Building a Primary Care Pathway for Depression

Dennis Pusch
A brief history of Shared Care

- Development of initial model (1998)
- Early ideas about pathway development
- The rise of PCNs
- The development of the Behavioural Health Consultant model
What does the BHC model look like in practice?

- Direct service to patients and physicians
- At least ½ day weekly per clinic
- Full integration into the clinic
- Up to 12 consults per day; minimal follow-up
- Emphasis on patient self-management
Integration can be a bit threatening . . .
Two phases of BHC program implementation

- Phase 1 – Horizontal integration
- Phase 2 – Vertical integration
Horizontal integration

- Most basic form of integrated care
- Designed to deliver a large volume of brief psychosocial services that systematically improve the health of the entire primary care population
Current BHC involvement in PCNs

- Partnership with 5 PCNs
  - Foothills PCN, South Calgary PCN, Mosaic PCN, Calgary West Central PCN, Highland PCN
- 24 BHCs; 450 Family Physicians
- 2 program evaluations
“I find it so much better to have someone in the clinic rather than going elsewhere as the behavioural consultant can work with my physician for my best care!”
Vertical Integration

- Built on the base of solid, ongoing collaboration between PCP and BHC
- Strategizing an approach to high frequency, high cost conditions in primary care
- Population- and evidence-based
Why start with a pathway for depression?
The facts about depression

- Only 30% of people with depression receive any treatment.
- Of those who do, 50% get appropriate medicine, but only 20% are seen 3 or more times in the next 3 months.
- 1/3 of patients discontinue meds within 1 month.
- Only 10% of depressed pts receive appropriate psychotherapies.
Common Medical Illnesses and Depression

- Major Depression: 30-50%
- Stroke: 11-15%
- Diabetes: 15-20%
- Heart Disease: 23%
- Multi-Condition Seniors: 23%

Note: Percentages are approximate and may vary.
Ofman (AMJ, 2004)

- Looked at the effects of disease management protocols designed to address 11 different chronic conditions
- Reviewed 102 articles that evaluated 118 disease management programs in various settings
- Depression management programs had the highest percentage of outcomes demonstrating substantial improvements in patient care
If you are lost in the forest ...
... form a working group!

- Physicians from all participating PCNs
- Senior Medical Director, Addictions & Mental Health
- Dept. of Psychology, University of Calgary
- Manager and team members from Standards and Clinical Pathways
- Data manager and Clinic Integration coordinator
- Primary Care Operations Lead, AHS
- Manager, Shared Mental Health Care
Some things in life seem more confusing the more you look at them.
Pioneers who helped point the way

- Kirk Stroshahl and Patti Robinson (Wash.)
- Alexander Blount (UMass)
- IMPACT (Jürgen Unützer; Wayne Katon)
- DIAMOND (CJ Peek, Paul Woods)
- Intermountain Healthcare (Utah)
- Pathway development in Great Britain
Key components of a clinical pathway

- Protocols
- Evidence informed practice
- Resources
  - Human
  - IT
  - Project management
- Education
- Communication/Marketing
- Documentation
- Evaluation
What might a clinical pathway for depression in Calgary look like?
Screening for depression

- Use of the PHQ-2 and PHQ-9
- Screen specific populations at high risk
  - New . . . patient, loss/stress, dx of disease
  - Aged
    - Chronic . . . pain, illness
    - Psych history . . . previous episodes, substance abuse, depression sx complaints
  - Expecting . . . pregnant, post-partum
  - Odd Presentations . . . “gut feeling,” vague presentations, negative test results
- Use a clinic-based registry to track treatment protocols for patients
- Screening is only useful if followed by effective treatment!
Using technology to help with screening (Patient Tools)
Stepped care following initial screening
Three assumptions of a “stepped care” approach (von Korff, 1999)

1. Different people require different levels of care
2. Finding the best level of care depends on monitoring outcomes
3. Moving from lower to higher levels of care based on observed outcomes can increase effectiveness while lowering overall costs
Levels of care in the pathway

- **No treatment** (PHQ-9 < 10)
- **Watchful waiting** (PHQ-9 10 – 14)
  - No meds or specialty consultations warranted
  - Pts receive targeted self-management info
  - Follow-up in one month (PHQ-9)
  - May stay on WW or move
  - Follow-up session 3 months after score is <10
## Documenting pathway outcomes

### PHQ 9 Score 10-14  Treatment Selection & Intervention Recording

At each visit consider PHQ 9 score:
- If less than 10 discontinue algorithm
- If 10-14 continue with watchful waiting
- If greater than 14 start new algorithm in green clinical chart

This sheet should be used in conjunction with the Pathway protocol and the algorithm.

### Visit 1

<table>
<thead>
<tr>
<th>Date</th>
<th>BHC</th>
<th>MD</th>
<th>PHQ 9 Score: -</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Book 2nd visit in 4 weeks.**

**Visit 2**

- Patient attended, **YES**. **NO**.
  - If No, please circle reason
    - 1. Unknown (follow-up protocol)
    - 2. Cancelled
      - a. unwell
      - b. another appointment arranged
      - c. physician cancelled
    - 3. Treatment changed
      - a. PHQ 9 score changed
      - b. physician decision
      - c. patient refusal
    - 4. Other

### Visit 3

<table>
<thead>
<tr>
<th>Date</th>
<th>BHC</th>
<th>MD</th>
<th>PHQ 9 Score: -</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please circle**

