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Integrative Efforts in Screening, Diagnosis, and Management of Depression in a Residents' Primary Care Clinic

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Depression causes functional impairment, decreased productivity, increased risk of suicide, and increased health care costs. There is ample evidence that treating depression positively influences the outcomes of chronic diseases such as diabetes and congestive heart failure. Only about half of all depression cases in the primary care setting are recognized.[1] Relatively "simple" changes, like routine use of the PHQ-9 for depression, incorporation of evidence-based motivational interviewing strategies into patient encounters, and training office-based personnel to help perform core support functions of behavioral health care managers, can improve patient care and help with establishment of patient-centered medical homes (PCMHs).[2]

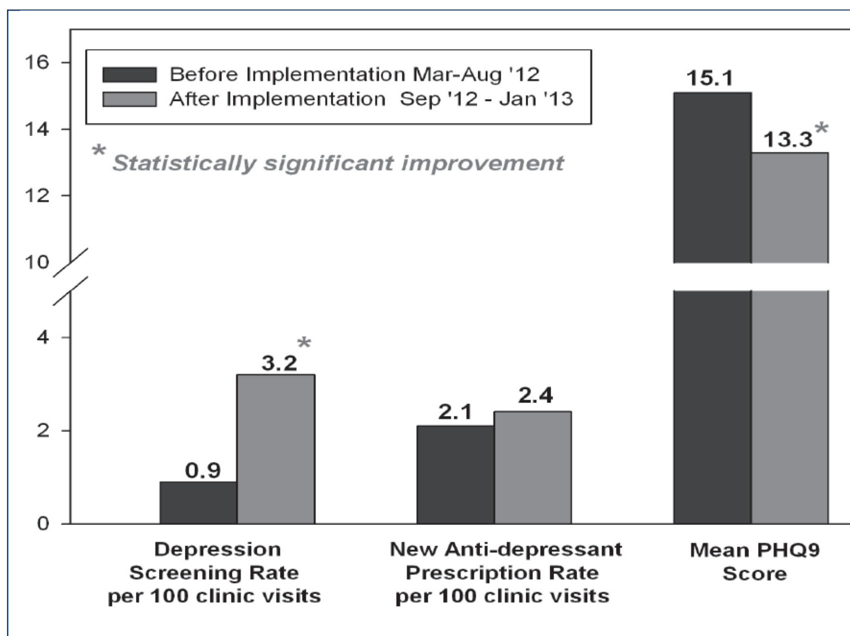

Figure 1. Overall Results

We launched an initiative to improve screening for depression in our residents' internal medicine clinic in March 2012. We aimed to increase internal medicine residents' awareness and knowledge of depression as a significant comorbidity. We also hoped to improve resident physicians' skills and comfort with screening for and diagnosing depression while working in collaboration with our health care team. Our team is comprised of patient care technicians, certified medical assistants, registered nurses, resident physicians, supervising attendings, and social workers. Fifty residents participated in this initiative, including 31 internal medicine categorical residents (post-graduate year (PGY) 1-3), three internal medicine preliminary interns, and 16 internal medicine/pediatric categorical residents (PGY 1-4). The patients involved in this initiative include those receiving their primary care in the internal medicine resident clinic. The patients tend to have lower incomes, and about 50% of them receive Medicare or Medicaid. Our patients have a wide variety of medical conditions and a mean age of 56.

Through lectures and meetings, resident physicians and office personnel were educated regarding the impact of depression on medical comorbidities. We created structured data in our electronic medical record (EMR) for documentation of the PHQ-9 score. Patients presenting to the internal medicine clinic for routine care were screened for depression using the PHQ-9. The resident physicians assessed the results and documented the PHQ-9 score in the EMR. Following the diagnosis of depression, treatment options—including pharmacological agents and counseling—were discussed with the patient. Treatment was then initiated by the residents after discussion with the attending physicians and the patient. Patients who had been newly diagnosed with depression or had a change in their pharmacologic treatment were then scheduled for follow-up visits within two to six weeks.

Our results indicate an overall increase in depression screening rates before and after implementation of the PHQ-9 from 0.9% (95% CI 0.8-1.2) to 3.2% (95% CI 2.8-3.7) and a mean decrease of in the PHQ-9 score of 1.81 points (p=0.032) (Figure 1). Prior to implementation of our quality improvement project, 16% of residents reported that they felt comfortable diagnosing and treating de-

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pression; 62% felt comfortable with diagnosis and treatment after implementation (Figure 2).

This to our knowledge is an innovative way of using the PHQ-9 to universally screen for depression in a resident primary care clinic. Our data reflect improvement in screening rates through resident education and collaboration among the clinical staff. Use of structured data in the EMR provides us the opportunity to track data closely and generate lists of patients to target for care management.

Resident education in primary care—especially in behavioral health—has been recognized as a weaker area of emphasis. We believe that an intervention like this could be implemented in internal medicine or family medicine resident clinics to achieve improved screening and diagnosis of depression while improving resident knowledge and experience in this very important area of primary care.

Our next goal is to aggressively care manage our patients with moderate and severe depression and, in the process, demonstrate positive impact on other comorbidities. Our social workers are provided with lists of patients with PHQ-9 scores of 15 or more. Social workers then contact these patients, address their needs as required, and provide care management. We aim to reduce health care costs by reducing hospitalizations and emergency department visits among these patients. We have also included depression as one of the important conditions as part of our PCMH.

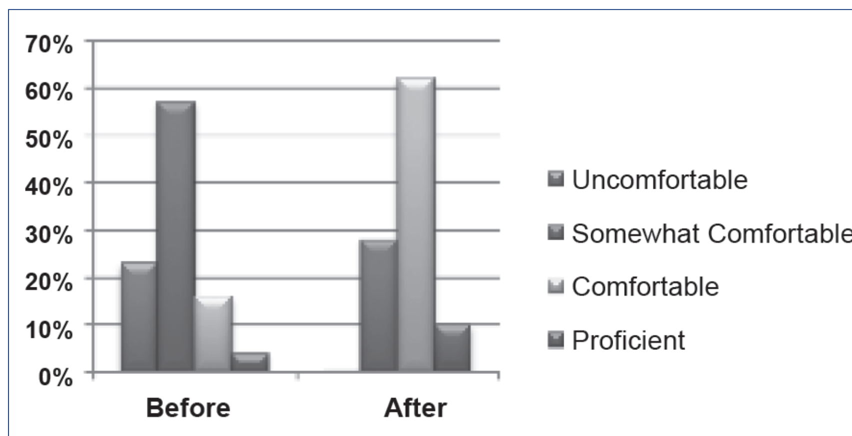

Figure 2. Residents' Comfort Level Before and After PHQ-9 Implementation

Acknowledgements: We express our thanks for the support of the internal medicine residents in the Department of Medicine as well as the clinic staff and administrators of the Greenville Health System in Greenville, SC.

References

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2. Unutzer J, Park M. Strategies to improve the management of depression in primary care. Primary Care 2012; 39(2):415-31.

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