

# Stepped Care Interventions to Improve the Management of Depression in Primary Care

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# Overview

- Depression and chronic illness
- Gaps in current depression management
- Effective strategies for chronic illness care
- Stepped Collaborative Care intervention
- Problem-solving treatment

# Depression and Chronic Medical Illness

- Increased prevalence of major depression in the medically ill
- Depression amplifies physical symptoms associated with medical illness
- Comorbidity increases impairment in functioning
- Depression decreases self-care and adherence to prescribed regimens
- Depression has direct maladaptive physiological effects and increases mortality

# Depression and Adherence

- Depression may affect adherence by
  - Adversely influencing expectations about benefits and efficacy of treatment
  - Increasing withdrawal and social isolation
  - Reducing cognitive functioning and memory
  - Influencing dietary choices and reducing energy to exercise and follow self-management regimens (i.e., checking blood glucose)

# PATHWAYS Study

## Epidemiologic Findings in 4,225 HMO Patients with Diabetes

- Major depression in 12% of patients with diabetes
- Depression significantly associated with:
  - HbA1c > 8%
  - More physical symptoms of diabetes (e.g., thirst)
  - Greater rates of smoking and higher BMI
  - Poorer social functioning
  - Greater number of days of household or work limitation
  - Poorer self care (i.e., exercise and diet)

## Recognition and Site of Treatment for Anxiety and Depression

- Only 1/3 to 1/2 of community respondents with anxiety or depression are treated
- Approximately half are treated only in primary care system
- For many Americans, primary care is the “defacto” mental health system

## Gaps in current management of mood disorders:

- Unplanned medication discontinuation
- Erratic follow-up care
- Minimal support for self-management
- Limited reach of traditional behavioral interventions

## System Barriers in Treatment

- Interruptions in treatment are the rule
  - 45% of primary care patients discontinue antidepressants in first 4 to 6 weeks
- Frequency of contacts falls far below minimum standards
  - Median performance of 297 health plans on 3 visits in 90 days after initial prescription was 20%



## System Barriers in Treatment

- Treatment intensity is rarely adjusted according to need
- Sub-optimal outcomes are the norm
  - 40% recovery in usual primary care
  - Many have persistent depression despite pharmacotherapy

# Underused Resources

- There has been little change in the duration of treatment, (i.e. 1-3 prescriptions in most patients), even though
  - the recognition rate of anxiety and depressive disorders has increased
  - the percent treated with SSRIs has increased
- Fewer depressed patients are getting psychotherapy and the number of visits may have also declined (Olfson et al, 2002, JAMA)

# Primary Care System Barriers to Care for Chronic Illness

- Care organized around infrequent 12- to 15-minute visits
- Sole reliance on the physicians
- Lack of adequate access to key clinical information to monitor patient progress and adherence
- Limited access to timely expertise of medical specialists and mental health personnel

# Patient-Level Barriers to Care of Depression

- Stigma regarding mental illness diagnosis
- Lack of insurance for mental health care
- Hopelessness, lack of energy inherent to depression make active participation in care difficult
- Chronic social stressors make self-management more difficult
- The attitude that depression is a personal problem that should be handled alone or within one's family

# Effective chronic illness management requires:

- Active follow-up
- Information systems to support monitoring
- Patient activation and self-management
- Appropriate access to expert systems (human or electronic)

Wagner, Austin, Von Korff. The Milbank Quarterly 1996; 74:511-544

Von Korff, Unützer, Katon, Wells. J Family Practice 2001; 50:530-1

Von Korff and Tiemens B. Western J Medicine 2000; 172:133-137

Katon, Von Korff, Lin, et al. Gen Hosp Psych 1997; 19:169-178

# Collaborative Care Involves

- Negotiated definition of clinical problem in terms that both patients and providers understand
- Joint development of care plan with goals, targets and implementation strategies
- Provision of self-management training and support services for behavioral changes
- Active, sustained follow-up (using visits, telephone calls, e-mail and web-based monitoring), and decision-support systems

# The Pathways Study Treatment Model

- Depression care at the patient's regular primary care clinic
- Collaborative care between: patient, regular primary care physician, and care manager / **Depression Clinical Specialist (DCS)**
  - Patient education using a brochure and videotape
  - Close follow-up and monitoring of symptoms and medication side effects
  - Brief psychotherapy: Problem Solving Treatment (PST-PC)
- Weekly consultation meetings with
  - Primary care physician
  - Team psychiatrist

