APPENDIX 1

Assessment of Clinician Depression Management in Psychiatry

Version 2

Please provide the following information about your care of your patients with depression.

Date:

_____/_____/_____

Month **Day** **Year**

Directions for Completing the Survey

This survey is designed to help move systems and provider practices toward state of the art guidelines for managing depression. The results can be used to help identify areas for improvement. Instructions are as follows:

1. **Answer each question** from the perspective of **your care of your patients with depression**.
2. For each row, **circle the point value** that best describes the level of care that currently exists for depression. The rows in this form present key aspects of depression care. Each aspect is divided into levels showing various stages in improving depression care. The stages are represented by points ranging from 0 to 5. The higher point values indicate that the actions described in that box are more fully implemented.

Send your completed survey to:

This survey was adapted with permission from Assessment of Chronic Illness Care (ACIC), Version 5, an instrument developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative, Seattle, Washington – www.improvingchroniccare.org.

Practice ID:
Staff ID: 11

APPENDIX 1

Assessment of Clinician Depression Management in Psychiatry

Please answer the following questions based on the procedures and approaches used by you and your immediate care team (e.g. professional and office staff that you work with most closely on a daily basis). <u>DO NOT</u> answer this on the basis of your overall practice settings (if you work in more than one) but based on YOUR practice site where you are implementing the depression management changes.

1. My level of commitment to improving the management of depression in my practice….[MODIFIED]				
…is relatively low **compared to other psychiatric illnesses** faced by my patients.		…is moderate, but I haven't really put much specific attention on improving depression care.		…is high, and I have worked actively along with other members of my care team to improve the care of my depressed patients
1	**2**	**3**	**4**	**5**
2. My approach to improving the care of my depressed patients can be characterized as… [MODIFIED]				
… I see these patients when they come in and provide the services they need.		… I try to keep track of my depressed patients so that I can make sure that they are receiving good care whether they come in for office visits or not, but I haven't established formal systems for doing this.		…I have implemented formal systems for making sure that my patients with depression are closely monitored, whether they come in for office visits or not.
1	**2**	**3**	**4**	**5**
3. Quality improvement….[MODIFIED]				
…does not exist in any formal way in my practice.		…is done formally in my practice, but has not addressed the care of depressed patients.		…has addressed (or is currently addressing) care of depressed patients.
1	**2**	**3**	**4**	**5**
4. Effective psychotherapy for my depressed patients…[NEW]				

Practice ID:
Staff ID: 11

…is difficult to arrange, and I have trouble arranging it for patients who seriously need it.		…is available by referral to mental health therapists who seldom communicate with me regarding treatment plans and patient progress.		…is provided by me or is coordinated with my care through active and effective communication with the mental health therapist.
1	**2**	**3**	**4**	**5**
5. When I receive a treatment referral from a mental health therapist …*[NEW]*				
…After providing therapist with results of my evaluation, I usually rely on the patient to inform the therapist.		…I usually contact at least once during the care of a patient to inform the therapist of patient progress.		….Usually involves regular communication between therapist and my office about patient progress (no less than once every 3 months if patient is not in remission)
1	**2**	**3**	**4**	**5**
6. When I receive a treatment referral from a primary care physician (PCP) …*[NEW]*				
…After providing PCP with results of my evaluation, I usually rely on the patient to inform the PCP of their progress		…I usually contact at least once during the care of a patient to inform PCP of patient progress		….Usually involves regular communication between PCP and my office of their progress about patient progress (no less than once every 3 months if patient is not in remission)
1	**2**	**3**	**4**	**5**

Self-Management Support. Self-management support does not equal patient education, although patient education can be an element of patient

self-management. Rather, patient self-management involves helping the patient to come up with a plan for managing his/her chronic condition. For depression, this can include such things as working with the patient to determine their treatment preferences or to develop a plan for such self-care strategies as exercise, increasing pleasurable activities, and seeking out social and/or family support.

7. I provide self-management support for my depressed patients…*[MODIFIED]*

…rarely, or by distributing educational materials about depression (pamphlets, booklets) that do not include any specific self-management strategies.		…by distributing materials to help patients develop specific self- management plans, but without formal follow-up on those plans with the patients.		…by distributing materials or providing counseling to help patients develop specific self-management plans, and following up with these patients by members of my care to reinforce their progress.
1	**2**	**3**	**4**	**5**

8. The information systems, follow-up files, and/or patient records that I use in my care of depressed patients …*[MODIFIED]*

…do not include information related to patient self- management goals.		… include results of patient assessments (e.g., functional status rating; readiness to engage in self-management activities), but no specific patient self-management goals.		…include results of patient assessments, self-management goals developed using input from the practice team and patient; and reminders to the patient and/or clinician about follow-up and periodic re-evaluation of goals.
1	**2**	**3**	**4**	**5**

