

Designing a Person-Centred Care Pathway for People with Depression in Primary Care

Judith R. Davidson and Raegan Mazurka

Queen's University

David Pinkerton and Laura Cassidy

Kingston Family Health Team

ABSTRACT

We created a person-centred care pathway for people with depression in a primary care team. An electronic form supported clinicians in assessing and documenting depression, accessing guidelines, making referrals and sharing the plan with the client. Assessment, documentation of depression, and referrals for cognitive behaviour therapy increased.

Keywords: depression care, quality improvement, patient-centred, primary care team, access to treatment

RÉSUMÉ

Nous avons développé un parcours de soins centré sur la personne pour la gestion de la dépression par une équipe de soins primaires. Un formulaire électronique a été élaboré afin d'aider les cliniciens à évaluer et documenter les troubles de dépression, à accéder aux lignes directrices, à procéder à des références et à partager le plan de soins avec le client. Au final, nous avons observé une intensification des activités de documentation ainsi qu'une augmentation du nombre de clients évalués pour des troubles de dépression et référés à une thérapie cognitivo-comportementale.

Mots clés : soins contre la dépression, amélioration de la qualité, soins centrés sur le patient, équipe de soins primaires, accès aux traitements

Judith R. Davidson, Department of Psychology, Queen's University, Kingston, Ontario; Raegan Mazurka, Department of Psychology, Queen's University, Kingston, Ontario; David Pinkerton, Kingston Family Health Team, Kingston, Ontario; and Laura Cassidy, Kingston Family Health Team, Kingston, Ontario.

Judith R. Davidson was formerly with the Kingston Family Health Team.

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Correspondence concerning this article should be addressed to Judith R. Davidson, Department of Psychology, Queen's University, 62 Arch St., Humphrey Hall, Room 232, Kingston, ON K7L 3N6. Email: judith.davidson@queensu.ca

BACKGROUND

Cognitive behaviour therapy (CBT) is a recommended treatment option for depression (Kennedy et al., 2009) but is under-used (Payne and Myhr, 2010). Our primary care team's psychologist noticed that few people with depression were being referred for CBT. Moreover, the prevalence of depression documented in the team's electronic medical record (EMR) system was lower than expected (2% versus population prevalence 5%). We wondered whether all of our team's clients with depression were being identified and offered best-practice treatments, hence we established the goal of creating a person-centred care pathway, providing optimal and seamless care for any adult presenting to the Kingston Family Health Team with depression. For this purpose we used storyboarding, a healthcare experience design method.

THE SETTING

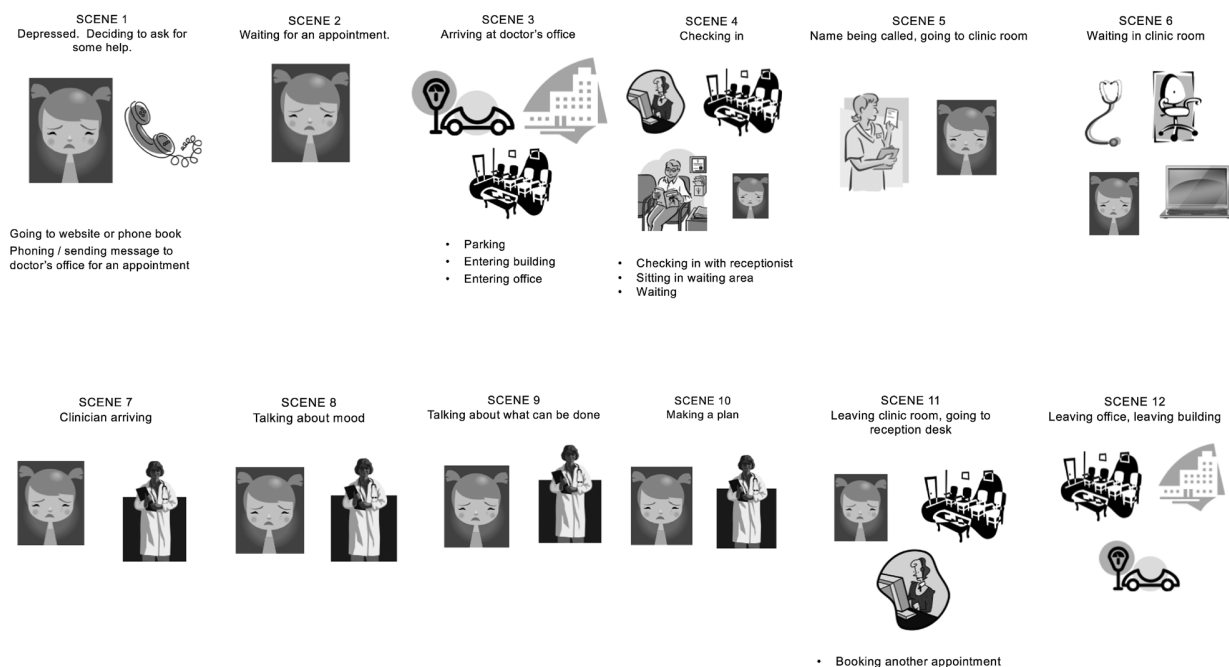
The Kingston Family Health Team (KFHT), an interdisciplinary primary care team, is funded by the Ontario Ministry of Health and Long-Term Care and serves 31,000 clients. The team, located at five sites in Kingston, Ontario comprised (in 2016) 21 family physicians, 4 nurse practitioners, 7.5 registered nurses, 1 physician assistant, 0.75 psychologist, 2 social workers, 1 dietitian, 0.25 pharmacist, and administrative staff.