# The Pathways Treatment Model

- Evidence-based stepped care treatment protocol
  - antidepressant medications and/or 6 - 8 sessions of Problem Solving Treatment (PST-PC)
  - Patients and their primary care physicians choose treatments
  - Proactive tracking of outcomes using the PHQ-9
  - Psychiatry consultations for patients who do not improve



# Challenges in Managing Depression

- Make a diagnosis
- Educate and activate the patient as a partner
- Initiate antidepressants or psychotherapy
- Use an adequate dose
- Treat long enough
- Follow outcomes and adjust treatment as needed
- Prevent relapse

# Key Intervention Principles

- Educate and activate patients and significant others
- Shared decision making for treatment
- Enhance self management and adherence
- Active follow-up to track clinical response
- Consultation and caseload supervision with PCP and specialist
- Facilitate treatment adjustment, and referrals

# Patient Role

- Patients as active collaborators in their care
- Patient education
  - educational brochure
  - videotape
  - clinical notes and treatment plans
- Involve significant others and family members whenever possible.

# Depression Clinical Specialist (DCS) Role

- Conducts initial assessment
- Educates patient
- Provides treatment
  - Support of antidepressant management
  - PST-PC
  - Pleasant events scheduling (behavioral activation)
- Provides proactive follow-up
  - Tracks depression symptoms and treatment response
  - Acute phase, maintenance phase, relapse prevention
- Consults with PCP, team psychiatrist and other providers to adjust treatment plans as needed and facilitate referrals

## Some DCS 'Core Skills'

- Diagnosing and educating patients about depression
- Educating patients about antidepressant medications
- Encouraging treatment adherence and dealing with medication side effects
- Brief, structured psychotherapy (PST-PC)
- Patient referral and initial telephone contact
- Conducting initial assessments and follow-up contacts
- Coordinating care with PCPs and consulting psychiatrists
- Relapse prevention

# Primary Care Provider Role

- May refer patient
- Confirms diagnosis of depression
- Initiates and adjusts antidepressant treatment according to evidence-based treatment algorithm
- Consults with DCS and team psychiatrist
- Facilitates additional consultations and referrals as needed

# Working with Primary Care Providers

- A good working relationship between the DCS and the PCP is essential
- Keep PCPs informed about the patients' progress
- Make yourself available
- Establish preferred method of communication with each PCP

## Clinical Consultation/Supervision

- Team psychiatrist
- Primary care expert
- Regular supervision during weekly team meetings
  - new cases
  - problems and questions about difficult cases
- Available by pager as needed



## Team Psychiatrist Role

- Clinical consultation to DCS and PCP
  - regular (weekly) team meetings
  - PRN for clinical questions / emergencies
- In-person consultation in primary care
  - diagnostic uncertainty or
  - persistent depression
- Referral to additional specialty mental health services.

# Consult Team Psychiatrist

- Incomplete response to treatment
- Intolerance to first or second line antidepressant medications
- Psychiatric emergencies
  - Serious thoughts of suicide or high risk behavior
  - Psychotic symptoms: delusions, hallucinations, confusion
  - Manic symptoms: elevated mood; irritability; increased energy, talkativeness, or activity; decreased sleep; poor judgment / risky behaviors
- Abuse of alcohol or other substances
- A recent history of severe psychiatric problems or hospitalizations
- Persistent, severe psychosocial problems, (e.g., marital problems)

# Diagnosing Depression

## Diagnostic Criteria for Major Depression

- **DEPRESSED MOOD**
- **LOSS OF INTEREST OR PLEASURE**
- Change in weight or appetite
- Insomnia or hypersomnia
- Lack of energy
- Psychomotor agitation or retardation
- Feelings of worthlessness or guilt
- Inability to concentrate or make decisions
- Thoughts of death or suicide

5/9 symptoms are present at least “more than half the days” for at least 2 weeks.

# “Talking Points” About Depression

- Depression is common in primary care.
- Depression affects the body, behavior, and thinking. For many patients, physical symptoms are the most apparent.
- The ‘cycle of depression model’
- Depression can almost always be treated with antidepressant medications or psychotherapy
- Recovery from depression is the rule, not the exception – but relapse is common if treatment is discontinued.
- Minor tranquilizers, drugs, and alcohol can make depression worse, not better.

# The Cycle of Depression



# Helpful Communication Skills

- Information gathering
  - Focused open-ended questions
    - “How has your mood / sleep / ... been lately”.
  - Facilitation
    - “Tell me more about...”
  - Surveying
    - “What else is bothering you?”
  - Summarizing
    - “Let me make sure I understand ...”

