ANNALS OF FAMILY MEDICINE

Online Supplementary Material

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

Appendix 5. Evaluation

In all 3 phases of the project, clinician surveys and care manager logs described the practice environments and the process of care. Clinical progress and outcomes were assessed using Patient health Questionnaire-9 (PHQ-9). For the phase 2 randomized controlled trial, depression severity and functional health of patients were determined through telephone interviews with evaluation center staff based at Weill Medical College of Cornell University using the SCL-20[1] and WHODAS-12,[2] respectively. Evaluation interviews for patients were conducted by telephone as soon as possible after the index clinician visit and no later than 14 days afterward. Follow-up telephone interviews were administered 3 and 6 months later. All phases rely on care manager logs and HCO administrative data to assess cooperation with implementation, number of care manager telephone calls, and changes in the process of care in each practice. For the pilot (phase 1) and for dissemination (phase 3) phases, PHQ-9 changes were used to assess depression outcomes.

Phase 2: Patient Evaluation Cohort

Adults who had a diagnosis of major depressive disorder, dysthymia, or both in the judgment of primary care clinicians and who were willing to accept active treatment constitute the target group. Active treatment is defined as prescribed antidepressant medications, referral for psychological counseling, or both. Clinicians recognize these patients in the course of typical care. For the randomized controlled trial, clinicians excluded patients younger than age 18 years, pregnant, already under the care of a psychiatrist, or expressing active suicidal thoughts.

All patients participating in the phase 1 pilot practices completed a consent process about receiving telephone care management. In the phase 2 randomized trial, however, patients could accept clinical care management but refuse to participate in the evaluation cohort. Patients accepting both the clinical and research activities completed an appropriate consent process and were then referred to the Cornell Evaluation Center for a structured assessment of clinical eligibility. Eligibility included meeting diagnostic criteria for major depressive disorder, dysthymia, or both, with no history of bipolar, current alcohol abuse, substance abuse, or post-traumatic stress disorders. Patients with active suicidal intent or plans and the means to act were excluded from both the evaluation cohort and care manager support. All other patients referred to care management received it, including those who did not meet evaluation cohort eligibility criteria. Patients meeting eligibility criteria were entered into a longitudinal evaluation cohort and received follow-up telephone calls at 3 and 6 months to assess their clinical course. The telephone interviewers were blind to the patients' study group.

References

1. Derogatis L, Rickels K, Uhlenhuth E, et al. The Hopkins Check List: a measure of primary symptoms. In Pichot P, ed. *Psychological Measurements in Psychopharmacology: Problems in Psychopharmacology*. Basel, Switzerland: Kargerman; 1974:79-110.

2. Epping-Jordan J, Ustun T. The WHODAS-II: Leveling the playing field for all disorders. *WHO Mental Health Bulletin.* 2000;6:5-6.