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Helping to Support CPC+ Initiative to Integrate Behavioral Health Within Primary Care: A Team-Based Approach to Improving Depression Management

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BACKGROUND
An estimated 10% of the US population currently suffers from depression. The World Health Association reports that up to 80% of those patients could be effectively treated with psychotherapy and antidepressant medications, but only 20% of depression sufferers are currently receiving treatment. In addition to higher rates of disability, divorce, and unemployment and lower educational attainment, depressed patients are statistically more likely to suffer from other chronic medical illnesses, including arthritis, asthma, cancer, cardiovascular disease, diabetes, hypertension, chronic respiratory disorders, and chronic pain, and the clinical courses of those illnesses are associated with greater morbidity and mortality. The economic burden of depression in the US—in the form of healthcare expenditure and decreased productivity—is estimated at $82 billion per year. The effects of depression, on the individual and the societal level, are far-reaching and destructive. We have to do better at managing this disease.

INTERVENTION
To improve rates of adequate depression treatment, objectively assessed as a PHQ-9 score ≤ 9 at 12 months, we obtained practice-wide datasets on patients who received a PHQ2/PHQ9 during the time periods 6/1/16-7/30/16, 8/1/16-9/30/16, and 10/1/16-11/30/16. This data was collected from Allscripts, our former Electronic Medical Record (EMR). Datamining narrowed our target population to those with a PHQ9 ≥ 9 who did not receive a follow-up medication or follow-up referral for a Therapist (DCPS) or Psychiatry. Chart biopsies of patients with and without a prior diagnosis of depression from each time period were performed. Chart biopsies overwhelmingly showed progress notes made no mention of an elevated PHQ9. Currently in JIMA, Medical Assistants screen for depression during the rooming process for annual wellness examinations and physicals. A PHQ9 is first administered, which refees to a PHQ9 when positive. After interviews with Medical Assistants (MAs) and Attending Physicians (PCPs), we theorized elevated PHQ9s were not being addressed by PCPs due to inadequate communication of the PHQ9 result from MA to PC. To improve our rates of adequate treatment of depression, it is imperative a depressed patients' physician is aware of a positive screening. Our intervention started with a presentation of our MA-driven protocol during a practice-wide staff meeting at JIMA on 4/28/17, followed by separate provider-specific and MA-specific emails with detailed intervention instructions sent on 5/1/17.

MEDICAL ASSISTANT-DRIVEN PROTOCOL
Targets patients with non-EAC (established acute care) appointments who:
A) have a pre-existing diagnosis of depression
B) screen positive for depression by PHQ2
Consists of:
1) automatic administration of a PHQ9 to be filled out pre-appointment
2) placement of a Delaware County Professional Services (DCPS) brochure on the back of the door to cue the provider to address depression that visit.

IMPACT ON PROVIDER WORKFLOW:
DCPS brochures will cue PCP to their patient's depression and could provide a possible intervention for patients who need further treatment. Completed PHQ9 forms will be delivered to the MAs' designated [pink] folders for entry into EPIC.

AIM
The objective of this project is to increase the rate of documented successful treatment of depression for both new and established diagnoses of depression at Jefferson Internal Medicine Associates (JIMA) from 29% to 50% over 12 months.

RESULTS
Given Jefferson Health's system-wide EMR transition to Epic, we were unable to glean data from the time period 11/26/16-present. Once datamining for depression is functional within Epic, results will be placed in a run-chart (see graph below) for analysis. Data from this graph represents patients from JIMA with a PHQ9 ≥ 9 for whom no pharmacologic or therapy-based interventions were undertaken during their visit. We expect our intervention will reduce the number of depressed patients who leave JIMA without having their condition addressed in some manner. Our hope is this intervention will have a downstream effect of improving overall rates of successful depression treatment.

DISCUSSION
In order to assess the efficacy of our intervention and develop an ongoing plan for the improvement of depression management at JIMA, we will use a data mining approach in EPIC (much like that utilized to obtain our initial data) to re-evaluate the rate of PHQ9 documentation. An improvement in the rate and consistency of documentation itself would constitute a significant step forward as it would, in turn, allow us to more clearly assess the objective efficacy of depression management at JIMA. This, then, would enable us to begin the process of identifying further interventions which may focus on the management of depression itself. Should the results reveal no improvement in the documentation and assessment of depression across the practice, we will critically assess our process, barriers which were encountered, and make corresponding modifications to the intervention of our subsequent PDCA cycle.

REFERENCES
Mental Healthcare Cost Data for All Americans (2006).}

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