# Communication Skills

## -Reflection

- “I can see this is difficult / disturbing for you.”

## -Legitimization

- “I certainly understand why you feel ...”

## -Support

- “I want you to know I am here to help ...”  
(BUT don't advocate excessively for the patient.)

## -Partnership

- “Why don't you and I together ...”

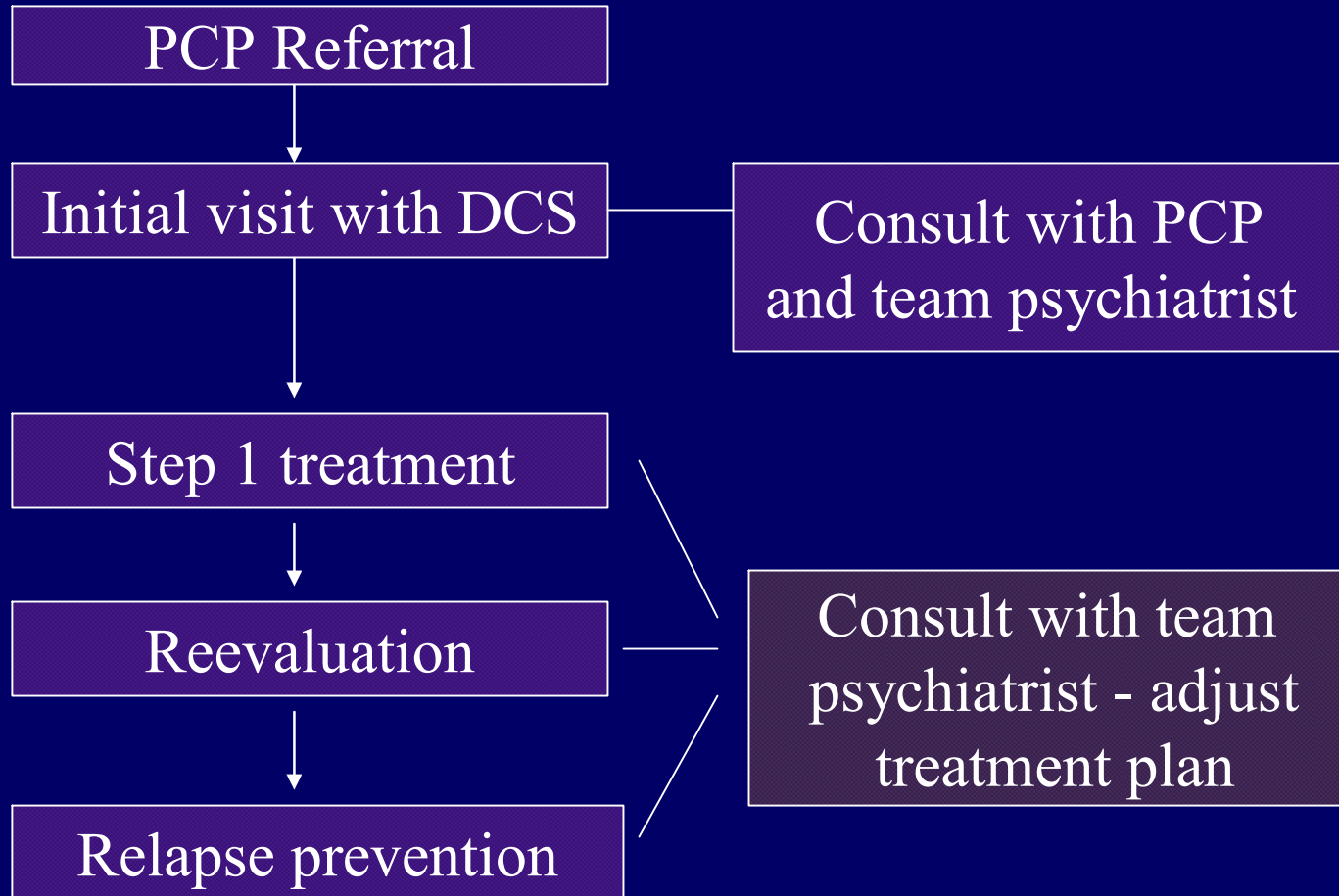
## -‘Activate’

- “That's a good question. Let's think what you can do about this...Maybe you can bring this up with your PCP ...”

