ANNALS OF FAMILY MEDICINE

Online Supplementary Material

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

Appendix 4. The Practice Change Strategy

This strategy provides a process whereby clinicians and practices are supported to apply and maintain the previously described Three Component Model (TCM). Key principles of the practice change process model are derived from research on diffusion of innovations.[1] These principles include working initially with practices and clinicians that (1) have an interest in the innovation (in this case, enhancing depression care), (2) view the innovation as compatible with their needs, values, and resources, (3) have the ability to try the innovation with minimal personal investment (in this case, supported by established quality improvement programs), and (4) can assess the impact of the innovation. The practice change strategy includes 4 steps.

Step 1: Engagement

After obtaining the health care organization (HCO) leadership buy-in confirming the organization's interest in the project, an HCO team was identified to work with RESPECT-Depression staff. In most cases, this team included the HCO medical director, a representative from the quality improvement program, and a representative from care management. This group identified and recruited practices appropriate to the project phase.

Step 2: HCO Capacity Building

The organizational and research teams collaborated in building an initial capacity of the HCO to support the clinical model and practice change strategy and subsequently to build capacity of practices to apply the clinical model. The HCO quality improvement program provided practice support in implementing and sustaining the depression care clinical model. While the research team led capacity building efforts with phase 1 pilot practices and initially in phase 2, each HCO quality improvement program became the central and sustaining source of ongoing practice support for most of phase 2 and for phase 3.

To support the clinical model, capacity was developed within the HCO for telephone care management of depressed patients and for a psychiatrist to provide weekly supervision for care managers, as well as needed or requested consultation with primary care clinicians. Care managers and the psychiatrist received training and materials skills needed to support TCM from the investigators. These included a suicide risk assessment protocol and explicit follow-up interventions for patients at risk. To track patients receiving care management and their progress, a patient registry was developed using commonly available software such as Excel or Access.

Step 3: Primary Care Capacity Building

Primary care practices are enabled to provide needed clinical services through participation in the "prepared practice" component of TCM. Clinicians in TCM practices are provided with a 2-hour interactive skills training program. The skills include the diagnostic assessment of depressive disorders, use of the PHQ-9 as an aid to diagnosis and treatment monitoring,[2] the role of care management, and use of decision support to modify management and achieve remission of the depressive disorder. Care managers and psychiatrists are introduced to primary care clinicians at these sessions. Office staff receive a 1-hour in-service session about the clinical model, including an overview of depression diagnoses and management, use of patient education and self-management materials, scoring the PHQ-9, procedures to facilitate communication between the practice clinicians and the care manager, and instructions for storing and

sending materials and forms. A paper case exercise allowed clinicians, practice staff, and care managers a trial run of procedures and forms before actual patients were involved.

Step 4: Ongoing Support

Ongoing support for practice change comes through supervision of care management and provision of feedback on the patient's clinical response to clinicians. The supervising psychiatrist working with the organizational quality improvement program and RESPECT-Depression staff monitor referral rates to care management and appropriateness of referrals. Thus, clinicians who are having difficulty implementing TCM can be identified and assisted one to one. Practices are invited to a reunion meeting about 2 months after implementing the clinical model and receive periodic newsletters that describe experience with the model.

References

1. Rogers EM. *Diffusion of Innovations.*5th ed. New York, NY: The Free Press; 2003.

2. Kroenke K, Spitzer RL. The PHQ-9: A new depression and diagnostic severity measure. *Psychiatr Ann.* 2002;32:509-521.