9. I use evidence-based guidelines for depression …*[MODIFIED]*

APPENDIX 1

… rarely or never		… to guide my patient care in general, but not in any formal way in my practice.		…as the template for my care of depressed patients, forming the basis for such things as flow charts and systems to assure patient monitoring.
1	**2**	**3**	**4**	**5**
10. I am able to involve mental health therapists in my care of depressed patients …*[MODIFIED]*				
… primarily through referral of depressed patients.		…by referring depressed patients to mental health therapists who communicate with me regarding the patients' management.		…through active co-management of depressed patients with mental health therapists.
1	**2**	**3**	**4**	**5**
11. I screen patients with a standard depression questionnaire or symptom checklist …*[NEW]*				
… rarely or never.		… only when I strongly suspect depression.		… routinely with at least subgroups of my patients.
1	**2**	**3**	**4**	**5**
12. I make the diagnosis of depression …*[NEW]*				
… based on the general pattern of what the patient tells me and other clinical information.		… through an exploration of the patient's symptoms based on the clinical criteria for depression.		…through the use of a questionnaire or symptom checklist.
1	**2**	**3**	**4**	**5**
13. I use a checklist or questionnaire with my depressed patients to monitor change in the number or severity of depression symptoms *[NEW]*				

APPENDIX 1

…. never		… sometimes, focusing on patients who do not seem to be improving.		…routinely, to monitor treatment response and to watch for relapse on stopping therapy.
1	**2**	**3**	**4**	**5**
14. The care of my patients with depression … [NEW]				
…primarily relies on me, with few other resources involved.		…centers on me, but with some help from other resources within my practice.		…is a well-coordinated team effort involving a number of different people and resources.
1	**2**	**3**	**4**	**5**
15. A follow-up file is a list of patients with a particular condition that includes such things as name, contact information, date of last contact, severity scores and services that are due to be provided. Such a follow-up file …*[MODIFIED]*				
…is not available in my practice.		…is available in my practice, but I don't use it for my patients with depression.		…is available in my practice, and I use it actively in tracking the care of my patients with depression.
1	**2**	**3**	**4**	**5**
16. I use flow sheets for my patients with depression to provide a guide to management and to track critical elements of care … [NEW]				
….never		…sometimes, with selected patients		…routinely, with most or all depressed patients
1	**2**	**3**	**4**	**5**
17. Reminders to providers (either electronically or through some sort of paper tickler system) … [NEW]				

Practice ID:
Staff ID: 11

… are not used in my practice.		… are used for some chronic conditions, but I don't use them in the care of my depressed patients.		…are used actively in the care of my depressed patients.
1	**2**	**3**	**4**	**5**
18. My planning for the management of my depressed patients …*[MODIFIED]*				
…does not involve a population-based approach.		…uses data from information systems to plan care for selected patients.		…uses systematic data and input from my care team to proactively plan population-based care, including the development of self-management programs and community partnerships that include a built-in evaluation plan to determine success over time.
1	**2**	**3**	**4**	**5**
19. Routine follow-up for appointments with my depressed patients…*[MODIFIED]*				
…is not ensured, for example, patients who do not show up are not followed up in a systematic way.		…is sporadically done, usually with my input and direction.		…is ensured by assigning responsibilities to specific staff (e.g., depression care manager) who uses the registry and other prompts to coordinate return visits .
1	**2**	**3**	**4**	**5**
20. Feedback regarding the care of my depressed patients… *[MODIFIED]*				

…is not available.		…is provided, but has little influence on how I practice.		…is routinely provided, and I use the feedback to monitor my performance and make changes in how I provide care to my depressed patients.
1	**2**	**3**	**4**	**5**
21. Information about relevant subgroups of my depressed patients needing services (such as those not refilling prescriptions, not returning for follow-up, etc)…*[MODIFIED]*				
…is not available.		…can be obtained upon request, and I occasionally use the information.		…is provided to me routinely and is used by me and my team to help deliver planned care to my depressed patients.
1	**2**	**3**	**4**	**5**

APPENDIX 2

Table 2: Use of standardized depression assessment by project psychiatrists at baseline and at 12 and 24-month follow-up

Function and Use of Standardized Depression Questionnaires		**Baseline N=14**		**12-Month N=14**		**24-Month N=14**		**Chi square, df, and P-value Baseline and 12 Months**	**Chi square, df, and P-value Baseline and 24 Months**	**Chi square, df, and P-value 12 Months and 24 Months**
	Levels	***n***	***%***	***n***	***%***	***n***	***%***			
Screening	Never, rarely, or occasionally	6	43	0	0	0	0	X^2=7.6 df=1 p<0.01	X^2=7.6 df=1 p<0.01	-----
	Usually or always	8	57	14	100	14	100			
Diagnosing Depression	Never, rarely, or occasionally	5	36	1	7	2	14	X^2=3.4 df=1 p=0.065	X^2=1.7 df=1 p=0.190	X^2=0.4 df=1 p=0.54
	Usually or always	9	64	13	93	12	86			
Monitoring Change	Never, rarely, or occasionally	10	71	1	7	1	7	X^2=12.1 df=1 p<0.001	X^2=12.1 df=1 p<0.001	X^2=0 df=1 p=1.0
	Usually or always	4	29	13	93	13	93			