## -Show respect and affirm

- “I'm impressed by how well ...”

# Intervention Flow





# Initial Visit with DCS

- Assessment
- Patient education
- Discuss treatment options and treatment plans
- Coordinate care with PCP
- Start initial treatment plan
- Arrange follow-up contact (in person or by phone – in one week or earlier)
- Document initial visit

# Follow-Up Contacts

- Weekly or every other week during acute treatment phase
  - In person or by telephone
  - Structured follow-up: depression severity (PHQ-9) and treatment response (and side effects)
- Initial follow-ups
  - focus on adherence to initial treatment and side effects
- Later follow-ups
  - focus on complete resolution of symptoms and restoration of functioning
  - focus on long term treatment adherence

# Initial Treatment (8-12 weeks)

- 1st line antidepressant
  - usually an SSRI or other newer antidepressant
  - consider other agents if
    - SSRIs not well tolerated or not effective before
    - Patient or close family members have responded well to other agents in the past
- (or) PST-PC
  - 6-8 individual sessions followed by monthly group maintenance sessions.
- Pleasant events scheduling (Behavioral Activation)

# Using Antidepressants

- Key principles
  - Use antidepressants, not minor tranquilizers
  - Use adequate doses for an adequate amount of time
  - Start slow and work with side effects but titrate to an effective dose as needed
  - Change to another medication if not effective after 8-12 weeks. All antidepressants work for about 50 % of patients; switch or augment if patients don't respond to initial choice.

# Commonly Used Antidepressants

- Serotonin Reuptake Inhibitors (SSRIs)
  - Fluoxetine (Prozac), paroxetine (Paxil), citalopram (Celexa), escitalopram (Lexapro), sertraline (Zoloft), fluvoxamine (Luvox)
- Tricyclics (TCAs)
  - Secondary amines: nortriptyline, desipramine
  - Tertiary amines: imipramine, doxepin, amitriptyline
- Newer Antidepressants (atypical)
  - Bupropion SR (Wellbutrin), mirtazapine (Remeron), nefazodone (Serzone), venlafaxine XR (Effexor)