**Visit 4**

- Patient attended, **YES**. **NO**.
  - If No, please circle reason
    - 1. Unknown (follow-up protocol)
    - 2. Cancelled
      - a. unwell
      - b. another appointment arranged
      - c. physician cancelled
    - 3. Treatment changed
      - a. PHQ 9 score changed
      - b. physician decision
      - c. patient refusal
    - 4. Other

### Visit 5

<table>
<thead>
<tr>
<th>Date</th>
<th>BHC</th>
<th>MD</th>
<th>PHQ 9 Score: -</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please circle**

### Workbooks Provided (please circle number)

<table>
<thead>
<tr>
<th>Self management workbooks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is Depression?</td>
</tr>
<tr>
<td>2. Medication &amp; Depression</td>
</tr>
<tr>
<td>3. Behavioural Activation</td>
</tr>
<tr>
<td>4. Self Care</td>
</tr>
<tr>
<td>5. Problem Solving</td>
</tr>
<tr>
<td>6. Assertiveness and Communication</td>
</tr>
<tr>
<td>7. Realistic Thinking</td>
</tr>
<tr>
<td>8. Maintaining Gains &amp; Reducing Relapse Risk</td>
</tr>
</tbody>
</table>

### Workbooks Provided (please circle workbook #)

<table>
<thead>
<tr>
<th>Workbook 1</th>
<th>Workbook 2</th>
<th>Workbook 3</th>
<th>Workbook 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

### Comments

- Please record reason and outcome on separate recording sheet 10-14 b.

### Patient Name
Self-management modules

- What is depression?
- Self care
- The role of medication
- Realistic thinking
- Problem solving
- Behavioural activation
- Assertiveness and communication
- Relapse prevention
Levels of care in the pathway

- **Clinical intervention** (PHQ-9 > 14)
  - BHC visits encouraged
  - Pts receive targeted self-management info
  - Meds, clinic therapy, outside referral options
  - 3 visits in 3 months; start in two weeks
  - Psychiatry consult available after 2 non-responses
Depression Algorithm
“Clinical Intervention”
Managing treatment non-responses

**Partial Response to Anti Depressant after 4 weeks**

- **A**: Increase dose of anti-depressant and review in 2 weeks (side effects allowing, and if not already at the maximum, see above)

- **B**: Change anti-depressant
  - Taper antidepressants over 1-2 weeks at the same time a new medication is started if the decision is made to change medications.

- **C**: Add Psychotherapy (CBT)
  - Consider emphasizing the addition of BHC visits or a referral for external psychotherapy if patient has not previously chosen either of these treatment options.

- **D**: Augment current antidepressant with one of the following:
  - Lithium Carbonate: begin with 600mg/d x 1 week, then 900mg/d and follow with blood levels targeted at 0.5-1.0 mEq/l (note need to follow TSH and renal function)
  - Atypical antipsychotic medication (note concerns for weight gain, Metabolic Syndrome, extrapyramidal side effects)
    - Risperidone (Risperdol): 0.25-2mg/d
    - Olanzapine (Zyprexa): 2.5-10mg/d
    - Quetiapine (Seroquel): 50-300mg/d
    - Aripiprazole (Abilify): 5-20mg/d
  - Thyroid augmentation: triiodothyronine (Cytomel) 25mcg/d x 2 weeks, if no response, increase to maximum of 50mcg (theoretical risk of reduced bone density with chronic use)
  - Add Bupropion (Wellbutrin): 150 - 300mg/d

**Pathway Management of Non Response**

Questions to be considered:
- Is there a chance this could be Bipolar Disorder?
- Is there any concern about adherence?
- Is there any concern about substance abuse?
- Are there concerns about side effects or suicidal ideation?

If satisfied with original diagnosis and this represents "non-response":
**Switch to alternative** first line antidepressant or institute CBT (with or without concomitant antidepressant).

Reference: Lam RW et al: Canadian Network for Mood and Anxiety Treatments (CANMAT) (2009)
“How do we implement this clinical pathway across such diverse practices?”
Go after the low hanging fruit first

- Start with a few pilot clinics
- Expand to all clinics where BHCs are integrated
- Continue to increase BHC integration into new clinics
Pathway implementation in new clinics

- Initial marketing in broader forums
- Initial clinic visit with physicians
- Training session with the BHC
- Environmental scan
- Clinic training meeting
- Weekly adherence checks
- Follow-up clinic meeting for troubleshooting
Pathway outcomes to date

- On the pathway: 21 CI, 8 WW = 29 total
- Off the pathway: 19 CI, 14 WW = 33 total
- 7 are off due to their own choice
- 26 are off by protocol (PHQ < 10)
- 4 patients are completely done (PHQ still low after 3 month follow-up)
- 3 patients have completed and then returned to the pathway (3 month PHQ > 9)
Anecdotal Information

- “I have seen many patients move from a severe PHQ score to complete the pathway in less than 3 months…extremely positive process to improve patient care”.

- “Patient acceptance has been excellent, both of pathway and opportunity to meet with BHC”.

- “…less intrusive on my time as patients are seen quickly by the BHC. An extremely collaborative approach to patient care.”

- “Patients like getting the depression handouts”

- “Patients don’t fall through the cracks”
Challenges & Next Steps

- Training new clinics
- Screening high risk groups
- Registry and EMR issues
- Sustainable financial & human resources
- Figure out if it works
- Dovetail with emerging pathways
- Utilize all clinic expertise
- Extend pathway along the continuum of care
With perseverance, what once seemed impossible can slowly become reality!
Questions or comments?

dennis.pusch@albertahealthservices.ca