ANNALS OF FAMILY MEDICINE

Online Supplementary Material

Dietrich A, Oxman T, Williams J, et al. Going to scale: re-engineering systems for primary care treatment of depression. *Ann Fam Med.* 2004;2:301-304.

http://www.annfammed.org/cgi/content/full/2/4/301/DC1

Appendix 3. The Clinical Model

The clinical model enhances the steps taken by primary care clinicians in managing a patient's depression. The Three Component Model (TCM),[1] which is the specific clinical model tested by RESPECT-Depression, includes care management, an improved interface between mental health consultants and primary care professionals, and preparation of primary care clinicians and practices to provide systematic depression management.

Monitoring is systematized across all 3 components through use of the Patient Health Questionnaire-9 (PHQ-9),[2-4] a simple but valid depression instrument that provides both depression diagnoses and a severity score. The primary care clinician administers the PHQ-9 as part of the initial diagnostic assessment. The PHQ-9 then becomes a common metric aiding communication across all programmatic elements. Thus, the 3components combined provide a system for depression management as recommended by the USPSTF. Similar systematic approaches have improved provision of preventive services.[5-7]

Component 1: Care Management

Patients agreeing to care management receive telephone support calls from a practice- or centrally-based care manager 1, 4, and 8 weeks after the initial visit and every 4 weeks thereafter until remission. Two final telephone calls are made to all patients during a 6-month continuation phase. Telephone calls require an average of 10 minutes and identify barriers to adherence with the clinician's management plan, help the patient to overcome them, and measure treatment response at 1-month intervals using the PHQ-9. Primary care clinicians receive a faxed report about patient progress, including PHQ-9 scores and care management actions after each care manager call. Care managers maintain a record of patient contacts through a registry created in Microsoft Excel or Microsoft Access.

Component 2: Primary Care-Mental Health Interface

Through weekly supervision calls, care managers discuss patient contacts with a psychiatrist from their HCO. Each patient is discussed at initial referral and after subsequent contacts, particularly when the care manager has questions and when the patient has not shown an initial clinically meaningful treatment response at 4 weeks or was not in remission by 12 weeks. A clinically meaningful response is defined in this study as a reduction of at least 5 points in baseline PHQ-9 score; remission is defined as a PHQ-9 score of less than 5.[4]

Based on information derived from supervisory calls, psychiatrists may provide feedback to primary care clinicians if they have suggestions about clinical management. If the feedback is routine, eg, a suggested change in medication dosage, it is provided on the care manager's faxed report. If the feedback is complex, requires additional clinical information, or is urgent, the psychiatrist telephones the primary care clinician. Primary care clinicians can also request informal advice about diagnosis or management from the psychiatrist, who typically is available during several defined periods each week.

Component 3: The Prepared Primary Care Practice

The primary care clinician is responsible for recognizing depressed patients, completing a diagnostic evaluation, initiating management, and providing follow-up care. At least 3 follow-up visits with the primary care clinician during the first 3 months of active treatment are encouraged, but scheduling is at each clinician's discretion. How the primary care clinicians and their practices are prepared is described in Appendix 4, which is available as supplemental data at http://www.annfammed.org/cgi/content/full/2/4/301/DC1.

References

1. Oxman TE, Dietrich AJ, Williams JW, Kroenke K. The Three Component Model of depression management in primary care. *Psychosomatics.* 2002;43:441-450.
2. Spitzer RL, Kroenke K, Williams JBW, et al. Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. *JAMA.* 1999;282:1737-1744.
3. Kroenke K, Spitzer RL, Williams JBW. The PHQ-9: Validity of a brief depression severity measure. *J Gen Intern Med*. 2001;16:606-613.
4. Kroenke K, Spitzer RL. The PHQ-9: A new depression and diagnostic severity measure. *Psychiatr Ann.* 2002;32:509-521.
5. Dietrich AJ, O'Connor GT, Keller A, Carney PA, Levy D, Whaley FS. Improving Cancer Early Detection and Prevention: a community practice randomized trial. *BMJ.* 1992;304:687-691.
6. Jackson R, O'Donnell L, Johnson C, et al. Office systems intervention to improve DES screening in managed care. *Obstet and Gynec.* 2000;96:380-384.
7. Bordley WC, Margolis PA, Stuart J, Lannon C, Keyes L. Improving preventive service delivery through office systems. *Pediatrics.* 2001;108:e41.