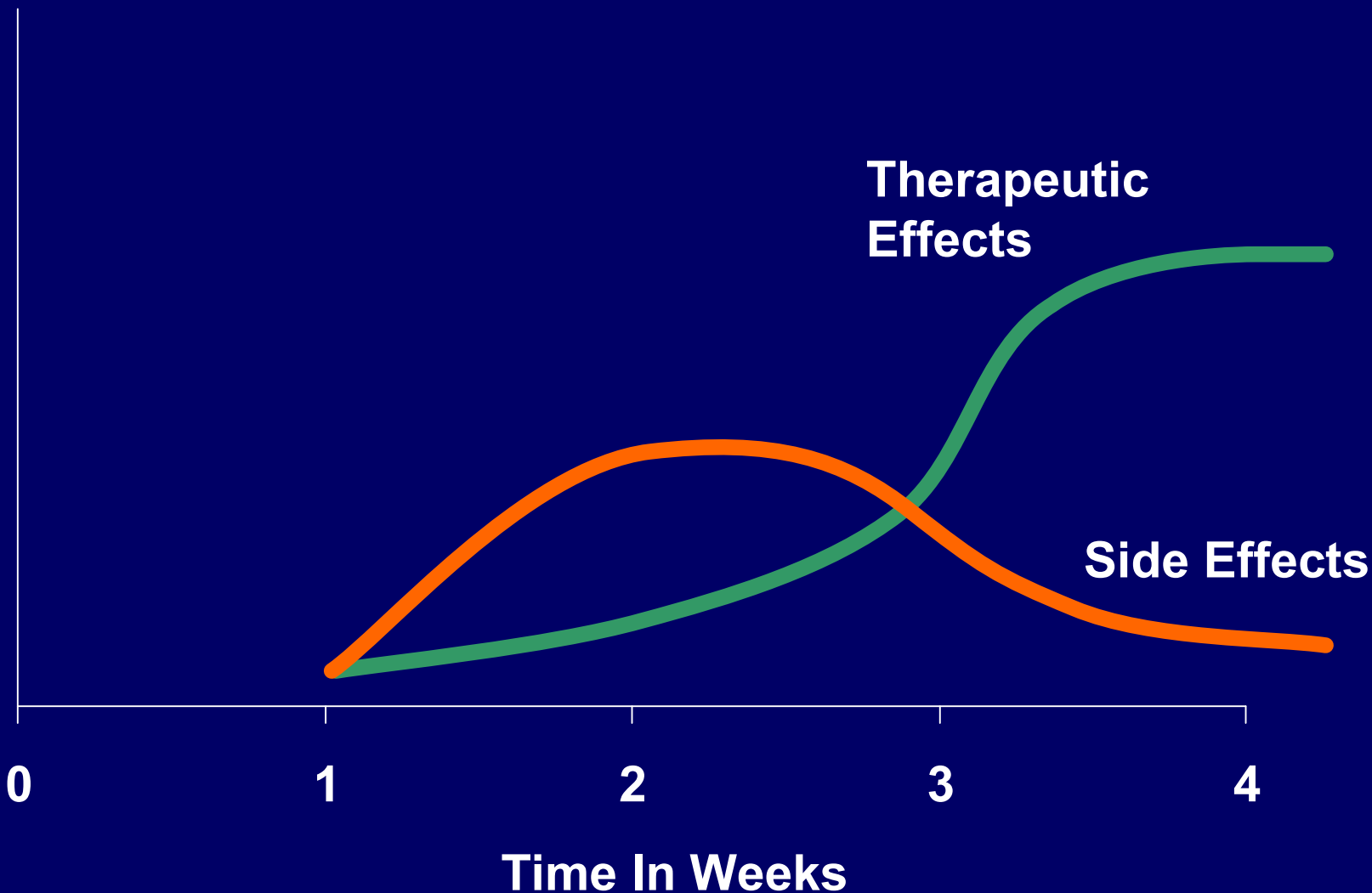
# Choosing Antidepressants

- Prior treatment history in patient/family members
- Patient preferences
- Expertise of prescribing provider
- Side effect profile (sedating or activating)
- Safety in overdose (10 days of a TCA can be a lethal overdose)
- Availability and costs
- Drug-drug interactions

# Drug Interactions

- Antidepressants are metabolized by the P450 isoenzyme system in the liver. They can
  - change blood levels of other drugs that are metabolized by the same hepatic enzymes
  - displace other protein-bound drugs.
- Rule of thumb: if a patient is on a drug with a narrow therapeutic window (e.g., digoxin, warfarin, theophylline, antiarrhythmics, lithium, TCA's, anticonvulsants), check a serum level of that drug when a steady state of the antidepressant is reached or if there are side effects.

