DEVELOPING AND IMPLEMENTING A STEPPED DEPRESSION CARE MANAGEMENT PROGRAM IN A COMMUNITY FHT

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AT THE END OF THIS PRESENTATION YOU BE ABLE TO:

- Recall the evidence for stepped depression care management and how it conforms to the collaborative model of care
- Discuss both benefits and challenges of the implementation of the research model of stepped care in the community
- Explore the possibility of applying this model to your clinical practice

QUESTION #1

How Does This Compare to My Clinical Experience and Practice Setting?

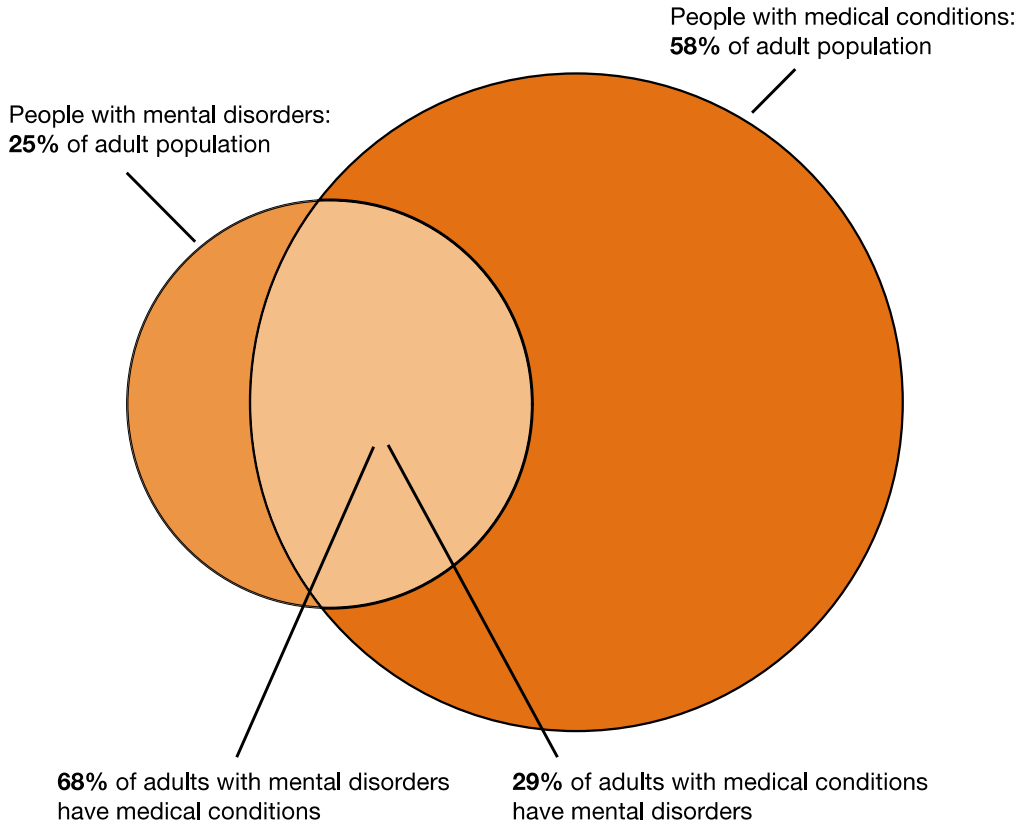
THE VILLAGE FAMILY HEALTH TEAM:

- A wave 5 FHT
- Opened in August 2011
- 6 FTE physicians, 1 MSW, 2 RNs, 1 NP
- Target of 10,000 rostered patients,
- 20-30% will be patients with serious mental illness and/or addictions (previously “orphan” patients)

WHY AT THE VILLAGE FHT

- Mandate to provide exemplary primary mental health care
- Observed high number of patients presenting with depression who are not connected to mental health services.
- Limited resources/access to mental health care, similar to any other primary care setting and limited sessional psychiatry funding

WHY DEPRESSION AND WHY IN THE PRIMARY CARE SETTING



Majority of depression care occurs in primary care setting

Patients often present to their PCP with co-morbid medical conditions

Care of those medical conditions more difficult when co-morbid depression present, leading to worse:

- Quality of life
- Symptoms
- Mortality
- Cost of Care

National Co-morbidity Study Replication, 2001-2003, in Druss, B.G., & Walker, E.R. (2011). Mental disorders and medical comorbidity. (Research Synthesis Report No. 21). Robert Wood Johnson Foundation.

