Treatment Plan

DIAMOND

Treatment and Timelines

Translating PHQ-9 Depression Scores into Practice

PHQ-9 Symptoms & Impairment	PHQ-9 Severity	Provisional Diagnosis*	Treatment Recommendations**
1 to 4 symptoms, functional impairment	5-9	Mild or Minimal Depressive Symptoms	-Education to call if deteriorates -Physical activity -Behavioral activation -If no improvement after one or more months, consider referral to behavioral health for evaluation
2 to 4 symptoms, question 1 or 2 positive, functional impairment	10-14	Mild Major Depression	-Pharmacotherapy or psychotherapy -Education -Physical activity -Behavioral activation -Initially consider weekly contacts to ensure adequate engagement, then at least monthly
≥ 5 symptoms, question 1 or 2 positive, functional impairment	15-19	Moderate Major Depression	-Pharmacotherapy and/or psychotherapy -Education -Physical activity -Behavioral activation -Initially consider weekly contacts to ensure adequate engagement, then minimum every 2-4 weeks
≥ 5 symptoms, question 1 or 2 positive, functional impairment	≥ 20	Severe Major Depression	-Pharmacotherapy necessary & psychotherapy when pt able to participate -Education -Physical activity -Behavioral activation -Weekly contacts until less severe

Sources: Fournier, 2010; Trivedi, 2009; Cuijpers, 2007; Hunot 2007; Kroenke, 2010

This table is designed to translate the PHQ-9 scores into DSM-IV TR categories and then integrate evidence-based best practice. It does not directly correspond to the PHQ-9 Scoring Guide

*Dysthymia = low level depression most of the day for more days than not for at least 2 years. Must include presence of at least 2 of the DSM-IV TR criteria affecting appetite, sleep, fatigue, self-esteem, concentration/decision making, hopelessness. Initiate pharmacotherapy or refer to mental health specialty clinician for evaluation.

**Referral or co-management with mental health specialty clinician if patient has:

- High suicide risk
- Other psychiatric disorders such as bipolar, substance abuse, etc.
- Inadequate treatment response
- Complex psychosocial needs

Depression Medication Treatment Duration Based on Episode

Episode	Treatment Duration*
1 st episode (Major Depression, single episode 296.2)	<ul style="list-style-type: none"> Acute phase typically lasts 6-12 weeks. Continue psychotherapy/medication treatment for 4-9 months once remission is reached. Total = approximately 6-12 months.
2 nd episode (Major Depression, recurrent 296.3)	Continue medication treatment for 3 years once remission is reached. Withdraw gradually.
Dysthymia (300.4) or 3+ episodes or 2 episodes (Major Depression, recurrent 296.3) with complicating factors such as: <ul style="list-style-type: none"> Rapid recurrent of episodes > 60 yrs of age at onset of major depression Severe episodes or family history 	Continue medication treatment indefinitely.

Sources: American Psychiatric Association, 2010; Segal 2010; Dobson, 2008; Hollon, 2005

*Treat to remission. Full remission is defined as a two-month absence of symptoms.

Depression Treatment Reference

Follow-up intervals for depression should take into account severity, clinician judgment and patient preference. Systematic review of the patient's response to treatment is particularly important in the first 6-8 weeks. The goal of treatment should be to achieve remission, reduce relapse and recurrence, and return to previous level of functioning.

For Screening/Diagnosis

Week	PHQ-9 score	Clinical status	Treatment plan
0	10-14	Major depression, mild	Education, pharmacotherapy or psychotherapy
0	15-19	Major depression, moderate	Education, pharmacotherapy and/or psychotherapy
0	>20	Major depression, severe	Education, pharmacotherapy and psychotherapy

For Treatment/Management

Week	PHQ-9 score	Clinical status of major depression	Treatment plan
2	≤5	Remission	Continue current treatment
	50% or greater reduction	Response*	
2	25-50% reduction	Partial response*	Gradually increase dose as tolerated
	Score is <25% improvement, same or increased	Nonresponse*	
4	≤5	Remission	Continue current treatment
4	50% or greater reduction	Response*	Continue current dose Consider increasing dose
	25-50% reduction	Partial response*	
4	Score is <25% improvement, same or increased	Nonresponse*	Consider increasing dose Switch to another antidepressant or therapy
6	≤5	Remission	Continue current treatment
6	50% or greater reduction	Response*	Consider increasing/maximizing dose Augment treatment (antidepressant or therapy)
	25-50% reduction	Partial response*	
6	Score is <25% improvement, same or increased	Nonresponse*	Switch to another antidepressant or therapy Augment treatment (antidepressant or therapy)
9	≤5	Remission†	Continue current treatment
9	50% or greater reduction	Response*	Increase dose Augment treatment (antidepressant or therapy) Switch to another antidepressant or therapy
	25-50% reduction	Partial response*	
9	Score is <25% improvement, same or increased	Nonresponse*	Switch to another antidepressant or therapy
12	≤5	Remission†	Continue current treatment
12	50% or greater reduction	Response	Switch to another antidepressant or therapy
	25-50% reduction	Partial response	
12	Score is <25% improvement, same or increased	Nonresponse	

* If problematic side effects, continue current dose and address symptoms. If patient unwilling or unable to continue, decrease dose or switch to another antidepressant.

† Once the patient has been in remission for 2 consecutive months (PHQ-9 = <5), initiate relapse prevention.



CARE TEAM COMMUNICATION FORM

Depression Collaborative Care

This form should be used in team-based care systems to facilitate efficient and effective communication. Exchanging the following information can help team members clarify workflows and care processes.

Date: _____

Patient Name: _____ DOB: _____

Team Member: _____ Role: _____

Preferred mode of communication:

☐ email ☐ telephone ☐ pager ☐ in person discussion ☐ other: _____

Preferred communication style:

☐ Brief and few details with focus on specific problem or issue

☐ Detailed discussion when time permits

☐ Include in communications (nurse, psychiatrist, other): _____

Baseline PHQ-9: _____ Date: _____ Most recent PHQ-9: _____ Date: _____

Treatment Plan: _____

Length of time patient on current treatment plan: _____

Patient strengths/resources/supports: _____

Patient concerns/barriers/side effects: _____

Primary symptoms not substantially improved (based on PHQ-9 scores): _____

Recommendations: _____



Section 2 Treatment Planning

Provider Education Tool: Questions for patients to ask their clinicians

Purpose

To encourage patients to write down questions they wish to ask their doctor and bring their list of questions to the visit (a.k.a. Doc Talk Cards)¹. This simple intervention requires few resources and is effective at generating communication between the caregiver and the patient and increasing patient satisfaction with their care.

How do they work?

Patients are asked to generate two to five questions about their problems or their reason for the visit that they would like to ask their physician during the office visit. Cards can be designed and sent to patients in advance of the appointment. The cards can prompt patients for questions by listing topic areas such as symptoms and medications. These cards (completed by the patient and when brought to the appointment) can be attached to the patient's chart by the rooming aid for the physician's review.

Tactics

- Have pre-printed cards available to distribute at the time of registering or rooming a patient
- Mail card to patient after scheduling patient appointment
- Provide form or card on website, at the time patient schedules appointment, have scheduler ask patient to go to the website, print form out and complete prior to visit
- Provide examples of questions to ask your clinic

Doc Talk Cards

Support communication and build patient satisfaction. Cards can be designed to include prompts for questions and sent to patients in advance of their appointment.



Examples of patient questions

- What do I want out of the visit today?
- What do I want to tell my doctor today?
- What do I want to ask my doctor today?
- What are the potential risks and benefits of the medication?
- Which side effects should concern me?
- What type of therapy do you recommend and why?
- When should I think about discontinuing the medication?
- What else can I do to help me recover more quickly?
- What can my family do to support me?

¹The CAHPS Improvement Guide Practical Strategies for Improving the Patient Experience;
cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/Communication/Patient-Comm-Tools.aspx

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Section 2

Treatment

Planning

Electroconvulsive Therapy (ECT)

What is ECT?

Electroconvulsive Therapy (ECT) is a type of brain stimulation therapy used to treat a variety of mental illnesses. ECT is used most commonly to treat severe depression, especially when other treatments have not worked. ECT was developed in 1938 and has changed a great deal since that time.

ECT works by passing electrical currents through the brain. The electrical currents cause changes in brain chemistry that relieve symptoms of certain mental illnesses. People who undergo ECT do not feel pain or discomfort during the procedure. It can be used safely by people who are pregnant, elderly or living with a variety of medical conditions. Research has shown that ECT can be one of the most effective treatments available.

What is ECT used to treat?

ECT is most commonly used to treat the following mental illnesses:

- Severe depression. Particularly when symptoms include psychosis, suicidal ideation or a refusal to eat.
- Long-term depression that does not improve with medication or other treatments.
- Schizophrenia when symptoms include psychosis, suicidal ideation, a desire to harm someone else or refusal to eat.
- Bipolar disorder when symptoms include severe mania. Signs of mania include impaired decision making, impulsive or risky behaviors, substance abuse and psychosis.
- Schizophrenia and some other psychiatric disorders where catatonia is a symptom. Catatonia is characterized by lack of movement or strange movements and difficulty with speech.

How does ECT work?

Chemical aspects of brain function are changed during and after ECT therapy. Chemical changes build upon each other resulting in relief from symptoms.

The road to recovery
has a new map.

Help and Healing connects you to quality
resources for depression care and recovery.
Get better, faster.

Visit > MNHealthScores.org/helpandhealing

Electroconvulsive Therapy (ECT)

What is the procedure?

Before ECT treatment begins, the person undergoes a physical exam to determine if they are healthy enough to have the treatment. ECT is performed under general anesthesia, which puts the person to sleep. People also receive muscle relaxant medication, which keeps them still. The person may receive other medications as well if they have certain health conditions. An anesthesiologist monitors the person's vitals throughout the procedure.

Electrode pads are placed on the person's head at precise locations. They are either placed on both sides of the brain, called bilateral ECT, or on one side, called unilateral ECT. Once the anesthetic and muscle relaxant take effect, the doctor presses a button on the ECT machine. This causes a short, controlled set of electrical currents to pass through the electrodes into the person's brain. This lasts only a few seconds. An electroencephalogram (EEG) records the person's brain activity. The EEG will show a sudden increase in activity as soon as the treatment begins.

After the treatment the person is taken to a recovery area and monitored. The anesthetic and muscle relaxant begin to wear off five to ten minutes after the treatment is complete. People who undergo ECT will often be prescribed an antidepressant or other mood-stabilizing medication after the treatment.

How long does ECT treatment last?

ECT treatment usually requires three sessions per week for two to four weeks. About six to side effects are quite common immediately after an ECT session but can usually be treated with prescribed medication. During ECT a person's heart rate and blood pressure increase. However, this is closely monitored and usually does not pose any danger.

How has ECT changed over time?

- Today, electricity is administered as an extremely quick pulse instead of a steady stream.
- Less electricity is used in ECT therapy today.
- People receive far fewer ECT treatments today.
- People recover from the confusion caused by ECT much more quickly today (usually within an hour).
- People are now monitored much more closely both during and after ECT treatment.
- People are now placed under general anesthesia for ECT treatment.
- People now receive muscle relaxants for ECT treatment.
- The medicine, software and procedures used in ECT treatment have greatly improved since it was first introduced.

Electroconvulsive Therapy (ECT)

Myths about ECT:

Myth: ECT does not work.

Fact: ECT is considered one of the safest and most effective medical treatments for severe depression and can improve the symptoms of several other mental illnesses.

Myth: ECT is painful.

Fact: ECT is not painful because the person is given a general anesthetic and muscle relaxant before the treatment. If a person has a headache or any discomfort after the procedure, medication is prescribed.

Myth: ECT is dangerous.

Fact: ECT is no more dangerous than any other medical procedure that uses a general anesthetic, and ECT has a low risk of complications.

Myth: ECT erases a person's memory.

Fact: ECT can disrupt a person's short term memory. However, this is usually only temporary. Memory will return to normal approximately one to three months after treatment. Some people have even reported improved memory following ECT because it can relieve the amnesia sometimes caused by severe depression. Although rare, some people (mostly people who have received bilateral ECT) have reported long term memory loss.

Myth: ECT can cause brain damage.

Fact: There is no evidence that ECT causes irreversible damage to the brain.



My Depression Treatment Plan

Patient Name: _____ Today's Date: _____

Contact/Appointment Information

Primary Provider: _____ Tel. Number: _____

Next Appointment: Date: _____ Time: _____

Care Coordinator: _____ Tel. Number: _____

Next Appointment: Date: _____ Time: _____

Medication Schedule

Depression Medication Name: _____	From:	To:
1st Take _____ tablet(s) of _____ mg for _____ days	_____	_____
THEN 2nd Take _____ tablet(s) of _____ mg for _____ days	_____	_____
THEN 3rd Take _____ tablet(s) of _____ mg for _____ days	_____	_____
Depression Medication Name: _____	From:	To:
1st Take _____ tablet(s) of _____ mg for _____ days	_____	_____
THEN 2nd Take _____ tablet(s) of _____ mg for _____ days	_____	_____
THEN 3rd Take _____ tablet(s) of _____ mg for _____ days	_____	_____

*EMR Medication List

Attach Electronic Medical Record Medication List, if available, instead of completing the list of comprehensive medications.

Other Treatment

Therapy/Counseling/Support Group/Class/ Community Resource/Book/Website/etc	Name / Information	Notes

Discussed with: ☐ Primary Care Provider ☐ Care Coordinator ☐ Other _____

Clinician Signature _____ Date _____

Help and Healing:

Resources for Depression Care and Recovery

Section 3: Managing Depression

How to Prepare for Your Health Care Appointment

A Roadmap to Wellness (NAMI Hearts & Minds brochure)

Healthy Eating Fact Sheet

Keeping Active Fact Sheet

Meditation & Mindfulness Training

Help for Sleep Problems

Depression Care Health Tracker

Relapse Prevention Plan



Section 3

Managing Depression

How to prepare for your health care appointment

The time you have with your doctor, nurse or therapist is very important to your health. Be sure to ask questions, explain any new symptoms or problems, and share your concerns.

Here are **Help and Healing** tips to help you get ready for your next appointment:

Before your next visit

Make a list of concerns and questions. List the most important questions and concerns first. A notebook can help you keep track of depression symptoms and questions in between visits.

Bring a list of all the medications you take. This includes drugs (prescription and non-prescription), vitamins, and other natural remedies such as herbal products.

Let the clinic know before your visit if you have special needs. Ask for an interpreter if you do not speak or understand English well.

Ask a friend or family member to come with you. This person can help listen, take notes and offer support.

For future visits

Use the PHQ-9 survey to compare any change in your score to your goal. Lower scores are a sign that your treatment plan is helping you get better.

Make goals for your treatment plan at each visit with your doctor, nurse or therapist. The *Depression Health Tracker* in **Help and Healing** can help you manage your goals. For example, you can write down your medications, the refill dates and any side effects.

Always follow up to get test results. Call your clinic and ask for results if you do not hear from your doctor, nurse or therapist when you expect to.

Depression symptoms

- Feeling irritated
- Appetite changes
- Sleep problems
- Low energy or motivation
- Problems concentrating
- Low interest in activities
- Feeling hopeless, worthless or empty
- Body aches and pains



Schedule a follow-up appointment (if needed) before you leave the clinic. Don't wait until you get home, since you might forget.

Where to learn more about how to prepare for your clinic visit

Here is a list of resources that may be useful for you or your family member. Our goal is to provide easy access to a list of resources and information that will help you seek out exactly what you or your family member needs to recover from depression.

This fact sheet was adapted from “What you can do to prepare for your doctor’s appointment.” The Partnership for Healthcare

Preparing for your clinic visit

Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
ahrq.gov/questions

Here to Help
heretohelp.bc.ca/skills/managing-depression

The Partnership for Healthcare Excellence
partnershipforhealthcare.org/patients_and_caregivers

Where to learn more about treatment for depression

MN Community Measurement
Help and Healing: Depression resources for care and recovery
mnhealthscores.org

National Alliance on Mental Illness (NAMI)
MN Chapter
namihelps.org

University of Michigan Depression Center
DepressionToolkit.org
depressiontoolkit.org



nami

National Alliance on Mental Illness

Hearts & Minds



**A Roadmap to Wellness
for Individuals
Living with Mental Illness**



A Roadmap to Wellness for Individuals Living with Mental Illness

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The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has more than 1,100 affiliates in communities across the country who engage in advocacy, research, support and education. Members of NAMI are families, friends and people living with a mental illness such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, posttraumatic stress disorder (PTSD) and borderline personality disorder.

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NAMI Hearts & Minds is an online wellness initiative. This booklet contains much of the information available, but the most up-to-date content, as well as fact sheets on wellness issues, are available at www.nami.org/heartsandminds.

OptumHealthSM
Public Sector



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National Alliance on Mental Illness

A Roadmap to Wellness for Individuals Living with Mental Illness

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Intro

The NAMI Hearts & Minds program is an educational wellness initiative promoting the idea of wellness in both mind and body. Generally, wellness is an ongoing process of learning about, and making choices toward, a more successful life.

Engaging in a wellness effort can make a huge difference in the quality of our lives. One study, published in the *Journal of the American Medical Association*, showed that taking a wellness approach could result in a 17 percent decline in total medical visits and a 35 percent decline in medical visits for minor illness.

Wellness is about the individual; you can decide what parts of your life you would like to change and you can determine your own level of success.

Why Hearts & Minds Is Important

People who live with mental illness are often at higher risk for heart illness and much of that risk is preventable: knowledge is power. People who live with mental illness are more likely to have classic heart risk factors such as cigarette smoking, obesity, diabetes, elevated cholesterol and hypertension (high blood pressure)—all of which can be made worse by some antipsychotic medications.

Certainly, living with mental illness can be quite a challenge already. NAMI Hearts & Minds offers a wealth of information. You do not need to figure this all out at once—NAMI Hearts & Minds will show you how to take it one step at a time. You are worthy of a happy, healthy and long life. Knowing the risks will help you make informed choices that can make that happen. When you are ready to work on one of these areas, focus and get going.

Major preventable risks for people living with mental illness:

- Smoking
- Obesity
- Diabetes
- Elevated cholesterol
- High blood pressure (also called hypertension)

These are risk factors that can be modified. With attention, you can live longer and enjoy a higher quality of life. Other risk factors, like age, gender, family history and even a history of psychological trauma, cannot be changed but need to be understood to assess your risk and the opportunities for prevention.

Medical Self Advocacy

Many people living with mental illness do not have access to quality medical care that meets all of their health care needs. Often, when someone tells a health care provider that he or she is taking antipsychotic medications or lives with a serious mental illness, a person will receive a lower quality of care or less attention. NAMI's Schizophrenia Survey demonstrated that many people find that even informing a health care provider of an illness worsened their care. The survey, wherein participants shared their mental health diagnoses, showed that nearly half (49 percent) of those surveyed say that doctors took their medical problems less seriously once they learned of their diagnosis; an additional 39 percent of those who responded say that their of schizophrenia made it more difficult to get access to other medical care.



It is important for people who live with mental illness to advocate for their own health care. Think of your health care providers as partners in your care. Make sure that you are communicating your concerns regarding your mental illness, but don't forget that think about the rest of your body and what you can be doing to prevent other medical conditions as well.

Engaging in Primary Health Care

Health care providers are a key part in improving and maintaining overall wellness. They have access to tests and information that can help identify issues and areas of need. Below are steps you can take to ensure the best from your primary health care visits.

- Be prepared. Before your health care appointment, make a list of concerns that you want to bring up with your provider and note which are the most important. Don't be afraid to ask follow-up questions if you don't completely understand your provider's responses; your health care provider is there to help you understand how to be healthy. You may want to keep a medical notebook where

you can jot down questions or thoughts that come up in between visits, track side effects or keep a chart listing medication refill dates.