THE APPROACH

Storyboard-based experience design involves, first, laying out a visual storyboard or pathway, scene by scene; then defining the ideal qualities of each scene; and finally building in mechanisms and processes to support and provide those qualities (Frohwerk, 2010). The ideal qualities were defined by clients and team staff based on their ideas about the best experience for the person with depression. The storyboard (Figure 1) encompassed the pathway of a client from the time of deciding to contact the KFHT for an appointment about his/her mood, until leaving the office after the first visit to the primary care provider. All staff were surveyed systematically online for their ideas on what would make each scene ideal if they were the depressed person. The instruction was: "Below each scene please put down your thoughts about what would make the scene ideal for you." In total, 38 staff contributed. Self-identification was optional and provided by 12 of the 38. This subset included nurses, physicians, receptionists, administrators, and interdisciplinary health professionals. Subsequently, seven clients who had experienced depression themselves, or depression of a family member, participated in one of two focus groups to provide their ideas on the same storyboard scenes. Two others who were unable to attend a focus group contributed their ideas through the online survey. Additionally, a poster of the storyboard was displayed in waiting areas at three KFHT sites. Clients were invited to add sticky notes to contribute to the ideal aspects of each scene.

All feedback was examined by three readers working independently at first, and then together, to summarize the data scene-by-scene. The main themes were categorized as ideas shared by clients and staff, ideas unique to clients, and ideas unique to staff.

Figure 1
Depression Storyboard



Source: Authors' compilation.

RESPONSE TO STORYBOARD FEEDBACK

We focused on implementing ideas that were shared by both clients and staff, or that were unique to clients. Ideas for easy, feasible improvements were acted on first. These arose from Scenes 1–2 of the storyboard where the depressed person realizes that he/she needs help, begins to look for assistance, and then awaits an appointment with the provider. We responded to clients' suggestions for enhanced depression information on the KFHT website (kfhn.ca) by providing information on the symptoms of depression, how to contact the family physician, links to depression information, and help for family and friends of a person with depression (DepressionHurts.ca; Mood Disorders Association of Ontario), and community crisis phone numbers. Based on clients' suggestions, we described the different mental health roles of the team's professions (family physician, psychologist, nurse practitioner and social worker). Feedback from Scenes 3–7 (arrival at the clinic, checking in, and waiting for the appointment) and Scenes 11–12 (booking follow-up and leaving the clinic)—which stressed the importance of a caring, respectful, and professional reception; notification if the clinician was running late; and booking of a follow-up appointment—was circulated to reception staff.