# Therapeutic and Side Effects with Antidepressant Treatment Over Time





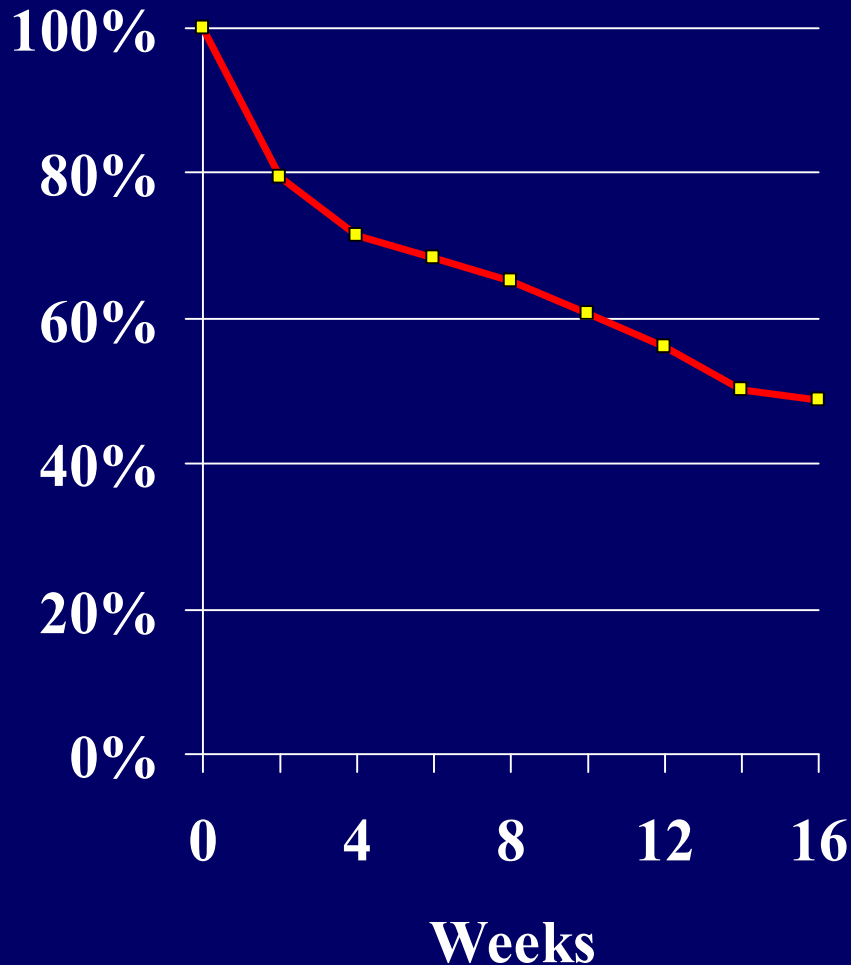
# Managing Side Effects

- Wait and support
- Consider temporary dose reduction
- Treat side effects
- Change to a different antidepressant
- Change to or add PST-PC

# Patient Education About Antidepressants

- Key messages
- Frequently asked questions
- **Anticipate** patient concerns about medications, side effects, and problems with adherence.
- Reinforce the need for continuation or maintenance treatment even after the patient feels better.

# Antidepressant Adherence



## Improve Adherence:

- Take medication daily
- 2-4 weeks for full effect
- Side effects can occur, but often resolve in 1-2 weeks
- Keep taking medication even if better
- Check with MD before stopping
- Not addicting

# When and How to Stop Antidepressants?

- Risk of relapse
  - 50% if 1 prior episode
  - 75% if 2 prior episodes
  - 90% if 3 prior episodes
  - also increased with dysthymia and residual depressive symptoms
- Treat all adults for 4-9 months after initial response
- Treat those at high risk for relapse for 2 years or longer. Some people may need lifetime treatment.
- Maintenance treatment should be at full dose.
- Make a relapse prevention plan.
- Taper antidepressants slowly to avoid discontinuation syndromes (particularly with paroxetine and venlafaxine).

# Psychotherapy

- Pros: no medication side effects, may last longer ('learning effect'), addresses interpersonal / real life problems
- Cons: may take longer to work (6-12 sessions), more time consuming, may not be as effective for severe major depression
- Cognitive behavioral psychotherapy
- Interpersonal psychotherapy
- **Problem-Solving Treatment (PST-PC)**
- Other models

## Reassessment of Initial Treatment (at 8-12 weeks)

- Treatment response
  - Depression severity (PHQ-9)
  - Side effects
- Discuss with PCP and consulting psychiatrist
  - ? Remission ? Partial response ? No response
  - Next steps
    - Consultation
    - Step Two treatment plan
    - Relapse prevention

## 'Step Two' (~8 weeks)

- Consultation with the team psychiatrist and the patient's PCP
- Options in 'Step 2' include
  - augmentation- initial treatment choice with PST-PC or an additional medication
  - switch to PST-PC or an(other) antidepressant (especially if NO response in step one)

## Example: Decision Points in Antidepressant Rx

<b>Proactive Tracking</b>	<b>PHQ Score</b>	<b>Problem</b>	<b>Solutions</b>
<b>Week 1-4</b> Patient stops medication	18	Non-adherence, discouragement, side-effects	Support and educate, adjust dose, address side effects
<b>Week 4</b> 20 mg fluoxetine	16	Minimal response, no side effects	Increase dosage
<b>Week 8</b> 40 mg fluoxetine	15	No response	Switch classes of antidepressant or switch to PST-PC



## 'Step Three'

- This should always involve a psychiatric consultation
- Treatment options at Step 3:
  - combination therapy (if not tried earlier)
  - augmentation with more than one medication
  - a 3rd antidepressant trial
  - referral to specialty mental health care for a different type of psychotherapy or electroconvulsive therapy (ECT).

# Maintenance Treatment for Depression

- After patient is 'in remission' from acute episode
  - fewer than 2 depressive symptoms
  - Usually a PHQ-9 score less than 5
- Make a relapse prevention plan in consultation with PCP
- Follow the patient with infrequent (monthly?) telephone calls.
- Bring patient back in for further evaluation if symptoms recur.
- Maintenance group (continued PST and social support)

# Clinical Emergencies

- Notify PCP / team psychiatrist if patient develops :
  - acute suicidal symptoms or behavior
  - psychotic symptoms
  - manic symptoms
  - severe lack of appetite / PO intake
  - alcohol or substance abuse
  - severe medication side effects
    - rash, seizures, vomiting, fever, edema, ataxia, confusion, joint or muscle pains, other