- Do your research. If you have been diagnosed with a specific medical condition, learn as much as you can about it before your next appointment, being careful to avoid self-diagnosis. Make sure that you are only reading information from credible sources. A good place to start is <http://health.nih.gov/>. Also, learn additional information on mental illness medications from the NAMI Web site and from the National Institute of Mental Health (NIMH) at www.nlm.nih.gov/medlineplus/druginformation.html.
- Don't be embarrassed. If you feel shy about addressing a problem with your health care provider, don't forget that you are not the first person to experience this; he or she has probably heard it all before. Just like any good relationship, trust and honesty are very important. The more open you are, the better the chance is that your health care provider will be able to partner with you on your road to health and offer you the best guidance.

Heart Disease, Family History and Risks

If you have a family history of heart health issues and smoking, you will need to adapt your lifestyle. You should learn what risk factors your family member had, what risks you yourself may face and what you can do to help prevent heart disease. Knowing your family history of heart disease is very important; it is a risk factor that cannot be controlled. Major risk factors that cannot be changed include:

Increasing age: About 82 percent of people who die of heart disease are age 65 or older.

Gender: Men have a greater risk of heart attack than women, and they have attacks earlier in life.

Heredity (including race): Those with a family history of heart disease are more likely to develop it themselves. African Americans can have more severe high blood pressure and a higher risk of heart disease. Heart disease risk is also higher among Latinos, American Indians, Pacific Islanders, Alaska Natives and some Asian Americans. This is partly due to higher rates of obesity and diabetes in these populations.

History of trauma: The Adverse Childhood Experience (ACE) Study, which looks at long-term health and wellness of children who live with

psychological trauma, found that traumatic experiences are substantial risk factors for several chronic conditions including heart disease and tobacco use.

Major risk factors that can be changed include:

Use of tobacco: Smokers' risk of developing heart disease is two to four times that of nonsmokers. Cigarette smoking also acts with other risk factors to greatly increase the risk for heart disease. Exposure to other people's smoke increases the risk of heart disease even for nonsmokers.

Obesity and weight: People who have excess body fat, especially around the waist, are more likely to develop heart disease, even if they have no other risk factors. Excess weight increases the heart's work; thereby, potentially raising blood pressure, blood cholesterol and triglyceride levels. Being overweight may also lower HDL (good) cholesterol levels. It can also make diabetes more likely to develop.

Diabetes mellitus: Diabetes seriously increases the risk of developing cardiovascular disease. Even when glucose levels are under control, diabetes increases the risk of heart disease and stroke, but the risks are even greater if blood sugar is not controlled. At least 65 percent of people with diabetes die of some form of heart or blood vessel disease.

High blood cholesterol: As blood cholesterol rises, so does risk of coronary heart disease. Learn more about cholesterol by exploring the NAMI Hearts & Minds Web site further.

High blood pressure: When high blood pressure exists with other risk factors such as obesity, smoking, high blood cholesterol levels or diabetes, the risk of heart attack increases significantly.

Physical inactivity: An inactive lifestyle is a risk factor for heart disease. Physical activity can help control blood cholesterol, diabetes and obesity, as well as help lower blood pressure.

Along with family history and an assessment of these and other factors, a health care provider will be better equipped to determine and address cardiac risk.

Integrated Treatment and Co-occurring Disorders

Many people living with mental illness are also living with substance abuse disorders and other medical conditions. The need for integrated health

care is even more critical for individuals with these co-occurring, or dual-diagnosis, conditions. The mental health and substance abuse treatment systems historically have had different cultures and expectations and didn't get too involved with each other. Now it is finally clear that in order to appropriately treat individuals, care should be integrated. The system of care for people with dual diagnosis is learning to get more integrated and more creative while improving the ability of mental health professionals to screen and intervene with substance abuse problems and vice versa.

There are many great resources available to help you understand this complex issue. A great place for information on this effort is U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) Web site on Co-Occurring Center for Excellence at <https://coce.samhsa.gov>.

Culturally Competent Care

America's population is rapidly becoming more diverse. The cultural competence of our health care providers is important to enhancing positive health care outcomes. Culturally competent care brings together a combination of attitudes, skills and knowledge that allows health care providers to better understand and take care of people whose cultural backgrounds, sexual orientation, religious beliefs or gender are different from their own.



Medical care that lacks cultural competence has caused well-documented disparities in access to services and in quality of care for many individuals and communities. State health care systems' efforts to improve the cultural competence of services were graded in the *NAMI Grading the States 2009* report. Some states demonstrated more sophisticated thinking about the issue than others. It is clear that the mental health care system has a long way to go to equip a workforce to be culturally competent. NAMI and other advocates must continue to press for a health care workforce that meets the needs of all who rely on the system for care. You should be open about any personal, cultural, spiritual or religious issues. You should inform your provider if you have certain cultural needs or preferences to support your own unique recovery.

People from diverse backgrounds face additional heart health challenges. For example, there is a higher rate of diabetes among Asian American, African American, American Indian and Latino individuals. This additional risk is important to know before planning to proactively manage weight through diet and exercise, especially if taking antipsychotic medications as a part of a treatment plan. Antipsychotic medications differ widely in how much they increase the risk of diabetes. See the chart on page 27 for an independent assessment of the risk by medication and visit the American Diabetes Association and American Psychiatric Association (ADA/APA) Guidelines at <http://care.diabetesjournals.org/content/27/2/596.full>.

There is a great deal more to learn about how culture and biology relate to psychiatric medication dosages. The number of people from diverse racial and ethnic backgrounds in research has been historically low, which hampers efforts to address this important issue. There is some evidence that Asians may require lower doses of antipsychotics. There is also evidence that African Americans have historically been given higher doses of antipsychotics. The right medicine dosage cannot yet be determined based on race or ethnicity. Diet and alternative treatments are also an area of interest with culturally competent health care, and there is a great deal more to learn. For example, Ginkgo Biloba, which is used often in Hispanic food, can have effects on the metabolism of other medicines such as anticonvulsants (seizure medicines), antidepressants and even blood thinners. You should be talk openly to your health care providers about your diet and medicines you are taking.

Smoking Cessation

People living with mental illness have a very high rate of smoking. A study by the *Journal of the American Medical Association* reported that 44.3 percent of all cigarettes in America are consumed by individuals who live with mental illness and/or substance abuse disorders. This means that people living with mental



illness are about twice as likely to smoke as other persons. A positive note is that people who live with mental illness had substantial quit-rates, which were almost as high as the group without mental illness. NAMI has led many changes in our mental health system—getting access to the tools to quit smoking is a way to improve the quality and quantity of life. Improving lives is a new advocacy pursuit.

The Connection between Mental Illness and Smoking

There is no one single, certain reason why so many people who live with mental illness smoke. It may be a combination of brain effects, psychological effects and the social world in which we live. From a brain-based perspective, research is being done to determine if and how nicotine is involved in some of the brain's memory functions. If nicotine is a factor, then this could explain why so many people living with an illness like schizophrenia or other illness involving cognitive deficits may smoke. Even though smoking is thought to enhance concentration and cognition, the effects are short in duration.

While we still have a lot to learn about why people smoke, there is plenty of information to support the serious health risks of smoking. So while there may be good reasons why you were attracted to smoking, the key is to figure out ways to increase rates of quitting. Nicotine isn't a health problem on its own, but when smoked and combined with hundreds of other chemicals that are present in cigarettes, the practice of smoking is toxic.

The Reality

People die from smoking-related illnesses. Every year, smoking kills about 200,000 people who live with mental illness. Smoking harms nearly every organ of your body and diminishes your overall health. Smoking is a leading cause of cancer and of cancer-related death.

Inhaled cigarette smoke is made up of 4,000 chemicals, including cyanide, benzene, ammonia and carbon monoxide to name a few. There is no safe tobacco product, so switching to a smokeless or chew product will not eliminate your risk of smoking-related diseases.

Smoking also causes heart disease, stroke and lung disease. With the increased risk of heart disease from second-generation antipsychotic medications (SGAs), individuals living with mental illness must try to quit. For more information on cancer risks, visit www.cancer.gov.

The mental health community is finally waking up to the fact that smoking is a true health hazard, and people need to quit in order to live longer. More mental health care facilities are going smoke-free, and NAMI is advocating for access to smoking cessation programs.

Effects on Symptoms and Medications

Research shows that people living with mental illness do not have worse symptoms after they quit. If you are a smoker and you quit, you can usually get the same treatment results from lower doses of psychiatric medications. Smoking increases the breakdown of medicines in your body, so smokers need to take higher doses to get the same results as someone who does not smoke. Without cigarettes you may need to take less medication. An additional benefit is that a dose reduction will likely reduce side effects of medicines, such as weight gain and other side effects.

Smoking and Diabetes

It is very hard to live with more than one medical problem. Diabetes is a big issue for many people who live with mental illness and, like smoking, it increases the chances of early death. The two problems together are doubly dangerous. For instance, smoking and diabetes increases your chances of having a heart attack 11 times higher than the general population.

Benefits of Quitting

It often takes multiple attempts to quit smoking; don't give up if your first try is unsuccessful. There are immediate and long-term benefits to quitting smoking. Several benefits you will notice right away include:

- your sense of taste will improve;
- your sense of smell returns to normal;
- your breath, hair and clothes will smell better;
- your teeth and fingernails stop yellowing;
- you will save a lot of money;
- you will have more energy and time for ordinary activities; and
- you will be more acceptable socially with nonsmokers.

Within minutes of smoking the last cigarette and beyond, the body begins to restore itself.

Time after quitting	Benefits to your Health
20 minutes	Your heart rate and blood pressure drop
12 hours	Carbon monoxide level in your blood drops to normal
Two weeks to three months	Your circulation improves and your lung function increases
One to nine months	Coughing and shortness of breath decrease; lung function normalizes
One year	Excess risk of heart disease is cut in half
Five years	Your stroke risk is that of a nonsmoker
10 years	Lung cancer death rate is half of a smokers
15 years	Risk of heart disease is that of a nonsmoker

Tools for Success: Alternatives, Treatments and Medications

To quit permanently, you may need to rely on more than one method at a time. Methods may include step-by-step manuals, phone support, self-help classes, counseling, nicotine replacement therapies (NRT) and/or prescription medications.

There are several products scientifically proven to help double or triple your odds of quitting for good. However, it is possible that you will feel some effects of nicotine withdrawal. Getting temporary nicotine in your system while quitting can help you feel more comfortable and in control as you start your tobacco-free life.

Nicotine Replacement Therapies (NRT)

NRT is a combined approach that includes a smoking-cessation product plus behavior change and support. If used properly, NRT can help double or triple your chances of quitting. All NRT products have side effects, so before deciding on an option, know the risks and benefits of each option. Use caution if you have heart disease or a history of heart disease and consult your doctor before taking medication.

Over-the-counter Options

Nicotine Patch	Patches are placed on the skin and supply a small, steady amount of nicotine to the body. Patches contain varied levels of nicotine, and the user reduces the dose over time.
Nicotine Gum	Gum is chewed to release nicotine. Gums also have varied concentrations to allow the user to reduce the amount of nicotine over time.
Nicotine Lozenges	Lozenges look like hard candy, release nicotine and dissolve in the mouth.

Prescription Options

Nicotine Inhaler	Allows the user to inhale nicotine through a mouthpiece at a predetermined dose.
Nicotine Nasal Spray	Allows user to spray nicotine straight into the nose. Can be used for fast craving control, especially for heavy smokers. <i>Caution is urged if you have high blood pressure because your condition could worsen. Also be aware if you have a heart condition, asthma or glandular problem (i.e., insulin dependent diabetes).</i>
Zyban Generic: Bupropion	Helps reduce nicotine withdrawal and the urge to smoke. Can be used safely with nicotine replacement products. Side effects: seizures and mood changes (Some people should not take Zyban including those who have ever had a seizure, a head injury, take some antidepressants [MAO inhibitors], take other medications containing bupropion or have/had an eating disorder.
Chantix Generic: Varenicline	<p>Helps ease nicotine withdrawal symptoms and blocks the effects of nicotine from cigarettes if the user resumes smoking. Side effects: change in mood (Reports of serious symptoms have been made claiming agitation, depressed mood, feeling hostile, changes in behavior, impulsive/disturbing thoughts or individuals thinking about hurting themselves or others.)</p> <p><i>Tell your doctor immediately if you have worsening of depression or other mental health issues as they could worsen while taking this medication.</i></p>

Substance Abuse and Alcoholism

According to the *Journal of the American Medical Association*, approximately 50 percent of individuals living with severe mental illness are affected by substance abuse. About 37 percent of individuals with alcoholism and 53 percent of individuals with drug addictions have at least one serious mental illness.

More deaths, illnesses and disabilities stem from substance abuse than from any other preventable health condition. Today, one in four deaths is attributable to alcohol, tobacco and illicit drug use. People who live with under-treated or untreated mental illness and substance dependence have higher risk of all bad outcomes including injuries, medical problems, incarceration and death.



Alcohol dependence is what people think of when they think of alcoholism. Alcoholism is a disease that occurs when a person has a strong need or urge to drink, the inability to stop drinking and/or physical dependence on the alcohol, including withdrawal symptoms or the need to drink greater amounts of alcohol to experience a high.

Recovered, or sober, individuals report that the craving an alcoholic feels for alcohol can be as strong as the need for food or water. An active alcoholic will drink despite serious family, health or legal problems.

Drug abuse is the habitual use of illegal, prescription or over-the-counter drugs for purposes other than they were intended. Drug abuse may substantially injure the user and interfere with social, physical, emotional and job-related functioning.

Although initial drug use may be voluntary, drugs have been shown to alter brain chemistry, which interferes with an individual's ability to make decisions and can lead to compulsive craving, seeking and use. This then becomes a substance dependency.

The impact of drug abuse and dependence can be far reaching, affecting almost every organ in the human body.

Getting Help

There are many resources and supports available for conquering addiction. As you work to put a plan in place, educate yourself about pharmaceutical options, treatment facilities, outpatient behavioral treatment and community-based social support. There are many ways to get sober and no one right path. But recovery is a process that is often strengthened by self-help support.

The self-help recovery movement is strong in the substance-abuse community. Alcoholics Anonymous (www.aa.org) is a free, 12-step organization that has helped millions of individuals. Al-Anon (www.al-anon.alateen.org) is a program for families to help them learn detachment and to separate their responsibility from that of the addicted person. Al-Ateen (www.al-anon.alateen.org) is a program geared for adolescents who have addicted family members. Smart Recovery (www.smartrecovery.org) is also a sobriety support program that does not share the religious focus of AA, but is rooted in science. Double Trouble groups (www.doubletroubleinrecovery.org) offer self-help support for individuals living with both mental illness and addiction.

Some self-help groups are sophisticated enough to help people achieve sobriety while accepting a psychiatric condition and the need for psychiatric medications. However, some AA groups have historically discouraged dually diagnosed persons from taking psychiatric medications. It can be useful to shop the meetings in your area to find one that best meets your individual needs. If you are taking medications for a mental illness and utilize AA support, be sure that your sponsor understands and respects your medication choices.

Your best ally in identifying help may be your primary care provider. He or she can refer you to specialized care by recommending someone with additional addiction training or to a treatment facility. Medication and behavioral therapy are often included in a comprehensive treatment program. Publicly funded treatment centers are available. For more information on these facilities in your state, please call (800) 662-HELP or visit www.findtreatment.samhsa.gov.

Healthy Eating

When we refer to our diet, we are referring to what we eat. We all need nutrition to support our bodies. A poor diet equals poor health, contributing to obesity, metabolic syndrome and diabetes—conditions

that many people living with mental illness are at high risk of developing.

Food doesn't just feed our bodies, it also nourishes our minds. Carbohydrates, fats, proteins, vitamins and minerals in food are essential parts of any diet that provide specific benefits for the body. A lack of any of these nutritional components can lead to physical difficulties, increased mental-health problems and even changes in brain functioning.



Nutrition is important for everyone. If you are living with mental illness, eating well is especially important for you, because what you eat can affect your daily life, mood and energy level. Healthy eating is not about being thin or deprivation. Healthy eating is about feeling good, having more energy, participating in your recovery and mapping out your future. Simply put, healthy eating is one of the best things you can do to improve wellness.

Learn more about healthy eating and how you can choose foods that are right for you. Use the guidelines and tips in NAMI Hearts & Minds to create and maintain a satisfying, healthy diet.

The Pyramid

Dietary guidelines set by the USDA state that a healthy diet is one that emphasizes fruits, vegetables, whole grains and fat free or low fat milk products. A healthy diet should include lean meats, poultry, fish, beans, eggs and nuts. Be sure to limit saturated fats, trans fats, cholesterol, sodium and added sugars. Learn more about the U.S. government's guidelines by reviewing the food pyramid.



By following the guidelines above, you will ensure that you will be consuming the appropriate amounts of carbohydrates, proteins, vitamins and minerals to help your body works efficiently.

Calories and Weight Loss

A calorie is a unit of energy. Depriving the body of needed energy impairs your mood and your ability to think clearly. People who consistently eat less than their bodies need may begin to experience irritability, lethargy, a lack of concentration and may feel sad and hopeless as a result of a poor diet. In addition, people who consume more calories than they need will always gain weight.

Are you concerned about your weight? If so, it is important to know that your weight is determined by the number of calories you ingest minus the number of calories you burn—period. If you consume 2,500 calories a day but only burn 2,000 through your daily activities and exercise, you will gain weight.

To help figure out how many calories you burn a day, consult with your health care provider, a nutritionist or access an online calculator. Once you have this information, you can use it to help kick-start weight loss, especially if used along with a food journal, which you will read about later.

There are 3,500 calories in one pound of body fat. In order to lose weight, a person must cut calories from his or her daily diet. Cutting 500 calories a day will result in the loss of one pound per week. Never consume less than 1,200 calories a day. Always consult with your doctor before drastically changing your diet.

If you are overweight, you will benefit from even the smallest weight loss. Losing excess body weight can reverse or prevent diabetes, lower blood pressure, cholesterol and triglyceride levels and improve sleep apnea and other sleep problems.

Food Labels

Food labels are very important in determining what ingredients and nutrients are in your food. While they can be confusing (and sometimes even misleading), the NAMI Hearts & Minds program will help you inform yourself, resulting in better food choices and achieving any diet goals you set.



Visit the FDA Web site for additional information on food labeling and nutrition at www.fda.gov.

What's a Serving Size?

Remember: One package does not necessarily equal one serving size. On this box of macaroni and cheese in the food label we have been using as an example, the label displays information for one serving even though the package contains two full servings.

Check the calories

Calories serve as a measurement of how much energy you are getting from a serving of food. It is common for people to consume more calories than they need in a day without eating enough healthy nutrients. Here's a quick guide to calories:

- 40 calories = low
- 100 calories = moderate
- 400 or more calories = high

Remember that most people only need about 2,000 calories a day. Aim to eat three meals a day that fall around the 500- or 600-calorie range and a few snacks if you get hungry between meals while also maximizing your nutrient intake. Think about the poor choices out there, like a large fast-food burger. Some of them come in at close to 800 calories—without french fries. That is nearly half of your day's calories! Eating too many calories on a daily basis will lead to obesity for most people.

Limit Fats, Sodium and Cholesterol

These three items are highlighted in yellow. Too much of any or all of these can result in chronic diseases. It is recommended to keep your intake of these nutrients to a minimum—check the footnote for the recommended daily value of each.

How Does Sodium Affect Lithium?

Lithium is a naturally occurring mineral with an electrical charge similar to salt. The level of salt in your body affects the action of lithium. Once lithium reaches therapeutic range, it can be altered by small changes in daily salt intake.

If you normally don't eat much salt and then sit down one night and eat a bag of potato chips or a pizza or canned soup, your lithium level will likely decrease. If you've been diligent with your lithium medicine routine but

have changed your salt-eating pattern, it may significantly interrupt your medication treatment outcome. Keeping your sodium intake fairly consistent is very important for people who take lithium.

