

Illustrating Local Community Initiative in Mental Health Reform: The Management and Treatment of Depression by Primary Care Physicians

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PRIMARY CARE PHYSICIANS care for patients with mental health problems on a daily basis. Patients with psychiatric disorders (depression, anxiety, mixed disorders) are common in primary care settings with a prevalence of about 25 percent.¹ The prevalence of major depressive disorders for lifetime was recently reported at 16.2 percent and for 12-months was 6.6 percent.² Depression results in significant difficulty with home and job performances in the majority of patients. Multiple studies continue to demonstrate that primary care providers in outpatient settings underrecognize and undertreat patients with depression.^{4 3 2}

During my residency in the late 1970s, little emphasis was placed on mental health training for primary care physicians. It was expected that patients with these disorders would be cared for by the mental health profession, either by private psychiatrists, psychologists, clinical social workers, or the public mental health sector. This distinct separation generally continued into the 1980s, but in the 1990s patients increasingly had difficulty accessing mental health providers due to a reduction in behavioral mental health benefits and increased disarray of the public mental health system.⁵ Thus, these patients complained about their poor mental health to primary care providers and requested care directed by/provided by their primary care physicians. What a challenge for primary care providers!

In 1995 the local health coalition in Buncombe County, NC (population 200,000) known as HealthPartners, conducted a comprehensive community assessment that identified the county's health care assets and needs. Only 29 percent of Buncombe County adults, who in the past year said that they had a major depressive episode, had ever accessed or tried to access mental health treatment. Low-income uninsured people were more likely to be depressed (40 percent) as compared to higher income, insured people (18 percent).⁶ Based on this information and increasing concerns from physicians and patients, HealthPartners identified funds to design and implement a primary care-based

depression program located at the Buncombe County Health Center, part of the county health department caring for 70 percent of our low-income uninsured. The program's design was based on data supporting the benefit of screening and feedback to providers; integrated treatment guidelines; care managers who work with physicians to monitor care; and a supervising psychiatrist.^{7 8 4}

Buncombe County Health Center Depression Program

The depression program originally was intended to 1) identify among low-income patients those who have severe depression, 2) provide collaborative specialist care managers to work with primary care physicians in a community practice setting to manage depression, and 3) reduce depressive symptoms in these patients.

New adult patients (aged 18-64) to the Health Center and existing patients receiving yearly/periodic health exams were asked to complete the screening questionnaire. Elderly patients aged 65 and over are eligible for Medicare and receive their medical care from private providers in the county. The Brief Health Questionnaire (BHQ) used in our program is a self-administered version of the PRIME-MD that has been validated among primary care patients.^{9 10} The 9-item depression questions correlate closely with the standard DSM-IV diagnosis for major depression. The depression items assist the clinician in diagnosing depression, in grading the severity of the depression, and can also be used to monitor the treatment progress over time. A score of 15 or more indicates severe depression and after validation by the physician is an indication to start treatment either with medication or psychotherapy.¹⁰ Care managers meet with patients after the physicians and patients agree on a plan of treatment. Care managers' main responsibilities are to monitor compliance with and side effects to medication, to

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connect patients with community treatment resources as needed, and to provide goal-directed short-term counseling. Care managers call or see patients every two weeks during the acute phase of medication treatment which generally lasts for 12 weeks, then every month. Physicians see the patients at four, eight, and 12 weeks during acute phase of medication treatment and then every two months until the patients finish their course of treatment at six to nine months. Medication treatment may be longer based on the number of previous depressive episodes. Patients identified as having a substance abuse problem or bipolar disorder are referred for treatment elsewhere, as are depressed patients who choose psychotherapy as their treatment option.

From December 4, 2000 until July 16, 2003, 5,396 patients were screened using the BHQ; 4,769 had a complete screening. Of those with a completed screening, 1,288 (27 percent) had severe depression with a BHQ score of 15 or more. Of those with severe depression, 815 (63 percent) received some services from the program. Four-hundred ninety-one were enrolled and received regular care management services according to the treatment algorithm. Three-hundred twenty-four met with the care managers, but chose not to enroll in the program and/or used the care managers to orchestrate referral for mental health counseling services elsewhere. About 473 (37 percent) did not receive care manager services for a variety of reasons (already getting care elsewhere, bipolar disorder, refused services, could not be contacted for initial visit with care manager, etc.).