WHY DEPRESSION AND WHY IN THE PRIMARY CARE SETTING

Systems barriers to providing guideline based depression care:

- Patients with mental health concerns often take more time, and PCP has limited time
- Limited access to resources, such as access to specialized psychiatric care, psychosocial resources

All of the above ultimately have a negative impact on overall patient care

The Evolution of Collaborative Mental Health Care in Canada: A Shared Vision for the Future, Kates et al., 2010, joint position paper between CPA and CFPC

FROM A SYSTEMS PERSPECTIVE

- *Cost of depression: direct vs. indirect*
- "Because [depression] exacerbates physical illness, it is a significant factor in driving up the cost of care. Inversely, when depression is treated successfully, overall health improves and costs go down. The economic cost of traditional depression care has been estimated to be 8.4 hours lost per worker per week, a reduction in productivity estimated to cost US employers $44 billion a year"

The Value of Providing Collaborative Care Models for Treating Employees with Depression, Institute for Clinical Systems Improvement, www.icsi.org

THE COLLABORATIVE CARE MODEL

- In response to limited resources in the face of significant need
- The triple aim of collaborative care:
  - Improve outcomes
  - Improve patient satisfaction
  - Minimize financial cost of care

The stepped depression model achieves all three

COMMON COMPONENTS OF SUCCESSFUL COLLABORATIVE PROGRAMS

- The use of a care coordinator or Social Worker
- access to psychiatric consultation
- enhanced patient education or access to resources
- introduction of evidence-based treatment guidelines
- screening of people with chronic medical conditions for depression or anxiety
- skill enhancement programs for primary care providers
- access to brief psychological therapies, including motivational interviewing

The Evolution of Collaborative Mental Health Care in Canada: A Shared Vision for the Future, Kates et al., 2010, joint position paper between CPA and CFPC

QUESTION #1

How Does This Compare to My Clinical Experience and Practice Setting?

QUESTION #2

How Would I Implement The Stepped Depression Care Management Program In My Clinic?

OUR OBJECTIVES

Provide evidence-based care of depression in primary care

Improve access to psychiatric care through caseload consultation

Opportunity for transfer of knowledge and skills between different professions

Prevent patients from “falling between the cracks”

To provide care to overall population effectively

- Treat-to-target approach, therefore active monitoring to reduce loss to follow-up
- Treat to remission – increase intensity of care for those who are not responding

THE STEPPED DEPRESSION CARE MODEL

IMPACT - IMPROVING MOOD-PROMOTING ACCESS TO COLLABORATIVE TREATMENT

- Multi-site RCT, with 1801 pts, 60+ yo, with depression/ dysthymia
- IMPACT program vs. Treatment as usual
- At 12 months:
  - Less depression
  - More depression care
  - More satisfaction with care
  - Less functional impairment
  - Greater quality of life

Unutzer J et al. (2002) Collaborative Care Management of Late-Life Depression in the Primary Care Setting, JAMA, 288(22) 2836-2845
Hunkeler EM, Katon W, Tang L, WIlliams JW Jr, Kroenke K, Lin EHB, et al., Long term outcomes from the IMPACT randomised trial for depressed elderly patient in primary care. BMJ 2006;332:259-62

IMPACT - IMPROVING MOOD-PROMOTING ACCESS TO COLLABORATIVE TREATMENT

POPULATION-BASED

- i.e. all patients actively tracked in a registry vs. patients that present to office

MEASUREMENT-BASED

- Objective rating scales, to guide treatment, track trends, while still leaving time to discuss pt's experience