If you are very active and sweating a lot, or have diarrhea or are vomiting, you could lose a lot of sodium and then your body may end up with too much lithium. Never take salt tablets or go on a salt-restricted diet without talking to your doctor if you are taking lithium. Lithium has predictable blood levels, and to understand what is too high or too low, talk with your health care provider about adjusting your lithium dosage if you are lowering your sodium intake.

Choosing the Right Foods

Following is a list of healthful foods and suggested balances of varieties of foods that will help you learn more about healthy eating. It may be helpful to visit our section on vegetarian diets on page 21.

Whole grains

The benefits of a high-fiber diet are well-known. Besides fiber, whole grains provide B vitamins, folic acid, iron and magnesium. Look at the ingredient list on breads and other grain products. The first ingredient should say “whole wheat” or “100 percent whole grain.” Look at the nutrition facts panel for at least two grams of dietary fiber per slice of bread.

The more fiber in a product, the better! Fiber normalizes bowel movements, helps maintain bowel health, lowers cholesterol levels, controls blood sugar levels and helps with weight loss. Fiber keeps you feeling full longer, helping you avoid over-eating or snacking when trying to lose weight.

Fats (including saturated fat, trans fats and Omega-3 fats)

There are good fats and bad fats. Foods that are high in saturated fats can increase our cholesterol levels. It is important to limit foods such as fatty meats, whole milk, butter and tropical oils such as coconut and palm.

Trans fats should be eliminated, so look at the nutrition facts panel and avoid foods that contain partially hydrogenated oils. Foods such as margarine, shortening, commercial french fries and pastries are often high in trans fat. When choosing cooking oil, use canola or olive oil whenever possible.

Omega-3 fats, which have health benefits, are found in fatty, deep-water fish such as salmon, tuna, bluefish, sardines and herring. Some studies show that Omega-3 fats provide protection against heart disease, stroke and may also be useful for depression and other health issues. Omega-3 fatty acids are a source of ongoing research in psychiatric conditions.

The American Heart Association recommends two servings of fatty fish per week. If you are planning to get pregnant, review information on mercury and other contaminants that are found in fish. Before taking Omega-3 supplements, be sure to talk with your doctor. Omega-3 capsules may interact with other medications and have a blood-thinning effect. If you are vegetarian, flaxseed oil can offer Omega-3 fatty acids as well.

Milk and Milk Products

Milk products are our main source of calcium and vitamin D, both of which are essential for healthy bones and teeth. Milk and milk products are also a good source of riboflavin, potassium, protein and magnesium. Vitamin D is a hot topic in research prevention at this time.



The recommendation for calcium is 1,000-1,200 mg per day. One serving of milk contains about 300 mg. Other sources of calcium include yogurt, cheese, dark green vegetables and calcium-fortified orange juice. The USDA MyPyramid recommends three cups of milk or milk products per day based on a 2,000-calorie diet. If you cannot tolerate milk products, try lactose-reduced products. Also, talk with your doctor about using calcium/vitamin D supplements.

Vegetables

Everyone knows that they should eat plenty of vegetables. Vegetables are low in calories but high in fiber, potassium, vitamins A, C and E and phytonutrients. Vegetables that are dark in color have the most nutrients. Examples are broccoli, spinach, sweet potatoes and carrots. Benefits of eating vegetables include reduced cancer risk, reduced risk of heart disease, lower blood pressure, diabetes prevention and help with weight control. The USDA MyPyramid recommends five (one-half cup) servings of vegetables every day based on a 2,000-calorie diet. Choose a wide variety of colors when selecting your vegetables each day for the most health benefits.

Fruits

Apart from vegetables, fruits are the most colorful foods on the pyramid. They provide fiber, folic acid and a variety of other nutrients such as vitamin C, potassium and health-protective phytonutrients. Also, they are relatively low in calories and



make a healthy, filling snack. Benefits of fruits are similar to those of vegetables. MyPyramid recommends four (one-half cup) servings of fruit every day based on a 2,000-calorie diet. Choose a wide variety of colors when selecting your fruits each day for the most health benefits.

Nuts and Seeds

Nuts can provide a powerhouse of nutrients. Each type of nut offers its own health benefits. For example, walnuts contain plant-based Omega-3 fatty acids, almonds are high in vitamin E and Brazil nuts are high in selenium (an antioxidant). Since nuts and seeds are high in calories, be sure to watch your portion size. MyPyramid recommends a small handful of nuts (about one oz., equal to 20 small nuts, or two tablespoons of peanut butter) every day based on a 2,000-calorie diet.

Beans

All beans are inexpensive, low-fat, nutrient powerhouses. They contain protein, fiber, B vitamins, iron, folic acid, potassium, magnesium and phytonutrients.

Protein

Meats are currently the main source of protein in the American diet. Reducing the amount of meats we eat and increasing our intake of vegetables, fruit and whole grains is essential to eating more healthfully. All red meat choices should be lean, and poultry should be skinless. Choosing white meats over red meats is a good general strategy. Fish should be eaten at least twice a week. Beans, tofu and nuts can substitute for meat in meals. This food group (meat, beans, seeds, nuts and fish) provides protein, B vitamins, iron, magnesium, zinc and vitamin E. MyPyramid recommends five to six oz. of meat protein a day based on a 2,000-calorie diet.

Special Diets

Dairy-free and Vegan Diets

A dairy-free and vegan diets contain absolutely no dairy products: no milk, butter, cheese, cream or yogurt. Those following a dairy-free or vegan diet are advised to make sure they get enough calcium, protein and vitamins from other food sources.

Dairy substitutes may include: almond milk, apple, pear or prune puree, cheese alternatives (soy, rice), multi-grain milk, nondairy frozen desserts, oat milk, rice milk or soy milk. When baking, milk may be substituted, in equal amounts, with water or fruit juice. In planning meals, make sure that each day's diet includes enough calcium. Many nondairy foods are high in calcium, such as green vegetables (broccoli, cabbage and kale) and fish, such as salmon and sardines. Incorporating tofu into meals also helps to ensure that you are getting calcium.

Vegetarian Diets

Some people choose vegetarian diets for environmental, cultural, religious and ethical factors, while some choose not to eat meat because they believe it's a healthier choice. If you are or are thinking about embracing a vegetarian diet, you will need to take extra steps to ensure that you're meeting your daily nutritional needs.

A healthy vegetarian diet consists primarily of plant-based foods such as fruits, vegetables, whole grains, legumes, nuts and seeds. A vegetarian diet generally contains less fat and cholesterol and typically includes more fiber. You will want to make sure that you are eating foods to give you and adequate amounts of protein, calcium, vitamin B-12, iron and zinc.

The key to a healthy vegetarian diet—or any diet for that matter—is to enjoy a wide variety of foods. Since no single food provides all the nutrients your body needs, eating a wide variety helps to ensure that you'll be getting the necessary nutrients that promote good health.

Dining Out

There is nothing wrong with asking restaurants may be able to make healthier versions of their dishes. Ask if you can get your food baked, roasted or steamed instead of fried. Ask for fat free milk rather than whole milk. Ask for salad dressing on the side. Part of the battle of eating healthy

is making minor decisions like these and you may not even notice the difference in taste.

Although buffets may give you the most food for the least amount of money, it can be pretty dangerous to have “all you can eat.” If you’re eating at a buffet, challenge yourself.

Fill up one healthy-sized plate with everything you want and don’t go up for seconds! It takes about 20

minutes for your brain to tell your body that you’re full so take your time digesting before assuming that you need more food.



Eating Well on a Tight Budget

It's easy to eat healthy, even if you're on a budget.



Avoid temptations while shopping at the grocery store by making a list of healthy items you want to buy. By doing this, you are less likely to get what you want and more likely to get what you need. Consider planning a week’s worth of meals and buy all of the ingredients for them at once. That way, you can plan to eat healthy every night and won’t have to take multiple trips to the grocery store.

Impulse buys are very common in the grocery store and if you’re hungry, you are more likely to give in to buying what you’re craving and not what you should be eating. So go to the grocery store after a healthy meal when you are feeling satisfied and not famished.

Be aware that pre-packaged foods can contain unhealthy chemicals and preservatives and are often high in sodium, sugar and fat. They also tend to be expensive. If you make your own food with fresh and frozen ingredients, not only will you save money, but you also can control every last thing that goes into your food and into your body.

Shop the perimeter of the grocery store. That’s where the healthier foods often are! If you think about the layout of the grocery store, you will realize that the freshest produce, such as fruits and vegetables, are

stocked around the store's perimeter. Why even tempt yourself by walking through the aisles of junk food and sugary sodas?

And finally, shop sales, buy in bulk with a friend and split large quantities and check out discount grocery outlets who usually offer a selection of healthy and fresh foods at reasonable prices.

Using Food Stamp Benefits

The goal of the U.S.D.A. food stamp program, now known as the Supplemental Nutrition Assistance Program (SNAP), is to help U.S. households enjoy healthy diets.

Food stamp benefits can buy any food intended to be eaten at home. This includes breads and grains, dairy products, fruits and vegetables, meat, fish and poultry, nonalcoholic beverages (juice, water), snack foods, etc.

Today, nearly 800 farmers' markets across the United States accept food stamps—it doesn't get any healthier than that! Farmers' markets offer the freshest produce, and often times dairy products such as cheeses, milk, eggs and even local meat products. To find a farmers' market that accepts food stamps near you, visit www.fns.usda.gov/fsp/ebt/ebt_farmers_markstatus.htm.

To learn more about SNAP, find your state office contact information or to see if you are eligible for assistance, visit www.fns.usda.gov/snap or call 1 (800) 552-3431.

Exercise

Movement can be good for body, spirit and mind. As with the everyone, activity and exercise are very important for people with mental illness. Currently, there is strong scientific evidence that physical activity can lower the risk of the following in adults and older adults:

- Early death
- Heart disease and stroke
- Type 2 diabetes
- High blood pressure
- Poor lipid profile (cholesterol/triglycerides)
- Metabolic syndrome
- Colon and breast cancers
- Weight gain
- Symptoms of depression
- Falls



Exercise doesn't have to be intimidating or expensive. Who needs a gym membership when you can walk with our without friends? As long as you

get up and do something, your body will thank you, and you may even surprise yourself and have some fun. Movement of most kinds can be very beneficial. Follow the steps below to form your own exercise routine:

Warm-up: This portion of the program helps your body adjust to an increased pace. Your warm up should last between five and 10 minutes.

Strength Training: This section of the program can be done in many different ways and will help protect your body from osteoporosis, help burn calories and increase lean muscle mass and well-being.

Aerobic Exercise: This part of the program includes exercise that makes your heart work harder and makes you breathe deeper and harder. This is the type of exercise best associated with reductions in depression and anxiety.

Flexibility Exercises: This portion of the program, more commonly known as stretching, can be done anywhere and anytime. Yōga, tai chi and Pilates are all ways to increase flexibility, build core strength and also reduce stress.

Cool-down: This last section of the program allows your body to slowly cool down. Once complete you should feel as though your heart rate and breathing rate are near normal.

Your Heart Rate

Your maximum heart rate is about 220 minus your age. For cardiovascular benefits you will want to exercise within 60-85 percent of your maximum heart rate.



Age	Average Maximum Heart Rate	Target Zone 60%-85% of Maximum
20	200bpm	120 to 170 bpm
25	195	117 to 166
30	190	114 to 162
35	185	111 to 157
40	180	108 to 153
45	175	105 to 149
50	170	102 to 145
55	165	99 to 140
60	160	96 to 136
65	155	93 to 132
70	150	90 to 128

Sticking to a regular exercise program can be challenging. For more resources, tips and information on exercise, visit www.nami.org/heartsandminds.

Metabolic Syndrome and Type 2 Diabetes

Unfortunately, the risk of diabetes is greater for people living with mental illness, especially those taking second-generation atypical antipsychotic medications (SGAs). In addition, another issue to be aware of is metabolic syndrome, a condition that can be a precursor to diabetes. Left untreated, these two issues can cause severe health problems and can shorten your life. NAMI Hearts & Minds can give you a start on the information you need to meet these problems head-on.

High Risk Individuals and Factors

Diabetes and the metabolic syndrome are found in higher numbers in these groups of individuals living with mental illness:

- People living with schizophrenia and bipolar disorder/mood disorders.
- African Americans, Latinos, American Indians and Asian Americans.
- People who smoke.
- People with a family history of diabetes and metabolic syndrome.
- People who take second-generation atypical antipsychotic medication (SGAs).

Metabolic Syndrome

Metabolic syndrome is a combination of medical risk issues. These issues include worsening sugar control, high blood pressure, elevated cholesterol and other problems. Metabolic syndrome raises the risk for diabetes and heart disease and can be thought of as a condition that precedes diabetes.

Waist circumference as well as glucose and lipid levels are key measures for metabolic syndrome. To stay safe, it is recommended that waist circumference not exceed 40 inches in men and 35 inches in women.

There is evidence that this is a real issue for people living with mental illness—the syndrome equally affects both men and in women and is more common in people who take SGAs. The same strategies you would consider in managing diabetes are the same you should consider if you have indications of metabolic syndrome—walking (and other exercise), nutrition and working with your health care provider to monitor your progress on this issue are the keys to its prevention.

Type 2 Diabetes

Diabetes is a problem related to how your body uses sugar. It is a serious medical problem. There are several types of diabetes—we will focus on the adult-onset type, also called Type 2 diabetes. Type 2 diabetes results from cells in person's body failing to use insulin properly. Insulin enables cells in the body to use glucose (a kind of sugar) to turn it into energy. In Type 2 diabetes, the rising glucose levels seen in the bloodstream are an indicator that the body is not using insulin well. Being overweight, especially around the middle/abdomen, is the most common underlying cause of adult-onset diabetes. Having a family history of adult-onset diabetes is another risk. By becoming more active and engaging in a weight-loss program, you may be able to halt and even reverse adult-onset diabetes. Talk with your health care provider before beginning an exercise or diet program.

SGAs and Diabetes Risk

All medications have side effects. Side effects may be rare or common, serious or merely annoying. A medicine with frequent mild side effects may be tolerated by a majority of people and be regarded as relatively safe. On the other hand, if a medicine has more serious side effects, it informs treatment decisions and indicates a need for risk-monitoring.

You should review and discuss the risks of side effects versus the expected benefits of any medication with your health care provider. In many cases, especially when considering the options of nontreatment, even serious side effects may be worth the risk.

Some medications offer greater risks than others, and the same is true for SGAs. The chart on the opposite page offers information on how these various medicines are ranked in terms of risk. It is imperative that you understand this information as you choose a medication in partnership with your health care provider. Talk with your health care provider about the relationship between your medicine and diabetes or diabetes risks.

Be sure to engage in a conversation with your health care provider about what medicine could be the best fit for you. While initial awareness of increased SGA risk for weight gain, metabolic syndrome and diabetes was slow to evolve, it is now very clear to the FDA as well as to individuals, family members and health care providers.

Symptoms

Type 2 diabetes can exist in a person for years before it is identified. The most common symptoms of undetected diabetes are increased thirst and urination. Fatigue is also common. Other signs include dry and itchy skin, blurry vision and slowly healing wounds. If you notice any of these symptoms, it is important to get your sugar (glucose) level checked when you see your health care provider. A simple blood test will tell you if you are either at risk for, or if you have, Type 2 diabetes. A fasting blood sugar over 126 mg/dl (milligrams per deciliter) is one key diagnostic criteria.

Monitoring

The best practices for heart-risk prevention and diabetes monitoring in people who take SGAs are ever-evolving. One of the key documents in both of these fields is the 2004 ADA/APA Guidelines. These Guidelines have since been viewed as not aggressive enough in monitoring for lipids like triglycerides and cholesterol by many clinicians. The ADA, www.diabetes.org, offers the latest information and guidelines for diabetes generally, which include information on children and teens that are at increased risk for developing diabetes.

The ADA suggests that if your blood glucose levels are in the normal range, it is a good idea to get checked every three years. If you have pre-diabetes, you should be checked for Type 2 diabetes every one to two years after your diagnosis.

Heart Risks of SGAs

SGAs and Diabetes Warning Signs			
Drug	Weight gain	Risk for diabetes	Worsening lipid profile
Clozapine	+++	+	+
Olanzapine	+++	+	+
Risperidone	++	D	D
Quetiapine	++	D	D
Aripipazole*	+/-	-	-
Ziprasidone*	+/-	-	-
+ = increase effect; - = no effect; D = discrepant results.			
* Newer drugs with limited long-term data.			

Source: *Diabetes Care*, February 2004

Note: This ADA chart was created in 2004. Newer SGAs such as Paliperidone (Invega) and Asenapine (Saphris), which are not included on this chart, do carry heart-related side effects. As these are newer medications, more will be learned about the details of their side effects over time. To keep up to date on the latest FDA-approved medicines, visit www.fda.gov.

Talk with your health care provider about your concerns. If you are taking SGAs, you should have or obtain a baseline of data that will help you monitor your risks. The chart below outlines a suggested schedule for you to discuss with your health care provider.

Schedule for Monitoring Patients On Second Generation Antipsychotics*							
	Baseline	4 wks	8 wks	12 wks	Quarterly	Annually	Every 5 yrs
Personal/family history	X					X	
Weight (BMI)	X	X	X	X	X		
Waist circumference	X					X	
Blood pressure	X			X		X	
Fasting plasma glucose	X			X		X	
Fasting lipid profile	X			X			X

More frequent assessments may be warranted based on clinical status
Source: *Diabetes Care*, February 2004

Treatment and Disease Management

If you have Type 2 diabetes, making exercise, such as walking, and a healthy diet part of your lifestyle are good first steps to treating your condition. There is no question that attention to exercise and diet is essential to managing and preventing these problems. In addition, there is increased interest in the use of antidiabetic medications such as metformin along with SGAs even before diabetes is identified.

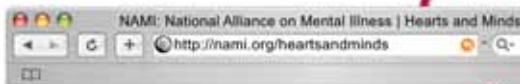
If you have diabetes, ask your health care provider to get a longer-term measure of your sugar control, called an HgbA1c (pronounced hemoglobin AYone see). This can tell you how your diabetes has been controlled over the previous months and is a good way to get information about your current condition. This can help to inform your future efforts. In general, a reading of seven or lower is considered good.

Remember

A very troubling fact is that most people with these conditions who also live with mental illness are not getting good preventive or medical care for these problems.

Even though they are trained as medical doctors, sometimes psychiatrists don't consider medical problems to be a core aspect of their responsibility. Conversely, some internists manage diabetes everyday but do not appreciate the increased risk of people living with mental illnesses or the risks associated with the use of SGAs. People can find themselves caught between the two systems with a lack of clarity about roles and responsibilities, resulting in fragmented care. Remember to seek out and demand the best health care you can find and afford. Everyone deserves a high level of health care—something NAMI is striving to achieve for every person living with mental illness. For more resources, including fact sheets and videos, visit www.nami.org/heartsandminds.

For more information about
the NAMI Hearts & Minds program visit





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Healthy Eating

Nutrition is important for everyone, but if you are living with mental illness, eating well is especially important for you. The foods you eat can affect your daily life, mood and energy level.

Healthy eating is not about being thin or deprivation. The word “diet” refers to eating habits. A healthy diet is about feeling good, having more energy, participating in your recovery and mapping out your future. A poor diet equals poor health, contributing to obesity, metabolic syndrome and diabetes—conditions that many people living with mental illness are at high risk of developing.

What's a Portion Size?

- **Woman's fist or baseball** = 1 serving of vegetables/fruit.
- **A rounded handful** = about 1/2 cup cooked or raw veggies or cut fruit, a piece of fruit or 1/2 cup of cooked rice or pasta. This is also a good measure for a snack serving, such as chips or pretzels.
- **Deck of cards** = 1 serving of meat, fish or poultry.
- **Golf ball or large egg** = 1/4 cup of dried fruit or nuts.
- **Tennis ball** = about 1/2 cup of ice cream.
- **Computer mouse** = 1 small baked potato.
- **Compact disc** = 1 serving of a pancake or small waffle.
- **Thumb tip** = about 1 teaspoon of peanut butter, butter or margarine.
- **Six dice** = 1 serving of cheese.
- **Check book** = 1 serving of fish (approximately 3 oz.).

