Brief Report

Ready for the Challenge of Depression Care in the Medical Home

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Jane Garbutt, MB, ChB[1], Randall Sterkel, MD[1], Karen Ruecker, MD[1], Sherry Dodd, BA[1], Elena Smith, BS[1], and Katie Plax, MD[1]

Introduction

Adolescent depression is common and often debilitating, yet frequently goes undiagnosed and untreated.[1] A national shortage of child and adolescent psychiatrists is long-standing and unlikely to improve,[1] leaving primary care providers (PCPs) to fill this care gap. Historically, PCPs have been reluctant to provide depression care.[2] In a 2011 survey, local PCPs reported they were unaware of national guidelines, felt inadequately trained, and lacked confidence to diagnose and manage these patients.[2] To assess PCPs' current attitudes and behaviors regarding providing depression care in the medical home, we recently repeated the survey. We compared findings from the 2 surveys to assess any change in PCPs' attitudes and behaviors. In this article, we report our findings to inform capacity building efforts.

Methods

We completed 2 cross-sectional surveys of PCPs affiliated with St. Louis Children's Hospital and Washington University. Eligible providers were either members of a pediatric practice–based research network or provided training in ambulatory pediatrics for residents in Washington University Department of Pediatrics. For each survey, eligible PCPs were invited to complete a self-administered, anonymous questionnaire. The survey was developed by the authors, based on the literature and clinical experience and took <10 minutes to complete. Questions assessed beliefs and behaviors regarding screening, diagnosis, and initial and ongoing management of depressed adolescent patients. Respondents used categorical scales to indicate agreement with attitudinal statements (strongly agree, agree, disagree, and strongly disagree) or confidence in delivery of depression care (very confident, moderately confident, not very confident, and not at all confident), then selected from a list of options to indicate strategies that might assist them in depression management. They also reported the frequency of encountering difficulties when accessing specialty care (all of the time, most of the time, some of the time, rarely, and never). Demographic information about the PCP and his/her practice were also collected.

Table 1. Characteristics of Study Samples.

Study year	2011	2017
Total participants	104	62
Female (%)	64% (65/102)	73% (44/60)
Years in practice, mean (SD)	17.5 (9.9)	19.6 (10.0)
Practice characteristics, %		
Pediatric group practice	70% (72/103)	71% (43/61)
Suburban setting	72% (73/102)	80% (49/61)
% Medicaid, mean (SD)	25% (28%)	23% (22%)

Categorical data are reported as percentages and continuous variables as mean, standard deviation. Categorical response scales were collapsed and reported as follows: "strongly agree" and "agree" as "agree"; "very important" and "moderately important" as "important"; and "not very" and "not at all" confident as "lack confidence." Responses from 2011 and 2017 were compared using the 2-sample test of proportions and Student's t test, as appropriate. $P < .05$ (2-tailed) was used to establish statistical significance, and data were analyzed using STATA 11 (StataCorp, College Station, TX). The Washington University Human Research Protection Office approved the study.

Results

In total, 104/229 (45%) PCPs completed the survey in 2011 and 62/132 (47%) in 2017. Characteristics of the study population did not differ by year (Table 1). Table 2 reports results from the 2017 survey and compares PCPs' beliefs and behaviors regarding depression care with prior results from 2011. In both surveys, virtually all respondents (96%, 99/103 in 2011; 97%, 60/62 in

[1]Washington University, St. Louis, MO, USA

Corresponding Author:
Jane Garbutt, Department of Pediatrics, Washington University School of Medicine, Campus Box 8116, 660 S Euclid Avenue, St. Louis, MO 63110, USA.
Email: jgarbutt@wustl.edu

Table 2. Primary Care Provider's (PCPs) Beliefs and Behaviors Regarding Care for Adolescents With Depression From Surveys in 2011 and 2017.