TREAT-TO-TARGET

- Increases functional recovery and reduces relapse by treating to remission

Unutzer J et al. (2002) Collaborative Care Management of Late-Life Depression in the Primary Care Setting, JAMA, 288(22) 2836-2845

CORE COMPONENTS OF EVIDENCE-BASED DEPRESSION CARE

New "Team Members" Supporting PCP

Two Processes	Care Manager/SW	Consulting Psychiatrist
1. Systematic diagnosis and outcomes tracking e.g. PHQ-9 to facilitate diagnosis and track depression outcomes	-patient education/self management support -close follow-up to make sure pts don't "fall through the cracks"	-caseload consultation for care manager and PCP (population-based) -diagnostic consultation on difficult cases
2. Stepped Care a) change treatment according to evidence based algorithm if patient is not improving b) relapse prevention once patient is improved	-Support antidepressant Rx by PCP -Brief counseling (behavioral activation, PST-PC, CBT, IPT) -Facilitate treatment change/ referral to mental health -relapse prevention	- consultation focused on patients not improving as expected -recommendations for additional treatment/referral according to evidence-based guidelines

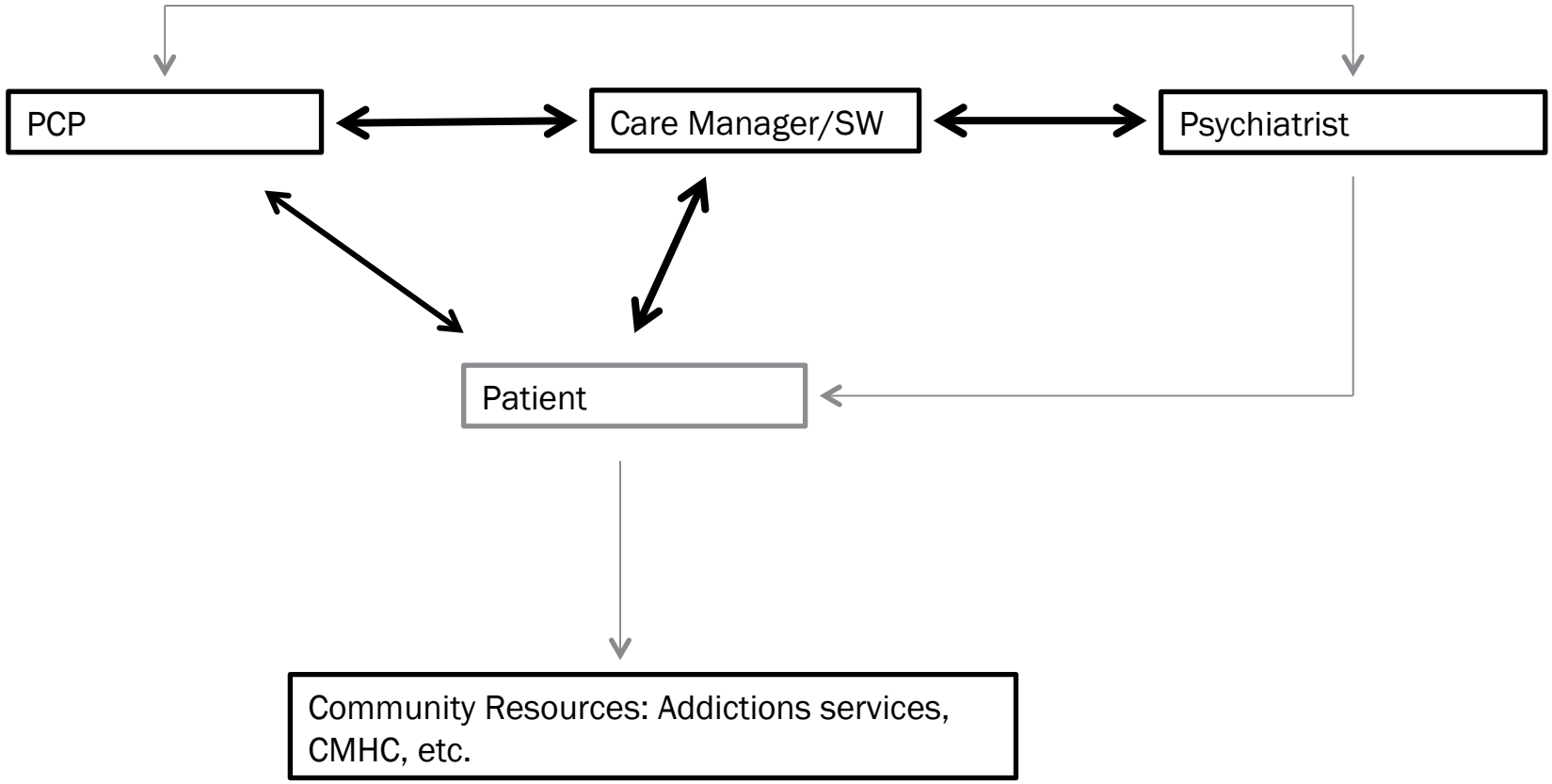
Unutzer J et al. (2002) Collaborative Care Management of Late-Life Depression in the Primary Care Setting, JAMA, 288(22) 2836-2845