What Is a Healthy Diet?

A healthy diet emphasizes fruits, vegetables, whole grains and fat-free or low-fat milk products. A healthy diet should also include lean meats, poultry, fish, beans, eggs and nuts. Be sure to limit saturated fats, trans fats, cholesterol, sodium and added sugars.

Here is a list of healthy foods. Visit www.mypyramid.gov to see the recommended balance for a good diet as suggested by the U.S. Department of Agriculture.

Whole grains

The benefits of a high-fiber diet are well-known. Besides fiber, whole grains provide B vitamins, folic acid, iron and magnesium. Look at the nutrition facts panel for at least two grams of dietary fiber per slice of bread. The first ingredient should say “whole wheat” or “100 percent whole grain.”

Fats

Foods that are high in saturated fats can increase our cholesterol levels. It is important to limit foods such as fatty meats, whole milk, butter and tropical oils such as coconut and palm.

Trans fats should be eliminated, so look at the nutrition facts panel and avoid foods that contain partially hydrogenated oils. Foods such as margarine, shortening, commercial french fries and pastries are often high in trans fat. When choosing cooking oil, use canola or olive oil whenever possible.

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The recommendation for calcium is 1,000-1,200 mg per day. One serving of milk contains about 300 mg. Other sources of calcium include yogurt, cheese, dark green vegetables and calcium-fortified orange juice. If you cannot tolerate milk products, try lactose-reduced



products. If you are dairy-free or vegan, go for calcium-fortified soy or rice milk.

Vegetables

Vegetables are low in calories but high in fiber, potassium, vitamins A, C and E and phytonutrients. Benefits of eating vegetables include reduced cancer risk, reduced risk of heart disease, lower blood pressure, diabetes prevention and help with weight control. Choose a wide variety of colors when selecting your vegetables each day for the most health benefits.

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Tips for Eating Well on a Tight Budget

- Bring a list to the grocery store, and stick to it.
- Eat a light snack before you shop to reduce impulse buying—don't shop hungry.
- Choose fruits, vegetables and meats that are on sale and use coupons. You can freeze anything extra that you pick up on sale.
- Buy produce in season because it is priced to sell.
- Consider buying generic store brands because they are generally the same quality as national brands but with a different label.

- Avoid buying individually bottled drinks.
- Look up recipes that use specific ingredients that you know you can get cheaply.
- Stock cupboards with quick, easy, cheap items: beans, brown rice, pasta, low sodium soup, frozen produce, condiments, canned fish and eggs.
- Buy nonperishables in bulk when they are on sale.
- Beans are an inexpensive and healthy source of protein.

Dining Out

Restaurants may be able to make healthier versions of their dishes, and there's nothing wrong with asking. Most restaurants just want to make customers happy. Ask if you can get your food baked, roasted or steamed instead of fried. Ask for fat-free milk rather than whole milk. Ask for salad dressing on the side. Part of eating healthy is making minor decisions like these, and you may not even notice the difference in taste.

Food Journals

Keeping a food journal will help you uncover patterns relating to what, when, why and how much you eat and aid you in deciding what changes to make. It is also a surefire way to determine whether you are deducting the correct amount of calories from your diet if you are trying to lose weight.

Get started on your journal today by using an old-fashioned paper and pencil or an online program like the www.my-calorie-counter.com, www.fitday.com or the www.myfooddiary.com.



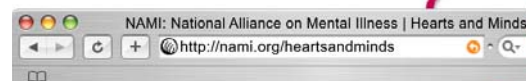
NAMI Hearts & Minds program is an online, interactive, educational initiative promoting the idea of wellness for individuals living with mental illness. This Fact Sheet is offered for informational purposes only. It does not intend to recommend specific treatment or strategies. Individuals should always engage with their health care provider before addressing diet.

This project was made possible with support from Optum Health Public Sector and the Smoking Cessation Leadership Center—University of California. NAMI does not endorse or promote any specific medication, treatment, product or service.

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For more information about healthy eating or the NAMI Hearts & Minds program, visit





Mental Illness and Exercise

As with the general population, activity and exercise are very important for people living with mental illness because of a higher risk for heart disease. Exercise can have a huge impact on your health. Physical activity can lower the risk of early death, heart disease and stroke, Type 2 diabetes, high blood pressure, weight gain and high cholesterol—all problems commonly found among people living with mental illness.

While exercise is extremely important, please engage with your health care provider before starting an exercise plan. He or she will confirm that you are putting together a safe and appropriate plan.

Tips for Exercising on a Budget

Take advantage of everyday opportunities. You don't need special equipment for an aerobic workout. Take a brisk walk every day, whether it is a path through your neighborhood or laps in a local mall. Make a workout of household chores.

Consider modest investments. Some inexpensive products to consider include dumbbells, resistance tubing, balance balls, jump ropes and exercise videos or DVDs—some may even be available for free from your local library.

Improvise. Exercise doesn't have to be intimidating or expensive. You don't need a gym membership to go for a light jog or a walk with a friend. Canned goods can serve double duty as hand weights, milk or water jugs can be filled with water or sand and a common step stool can become exercise equipment if you use it for step training.

Be a savvy shopper. Check out your local recreational department or check into the fitness center of a local college or church for bargain access. Online classifieds or used exercise equipment stores often have deals on equipment. Sharing the expenses with a friend can both help defray costs as well as provide motivation and support for a new fitness routine.

Steps to Success

Follow the steps below to form your own exercise routine.

Warm-up

The warm-up will slowly increase your breathing, heart rate and body temperature. Your warm-up should last between five and 10 minutes.

Strength Training

This part of an exercise program can be done in many different ways and will help protect your body from osteoporosis, help burn calories and increase lean muscle mass.

Good examples:

- push-ups
- crunches
- pull-ups
- squats
- lunges
- dips



Strength training should be done twice a week when you are first starting out. Try building up as you progress to three or four times per week.

Aerobic Exercise

This part of an exercise program includes activity that raises your heart rate. This is the type of exercise best associated with reductions in depression and anxiety.

Basic aerobic exercises include but aren't limited to jogging, swift walking, swimming, step or stair climbing, cycling and inline skating. Start with just 20 minutes a day, and eventually try working up to five hours of aerobic exercise into every week.

Flexibility Exercises

This portion of an exercise program, also known as stretching, can be done anywhere, anytime. Stretching can increase flexibility, your range of motion and the blood

flow to your muscles. Stretching also relieves stress, improves balance and helps relax tense muscles. Here are some important tips:

- Be sure to stretch major muscle groups including calves, thighs, hips, back and shoulders.
- Do not bounce as you stretch because this can cause slight tears in the muscles, making them tighter no matter how consistently you stretch.
- Stretching should not be painful, but expect to feel some tension. If you feel pain, you have stretched too far. Ease up and hold the stretch lightly.

Cool-down

Gradually decrease the intensity of the exercise over a five- to 10-minute period until your heart rate and breathing rate are near normal.

How Hard Should I Work?

There are several ways you can determine your exercise intensity level. The easiest way is known as the talk test. As a rule of thumb, if you can talk easily you aren't at the high end of your exertion. If your goal is to exercise at a moderate intensity, you should be able to talk, but not sing, while performing your activity. If your goal is to be exercising at a vigorous intensity, you will not be able to say more than a few words without pausing to take a breath.

Tips for Staying Motivated

Barrier 1: "I don't have time."

Solution: Squeeze in a few short walks throughout the day, get up a few minutes earlier, take the stairs or do housework at a fast pace, combine activities (e.g., instead of a meeting a friend for coffee, meet for a walk), put your exercise on your calendar, stretch and do strengthening exercises while you are watching television, get off one bus stop before your desired stop or park your car further from the store.

Barrier 2: "Exercise is boring."

Solution: Choose activities you enjoy; vary your routine; get an exercise partner and/or check out exercise classes or sports leagues at your local recreation center.

Barrier 3: "I worry about how I look during exercising."

Solution: Remind yourself that you are doing yourself a favor and focus on how you feel after a

workout and praise yourself after your improvements and each time you keep your commitment to exercise.

Barrier 4: "I can't afford to join a gym."

Solution: Get a great workout by simply using the resources that surround you, take a walk, play basketball, go bowling, ride your bike, dance, go hiking, go roller or ice skating and/or spend some free time gardening.

Barrier 5: "I am afraid that I will hurt myself."

Solution: Be sure to check with your health care provider before you start an exercise program. If you are new at this, begin your new program slowly so you do not get hurt or get such sore muscles that you won't continue. Choose an activity that is appropriate for your age and ability level. If you decide to go to a local YMCA or recreation center, ask for assistance from the staff at the facility. Finally, remember to warm up and cool down before and after exercise.

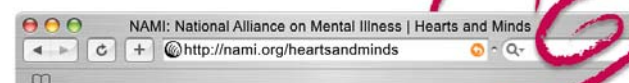
NAMI Hearts & Minds program is an online, interactive, educational initiative promoting the idea of wellness for individuals living with mental illness. This Fact Sheet is offered for informational purposes only. It does not intend to recommend specific treatment or strategies. Individuals should always engage with their health care provider before starting an exercise plan.

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For more information about exercise or the NAMI Hearts & Minds program, visit





Section 3

Managing Depression

Meditation and Mindfulness Training

Meditation, yoga, mindfulness training and relaxation techniques have been found to be very helpful to people with depression and anxiety¹.

The term *meditation* refers to a group of techniques, such as mantra meditation, relaxation response, and Zen Buddhist meditation. In meditation, a person learns to focus attention. Some forms of meditation ask you to become mindful of thoughts, feelings, and sensations and to observe them in a nonjudgmental way. This practice is believed to result in a state of greater calmness and physical relaxation, and psychological balance. Practicing meditation can change how a person relates to the flow of emotions and thoughts.

The 4 common elements of meditation

Most types of meditation have four elements in common:

1. **A quiet location**

Meditation is usually practiced in a quiet place with as few distractions as possible. This can be particularly helpful for beginners.

2. **A specific, comfortable posture**

Depending on the type being practiced, meditation can be done while sitting, lying down, standing, walking, or in other positions.

3. **A focus of attention**

Focusing one's attention is usually a part of meditation. For example, the meditator may focus on a mantra (a specially chosen word or set of words), an object, or the sensations of the breath. Some forms of meditation involve paying attention to whatever is the dominant content of consciousness.

Want to learn more?

Visit the **National Center for
Complementary and
Alternative Medicine
(NCAM)** website:

<http://www.nccam.nih.gov/health/meditation/overview.htm>



4. **An open attitude**

An open attitude during meditation means letting distractions come and go naturally without judging them. When the attention goes to distracting or wandering thoughts, they are not suppressed; instead, the meditator gently brings attention back to the focus. In some types of meditation, the meditator learns to “observe” thoughts and emotions while meditating.

Understanding relaxation techniques

Relaxation is more than a state of mind; it physically changes the way your body functions. When your body is relaxed, breathing slows, blood pressure and oxygen consumption decrease, and some people report an increased sense of well-being. This is called the “relaxation response.” Being able to produce the relaxation response using relaxation techniques may counteract the effects of long-term stress, which may contribute to or worsen a range of health problems including depression, digestive disorders, headaches, high blood pressure, and insomnia.

Relaxation techniques often combine breathing and focused attention on pleasing thoughts and images to calm the mind and the body. Most methods require only brief instruction from a book or experienced practitioner before they can be done without assistance. These techniques may be most effective when practiced regularly and combined with good nutrition, regular exercise, and a strong social support system.

Common relaxation methods

- **Autogenic training** - When using this method, you focus on the physical sensation of your own breathing or heartbeat and picture your body as warm, heavy, and/or relaxed.
- **Biofeedback** - Biofeedback-assisted relaxation uses electronic devices to teach you how to consciously produce the relaxation response. Biofeedback is sometimes used to relieve conditions that are caused or worsened by stress.
- **Deep breathing or breathing exercises** - To relax using this method, you consciously slow your breathing and focus on taking regular and deep breaths.
- **Guided imagery** - For this technique, you focus on pleasant images to replace negative or stressful feelings and relax. Guided imagery may be directed by you or a practitioner through storytelling or descriptions designed to suggest mental images (also called visualization).



- **Progressive relaxation** - For this relaxation method, you focus on tightening and relaxing each muscle group. This method is also called Jacobson's progressive relaxation or progressive muscle relaxation. Progressive relaxation is often combined with guided imagery and breathing exercises.
- **Self-Hypnosis** - In self-hypnosis, you produce the relaxation response with a phrase or nonverbal cue (called a "suggestion"). Self-hypnosis may be used to relieve pain (tension headaches, labor, or minor surgery) as well as to treat anxiety and irritable bowel syndrome.

1-Adapted from the National Center for Complementary and Alternative Medicine.

Section 3

Managing

Depression

Help with Sleep Problems¹

Sleep problems can be overcome

Insomnia is the most common type of sleep problem. It is very distressing when others do not understand the difficulties that you are having with sleep and how it can affect your life. The good news is that you can overcome your sleep problems.

About sleep

The amount of sleep that people need varies considerably. Most adults sleep between seven and eight hours at night. However, it is usual for some people to have less sleep without being badly affected. Often, people over 60 complain of having sleep problems, mainly because they have noticed that they are sleeping less. This change in sleep patterns is common and is a natural part of ageing.

It doesn't matter how much you sleep, what is more important is how well you feel physically and mentally as a result of your sleep pattern.

Effects of poor sleep

If you do have a sleep problem, it is very likely that you are experiencing mental and physical problems as a result. You might have difficulties with concentration and this can create problems while you are driving or at work.

Some of the effects of poor sleep can include:

- falling asleep during the day
- feelings of tiredness
- poor concentration and/or memory problems
- problems in making decisions
- irritability
- frustration
- increased risk of accidents and injury.

About medication

It is important to note that medication alone will not cure your sleep problem. Long-term use can lead to dependence, which means when you stop using the medication your problems can become much worse. If you are going to use medication, only short-term or intermittent use is recommended. For example, someone who has suffered a loss may find it difficult to sleep and may benefit from the short-term (a few days to two to three weeks) use of sleeping pills as needed.

The road to recovery has a new map.

Help and Healing connects you to quality resources for depression care and recovery.
Get better, faster.

Visit > MNHealthScores.org/helpandhealing

Help with Sleep Problems

Keep in mind that sleeping pills:

- can be addictive
- can interact in a harmful way with alcohol and other drugs, which can cause problems in elderly people
- can be harmful to your baby if you are pregnant.

What may be causing your sleep problem?

There can be many causes of sleep problems. Sleep problems can be caused by physical illness, emotional factors or lifestyle factors such as too much coffee or tea, environmental factors like noisy streets, overcrowding or pollution or by a sleep disorder, such as sleep apnea.

Physical causes

Physical illness and medications are known to affect sleep. If you have a long-term physical problem or you have been taking medication for some time, your sleep can be affected in an ongoing way. Have a look at the list below, and mark any item that is relevant to you. If there are others, write them in the space below.

Possible physical causes:

- ☐ Indigestion
 - ☐ Headaches
 - ☐ Backache
 - ☐ Arthritis
 - ☐ Heart disease
 - ☐ Diabetes
 - ☐ Asthma
 - ☐ Sinusitis
 - ☐ Ulcers
 - ☐ Other physical illness
-
-
-

If you have marked any of the above, you should consult your doctor. Although it may not be possible to cure a chronic illness, there might be better ways to manage the symptoms so it is less disruptive to your sleep.

Emotional causes

It is more common to experience sleep problems when feeling depressed, anxious or angry. Think about your situation, read through the list below and mark those items that apply. If you have another emotional problem that is not listed, write it in the space below.

Help with Sleep Problems

Possible emotional causes:

- ☐ Feeling stressed
- ☐ Worrying a lot
- ☐ Feeling tense or anxious
- ☐ Feeling sad or depressed
- ☐ Anger
- ☐ Other

If you have marked any of the above, we recommend that you discuss your feelings with your health worker. You might also want to try the relaxation exercise and other strategies outlined in the leaflet How to get a better night's sleep.

Lifestyle causes

Lifestyle causes of sleep problems are very common. Read the list and mark items that apply. If you are aware of other lifestyle causes, write them in the space below.

Possible lifestyle causes:

- ☐ Drinking coffee or tea
- ☐ Drinking alcohol late at night
- ☐ Eating just before sleep
- ☐ Late dinners, going to sleep on full stomach
- ☐ Smoking a lot of cigarettes
- ☐ Strenuous physical activity before going to sleep
- ☐ Too much mental activity before sleep
- ☐ Too little exercise during the day
- ☐ Shift work
- ☐ Daytime naps
- ☐ Not having regular times for going to sleep
- ☐ Not having regular times for waking up

Help with Sleep Problems

If you have marked any of the above, we recommend you try some of the strategies in the section 'How to get a better night's sleep'.

Environmental causes

- ☐ Noisy sleep environment
 - ☐ Too much light in sleep environment
 - ☐ Pollution
 - ☐ Overcrowding
-
-
-
-

If you have marked any of the above, we recommend you try some of the strategies in the section '**How to get a better night's sleep**'.

Sleep disorders

It is important to determine whether you are suffering from a specific sleep disorder in addition to other possible causes. Think about the following questions.

- **Has anyone told you that your snoring is loud and disruptive?**
If so, you might be suffering from sleep apnea. This is a dangerous condition in which you stop breathing during sleep. There are effective treatments for this condition.
- **Have you ever experienced sudden attacks of irresistible sleepiness during the day in which you could not stay awake?**
If so, you may be suffering from narcolepsy in which people feel forced to sleep for a period ranging from a few seconds to half an hour. This can be dangerous, particularly when driving or operating machinery. However, the condition responds to medication.
- **Do you experience uncomfortable feelings in your legs or feet before falling asleep? Does strong movement ease the discomfort? Has anyone told you that your muscles twitch or jerk?**
If the answer is yes to any of these questions, you may have 'nocturnal myoclonus' in which there are numerous episodes of muscle twitching during the night. This condition can be treated with medication.

You should consult your doctor if you have answered 'yes' to any of the above questions.

If you are not able to find the cause of your problem, you should consult your doctor. Using a sleep diary can help you identify possible causes. Once the problem is identified, it will be possible to work out a solution to help you get back to a regular sleep routine.

Help with

Sleep Problems

Sleep diary

Keeping this sleep diary can help you identify possible causes of your sleep problem. It can also be a useful way of keeping track of your progress.

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Help with Sleep Problems

How to get a better night's sleep

The following pages outline a number of good sleep habits, as well as some of the most common causes of sleep disturbance. Practical guidelines for dealing with these disturbances are also covered. It is important that you read all of this section since most sleeping difficulties result from a number of different factors which all work together to disrupt your sleep.

Remember to get a friend or a family member to help and support you.

Establish a regular waking time

Establishing a regular sleep–wake pattern is very important, especially waking up at the same time each morning. The time that you wake helps to set (or synchronise) all of your body's circadian rhythms. In fact, you should try not to vary the time of day that you get up by more than one hour, even across the weekends. In particular, avoid laying in bed until 12 noon on the weekend if you get up at 6 o'clock each weekday morning for work.

Establish a proper sleep environment

1. Comfort

The discomfort caused by a rumbling stomach, persistent aches and pains, or being too hot or cold, can prevent you from relaxing enough to fall asleep. Therefore, it is necessary that all your immediate needs have been met before you try to sleep. If you are hungry, have a light snack or a warm milk drink (caffeine-free) before you go to bed. If you are in pain, take a mild pain reliever. It is much easier to sleep if you are comfortable.