	2011	2017	*P*
Beliefs (agree with statement)			
Total participants	104	62	
Most adolescents with depression should be cared for in their medical home by their PCP	47% (48/103)	77% (48/62)	<.001
I am adequately trained to provide effective care	29% (30/102)	48% (30/62)	.01
I feel confident in providing care	36% (36/100)	47% (29/62)	.17
I feel confident prescribing SSRIs	57% (57/100)	57% (35/62)	.95
A brief, easy to use diagnostic tool is available	52% (49/95)	82% (51/62)	<.001
A brief, easy to use tool to assess treatment response is available	34% (32/93)	52% (28/54)	.04
Most patients will return for follow-up visits	58% (56/97)	46% (28/61)	.15
Treatment is usually effective	77% (70/91)	59% (36/61)	.02
Referral to a mental health professional is seldom necessary	6% (6/101)	13% (8/61)	.12
Easy to use clinical practice guidelines are available	28% (26/92)	26% (15/57)	.80
Behaviors			
Routinely use a depression screening tool (PHQ-2, PHQ-9, or Beck)	17% (17/102)	76% (45/59)	<.001
Estimated % of patients diagnosed with depression in past year who were identified by screening, mean (SD)	13% (15%)	27% (22%)	<.001
Do not prescribe SSRIs	29% (28/98)	5% (3/61)	<.001
Encounter problems accessing high-quality psychiatric care all or most of the time	83% (86/104)	84% (51/61)	.88
Encounter problems accessing high-quality therapy/counseling all or most of the time	46% (46/99)	27% (17/62)	.02
Requested resources			
Timely referral to psychiatry	95% (98/103)	93% (58/62)	.66
Up-to-date list of local providers for referral	84% (87/103)	92% (57/62)	.16
Timely referral for therapy	84% (87/103)	79% (49/62)	.37
Expert recommendations regarding drug prescribing	66% (68/103)	76% (47/62)	.19
Additional training	74% (76/103)	66% (41/62)	.29
Opportunity for timely telephone consultations with psychiatry	60% (62/103)	60% (37/62)	.95
Educational materials for adolescents and their families	67% (69/103)	60% (37/62)	.34
Help monitor and coordinate care	50% (52/103)	44% (27/62)	.39

Abbreviation: SSRIs, selective serotonin reuptake inhibitors.

2017) wanted to improve the care they provided for their patients with depression, and the majority reported frequently encountering difficulty accessing psychiatric help for their patients (83%, 86/104 in 2011; 84%, 51/61 in 2017). In 2017, most PCPs agreed adolescent depression should be cared for in the medical home (78%, 48/62), used validated diagnostic tools (76%, 45/59), and prescribed selective serotonin reuptake inhibitors (SSRIs; 95%, 58/61), a significant increase in depression care from the 2011 survey. However, only 47% (29/62) felt confident in providing depression care and few were aware of national guidelines (26%, 15/57), similar findings to 2011. Fifty-nine percent (36/61) felt that treatment was effective, a significant decrease from 2011, and 46% (28/61) expected patients to return for follow-up visits (a nonsignificant decrease). To assist them in providing care, almost all PCPs wanted timely referral to psychiatry (94%, 58/62) and therapy (79%, 49/62), guidance about pharmacotherapy (76%, 47/62), and additional training (66%, 41/62). This list of desired resources had not changed from 2011.

Discussion

Study findings suggest recent changes among local PCPs regarding their willingness to provide depression care. Our survey in 2011 showed few PCPs in our community provided depression care,[2] but by 2017, the majority believed that depression care belongs in the medical home and were screening for depression using a validated tool and prescribing SSRIs. Yet they remained uncertain about the adequacy of their efforts and wanted guidance and support from local psychiatrists regarding pharmacotherapy as well as opportunity for timely referrals when

needed. These findings suggest that PCPs are willing and able to provide care for their adolescent patients with depression, but need and want assistance to ensure the care they provide is most effective for their patients.

Several models of collaborative care for depression management have been shown to be acceptable to providers and to improve patient outcomes. These include on-demand consultation with a psychiatrist, support for the PCP from a care coordinator and a mental health professional, and colocation of a mental health professional.[3-5] To optimize depression care in the medical home, these effective strategies must be deployed. Some states have already implemented these programs, but in others, such as Missouri, current reimbursement models do not support such innovation. An alternative approach to build capacity using existing resources could involve local psychiatrists guiding and coaching PCPs to master depression care by sharing treatment algorithms and protocols. National guidelines are available to support this approach, but our findings suggest that most PCPs are unaware of this resource.[1] Quality improvement methods could support practice change needed to implement this new treatment paradigm.[6] However, most primary care practices are small-scale, independently run enterprises that operate on a narrow margin and lack the infrastructure and support for practice change.[7,8] They will likely need help, such as external facilitation,[9,10] to develop and implement effective systems of care for their depressed patients.

Our findings may not be generalizable because the study sample was small and from one geographical location, and we relied on self-report and cannot verify responses by survey participants. Due to the anonymous nature of our surveys, we were unable to identify how many providers took part in both surveys or pair respondents to strengthen the study design to assess the magnitude of any changes. Yet our data suggest an urgent need for support for PCPs who are ready to take on the challenge of providing depression care and especially to help them develop capacity in providing effective pharmacotherapy and follow-up care. This could increase specialty access for those patients with more complex mental health needs.

Author Contributions

All authors made substantial contributions to the conception and design of the project, acquisition of data, or analysis and interpretation of data. They all participated in either drafting or critically revising the article, and all provided final approval of the version submitted for publication.

Declaration of Conflicting Interests

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ORCID iD

Jane Garbutt https://orcid.org/0000-0001-7252-9198

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