RESOURCE USE

1FTE depression care manager and 0.2 FTE psychiatrist for 50-100 patients

Number of patients that can be followed varies based on complexity of patient's presentation

STEPPED DEPRESSION CARE PROGRAM



THE STEPPED DEPRESSION CARE PROGRAM IN POPULATION WITH CO-MORBID DIABETES

PATHWAYS EPIDEMIOLOGY STUDY

- Epidemiological study that collected information from 5000 pts with diabetes from 9 primary care clinics
- Purpose: to look at impact of depression on diabetes management
- The prevalence of Major Depression was 12% among the patients with diabetes
- An additional 8.5% of patients met criteria for Minor Depression

http://pathways-uw.org/, obtained on September 4, 2012

PATHWAYS EPIDEMIOLOGY STUDY CONTINUED:

Diabetic patients with minor and major depression had:

- more severe symptom burden
- greater disability
- a higher number of diabetes complications
- increased mortality
- higher medical costs than non-depressed patient

http://pathways-uw.org/, obtained on September 4, 2012

PATHWAYS INTERVENTION STUDY

In a randomized trial, approximately 330 patients were assigned to usual care or collaborative care for depression

Patients with diabetes who received collaborative care had:

- higher global improvement scores
- lost more weight,
- experienced higher satisfaction with their care
- had lower medical costs than patients with depression treated with usual care

http://pathways-uw.org/, obtained on September 4, 2012

IMPLEMENTATION AT VILLAGE FHT

- The Team: Two PCPs, One Social Worker, One Psychiatrist and One Psychiatric Resident
- Aspects of Model that HAVE been implemented:
  - Regular case consultations
  - PHQ-9 and Addictions scale when pt identified by PCP with concerns around depressed mood
  - Referral to Social Worker, who provides psychoeducation, therapy, access to community resources

IMPLEMENTATION AT VILLAGE FHT

- Aspects that have NOT been implemented
  - Routine PHQ-9 at follow-up
  - Formal registry of patients
  - Formal psychoeducation program upon admission to program and for relapse prevention
  - Challenges around differentiating treatment-as-usual vs. stepped depression care management program
  - Objective method of identifying pts for treatment-as-usual vs. stepped depression care management program

QUESTION #2

How Would I Implement The Stepped Depression Care Management Program In My Clinic?

QUESTION #3

How Could Things Be Done Differently?

SUCCESSES DURING IMPLEMENTATION

- Meetings between team members, encourages collaborative vs. co-located care
- Able to review situations where potential loss to follow-up due to worsening clinical presentation
- Development of Women's Arts based Narrative Therapy Trauma Group

FUTURE DIRECTIONS

- Incorporate psychoeducational materials around depression
- Develop relapse prevention program
- Improve electronic charts to reflect use of scales, to easily identify patients in stepped care model
- Utilize PHQ-9 tool routinely at follow-up

QUESTION #3

How Could Things Be Done Differently?

QUESTIONS