2. Noise

Noise during the night (such as traffic) is another common source of sleep disturbance. Even if you do not awaken and cannot remember the noises the next day, the noises can interfere with your normal sleep pattern. If you sleep in a place that tends to be noisy, try to shut out sound by closing windows and doors, wearing earplugs, or soundproofing the room. Even if you think that you cannot fall sleep without a radio or television in the background, remember that this noise will disrupt your sleep during the night. A clock radio that will automatically turn itself off may be useful.

3. Light

A light room will make it more difficult for you to sleep. Therefore, if you have trouble sleeping, it will be helpful to darken the room before going to bed and to ensure that the morning light does not wake you up in the morning. If you have a tendency to oversleep, it may be helpful to allow the light to enter the bedroom in the morning.

Help with
Sleep Problems

Allow a wind-down time before sleep

Make sure that you stop work at least 30 minutes before you go to bed and do something different and non-stressful, such as reading, watching television, or listening to music.

Use your bed only for sleep

Your bedroom should only be used for sleep, and of course sexual activity (which may help you to sleep). Activities such as eating, working, watching television, reading, drinking, arguing, or discussing the day's problems should be done elsewhere, because their associated arousal may interfere with you getting to sleep. These activities also make you associate your bed with wakefulness and alertness rather than drowsiness and sleep onset. It may be useful to remove all objects in your bedroom that are not associated with sleep.

Do not stay in bed when you are not asleep

If you have been having problems falling asleep, only go to bed when you are sleepy. If you do not fall asleep in about 10 minutes, get up and go to another room. Stay up until sleepy and only then return to your bed to sleep. If you return to bed and still cannot sleep, repeat the preceding instruction. Do this as often as is necessary to fall asleep in 10 minutes.

Coping with worry and anxiety

One of the most common causes of sleep disturbance is anxiety. Many people find it difficult to wind down when they climb into bed at night after a hectic day. Often this is the first chance they have had to think about things that are concerning them. People can find themselves lying in bed worrying about their problems when they would really rather be asleep. The feelings of tension and arousal that accompany these thoughts make it more difficult to fall asleep; therefore, these individuals also begin to worry about their sleeplessness as well as their other problems. They may end up tossing and turning well into the night. If you think you are having trouble sleeping because you are anxious about things that are happening in your life, there are two things you can do to improve your sleep.

1. Set aside time for problem solving during the day

Bed is not the place for thinking about things that distress you. If you do not normally find time during the day for thinking about things that are happening in your life then you need to set aside a time each day to do so. It should be a time when you are alone. Try to think of ways to resolve your problems. Usually this will require you to make decisions, some of which may be difficult because they concern important features of your life such as family and work. However, putting off stressful decisions only extends your feelings of anxiety. In most cases, the uncertainty that accompanies difficult decisions is much more stressful and unpleasant than living with the outcome of the decision once the decision is made. Talk to your health worker if you would like more information about useful problem solving techniques.

Help with Sleep Problems

2. Learn to relax

Learning ways to relax can help sleep problems. There are many relaxation techniques. Here, we will give you a breathing relaxation technique from which you will benefit:

- Breathe in slowly to the count of three seconds.
- When you get to three, slowly breathe out to the count of three seconds.
- Pause for three seconds before breathing in again
- After five minutes or so, say the word 'relax' to yourself as you breathe out
 - Breathe in using your abdomen (not your chest) and through your nose
 - Practise five to ten minutes at night in a comfortable chair
 - Keep in mind that the benefits of relaxation will not occur unless you practice
 - Do not try hard to relax or to sleep; just carry out the exercise.

3. Get out of bed

If you find yourself unable to stop worrying about things when you are in bed, get up and do something that is distracting yet relaxing, like knitting, listening to music, or reading a book. You may even want to listen to a relaxation tape. Do not return to bed until you feel sleepy again. When you do go back to bed, if you find that you are still worried and sleepless, get out of bed again and do something relaxing (as above) until you are sleepy enough to return to bed once more. At first, you may find you need to get out of bed a number of times before you are finally able to fall asleep. The important thing is that you will learn to associate your bed with sleep and not with worry.

Avoid napping during the day

It is not uncommon for people who have had a particularly bad night's sleep to feel sleepy the next day. This daytime sleepiness can make it very tempting for you to take a nap in the middle of the day or early afternoon. However, if you have insomnia and nap in the afternoon, you make it much more likely that you will have another night of poor sleep. This is because when it comes to time for bed you will be less tired and will need less sleep because you have slept during the day. You will probably take longer to fall asleep and you will awaken more frequently during the night. The next day you are likely to feel sleepy again and will be tempted to have another daytime nap.

As you can see, this pattern of napping soon becomes a vicious cycle that makes your original sleeping problem even worse. If you have insomnia, no matter how tired you are during the day, try to avoid daytime naps (unless you are doing shift work). Stick to regular sleep times by going to bed at the same time every night and waking up at the same time every morning. If you cannot get to sleep until later than your normal sleep time, do not sleep late the next morning — get up at your normal waking time. By following these instructions, you will help to ensure that your natural body rhythm works with you, helping you to sleep at the times you want to sleep.

Help with
Sleep Problems

Avoid caffeine

This drug is found in coffee, tea, cocoa, cola drinks, as well as some over the counter medications. Consuming caffeine before bedtime, or drinking too much caffeine during the day will increase feelings of energy and wakefulness and make it more difficult for you to fall asleep. Any caffeine consumed after about 4 pm will still have an effect by the time you go to bed.

The table below shows the average quantity of caffeine in a variety of common drinks.

Caffeine content of common drinks per 150ml cup
(One mug = 200–300ml)

Roasted and ground coffee (percolated)	83 mg
Instant coffee	59 mg
Decaffeinated coffee	3 mg
Tea	27 mg
Cola drinks	15 mg
Milk chocolate (60ml)	40 mg
Cocoa (African)	6 mg
Cocoa (South American)	42 mg

Sometimes individuals get into a pattern of drinking too much caffeine during the day, sleeping badly at night time, and then consuming even larger quantities of caffeine the following day to help ward off sleepiness. Such behaviour sets up a vicious cycle, which is to be avoided wherever possible. Some helpful suggestions about caffeine are provided below:

- limit caffeine intake
- avoid drinking caffeine after about 4pm
- avoid using caffeine as a means of staying awake.

Avoid nicotine

Nicotine stimulates the nervous system by releasing a hormone called ‘adrenaline’. Adrenaline acts to arouse the body and mind, making you alert and ready for action. Your body normally releases small doses of adrenaline throughout the day and large doses when you are faced with something challenging or threatening. Therefore, smoking prior to bedtime causes adrenaline to be released, thereby increasing energy and liveliness at the very time when you want to be relaxed and ready for sleep. If you are a smoker and you normally have trouble getting to sleep at night, it is best that you do not smoke for at least an hour before going to bed (preferably an hour and a half), since this is the length of time it takes for the stimulating effects

Help with Sleep Problems

of nicotine to wear off. Furthermore, if you wake up during the night and cannot go back to sleep, try not to smoke because the nicotine will make the sleeplessness worse.

Avoid excessive alcohol

A popular belief about alcohol is that alcohol will help you sleep if you are uptight and anxious. One or two glasses of wine or beer in the evening may help you to relax, but regularly having several drinks in the evening causes you to get much poorer sleep overall. As the alcohol in your system is broken down by your body, you tend to awaken more frequently and you spend less time in the deeper stages of sleep. If you drink regularly, you may find that you come to depend on the alcohol to reduce your anxiety and help you get to sleep. Not only will alcohol leave you feeling unrefreshed the next morning (because you are robbed of better quality sleep), but you are likely to have rebound anxiety which will last throughout the day and make it even more difficult to sleep at night. Alcohol is not the solution to sleeping problems so do not drink before you go to bed.

Avoid sleeping pills

The use of sleeping pills (sedative hypnotics) for any length of time causes as many problems as it solves. While sedative hypnotics will help you fall asleep and will decrease your anxiety in the short term, these benefits will disappear in the long term if you continue to use the sedatives regularly. That is, you will begin to feel anxious and sleepless even though you are taking the pills. When this happens you will be tempted to take more sleeping pills since doing so will bring back the benefits of the drug. Unfortunately, however, these benefits will not be permanent either so that after a time you again experience the unwanted symptoms of anxiety and sleeplessness. The process that makes you less sensitive to the benefits of the drug over time is called tolerance. While sleeping pills are useful for overcoming temporary sleep loss, the development of tolerance means that these drugs do not provide a long-term solution to sleeping problems.

Continual use of sleeping pills also has the disadvantage that you will find it extremely difficult to give up the drugs because doing so will cause you to experience withdrawal effects. The levels of anxiety and sleeplessness that you experience after stopping the drug are likely to be greater than the anxiety and sleeplessness that made you start using the drug. Coming off sleeping pills can also cause you to have vivid dreams and nightmares. These dreams are often highly emotional and disturbing.

If you do not use sleeping pills, or use them only occasionally, take heed of these warnings and do not start using them regularly. If you do use sleeping pills every night to help you sleep, it is recommended that you talk to your family doctor about reducing your intake of sleeping pills over time until you can stop using the pills altogether. Your doctor can help you come off the sleeping pills slowly without causing too many unpleasant side effects. Do not stop taking your sleeping pills without first talking to your doctor.

Help with
Sleep Problems

Take a late snack

A light bedtime snack, such as a warm glass of milk or a banana, will help some people get to sleep. These foods are high in an amino acid called tryptophan, which is thought to be involved in the biochemical systems that induce and maintain sleep. If nothing else, the snack will prevent you from getting hungry during the night.

Don't exercise before going to bed

Avoid exercise in the three hours before you go to bed, otherwise you may still be too aroused following the exercise to be able to fall asleep.

Coping with crying babies

Young babies need frequent feeding and nappy-changing, therefore they tend to wake up often during the night. Moreover, a baby's sleep cycle is much shorter than an adult's sleep cycle. A baby usually has a 50-minute sleep cycle and tends to have about two to four cycles per sleep period. Therefore, babies tend to awaken much more frequently than adults who have a 90 minute sleep cycle and experience about 5 to 6 cycles per sleep period.

If you have a young baby to look after, there are a number of things that may help to reduce the extent of the baby's crying. When a baby cries during the night, he/she usually wants food, or to be comforted. Trying to discipline a young baby by yelling at or ignoring a baby does not usually work. Many parents find it better to give the baby plenty of cuddles and kisses so that the baby quietens down and goes back to sleep feeling safe and secure. Moreover, it may help if you alter the baby's feeding time so that the baby is fed immediately before you go to bed rather than, say, two hours later. This way, you may not have to get up as often during the night. These suggestions do not always work, but take heart — babies do grow up and one day they will actually sleep undisturbed all night long!

Help with
Sleep Problems

Summary of good sleep habits

1. Go to bed when you are sleepy and get up at the same time every morning. Do not sleep late in the mornings trying to make up for 'lost sleep' and, if you think you have insomnia, do not take naps during the day.
2. Set aside time for problem solving during the day, not last thing at night. Identify any problems that are causing you to be anxious and try to resolve these problems by making decisions.
3. Do not lie in bed worrying for long periods of time. If you cannot sleep, get out of bed and do something that is distracting yet relaxing, such as knitting or listening to music. (It will be important to plan appropriate activities in advance.) Return to bed only when you feel sleepy again.
4. Do not use alcohol to help you sleep.
5. If you experience insomnia, avoid drinking caffeinated drinks after about 4 pm and do not drink more than two cups of caffeinated drinks each day.
6. Do not smoke for at least an hour (preferably an hour and a half) before going to bed.
7. Avoid sleeping pills: they do not provide a long-term solution to sleeping problems.
8. If you sleep in a noisy place, try to reduce noise levels by closing windows and doors and wearing ear-plugs.
9. Ensure the room is dark and that the morning light does not filter in. If you have a tendency to oversleep, it may be helpful to let the morning light enter the bedroom.
10. Getting to sleep when you are comfortable is much easier than getting to sleep when you are hungry, cold, in some kind of physical pain, or when you need to go to the toilet. Make sure all your immediate needs have been met before you go to bed.
11. Regular exercise during the day or early evening can improve sleeping patterns. Try to avoid exercise late in the evening as this may make it more difficult for you to get to sleep (with the exception of sex, which may help you to sleep).
12. By doing the same thing every night before you go to bed you can improve your chances of falling asleep quickly. It is a good idea to develop a short routine involving things like washing your face and cleaning your teeth, which you can easily perform before going to bed at night. A hot bath for 20 minutes may also be helpful.
13. Be aware of things in the environment that may interfere with your sleep. For example, pets can disturb your sleep if they become active during the night or if they prevent you from moving freely in the bed. Moreover, digital clocks can be distracting if they glow or flash. It is often helpful to face the clock in the opposite direction.

¹ The leaflet has been adapted with permission from World Health Organization. *Mental Disorders in Primary Care: A WHO Educational Package*, 1998, and Andrews G, Jenkins R. *Management of Mental Disorders (UK Edition)*. Sydney: World Health Organization Collaborating Centre for Mental Health and Substance Abuse, 1999. Distributed for the publishers in the UK by IN 2 Mail Ltd, Fax: +44 (0) 1252 322315; PO Box 55, Aldershot, Hampshire GU12 4FP.



Depression is more than feeling sad or “blue;” depression can interfere with daily life. The best care for depression includes treatments that help you make progress with symptoms. The Depression Care Health Tracker was created to make it easier for patients and doctors to focus on actions that have been shown to help people feel better.

DEPRESSION CARE HEALTH TRACKER

HOW PROGRESS IS MEASURED

Using the Patient Health Questionnaire (PHQ-9) tool, your provider will ask 9 questions about the problems you might be having and how you are feeling. Your provider will let you know if you are getting better by using the PHQ-9.

TREATMENT GOALS

REMISSION:

When people who seek treatment get to a PHQ-9 score of less than 5.

RESPONSE:

When people who seek treatment start to make progress toward feeling better by making a 50% improvement from their first PHQ-9 score. Lower is better.

MY PHQ-9 GOALS: (desired PHQ-9 score by a specific date)

DATE	Remission (Feeling Better)				Partial Remission/Mild Depressive Symptoms					Mild Major Depression					Moderate Major Depression					Severe Major Depression							
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27

MY PHQ-9 SCORES: (actual PHQ-9 score at a specific date)

DATE	Remission (Feeling Better)				Partial Remission/Mild Depressive Symptoms					Mild Major Depression					Moderate Major Depression					Severe Major Depression							
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27

Fill out this form with your doctor and work together to achieve the best care for treatment of depression. For more information visit [MNHealthScores.org](https://mnhealthscores.org).

TAKING CARE OF MYSELF

Because my doctor and I are committed to improving my health, we will use this form to track my progress.

My next appointment is:

date

time

My doctor wants me to call if:

My doctor's phone number:

BETWEEN NOW AND MY NEXT VISIT I PLAN TO:



GET RESTFUL SLEEP

A certain amount of restful sleep can improve your mood, health and safety. Everyone's needs are different.

My goal is _____
hours of sleep each night.

Suggestions for how to improve sleep: Weaning off/ stopping caffeine and/or alcohol; getting up and going to bed at the same time; exercising daily but not immediately before bedtime.



TAKE MEDICATIONS

If other treatments don't work, your doctor may prescribe medicine to reduce your symptoms.

Name	Dose	Time
_____	_____	_____
_____	_____	_____
_____	_____	_____



INCREASE EXERCISE

Depression symptoms often improve with exercise.

An activity I would enjoy is:

_____ minutes _____ times per week



EAT HEALTHY

The foods you eat can affect your daily life, mood and energy levels.

My diet goal is: _____



AVOID USE OF HARMFUL SUBSTANCES

If you use tobacco, recreational drugs or alcohol, the best you can do is to avoid them.

My goal is: _____



ENGAGE IN PLEASANT SOCIAL INTERACTIONS

Regular contact with family, friends or other supporters helps depressive symptoms.

I will call/email/visit with _____
people I enjoy spending time with.



FIND WAYS TO RELAX

Easing stress and anxiety can help you relax. Try different techniques to learn what works best for you.

An activity I would enjoy is:

_____ minutes _____ times per week

NOTES

Visit notes and questions I want to ask my doctor:



Section 3

Managing

Depression

Relapse Prevention Plan

The goal of making a relapse prevention plan is to prevent a recurrence of depressive symptoms as much as possible. After the patient has been in remission (PHQ-9 less than 5) for two consecutive months, initiate the Relapse Prevention Plan.

Patient Name: _____ **Today's Date:** _____

Contact / Appointment Information

Primary Care Provider: _____ Tel. No. _____

Next appointment: Date: _____ Time: _____

Depression Care Manager: _____ Tel. No. _____

Next appointment: Date: _____ Time: _____

Maintenance Antidepressant Medications

1. _____ : _____ tablet(s) of _____ mg _____ Take at least until _____

2. _____ : _____ tablet(s) of _____ mg _____ Take at least until _____

3. _____ : _____ tablet(s) of _____ mg _____ Take at least until _____

4. _____ : _____ tablet(s) of _____ mg _____ Take at least until _____

Call your primary care provider or your depression care manager with any questions (See contact information above)

Other Treatments

1. _____

2. _____

3. _____

**Relapse
Prevention Plan**

Goals: How to Minimize Stress from Depression

1. _____
2. _____
3. _____
4. _____

Personal Warning Signs

1. _____
2. _____
3. _____
4. _____
5. _____

If symptoms return, contact: _____

Clinician Signature _____ **Date** _____

DIAMOND Relapse Prevention Plan • last rev. 02/29/12 • © 2012 Institute for Clinical Systems Improvement • Adapted from the IMPACT Project



Help and Healing:

Resources for Depression Care and Recovery

Section 4: Implementing Systems

Implementation Planning Guide

Tip Sheet

*Strategies to Develop a Mental Health (MH) Provider
Resource List*

Example Mental Health Referral List

PDSA Worksheet

Data Collection Planning

Using Patient Data for Care Management and QI

Example Data Interpretation Template

Example of Depression Custom Report

*Crosswalk Between Patient Centered Medical Home and
Depression Core Components*

Best Practice Strategies for Quality Improvement

Section 4

Implementing Systems

Implementation Planning Guide

The following are guiding questions from the Institute for Clinical Systems Improvement (ICSI) for care systems preparing to implement a quality improvement program or initiative.

1. How is/will your implementation structure be organized? (eg: teams, committees, ad hoc groups, etc)

- What teams and/or committees are involved (or could be involved) in oversight and management of your QI projects?
- Are their benefits/downsides to your current structure?
- What group or committee chooses the topics?

2. Who will be part of the implementation structure?

- How is leadership involved (or could be involved) in your quality structure?
- Who are (or could be) members of your quality team (i.e. physicians, nurses, quality staff, other staff?)?
- How far reaching is your structure across the organization? Could this be improved?

3. How will your structure support rapid cycling?

Think of your quality improvement topic/process:

- Are the people on the team familiar with the topic/process (i.e. diabetes educator, nurse)?
- Are the people on the team familiar with rapid cycling? If not, how will you train them?
- Are the people on the team familiar with team structure & process? If not, how will you train them?

The road to recovery
has a new map.

Help and Healing connects you to quality
resources for depression care and recovery.
Get better, faster.

Visit > MNHealthScores.org/helpandhealing

Implementation
Planning Guide

4. Who will be involved in rapid cycles of change?

- Are there one or two champions of the improvement that would be receptive to testing a small change?
- How could the team members involve front line staff to test the change?

5. Who will coordinate rapid cycles? How?

- Is there a particular team member interested in making the change that would take on this role?

6. How will the learnings of rapid cycles be captured?

- How could the team record what went well and what did not? (i.e. at team meetings take minutes?)

7. How will process changes be communicated to others?

- What are some options for spreading the change within the organization?

8. To whom/what group internally will the progress of the project be reported?

- Is there an oversight committee for all projects?
- Is there a sponsor of the project?

9. How will leadership be involved in the project?

- Does leadership sanction the team(s)?
- Is leadership involved with setting the project aims?
- Is there a way of communicating regularly with leadership?