## Document and Track Progress

- Track patient and PCP contact information
- Track initial assessments and treatment plans
- Track follow-up contacts, treatment plan updates, treatment response, and relapse prevention plans
- Produce regular follow-up and treatment reminders
- Summarize individual patient progress
- Summarize entire caseload



# IMPACT

## Clinical Information System

- Accessed on the internet 24 hours / day
- Nurses or psychologists recorded data on over 10,000 clinical contacts with study patients
- Structured data entry forms
  - Initial assessment, follow-up, treatment plan
- Reports
  - Individual progress report, caseload summary
- Reminders
  - Overdue follow-up contacts, treatment plan outdated and not effective

Study or Prescreen ID :  [Clinic Notes](#) [Caseload](#) [Recruitment](#) [Logout](#)



# Project Impact - Caseload Tracking Report

Records Found : 28, Records Displayed : 10, Records per Page : , Page :  of 3

Caseload Report for : Youlim Choi, DCS

Report Created on : Tuesday, March 12, 2002, 04:30 PM

Patient	Enrollment Date	Initial Visit			Last Treatment Plan (Step)	# of Follow Ups	Last Follow Up				Last Psychiatric Evaluation	Relapse Prevention Plan
		Date	PHQ-9	DSM IV			Date	PHQ-9	DSM IV	Treatments		
0	04/13/2001	04/18/2001	15	5 4	07/31/2001 (2)	18	02/28/2002	5 #	1 0	Med		10/29/2001
1	04/16/2001	04/23/2001	13	5 3	01/16/2002 (1)	14	03/04/2002	1 #	0 0	Med		03/05/2002
2	04/18/2001	04/25/2001	12	5 3	05/09/2001 (2)	14	03/04/2002	14 #	4 0	Med		06/28/2001
3	04/27/2001	05/03/2001	13	4 4	08/31/2001 (3)	15*	02/06/2002	3 #	0 0	Med, Therapy		10/25/2001
4	05/01/2001	05/09/2001	14	5 0	10/12/2001 (2)	13*	03/11/2002	1 #	0 0			03/11/2002
5	05/02/2001	05/07/2001	13	5 3	05/21/2001 (1)	16	02/21/2002	#	0 0			08/06/2001
6	05/03/2001	05/10/2001	15	7 5	05/18/2001 (1)	15	02/11/2002	8 #	2 0	Med	10/15/2001	08/31/2001
7	05/14/2001	05/17/2001	20	7 3	05/17/2001 (1)	17*	03/06/2002	10 #	2 0	Med, Therapy		08/30/2001*
8	05/21/2001	05/25/2001	8	3 3	01/07/2002 (3)	18	03/11/2002	2 #	0 0	Med		02/20/2002
9	05/22/2001	05/31/2001	15	5 5	05/31/2001 (2)	17*	03/05/2002	10 #	2 2	Med, Therapy		09/04/2001*

Study ID :  Initials :  [Clinic Notes](#) [Caseload](#) [Logout](#)

## Treatment History for 91-222 ( JJ )

### 1. Enrollment Information ( Enrollment Date: 06/21/1999 )

DCS : Youlim Choi, DCS                      PCP : Dr. Primary Care                      PCP Phone : 310-111-2222

### 2. Initial Assessment

Date : 09/21/2000                      PHQ : 27 (severe)                      DSM IV Symptoms : 7 / 0

### 3. Follow Up Contacts ( 8 )

Date	Wk. in T.	Visit Type	PHQ	DSM IV	Antidepressant	Daily Dose	Change in Med	Daily Dose	PST	Comments
10/06/2000	2	Clinic	25	6 0	Fluoxetine	10	Fluoxetine	20	1	
10/20/2000	4	Phone	23	5 0	Fluoxetine	20			2	
11/04/2000	6	Clinic	22	5 0	FLuoxetine	20			3	
11/18/2000	8	Clinic	20	4 0	Fluoxetine	20			4	
11/25/2000	9	Clinic	19	4 0	Fluoxetine	20	Fluoxetine	30	5	
12/06/2000	10	Phone	11	3 0	Fluoxetine	30				
12/21/2000	13	Clinic	4	1 0	Fluoxetine	30				
01/21/2001	17	Phone	3	1 0	Fluoxetine	30				

### 4. Treatment Plans

Date	Step	Antidepressant	Daily Dose	PST	Comments
09/21/2000	1	Fluoxetine	10 -> 20	Y	