We then focused on feedback for Scenes 8–10 which depict the person with depression interacting with the provider: talking about mood (Scene 8), discussing what can be done (Scene 9) and making a plan

(Scene 10). Clients indicated that, if they were to fill out a symptom checklist for depression, they would prefer to do this with the clinician, rather than before the appointment in the waiting area. Both clients and staff expressed the importance of the clinician being genuine and warm, and listening. In addition, both suggested that the clinician offer hope or optimism, provide help right away, and discuss medications and non-pharmacologic treatment approaches. Both groups suggested that the treatment plan be a collaboration, giving importance to the client's preferences, opinions, and ideas. Furthermore, the information needed to be easy to understand, not overwhelming, and given in written form. Clients suggested that the treatment plan be "keyed into the patient's record and a copy printed to take with them." The plan would include how the person can help him/herself, e.g., nutrition, sleep schedule, journaling, or other self-help strategies. "The plan achieves a balance between medicine, talk therapy and strategies I can learn to help manage depression myself." Both groups expressed the need for follow-up.

Based on these principles, we created an electronic form in the EMR system to support both the clinician and the client in discussing and planning treatment for depression.

THE ELECTRONIC FORM

This form is a tool that provides the Patient Health Questionnaire 9 (PHQ-9, a brief inventory of DSM-based criteria for major depressive disorder), treatment guidelines for depression, and areas for subjective, objective, assessment, and planning (SOAP) progress notes. The PHQ-9 self-scores and can be easily opened on the screen so the client and clinician can go through it together. The following guide to interpreting the PHQ-9 data was based on CANMAT (Kennedy et al., 2009), National Institute for Health and Care Excellence (NICE; 2009) and Institute for Clinical Systems Improvement (2013) guidelines:

Depression is diagnosed if at least one of the first two PHQ-9 symptoms occurs "more than half the time" AND if functional impairment is at least "somewhat difficult" AND the PHQ-9 score is at least 10.

0–4 suggests no depression—No treatment warranted

5–9 suggests MINIMAL symptoms—Support

10–14 suggests MILD symptoms—Support, behavioural activation (exercise, schedule activities, contact with others)

15–19 suggests MODERATE symptoms—Medication or CBT or both

= or > 20 suggests SEVERE symptoms—Medication and CBT

Suicidal or psychotic: Assess need for visit to emergency department and/or help from Addiction and Mental Health Services crisis team.

There is also a link to the Edinburgh Postnatal Depression Scale. By clicking a box, "depression" is added to the client's problem list, thereby documenting it. A link opens to guidelines for the pharmacologic treatment of depression, based on CANMAT guidelines, prepared by the KFHT pharmacist. There are links for referral to the team psychologist (for CBT) or to the team social workers, one of whom has expertise in perinatal depression care. Another link opens to community psychiatry resources. Links are only opened as needed; the form is designed to be streamlined and uncomplicated. Following clients' suggestions, we built

in a “Patient Care Plan,” in which the clinician enters the plan discussed with the client. This may include items such as medication being prescribed, referral information, advice on behavioural activation such as exercise or activity scheduling, and any other information for the client. At the bottom of the form are URLs for the KFHT website and online self-help workbooks, and phone numbers for the community mental health crisis team. The Care Plan is printed as a single page for the client to take home, and saved in the EMR.

Using healthcare quality improvement run charts, we tracked the monthly use of the PHQ-9. We also examined the number of clients who had depression documented in their EMR problem list, and the number of referrals to the psychologist for depression-related CBT.

RESULTS

Use of the PHQ-9 increased from twice per month (January 2015) to 50 times per month (May 2016). The prevalence of documented depression increased from 2% in 2015 to 3% in 2016. This 1% increase represents 930 clients. Over the same timeframe, referrals to the team psychologist for depression-related CBT increased from approximately one per week to two or three per week. Challenges included technical issues with customizing aspects of the electronic form, and communication about the depression initiative and the electronic form across a multi-site team. We learned the importance of including all disciplines, staff, and especially clients in designing the pathway, and keeping all sites engaged in the initiative.

IMPLICATIONS

Storyboard-based experience design is a useful method of creating a person-centred care pathway. The input of clients is essential; they provide information that would otherwise be missed. An EMR form can support providers in assessing, providing evidence-based treatment, and discussing depression with clients. This is consistent with standards recently published by Health Quality Ontario (<http://www.hqontario.ca/portals/0/documents/evidence/quality-standards/qs-depression-clinical-guide-1609-en.pdf>). These methods can be used to enhance recognition of depression and provision of best care.

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