10. How does or will your culture support your implementation plan & rapid cycling?

- How does your culture support this?
- Will you feel resistance to rapid cycling?
- Will your Physician Champion/Sponsor support that culture?

Section 4

Implementing

Systems

Tip Sheet

Electronic Medical Records and Other Information Technology

Purpose of this Tip Sheet:

Electronic Medical Records (EMRs) used by Minnesota physicians don't have "out of the box" capabilities to support the collection and reporting of Minnesota Community Measurement's (MNCM's) depression care measures¹. Based on the records submitted by the clinicians, the MNCM data portal programming logic identifies the patient's index date, defined as the date of the first visit where the patient has both a Depression or Dysthymia diagnosis and a score of 10 or more on the PHQ-9 (Patient Health Questionnaire - 9) survey. A score of 10 or more may be an indication the patient has clinical depression. In order for clinicians to determine when a patient is due for a follow-up assessment, **they need to identify and keep track of the index date as well.** This tracking system can be set up in many different ways in a practice setting. Read further to get some ideas on how to track and monitor these patients. If you don't have a registry, one way to get started is mentioned on page 3 using the exact patient information you submitted to the MNCM data portal.

Equally important to identifying and tracking patients, systematic administration of a PHQ-9 questionnaire is one way to monitor a patient's response to the treatment plan. Treatment for Depression and a response to it takes time. The MNCM depression measures reveal the percentage of patients that achieve response to therapy (50% improvement in PHQ-9 score) and remission (mild or minimal symptoms resulting in a PHQ-9 score of less than 5) at six and twelve months from the index date. PHQ-9 scores are submitted to MNCM periodically for calculation of response and remission rates and ultimately for public reporting.

To **submit** a data file to MNCM, clinics must have a means of identifying:

- Adult patients who have been diagnosed with depression and/or dysthymia (see MNCM measure specification for diagnosis codes and age ranges) and
- Subsequent PHQ-9 assessments administered to the patient, the date of each survey administration and each score.

To achieve the high follow-up rates, and increase the likelihood of reporting a patient in remission, clinics need to have a means of identifying the following:

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Visit > MNHealthScores.org/helpandhealing

Tip Sheet

- The patients due for follow up and
- When a PHQ-9 survey should be administered (plus or minus 30 days, six months after the index visit and plus or minus 30 days, twelve months after the index visit), and record these scores.

Because EMRs have not developed tools to support these processes - providers and in some cases their vendors, have developed customized capabilities to address this issue.

Below are some ideas (Tips) in four broad areas to help you start thinking about automated approaches to use in your clinic.

1) Automate the recording of PHQ-9 Scores within EMRs

Incorporate a “Smart Form” into your EMR. A Smart Form is an EMR-based, clinical workflow tool designed to capture data (in this case the PHQ-9 survey score completed by a patient). In addition to this form aiding documentation of scores and providing decision support for the patient’s treatment plan, the tool will help to capture the data in a method so that scores can be automatically pulled out of the system into a report. The Smart Forms can be completed in many different ways, by clinical personnel as well as by patients, at the point of care. Examples of how these are being implemented include:

- Paper PHQ-9 form is given to patient upon check-in to their visit. Patient completes form while waiting for visit to start and gives form to rooming person who then transfers the answers into the Smart Form.
- Some groups have used a laminated PHQ-9 and a dry erase marker, always present in the exam room, as an alternative to the paper form. The patient’s scores are then manually transferred into the EMR by clinic staff.
- Rooming personnel may interview the patient while in the exam room, completing the Smart Form with PHQ-9 survey answers.
- Rooming personnel may call up the PHQ-9 survey Smart Form on the EMR, locking the screens so patients don’t have access to other EMR information, leave the room and return after the patient has completed the survey in private.

Build into EMR “Point of Care” decision support to trigger PHQ-9 completion. Examples include:

- Health Maintenance Reminders that track when PHQ-9s need to be completed for each patient and may be viewed during pre-visit planning or while the patient is in the room.
- Best Practices alerts that remind staff when PHQ-9s are required, e.g., patients with an established diagnosis of depression at every visit and at least every six months.

Tip Sheet

Develop or use “return to clinic” alerts. These alerts would provide a date for staff to schedule a follow-up visit for a patient to have their treatment plan evaluated. At this visit, a PHQ-9 would be completed along with the clinician’s assessment. For purposes of capturing data to report on MNMCM’s 6 and 12 month response and remission measures, a follow-up visit² at 6 months from the index visit date (plus or minus 30 days) and 12 months from the index visit date (plus or minus 30 days) is required.

2) Build custom registries for patients being treated for depression

More experienced groups are able to produce reports using Clarity or Crystal reporting software. Groups, who do not have the internal information systems expertise to develop these reports, retain consultants with expertise in programing and using this software. These reports should, at a minimum, clearly identify:

- All adult patients diagnosed with Depression and/or Dysthymia (see MNMCM measure specification for Diagnosis codes and age ranges to assist with data reporting to MNMCM)
- The index visit date and associated PHQ-9 score
- **All** subsequent follow-up PHQ-9 scores and dates
- The plus and minus 30 day follow-up window that is consistent with the 6 and 12 months follow-up visit dates - to aid in scheduling follow-up visits within this window timeframe.

A registry can be built by downloading a list of all your patients from the MNMCM portal into an Excel file (for details on how to do this, see Using Patient Data for Care Management and Quality Improvement located directly after this document in the Systems Implementation section of the Toolkit). ***TIP – this file includes the patient index date.***

Develop and use custom registry reports to support multiple types of outreach and follow-up

- Develop ad hoc and/or scheduled **reports** that identify patients requiring follow up by staff doing outreach calls or secure email reminders, if available
 - Include date and score of each PHQ-9
 - Include 6 and 12 month window time frames
 - Extend date range to 14 months to identify patients who haven’t achieved remission (a PHQ-9 score <5) in 13 months (12 months + 30 day window). Include these patients in your reports as they will require ongoing treatment and monitoring and will be included in the MNMCM measures (see 3 below).
- Patient letters may be automatically generated from these reports

Tip Sheet

3) Develop Aggregate Reports to Support Internal Quality Reporting and Improvement

Develop reports of data pulled from your EMR or registry, for comparison of physicians, care teams, clinics or other structures applicable to your organization for a given period of time and with trending over time.

These reports could mirror the MNCM measures. For the purposes of mirroring MNCM measure calculation, an individual patient's measurement will end 13 months from the index visit date. Thirteen months allows for the +30 day window to obtain a follow-up PHQ-9 score for the 12 month measures. If, after this point a patient still meets the inclusion criteria by having a PHQ-9 score of 10 or higher; a new index score and new index date should be created and measurement will start over for this patient. **NOTE:** for this re-indexing process, a diagnosis does not need to be sent again as the original diagnosis remains on file.

Include a report on PHQ-9 use (a process measure on how many times a PHQ-9 is administered, when appropriate), as well as response and remission rates at 6 and 12 months.

4) Use a Patient Portal to communicate with your patients

Most EMRs have, or are developing, the capability to communicate with patients through secure electronic messaging to meet requirements of Meaningful Use, Stage 2. In some cases, this includes the use of a Personal Health Record (PHR) where patients may view provider information and also submit information to the provider. Electronic reminders can be sent to patients through secure email asking them to complete the PHQ-9 survey. Provisions can be made to have the patient respond electronically and their scores are automatically recorded in the PHR/EMR. If this is not currently a feature of your EMR, ask your vendor/s when they plan to develop this capability. You will also want to consider what additional processes are required, such as staffing replies to secure e-mail messages and the follow-up care.

¹ Several interviews were conducted with healthcare providers and EMR vendors, including Cerner, e-Clinical Works, Epic, GE-Centricity and NexGen, to learn what information technology tools were being used to support MNCM's depression care measures.

² A qualifying follow-up visit can include capturing the PHQ-9 score via any type of visit (office, nurse only, care coordination visit, etc.); via secure e-mail visits, a telephone interview or via postal mail.



Section 4 Implementing Systems

Developing a Mental Health (MH) Provider List

Questions to ask

1. What types of MH treatment specialties does the provider offer, e.g. adult, child and adolescent and/or geriatric services; chemical dependency services; specialty services for targeted conditions such as eating disorders, autism disorders, schizophrenia or bipolar disorder?
2. What types of MH treatment modalities does the provider offer, e.g. medication management, psychotherapy, psychological testing, neuropsychological testing, day treatment, rehabilitation services, residential treatment?
3. How does the MH provider handle crisis services requests for new patients? For existing patients?
4. What is the process for accessing psychiatric services, if offered?
5. What health plan networks does the MH provider participate in?
6. What information does the MH provider communicate to primary care?

Types of mental health providers (an organization may fit more than one category)

Community mental health centers: Not-for-profit agencies that tend to provide a variety of mental health services and may provide chemical dependency treatment, crisis outreach and other special services. They are licensed to accept public and private insurance, and because they are safety-net providers, they set services on a sliding fee schedule.

Acknowledgement:
*Mary Henry, BlueCross Blue
Shield of Minnesota 2012*



Rule 29 mental health clinics: Voluntary state certification that allows for reimbursement of services by public insurance. Certification requirements include meeting standards for patient intake, assessment, treatment planning, case consultation, emergency services, access to hospitals and multidisciplinary staffing. A psychiatrist and licensed psychologist are requisite staff members.

Rule 31 chemical dependency treatment programs: State license that ensures programs meet standards for assessment, treatment planning and documentation, required treatment services, staff qualifications and healthcare and medication services.

Independent mental health clinics: Privately owned mental health clinics that vary in size and array of services.

Mental health departments in care systems: Departments typically provide outpatient psychotherapy and psychiatric services.

Strategies to identify local providers

1. Check search engines on professional organization Web sites

- Minnesota Association of Community Mental Health Centers www.macmhp.org
- Minnesota Psychiatric Society www.mnpsychsoc.org
- Minnesota Psychological Association www.mnpsych.org
- Minnesota Division of the American Association for Marriage & Family Therapy www.minnesotafamilies.org

2. Check lists of providers that maintain Rule 29 or 31 licenses

- Rule 29 list: <http://www.dhs.state.mn.us/Licensing/ProgramLists/pdf/flmhc.pdf>
- Rule 31 list: <http://www.dhs.state.mn.us/Licensing/ProgramLists/pdf/flcdt.pdf>

3. Check with health plans

EXAMPLE OF MENTAL HEALTH REFERRAL LIST

*PLEASE CONTACT YOUR INSURANCE FOR BENEFITS AND IN-NETWORK PROVIDER INFORMATION

PSYCHOLOGISTS

*Croix Counseling (Hudson)	Psychology (child-adult)	715-377-0000
Family Means (Hudson)	Psychology (child-young adult)	715-386-2066
Family Means (Stillwater)	“ “	651-439-4840
*Hudson Counseling Service	Psychology (child-adult)	715-531-6760
Integra (Hudson)	Psychology (child-adult)	715-386-9011
*Kittilson Counseling Service	Psychology (K-preteen)	715-425-9180
Midwest Psych Service (Hudson)	Psychology (child-adult)	715-381-1980

PSYCHOLOGISTS THAT DO ADHD/ADD EVALUATIONS

*Croix Counseling (Hudson)	Psychology (child-adult)	715-377-0000
Northwest CounselingNO MA	Psychology (child-adult)	715-246-7777
Northwest Counseling (Hudson)	Psychology (child-adult)	715-381-1070
Nuview (Stillwater)	Psychology (child-adult)	651-430-0888
Riverside Clinic (Cris Johnston)	Psychology (child-adult)	715-262-5559
St. Croix Psychological Clinic	Psychology (child-adult)	715-425-7031
Woodbury Counseling Clinic	Psychology (child-adult)	651-365-8209

PSYCHOLOGISTS/PSYCHIATRISTS

Allina Behavioral Health	Psychol/Psychiatry (adult)	651-241-5959
BHSI (Stillwater)	Psychol/Psychiatry (adult)	651-662-0800
*BHSI (Woodbury)	Psychol/Psychiatry (adult)	651-730-7525
*Children's Specialty Clinic	Psychol/Psychiatry (child)	651-220-6753
*Eagan Counseling Clinic (Woodbury)	Psychol/Psychiatry (child-adult)	651-454-0114
Fairview Red Wing Clinic	Psychol/Psychiatry	800-464-2296
Gillette Children's	Ped/Adol Psychiatry (child)	651-229-3855
HealthPartners Behavioral Health	Psychol/Psychiatry	612-627-3500
Regions Behavioral Health	Psychol/Psychiatry	651-254-3456
U of M/Pediatric Family Center	Psychol/Psychiatry (child)	612-626-3087

River Falls Pregnancy Help Line/Counseling 715-425-8539 for other info see file folder

CHEMICAL/SUBSTANCE DEPENDENCY:

Programs for change - Adult Outpatient Chemical health assessments and treatment

- At the Hudson Hospital for appointments and info call 715-531-6755
- Haven Chemical Health (Woodbury) 651-734-9633
- Avalon(Stillwater) 651-351-9325 *they prefer patient call, No licensed counselor on staff/advisor. Can usually get in within a week or so.
- Eagan Counseling Treatment Program (Eagan site only) 651-454-0114
- 24-hour In-patient Behavioral Health In-take thru Allina Systems 612-863-8633/800-782-3520

Example provided by Christopher Tashjian, Medical Director, Western Wisconsin Medical Associates

PDSA Process Worksheet

Use as a guide for planning and carrying out a PDSA cycle; complete as appropriate.

Project Name:	Date:
Cycle # and Brief Description of Cycle:	
Objectives of this PDSA cycle (what are we trying to accomplish?):	
<input type="checkbox"/> Collect baseline data (if chosen, go to Data Collection Plan for PDSA Cycle) <input type="checkbox"/> Develop a change - or modify a change from a previous change <input type="checkbox"/> Test a change <input type="checkbox"/> Implement a change	

PLAN: Answer Questions, Predict Results and Determine Data Collection Strategy

Questions: (what do we want answered by data?) Predictions: (what will happen if plan is carried out?)

- | | |
|----|----|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |

What is the plan to carry out this cycle (who, what, where, when)?

- 1.
- 2.
- 3.
- 4.

Other Considerations:

- a) Is training needed? Y___ N___
- b) Is the plan consistent with the project charter? Y___ N___
- c) Can the plan be carried out on a small scale? Y___ N___
- d) Have you considered people outside the team who will be affected by this plan? Y___ N___ If yes, who?

Data Collection Plan for Process Measure of PDSA Cycle
(how will we know that a change is an improvement?)

What data will be collected during this time?

How will the data be collected?

i.e., - Surveys, Observations, Interviews

Who will collect the data?

How often will the data be collected?

DO: Carry out the Plan, Collect Data and Begin Analysis

Document observations made in carrying out the plan:

-
-
-
-

Document problems and unexpected observations:

-
-
-
-

Study: Complete Analysis of Data

What are the answers to the questions in the Plan?

- *Question:*
 - *Answer:*
- *Question:*
 - *Answer:*

What are the results compared to the predictions in the Plan?

- *Prediction:*
 - *Result:*

- *Prediction:*
 - *Result:*

Summarize what was learned (new knowledge) in this cycle:

ACT: Determine Next Steps and Plan for the Next Cycle

Based on the analysis findings:

What changes will be made to the process?

Who will be affected by the changes (organizations and people)?

What new questions were generated?

What will the next cycle be?

Next Step:

- ☐ Revise the PDSA cycle
 - ☐ Start new PDSA cycle
 - ☐ Implement the change
 - ☐ Spread the change
-

Data Collection Planning

The following is guidance from the Institute for Clinical Systems Improvement (ICSI) for establishing a process for collecting and measuring clinical process and/or outcomes data.

Improvement Topic/Aim:

Measurement Definition(s):

Key Players to Involve:

Defining Patient Population:

(ie: gender, age, diagnosis driven)

Ways to Identify the Patients:

- ie:
- IS runs based on age, gender, visit dates
 - IS runs base on diagnosis
 - Current or past schedules: computerized or manual
 - Log books

Methods of Data Collection:

- ie:
- Retrospective chart review
 - Concurrent chart review
 - Patient survey
 - Visit Planning forms

Sample Size:

(Consider: size of the patient population, what resources allow, whether results will be communicated as aggregate across sites, site specific, provider specific)

Frequency of Data Collection:

(ie: ongoing, monthly, quarterly)

Data Collectors:

(ie: QI staff, patient care staff, physicians)

Where will the data be presented?

(ie: Quality oversight committee, implementation team, clinic sites, individual physicians)

Sample Data Collection Plan Example

Improvement Topic/Aim:

Improve the percent of patients with type II diabetes who had a HbA1c in the last 6 months and have a HbA1c level <8

Measurement Definition(s):

1. Percent of patients with diabetes who have had HbA1c in the last 6 months
2. Percent of patients with diabetes who have a HbA1c level <8

Key Players to Involve:

Information systems
Laboratory
Medical records
QI staff

Defining Patient Population:

Gender: male and female
Age: 18-75
Dx: Code: 250.XX

Ways to Identify the Patients:

1. Registry – by diagnosis or by eye exam
2. Lab log – by test number (CPT or other lab code)
3. Chart audit – IS run by diagnosis code

Methods of Data Collection:

1. Registry
2. Lab log
3. Chart audit

Sample Size:

1. total number in registry
2. total number in log
3. 20 charts per month

Frequency of Data Collection:

Monthly charts
Weekly checks in the logbook
Quarterly summary

Data Collectors:

Lab staff
Medical Record clerk
QI staff

Where will the data be presented?

Internal team
Clinic break room bulletin board
Quality Committee



Using Patient Data for Care Management and Quality Improvement

There is the functionality within the MNCN Data Portal that allows you to download patient level data for several different purposes, some of which include:

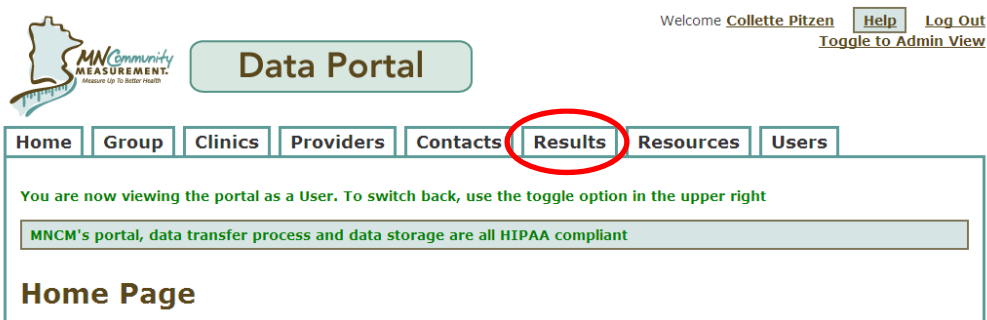
- Analysis of patient population
- Populating a registry of patients with major depression or dysthymia
- Creating a list of patients for follow-up

Log in to the MNCM Data Portal

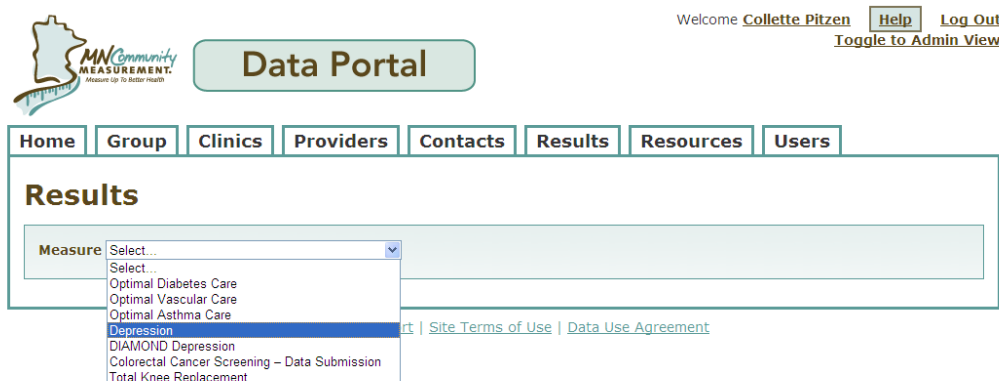
<https://data.mncm.org>

Steps in Portal to Download Spreadsheet of Patient Level Data

After logging in to the data portal, you will see your medical group's Home Page. From this page, click on the Results tab:



On the Results tab, use the drop down menu to select Depression Results:



The results selection contains many mechanisms for reviewing comparative data by measure, but there is also the option for the medical group to download their own data. This can be valuable because the download file available is programmed at a patient level, versus the data that is submitted by medical groups is at the visit level and can be difficult to analyze or track patients.



