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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 of < 9 at 12 months, we obtained practice-wide datasets on patients who received a PHQ-2/PHQ-9 during the time periods 6/1/16-7/30/16, 8/1/16-9/30/16, and 10/1/16-11/25/16. This data was collected from Allscripts, our former Electronic Medical Record (EMR). To improve rates of adequate depression treatment, it is imperative that patients or their physicians receive a positive screening result. 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. Our intervention was completed on 5/16/17.

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 PHQ-9 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.

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.

IMPACT ON PROVIDER WORKFLOW:

DCPS brochures will cue PCP to their patients’ 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.

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 data mining for depression is functional within Epic, results will be placed in a run-chart (see graph below) for analysis. Data from this graphic represents patients from JIMA with a PHQ-2 > 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 PHQ-9 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