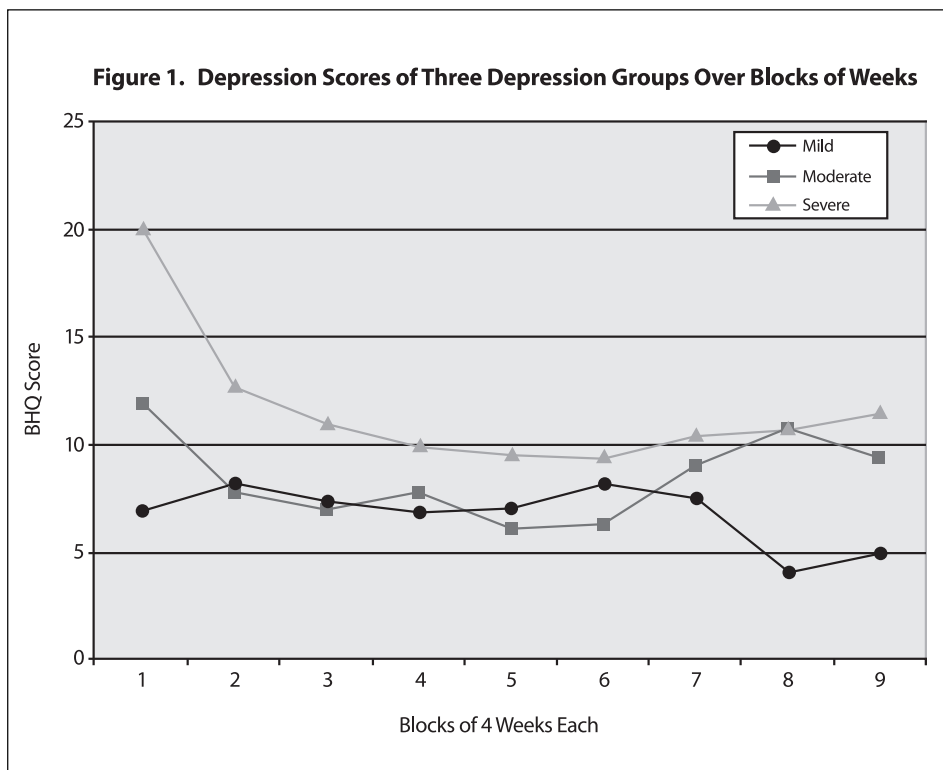
Although the program was originally intended to serve only those patients with severe depression (BHQ score of 15 or more), the physicians often felt the need to utilize services of care managers for those patients with less severe depression. Including those patients with less severe depression and those who did not fully complete the initial BHQ, the total number of patients who received any services through this program totaled 1268, about 27 percent of the screened population.

Among patients with severe depression (score of 15 or more) and enrollment in the program with care management augmenting primary care, the depression scores significantly dropped from a mean of 20.1 to 10.8 over eight weeks; a drop of five or more correlates with significant improvement in depressive symptoms. The majority of patients completed their treatment in four to six months with a mean score of nine. Among those patients remaining in the program for seven to nine months (N=90),

these more difficult to treat patients' average BHQ scores were slightly higher (see Figure 1). This could suggest two populations of patients—one which will improve within the standard treatment period and another one that requires additional treatment options such as psychotherapy, or may just not remit. The moderate depression group (scores of 10-14) and mild depression group (scores of 5-9) had modest reductions in the mean BHQ scores over the first eight weeks and then at nine months (see Figure 1).

There has been a consistent decrease over time in the percentage of patients in the program who missed work or school due to emotional reasons. At the beginning of receiving services about 70 percent had missed school/work in the past month for emotional reasons. By 25 weeks only about 28 percent had missed any school/work for emotional reasons.

Stakeholder interviews were conducted in the summer of 2002 among various health care provider organizations in the county. Twenty-two people were interviewed individually for 45 minutes to one hour each. The area of greatest perceived strength was service delivery. Specifically respondents indicated that outpatient mental health services were desperately needed and that this program was able to meet part of the need. Patients were being connected to a greater variety of services through referrals and that there was less wait time to get mental health services than before this program. In addition, the respondents felt that health care personnel at the Health Center had an increased awareness of and knowledge about mental health now as compared to before the program. There was also improvement in cross-agency collaboration and coordination.



Severe-Brief Health Questionnaire (BHQ) initial scores of 15 or more (N=821); Moderate-BHQ initial scores of 10-14 (N=232); Mild-BHQ initial scores of 5-9 (N=133).

Future Plans

The Buncombe County Health Center plans to continue the program but expand screening to include panic disorder and expand treatment services to include not only medication but cognitive behavioral therapy for panic disorder. Two other practices in our region, Hot Springs Health Program in Madison County and the MAHEC Family Health Center in Asheville are now participating in a randomized clinical trial

among depressed adult Medicaid patients assessing whether generalist care management services are cost effective compared to usual care. Primary care physicians in our region now recognize and agree that the identification and treatment of major depression and panic disorder can and should be managed through their practices; the challenge now lies in restructuring their office practices to ensure adequate identification and treatment of these common mental health conditions.

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