To obtain your download file (your medical group's patients only), select Patient Detail

Measure: Report Type:

[Contact Support](#) | [Site Terms](#)

You will then be presented with the option for defining the index contact dates that you wish to include:

Measure: Report Type:

Index Start Date: Index End Date:

[Contact Support](#) | [Site Terms of Use](#) | [Data Use Agreement](#)

The index start and stop dates indicate the date that the patient initially met criteria for inclusion in the measure, the contact date that is associated with both the correct diagnosis (296.2x, 296.3x or 300.4) and PHQ-9 score greater than 9.

There are a couple of choices, depending on your use of the data.

Example # 1 Creating a list of patients who may need follow up for six month measure

If you want to find patients who may be in need of follow-up, perhaps a call from the case manager, you could select fairly recent dates, knowing that you will not be able to measure the six or twelve month outcome measures because not enough time has passed to collect that data.

For this example I have used the dates I know reflect the most recently submitted data; 10/1/2011 to 1/31/2012. Please keep in mind that the only data that is available is the data that you have already submitted to the MNCM data portal.



There is a long list of fields that you could include for your downloaded file. For this purpose of tracking patients I would recommend the following fields:

Medical Group Name

Clinic Name

Patient ID

Date of Birth

Primary Language

Age (Calculated)

Severity by Initial PHQ-9

Index Contact Date

Index Contact Month/Year


Initial PHQ-9

Exclusion Date (if applicable)

Exclusion Reason (if applicable)

Patient Measurement End Date (13 months after index contact - Calculated)

After you select your fields, run your report. You will need to click the refresh button to see if the report has finished, or if you wish you can come back to this report later.



Welcome [Collette Pitzen](#) [Help](#) [Log Out](#)
[Toggle to Admin View](#)

Data Portal

[Home](#) [Group](#) [Clinics](#) [Providers](#) [Contacts](#) [Results](#) [Resources](#) [Users](#)

Results > My Reports

Your report was successfully submitted to the report queue. When it has finished generating, you will be able to view it from within your Report Queue.

Current Report Requests [Refresh](#)

Report	Measure	Requested	Status
Test Tracking	Depression: Index from 10/01/2011 to 01/31/2012	05/23/2012 12:15 PM	Generating...

Reports Archive

Report	Measure	Requested	Finished	
6 month remission for index 7-1-2010 to 6-30-2011	Depression - Oct 1 2009 through Jan 31 2010	05/09/2012 04:49 PM	05/09/2012 05:22 PM	Remove
Depression Response 6 month 7-1-2009 - 6-30-2010 updated w fup	Depression - Oct 1 2010 through Jan 31 2011	01/31/2012 02:15 PM	01/31/2012 05:23 PM	Remove

You can then download your file to excel. Please see the example below (no real PHI)

Clinic Name	Patient ID	Date of Birth	Age	Primary Language	Severity by Initial PHQ-9	Index Contact Date	Index Contact Month	Initial PHQ-9 Score	Patient Measurement End Date	Exclusion Date	Exclusion Reason Code
Clinic A	1	9/3/1986	25	English	Moderate	12/29/2011	Dec-11	13	1/29/2013		
Clinic A	2	11/26/1990	21	English	Moderately severe	10/6/2011	Oct-11	16	11/6/2012		
Clinic A	3	11/1/1946	65	English	Moderate	10/10/2011	Oct-11	10	11/10/2012		
Clinic A	4	12/18/1964	46	English	Moderately severe	11/21/2011	Nov-11	16	12/21/2012		
Clinic A	5	3/6/1969	42	English	Moderate	11/2/2011	Nov-11	10	12/2/2012		
Clinic A	6	5/26/1961	50	English	Moderate	11/1/2011	Nov-11	12	12/1/2012		
Clinic A	7	4/8/1968	43	English	Moderately severe	10/5/2011	Oct-11	16	11/5/2012		
Clinic A	8	11/6/1957	53	English	Moderately severe	10/28/2011	Oct-11	16	11/28/2012		
Clinic A	9	5/25/1966	45	English	Moderate	10/14/2011	Oct-11	13	11/14/2012		
Clinic A	10	12/2/1956	54	English	Moderate	1/10/2012	Jan-12	12	2/10/2013		
Clinic A	11	7/29/1966	44	English	Moderate	1/5/2012	Jan-12	14	2/5/2013		
Clinic A	12	10/25/1952	59	English	Severe	10/6/2011	Oct-11	24	11/6/2012	1/17/2012	1

Example # 2 Creating a list of all your patients to start a registry

Follow the steps in the first example except use a wider date range of index contact dates. In creating a brand new registry, you could include all of the contact dates that span the length of time that you have been submitting depression data. In this example, for a group that has been submitting data since 2008, I would use the following index contact dates 1/1/2008 to 1/31/2012 (most recent submission)

I would recommend selecting all of the following fields to create a registry:

Medical Group Name

Clinic Name

Patient ID

Date of Birth

Gender

Race/Ethnicity

Primary Language

Age (Calculated)

Severity by Initial PHQ-9

Provider ID

Provider Specialty

Health Plan Member ID

Insurance Coverage Code

Index Contact Date

Index Contact Month/Year

Initial PHQ-9

Exclusion Date (if applicable)

Exclusion Reason (if applicable)

Patient Measurement End Date (13 months after index contact - Calculated)



Suggestion for updating a registry once you have created it: You could then find future “new” patients in the data submission by creating a future report that would be querying for new index contact dates, not overlapping with index contact dates that you have pulled previously.

Example # 3 Reviewing your outcome results in the portal- Depression Remission at Six Months

Click on the results tab, select depression.

Then select the measure you are interested in, in this example we will be examining 6 month remission

Home Group Clinics Providers Contacts Results Resources Users

Results > Depression > Oct 1 2011 through Jan 31 2012

My Reports | View Individual Patient History

Measure: Depression Report Type: Select...

Report Type options:

- Select...
- MNCM Measures 1-4
- MNCM Measure 5: 6 Month Response Rate
- MNCM Measure 6: 12 Month Response Rate
- MNCM Measure 7: 6 Month Remission
- MNCM Measure 8: 12 Month Remission
- MNCM Measure 9: 6 Month Usage Rate
- MNCM Measure 10: 12 Month Usage Rate
- Patient Detail

Contact Support | Site Terms

Select the measure period that you are interested in:

Home Group Clinics Providers Contacts Results Resources Users

Results > Depression > Oct 1 2011 through Jan 31 2012

My Reports | View Individual Patient History

Measure: Depression Report Type: MNCM Measure 7: 6 Month Remission

6-Month Reporting Period: Select...

Reporting Period options:

- Select...
- July 01 2010 to June 30 2011
- July 01 2009 to June 30 2010
- July 01 2008 - June 30 2009
- Jan 01 - Jun 30 2008

MNCM Measure Results

MNCM Measure #7: Remission Rate - 6 Month

Clinics

Contact Support | Site Terms of Use | Data Use Agreement

The reporting periods displayed represent the time periods 1) currently or previously reported on MN HealthScores and 2) only those periods for which enough time has passed to allow for the appropriate time of follow-up. In this example we are choosing the most recent reporting period.

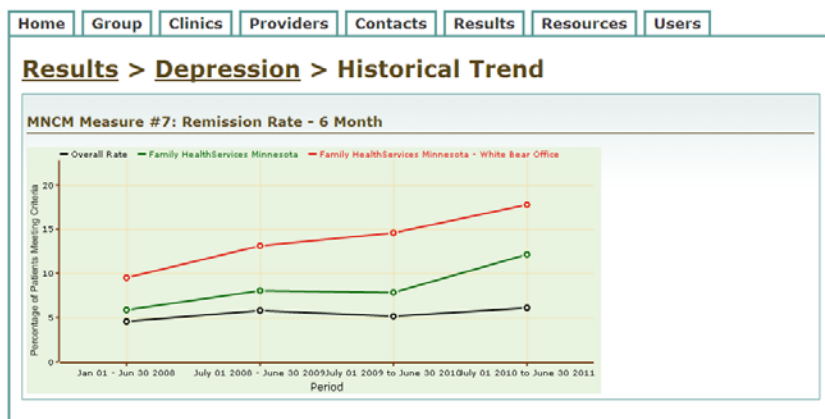
All rates are transparently reported in the portal (all are publicly reported as well), so the view you are presented with is more than your own clinic's data. You can find your own clinic (or look at other clinic's rates) and there is added functionality 1) having a medical group rate and drilling down on individual clinics data, and 2) graphics to display historical trends. Please see examples below:



Drilling down on Family Health Services Minnesota Clinics:

Family HealthServices Minnesota	[±]	12.13%
Family HealthServices Minnesota	Family HealthServices Minnesota - White Bear Office	17.75%
Family HealthServices Minnesota	Family HealthServices Minnesota - Gorman Clinic	16.79%
Family HealthServices Minnesota	Family HealthServices Minnesota - Afton Road	15.55%
Family HealthServices Minnesota	Family HealthServices Minnesota - Woodbury Office	14.81%
Family HealthServices Minnesota	Family HealthServices Minnesota - Vadnais Heights Office	13.27%
Family HealthServices Minnesota	Family HealthServices Minnesota - Inver Grove Heights	12.14%
Family HealthServices Minnesota	Family HealthServices Minnesota - Shoreview	11.84%
Family HealthServices Minnesota	Family HealthServices Minnesota - Banning Avenue	11.01%
Family HealthServices Minnesota	Family HealthServices Minnesota - Larpenteur Clinic	8.97%

Looking at the historical trend for a measure, both at the medical group and an individual clinic site level:





Example # 4 Using Pivot Tables on Patient Level Data

One useful tool in excel that can be used to better understand your population is a pivot table.

After your excel spreadsheet, downloaded from the portal, is saved to an area on your computer, you can begin to use pivot tables to analyze your population of patients with depression that are included in the denominator for the MNCM Depression outcome measures.

You will want to create a patient detail report that includes the results of outcome measures, but there is a caution in doing so:

- **ONLY include Index contact dates where you have enough history** to calculate the measures you are seeking (e.g. in pulling for six month remission and response, make sure that you have 7 months of data beyond the index contact date you are selection)
- **It is better to pull patient detail for six month measures separately** from twelve month measures because the length of time needs to be consistent and is dependent by measure.

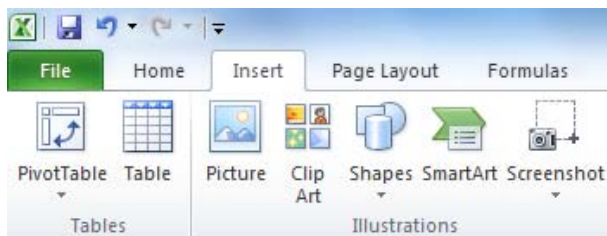
So, in our example in a patient level report looking at six month measures; I would select the following fields for inclusion in the patient level file for analysis purposes:

Medical Group Name	Primary Language Code
MNCM ID	Primary Language Description
Clinic Name	Primary Language Other
Clinic ID	Diagnosis
Portal Clinic ID	Severity by Initial PHQ-9
Patient ID	Insurance Coverage Code
Patient ID2	Insurance Coverage Description
Date of Birth	Health/Insurance Plan Member ID
Age	Index Contact Date
Patient Gender	Index Contact Month
Patient Zip Code	Initial PHQ-9 Score
Race1 Code	Patient Measurement End Date
Race1 Description	6 Month +/- 30 days PHQ-9 Score
Race2 Code	PHQ-9 obtained at 6 mos +/- 30 days?
Race2 Description	6 month remission?
Race3 Code	6 month response?
Race3 Description	Exclusion Date
Race4 Code	Exclusion Reason Code
Race4 Description	
Race5 Code	
Race5 Description	
Country of Origin Code	
Country of Origin Description	

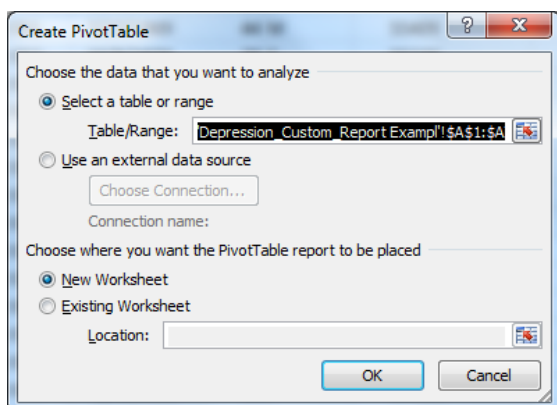
Once you have your patient level download, you can create pivot tables to start answering questions about your patient population.

Basic Instructions for Pivot Table Functions and Application to Depression Population

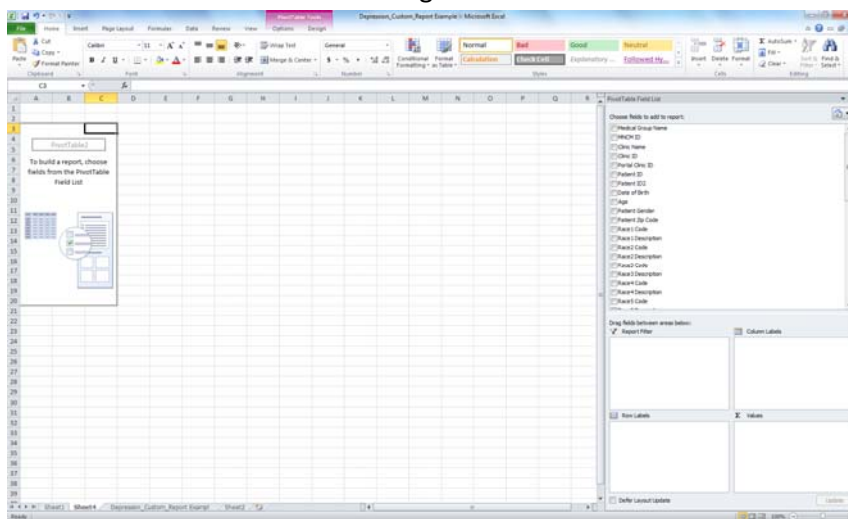
1. Place your cursor in any active cell on the excel spreadsheet (a cell that has data in it)
2. Click on the Insert Tab; then click on the Pivot Table icon



3. You will see a dialog box that looks like this; basically is highlighting all of you active cells. You want the pivot table to go in a new worksheet, so leave the default at New Worksheet and click OK



4. You will then see a cube for starting to create results that summarizes your data



- There are four parts to the reporting function; starting with the lower left hand box which provides counts or sums. By simply dragging in the text field called “Patient ID”, the results give you a count of the patients in your population.

Drag fields between areas below:

Report Filter

Column Labels

Row Labels

Σ Values

Count of Patient ID

Defer Layout Update

Update

Count of Patient ID

76

- Of my population, who was in remission at six months? My cube would look like this by dragging the 6 month remission field into the row labels. This now divides my patients by remission or not remission

Drag fields between areas below:

Report Filter

Column Labels

Row Labels

Σ Values

6 month remission?

Count of Patient ID

Defer Layout Update

Update

Count of Patient ID	
Row Labels	
No	74
Yes	2
Grand Total	76

- Say that I want to know that of my patients who had a PHQ-9 obtained at six months +/- 30 days and how this related to remission? This gets a little bit tricky here as you can see that Excel does nothing to assist us with remembering what we selected as rows or columns, **but** one can always copy-paste special the pivot table as values and then re-label the columns. The reporting cube and output would look like this:
Put the 6 month remission? Field the column label and the PHQ-9 obtained at 6 mos +/- 30 days field as your row label, leaving the patient ID in the values for counting. Output by itself is not that descriptive, but it can be relabeled correctly.

Drag fields between areas below:

☒ Report Filter

☐ Column Labels

☐ Row Labels

☐ Values

☐ Defer Layout Update

Update

Count of Patient ID			
Column Labels		Grand Total	
Row Labels	No	Yes	
No	60		60
Yes	14	2	16
Grand Total	74	2	76

8. Relabeled data looks like this:

6 month remission?			
6 month PHQ-9?	No	Yes	Grand Total
No	60		60
Yes	14	2	16
Grand Total	74	2	76

And tells us:

- 60 of 76 or 78.9% did not have a follow up PHQ-9 at 6 months, conversely
- Our follow-up rate is 16 of 76 or 21.1%
- Of the 16 patients who did have follow-up, 2 of them were in remission (PHQ-9 < 5) at six months +/- 30 days
- Remission rate for the population was 2 of 76 or 2.6%

The last section of the pivot table reporting cube is the Report Filter and I would highly recommend using it to exclude those patients that have an exclusion date submitted (need to come out of the denominator)

Drag fields between areas below:

☒ Report Filter

☐ Column Labels

☐ Row Labels

☐ Values

☐ Defer Layout Update

Update

Exclusion Date (All)			
Column Labels		Grand Total	
Row Labels	No	Yes	
No	60		60
Yes	14	2	16
Grand Total	74	2	76

This function then sits at the top of the pivot table results and always defaults to (All), but you can use the drop down feature to exclude cases from the results. In this case I only want to include those patients who do not have an exclusion date, so by selecting blank from the drop down box, I am removing those patients:

Exclusion Date		(blank)	
Count of Patient ID	Column Labels		
			Grand
Row Labels	No	Yes	Total
No	59		59
Yes	14	2	16
Grand Total	73	2	75

Example EMR Template

Reporting Period: Month/Qtr, YR

Goal: _____ Analysis Completed by: _____

Descriptive Analysis

Data Interpretation

- For example, insert your interpretation / analysis of the data here
- For example, what is the mean, median or range of the data?
- For example, what is the data pattern / trend over time vs. recent period?
- For example, is the data trending well, poorly, positive, negative and for what time period?

Conclusions

- For example, are the goal / target being met, on target, exceeding target, below target, at risk of not being met?

Action Step(s) / Key Activities

- For example, insert your action step(s) to improve and timetable for completion
- For example, if data is at or exceeding target, consider; continue to monitor, decrease reporting frequency or discontinue measure
- For example, what work is currently underway or what are the key initiatives?

