Introduction

Depression is ... CHALLENGING!

Common:
- At some point in their lives, 20 to 25 percent of adults go through a major depressive episode.
- From 2007 to 2010, antidepressants were the 3rd most commonly prescribed drug taken by patients of all ages in the US.

Costly:
- In 2010, depression cost the US over $210 billion in healthcare costs with an estimated additional $1 trillion in lost productivity in the workplace.

Harmful:
- There is a 10-25 year reduction in life expectancy for people with severe mental illness, including depression.

Objectives

To improve symptoms of clinical depression in at least 50% of clinically depressed adult primary care patients at Knightdale Family Medicine within one year and then spread learnings to other clinics.

Methods

Depression is ... TREATABLE!

Not only do 20% of primary care visits involve providing care for mental health needs, but we learned from work in the STAR*D trial that identical remission and response rates can be achieved in primary and specialty settings when identical care is provided. The strategy for project UPLIPHT was to connect patients with depression with Julie, the LCSW at Knightdale Family Medicine, track their PHQ-9 scores over time, and design Plan-Do-Study-Act (PDSA) cycles to test which of Julie’s interventions was most effective.

References:
- http://www.mayoclinic.org/diseases-conditions/depression/patient-visit/PD000319/DV

Findings

Project UPLIPHT was designed as a year-long project focused first on interventions in depression management at Knightdale Family Medicine, with a plan to spread to other clinics in the UNC Physician Network. Through a complete care team model, engaging the primary care providers, care manager (Julie, LCSW), a consulting psychiatrist (Dr. Reed), and support staff, the team was able to provide additional intervention for patients with depression.

Patients were first identified as having depression symptoms through a registry report from Epic or during an office visit. On a weekly basis, Julie would reach out to those patients who were identified to have a PHQ-9 score greater than 15 by phone. Julie’s outreach was designed to encourage medication compliance, gauge interest and schedule behavioral health visits, and follow-up on any problems or discussion from the office visit.

Through the PDSA cycles of the project, the team learned that provider engagement was a critical piece to connect patients with Julie’s services. Providing data to the clinic regularly, setting goals for clinical outcomes, and sharing that information transparently with clinic staff encouraged the entire clinic to be engaged in the outcomes. The team saw the greatest improvement when Julie began a 1-week phone call follow-up to PCP clinic visits, and following provider-level data sharing. Each of these ideas became part of the best practice standard work.

During the first six months of the project, the team saw a similar upward trend in the general population of depressed patients as with the subset of patients seen by Julie. Beginning around the eighth month of improvement work, the improvement in patients who had Julie on their care team began showing more rapid and dramatic improvement in their depression symptoms. This growth continued through the duration of Project UPLIPHT and confirmed the hypothesis of improved depression management when engaging the full care team. Adding the LCSW outreach, behavioral health, and clinical support improved depression symptoms and outcomes for patients with depression.

Conclusions

At 12 months, 45% of intervention patients had a 50% or greater reduction in depressive symptoms from their baseline, compared with 19% of usual care participants.

Lessons Learned:
- Invested team members are key to success!
  - Students, interns — LCSW
  - Clinic Leadership — Executive Leadership
- Balance of measurement and respect for clinical responsibilities is critical to project success
- Respect the bottom line. Every clinic is still a business.
- Define a reliable, reproducible, standard process.

Expectations in Clinics Adopting Best Practice:
- Improved PHQ-9 scores, with a focus on quality metrics monitoring depression management.
- Improved engagement of the entire Care Team in providing support for patients with depression.
- Increased communication between Care Manager, Clinical Support Staff, and PCP regarding patients’ needs, some in the form of messages through Epic, some face-to-face consultation during an office visit.
- Transfer of some aspects of depression care from Providers to Care Managers and other support staff.
- Closer monitoring and increased outreach for patients with significant depressive symptoms.
- Increased opportunity to build relationships with patients through face-to-face consultation while in the clinic.

What does it take?
- Leadership Engagement
- Support expanding clinic capacity
- Empower clinic and admin staff
- Clinical Support: for a clinic with about 800 patients with depression:
  - 10 minutes to run reports / week
  - Weekly call with Liaison Psychiatrist
  - About 18-20 patients screened each month with PHQ-9 > 10
  - Average 4-5 patients / week
  - Average 15 minutes / call
  - About 75 minutes / week for patient outreach and follow-up calls
  - Time blocked for total weekly effort = 85 minutes + psychiatrist call
- Administrative Outreach
  - Letters for lost to follow-up
  - Generate office visits

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