### 5. Relapse Prevention Plans

Date	Antidepressant	Daily Dose	Comments
12/21/2000	Fluoxetine	30	Relapse Prevention Plan

### 6. Psychiatric Evaluations

11/18/2001

### 7. Next Appointment

Next PCP Follow-up : Date: 02/10/2001      Time: 16:00  
 Next DCS Follow-up : Date: 02/21/2001      Time: 15:00

## Effective chronic illness management requires:

- Active follow-up
- Information systems to support monitoring
- Patient activation and self-management
- Appropriate access to expert systems (human or electronic)



## Limited reach of traditional behavioral interventions:

- Accessibility - appropriately trained providers unavailable
- Acceptability - many patients referred never attend, and modal number of visits is one
- Affordability - resources devoted to mental health care will not support 12+ one-hour therapy sessions for all those in need

# Problem Solving Treatment for Primary Care (PST-PC)

A brief and practical skill-building treatment for depression designed for use in primary medical care setting

# Problem Solving Treatment for Primary Care (PST-PC)

- Effective for the treatment of depression and other types of emotional distress
- Effective for persons of all ages and with a variety of medical illnesses
- With training, PST-PC can be provided by mental health specialists and general medical staff (nurses and physicians)
- Brief, practical and time-limited: typically four to six half-hour sessions

## Goals of PST-PC

- Increase patient's understanding of the link between their current symptoms and their current problems in living
- Increase patient's ability to clearly define their problems and set concrete and realistic goals
- Teach patient a specific, structured problem-solving procedure

## Goals of PST-PC

- Increase pleasant activities
- Produce positive experiences of patient's own ability to solve problems, thereby increasing their confidence and feelings of self-control

# The seven steps of PST-PC

1. Defining and breaking down the problem
2. Establishing a realistic goal
3. Brainstorming multiple solution alternatives
4. Implementing decision-making guidelines (i.e., evaluating the pros and cons)
5. Evaluating and choosing the solution
6. Identifying specific steps for plan of action
7. Evaluating the outcome after solution has been implemented (“review and renew”)

# PST-PC problem list breakdown

1. ~30% Activities
  - Few pleasant events
  - Daily function (e.g., home repairs, transport)
  - Health promotion (e.g., exercise, diet)
2. Health
3. Marital
4. Finances
5. Other social
6. Children
7. Job

## Sally's example

- Selecting the problem from the problem list: “Which problem area is affecting your life the most right now?” **financial problems**
- Specifically defining and breaking down the problem: “When are you most aware of the problem?” **when I see the months of unpaid bills piled up**
- Establishing a realistic goal: “What would you like to see happen?” **not having my utilities cut off**



## Sally's example

- Generating multiple solutions: “What kinds of things can you do to reach your goal? We’ll address concern next!”

Borrow money from daughter Pat

Pay some bills with credit card

Sell car

Pay the most outstanding utility bills

Take in a roommate

Call the utilities to arrange extended payment plan

# Sally's example

- Implementing decision-making guidelines (“What are the advantages and disadvantages for you or for others?”)

## Borrow money from Pat

- Pros: could pay most of the bills right away, wouldn't have to pay interest
- Cons: already borrowed \$2,000 that hasn't been paid back, could hurt the relationship, I would feel guilty

## Sally's example

- Choosing the solution “Which ones have the best chance of success?” (i.e., have impact on problem, high likelihood of being able to carry out, fewer negative consequences for others)

Pay the most outstanding utility bills

Call the utilities to arrange extended payment plan

# Sally's example

- Developing plan to implement the solution;  
“Let's figure out what steps need to be taken...”
  1. Make space on dining room table
  2. Sort mail into bills and other mail
  3. Sort bills into those that need to be paid right away and those that can be put off
  4. Call utilities (during business hours) to negotiate payment plan

## Sally's example

- Evaluating the outcome: “How did it go? “How did accomplishing that affect your mood?”

“Felt like a weight lifted off my shoulders....”

## Sally's example

- Planned pleasant activities (type and how often):
  - Visit with grandchildren on Saturday
  - Tea with church friends on Thursday
  - Walk by the lake with neighbor on Monday and Wednesday mornings
  - Church potluck on Sunday

# Advantages of PST-PC

- Focuses on current real-life problems
- Collaborative between patient and treatment provider
- “Empowering”
- Non-stigmatizing and “face valid”

# Key Provider Roles for Effective Depression Care