Insert Data Table here

Insert run table here

Identify data source

Example of Depression Patient Custom Report

	Patient ID2	Age	Diagnosis	Severity by Initial PHQ-9	Index Contact Date	Index Contact Month	Initial PHQ-9 Score	Patient Measure ment End Date	6 Month +/- 30 days PHQ-9 Score	12 Month +/- 30 days PHQ-9 Score	PHQ-9 obtained at 6 mos +/- 30 days?	6 month remissio n?	6 month response ?	Exclusion Date	Exclusion Reason Code
1	Patient 015	39	296.33	Severe	2/3/2009	Feb-09	20	3/3/2010	23		Yes	No	No		
2	Patient 067	25	296.22	Moderately severe	2/6/2009	Feb-09	15	3/6/2010			No	No	No		
3	Patient 004	66	296.32	Moderate	2/10/2009	Feb-09	11	3/10/2010			No	No	No		
4	Patient 051	63	296.35	Moderately severe	2/10/2009	Feb-09	15	3/10/2010	12	14	Yes	No	No		
5	Patient 001	27	296.3	Moderately severe	2/11/2009	Feb-09	16	3/11/2010			No	No	No		
6	Patient 061	44	296.3	Moderate	2/11/2009	Feb-09	11	3/11/2010			No	No	No		
7	Patient 052	39	296.22	Moderate	2/12/2009	Feb-09	10	3/12/2010			No	No	No		
8	Patient 055	56	296.32	Moderate	2/13/2009	Feb-09	14	3/13/2010	8		Yes	No	No		
9	Patient 023	57	296.23	Moderately severe	2/17/2009	Feb-09	18	3/17/2010			No	No	No		
10	Patient 024	59	296.36	Moderate	2/17/2009	Feb-09	11	3/17/2010			No	No	No		
11	Patient 019	36	296.32	Moderate	2/18/2009	Feb-09	10	3/18/2010			No	No	No		
12	Patient 036	27	296.3	Severe	2/18/2009	Feb-09	24	3/18/2010			No	No	No	2/10/2011	5
13	Patient 033	57	296.35	Moderately severe	2/18/2009	Feb-09	18	3/18/2010	21		Yes	No	No		
14	Patient 013	58	296.22	Moderately severe	2/19/2009	Feb-09	18	3/19/2010			No	No	No		
15	Patient 022	78	296.22	Moderate	2/20/2009	Feb-09	12	3/20/2010	6		Yes	No	Yes		
16	Patient 005	47	296.23	Moderate	2/23/2009	Feb-09	12	3/23/2010	4		Yes	Yes	Yes		
17	Patient 074	64	296.32	Moderate	2/23/2009	Feb-09	10	3/23/2010	7		Yes	No	No		
18	Patient 059	32	296.3	Severe	2/27/2009	Feb-09	20	3/27/2010			No	No	No		
19	Patient 044	33	296.35	Moderate	3/3/2009	Mar-09	14	4/3/2010	8		Yes	No	No		
20	Patient 058	36	296.22	Moderate	3/9/2009	Mar-09	11	4/9/2010		7	No	No	No		
21	Patient 060	42	296.33	Moderately severe	3/16/2009	Mar-09	16	4/16/2010			No	No	No		
22	Patient 068	28	296.22	Moderately severe	3/16/2009	Mar-09	16	4/16/2010			No	No	No		
23	Patient 028	22	296.3	Moderate	3/17/2009	Mar-09	10	4/17/2010			No	No	No		
24	Patient 037	22	296.2	Moderately severe	3/17/2009	Mar-09	15	4/17/2010			No	No	No		
25	Patient 003	62	296.22	Moderately severe	3/24/2009	Mar-09	15	4/24/2010			No	No	No		
26	Patient 031	50	296.32	Severe	3/25/2009	Mar-09	21	4/25/2010			No	No	No		
27	Patient 048	40	296.3	Moderately severe	3/25/2009	Mar-09	17	4/25/2010	8		Yes	No	Yes		
28	Patient 071	59	296.33	Moderately severe	3/27/2009	Mar-09	16	4/27/2010			No	No	No		
29	Patient 043	28	296.33	Moderately severe	3/31/2009	Mar-09	17	4/30/2010			No	No	No		
30	Patient 066	44	296.2	Moderately severe	3/31/2009	Mar-09	16	4/30/2010			No	No	No		
31	Patient 006	47	296.32	Moderately severe	4/1/2009	Apr-09	17	5/1/2010			No	No	No		



Section 4

Implementing

Systems

Crosswalk Between Patient Centered Medical Home and Depression Core Components

Patient Centered Medical Home Components	Depression Components
Registry and tracking for patients identified with multiple chronic or complex conditions	Registry and tracking for depression
Care coordination – specific role for levels of care with particular conditions/diseases	Care manager role focusing on depression care management/coordination
Care plans for every patient identified with multiple chronic or complex conditions	Summary of behavioral activation goals and other follow ups on meds and any referral appts. As well as relapse prevention visit and document
Team approach patient care in the HCH (physician lead)	Consulting psychiatrist to review case load and connect with care manager and PCP as part of a team
Evidence-based protocols and treat to target approaches to best management	Evidence-based protocols –stepped care approach to best management
Use of standardized tests or tools for assessment of progress (e.g., A1C, BP)	Use of standardized assessment tool – PHQ-9
Access to care and good team Communication	Access to care and good team Communication

Quality Measurement and Incentives: Strategies Adopted by Higher Performing Clinics

Angeline Carlson¹, Kris Soegaard², Maren Fustgaard³

¹ Data Intelligence Consultants, LLC, Eden Prairie, MN; ² Buyers Health Care Action Group, Bloomington, MN; ³ Novartis Pharmaceuticals Corporation, East Hanover, NJ.

RESEARCH OBJECTIVES

Minnesota has led the way in publicly reported, provider-level, composite, all-or-none care measures through efforts such as Minnesota Community Measurement (MNCM) and Minnesota Bridges to Excellence, an employer-funded, pay-for-performance program administered by the Buyers Health Care Action Group (BHCAG). Published performance rates expose wide variability among the individual clinics.

The purpose of the study, Best Practices Associated with Optimal Diabetes and Optimal Cardiovascular Care Measures, was to elicit information regarding clinical practices associated with clinics achieving higher and lower performance scores.

STUDY DESIGN & METHODS

Thirty-nine individuals from Minnesota and Wisconsin border clinics participated in a qualitative study consisting of thirty-minute, semi-structured telephone interviews . Clinics were randomly selected from a list of clinics participating in the MNCM 2009 direct data submission process.

Clinics responding to an e-mailed invitation designated a medical director and an administrator to participate.

Interviews were designed to gain insights into clinic and system factors that contributed to individual clinic care performances.

MINNESOTA COMPOSITE CLINICAL MEASURES

	Diabetes	Vascular
Hgb A1c	<7 (change in metric to < 8 for 2010)	NA
LDL	<100	<100
One aspirin daily	>40 years (change under consideration)	All
Smoking	Non-smoker	Non-smoker
Blood Pressure	<130/80	<130/80

PRINCIPLE FINDINGS

Acceptance, commitment to, and ownership of measurement and public reporting was the hallmark of higher performing clinics.

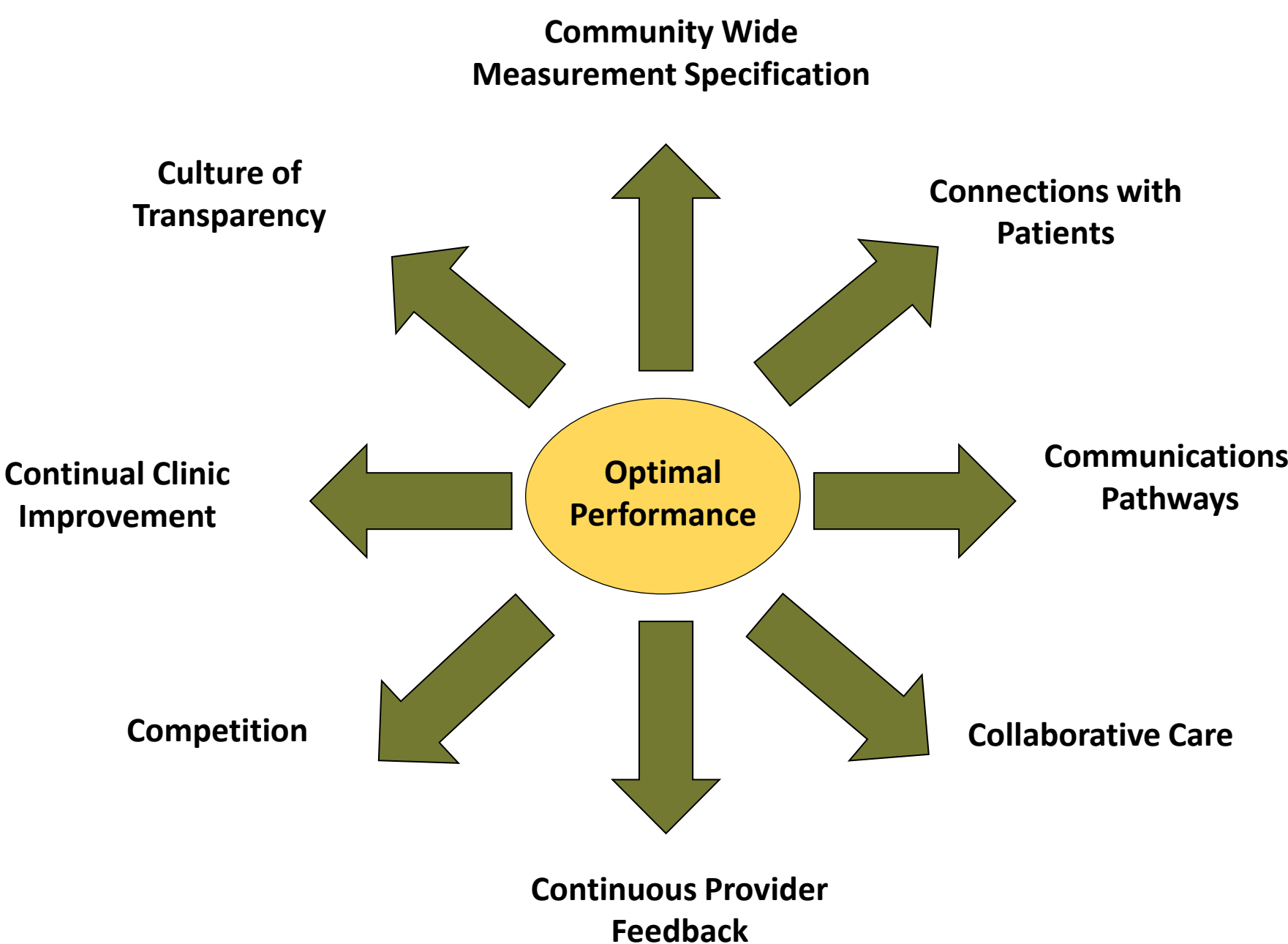
Factors contributing to optimal management:

- **Use of patient registry and “working the registry list”** – identifying patients who have not been seen in the clinic recently and establishing contact with them to request an appointment to review their status
- **Electronic medical records, especially when used in conjunction with a patient registry** – provides ability to retrieve information on care components, alerts provider to any health issues or updates, generates reports to monitor goals
- **Reliance on clinic personnel other than physician** – all staff in the clinic take responsibility for patients’ health, increasing ability to monitor and follow up with patients
- **Standing orders to facilitate care processes** – nurses are authorized to provide identified care services according to physician-approved protocol
- **Team approach to care delivery** – health care professionals with differing knowledge and expertise act in a patient-focused manner to meet the optimal care needs of patients
- **Acceptance and commitment to the process of performance measurement** – all staff are aware of goals and processes, and are committed to quality improvement
- **A strategy of capturing the moment** – using every possible opportunity to monitor progress and interact with the patient about their management goals
- **Pre-visit planning** – review of laboratory results for currency and perform updated lab tests, if necessary, with results available to physician at appointment
- **Internal monitoring of performance rates** – measurement of performance as an on-going process with performance displayed internally in a public area within the clinic
- **Organizational commitment** – all levels of the organization are involved with and committed to quality improvement

Factors challenging to optimal management:

- **Patient characteristics**
 - persons from economically distressed areas
 - lower economic status individuals
 - recent immigrants
 - persons with lower educational levels
- **Patient motivation**
- **Effective, culturally sensitive patient educational materials**
- **Time to accomplish important tasks**
- **Low reimbursement rates for services that are time consuming and labor intensive**

CRITICAL COMPONENTS FOR OPTIMAL PERFORMANCE



RELEVANCE TO POLICY

Despite broad recognition of the high cost and health implications of uncontrolled chronic disease, there remains a gap between the care persons with chronic diseases receive and the documented performance of care in keeping with evidence-based guidelines.

Our findings point to an opportunity to accelerate adoption of individual and health system practices that higher performing clinics have utilized to continually improve performance. This requires two elements: 1) a philosophical acceptance of the merits of quality measurement and 2) implementation of existing strategies and tactics embraced by higher performing clinics.

While pay-for-performance incentives are recognized as important by clinic personnel, other factors found in this study may play a larger role.

ACKNOWLEDGEMENTS

Funding for this study was provided by Novartis Pharmaceuticals.

Help and Healing:

Resources for Depression Care and Recovery

Section 5: Resources

Depression Resource List for Patients and Families

Depression Resource List for Clinicians



Section 3

Managing Depression

Depression Resource List for Patients and Families

Patient and Family Resources

Authentic Happiness

authentichappiness.sas.penn.edu

reflectivehappiness.com

Authentic Happiness is the homepage of Dr. Martin Seligman, Director of the Positive Psychology Center at the University of Pennsylvania and founder of positive psychology, a branch of psychology which focuses on the empirical study of such things as positive emotions, strengths-based character, and healthy institutions. This website has more than 2 million users from around the world, and you are welcome to use all of the resources available here for free.

Med Ed PPD

mededppd.org

Online education about perinatal mental health and treatment options.

National Alliance on Mental Illness

namihelps.org

Advocacy, links to Minnesota chapter support groups

National Center for Complementary and Alternative Medicine (NCAM)

nccam.nih.gov/health/meditation/overview/htm

Meditation: An Introduction. This Backgrounder provides a general introduction to meditation and suggests some resources for more information.

Postpartum Support International

postpartum.net

Provides information on postpartum depression for providers of care as well as patients/consumers interested in learning more about postpartum depression. Expanded section for dads.



Minnesota Attorney General's Office of Healthcare Complaint Private Insurance

ag.state.mn.us/Consumer/Complaint.asp

Minnesota healthcare consumers can use the form below to file a complaint with the Attorney General's office if they have had a problem or dispute with a private insurance issue.

Minnesota Department of Human Rights

humanrights.state.mn.us

This state agency investigates charges of illegal discrimination; the website also includes information about your rights under the state Human Rights Act.

MN Department of Health Office of Mental Health Practice

health.state.mn.us/divs/hpsc/hop/omhp

This office investigates complaints against unlicensed mental health practitioners in Minnesota.

State of Minnesota Office of Ombudsman for Mental Health and Developmental Disabilities

ombudmhdd.state.mn.us

This state office receives complaints and comments about services; it also provides information about the civil commitment process.

Advocacy Organizations

Mental Health Association of Minnesota

mentalhealthmn.org

Provides patient information, depression screening tool, community resources and discussion board.

Mental Health Consumer Survivor Network of Minnesota (CSN)

mhcsn.org

Offers self-help tools, training, and education for consumers. CSN believes in a mental health system focused on wellness and recovery.



Community-Based Services and Supports

MN Department of Human Services

mn.gov/dhs

Contains information about various types of community-based and residential treatment services; includes links to county mental health staff, information on mental health programs, and services for adults in Minnesota.

Minnesota Health Care Programs Provider Directory

mhcpproviderdirectory.dhs.state.mn.us

Click on Mental Health, and then find the sub-category of service you are looking for.

Minnesota Help Info

minnesotahelp.info/public

MinnesotaHelp.info Search engine used to help find local community services and supports.

Employment

MN Department of Employment and Economic Development

[positivelyminnesota.com/JobSeekers/People with Disabilities](http://positivelyminnesota.com/JobSeekers/People_with_Disabilities)

Extended employment services offer support to individuals with disabilities who have difficulties finding/maintaining jobs independently.

Work Incentives Connections

mnworkincentives.com

Provides information on how work affects public benefits.

The Partnership for Workplace Mental Health

workplacementalhealth.org

Launched Employer Innovations Online to help employers take action to address mental health at the workplace by providing case examples of successful corporate approaches.



Books

What to Do When Someone You Love is Depressed – Mitch Golant

How You Can Survive When They're Depressed – Anne Sheffield

The Noonday Demon – Andrew Solomon

Out of the Darkened Room: When a Parent is Depressed – William Beardslee

The Depression Workbook – Mary Ellen Copeland

On The Edge of Darkness – Kathy Cronkite

Getting it Done When You're Depressed – Julie A. Fast and John D. Preston

Section 5

Depression

Resources

Depression Resource List for Clinicians

American College of Physicians (ACP) Depression Care Guide

<http://depression.acponline.org/>

Evidence-based online resource on team based practices for screening, diagnosis, and management in primary care settings. Free CME or CE available for internists, family practitioners, psychiatrists, psychologists, physician assistants, nurse practitioners and nurses.

Columbia-Suicide Severity Rating Scale (C-SSRS)

<http://www.cssrs.columbia.edu/>

A questionnaire for suicide assessment developed by Posner, K., Brown, G.K., Stanley, B., Brent, D.A., Yershova, K.V., Oquendo, M.A., Currier, G.W., Melvin, G., Greenhill, L., Shen, S., & Mann, J.J. "The Columbia- Suicide Severity Rating Scale (C-SSRS): Initial Validity and Internal Consistency Findings from Three Multi-Site Studies with Adolescents and Adults." Am J Psychiatry 2011;168:1266-1277.

Gilbody, S., Bower, P., Fletcher, J., Richards, D., Sutton, A. Collaborative care for depression. Arch Intern Med. Vol 166, Nov 27, 2006. 2314-2321.

Meta-analysis of 37 randomized studies on collaborative care for depression. Short-term (6 months) and long-term (up to 5 years) effectiveness was found based on factors of medication compliance and the professional background and method of supervision of care managers.

The Institute for Clinical Systems Improvement (ICSI) Guideline: Major Depression in Adults in Primary Care

http://www.icsi.org/guidelines_and_more/

Evidence-based resource including implementation strategies and recommended measures for improving quality of care.

Depression
Resource List
for Clinicians

Kroenke, K. MD, et al. The PHQ-9: Validity of a brief depression severity measure. J Gen Intern Med 2001;16:606-613.

Case-control study validating the PHQ-9 for assessing depression severity. The sensitivity of detecting a PHQ-9 of greater or equal to 10 was 88% and sensitivity was also 88%.

Other PHQ-9 language versions can be found at: <http://www.phqscreeners.com/overview.aspx>.

The MacArthur Initiative Clinician Manual

www.depression-primarycare.org

The manual has a number of tools that can be useful, for example:

- Suicide screening strategy
- Patient education materials on depression
- Medication information sheet
- Brief counseling questions
- Template for behavioral health communication with primary care
- Referral form to behavioral health
- Patient education sheet on psychotherapy

Minnesota Association of Community Mental Health Programs (MACMHP)

<http://www.macmhp.org/>

This association works to improve mental health services among providers; website includes training information for mental health professionals.

Minnesota Tribal and County Health Care Directory

http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_008265.pdf

A listing of county and regional offices and county human services agencies in Minnesota.

Minnesota Department of Health (MDH)

<http://www.health.state.mn.us/divs/fh/mch/fhv/strategies/ppd/index.html>

State of MN mandated patient education materials in English, Spanish, Hmong and Somali for health providers to download and give to their patients.

National Institute of Mental Health (NIMH)

<http://www.nimh.nih.gov>

This government-sponsored site provides comprehensive information on the following topics: Clinical trials, research and funding opportunities, and patient education materials for adults and children.

Depression
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Rush, A. John, MD., et al. Acute and longer term outcomes in depressed outpatients requiring one or several treatment steps: A STAR*D report. *Am J. Psychiatry* 2006; 163:1905-1917.

Later phase analysis of the STAR*D clinical study reporting patients who require several medication changes to achieve remission of an acute major depressive episode have a higher rate of relapse and shorter period of time until relapse compared to patients who require fewer medication changes to achieve remission.

Shared Decision-Making in Mental Health Care: Practice, Research, and Future Directions

www.samhsa.gov

HHS Publication No. SMA-09-4371. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2010.

Unutzer, Jurgen, Katon, Wayne, Ming-Yu, Fan, Schoebaum, Michael, Lin, Elizabeth, Penna, Richard, Powers, Diane; Long-Term Cost Effects of Collaborative Care, *American Journal of Managed Care*, Vol 14, No. 2

Randomized controlled trial comparing collaborative care with usual care at two IMPACT sites in which four-year cost data were available. Results showed a slight increase in costs to put the new care in place but then over time, in 2-4 years post implementation, there is an overall health care cost savings of \$3,300 per patient compared to patients receiving usual care.