

Quality Improvement: Addressing Patient Treatment Preferences in Depression

Dwight-Johnson M, Unutzer J, Sherbourne C, et al. Can quality improvement programs for depression in primary care address patient preferences for treatment? Med Care 2001;39:934-44.

Study Overview

Objective. To examine whether a primary care-based depression quality improvement (QI) intervention that is designed to accommodate patient and provider treatment choice increases the likelihood that patients enter depression treatment and receive preferred treatment.

Design. Group-level, randomized controlled trial. Analysis was at patient-level and by intention-to-treat.

Setting and participants. The study took place in 46 clinics in 6 managed care organizations in the United States with different organizational structures: staff-model HMO, primary care network with single prepaid insurer, multiple prepaid insurers, prepaid and managed fee-for-service insurers, and 1 public health system. All clinics had at least 2 providers (internists, family practitioners, general practitioners, and nurse practitioners) for a total of 181 providers. The 46 clinics were grouped into 27 "clinic clusters" that could be a single clinic, a group of small clinics, or a clinical care team within a large clinic. The clusters were grouped into 9 blocks by geographic region and stratified by proportion of Mexican-American patients. The matched "clinic clusters" were randomly assigned to 3 intervention groups: medication quality improvement (QI-MED), psychotherapy quality improvement (QI-THERAPY), and usual care. Patients were selected through screening using the Composite International Diagnostic Interview (CIDI) of the World Health Organization to identify current depressive symptoms and either lifetime or current depressive disorder.

Intervention. The quality improvement intervention was designed as a dissemination trial in which the study sites received education and training on how to implement Agency for Health Care Policy and Research (AHCPR) practice guidelines for depression [1] and were also responsible for the implementation. Local leaders (ie, a primary care clinician, a nurse supervisor, a psychiatrist for QI-MED, and a psychologist for QI-THERAPY) were trained in the study's model of treatment and principles of collaborative care; a manual of the model was available. Patients in the interven-

tion groups were encouraged to express treatment preferences, and their primary care providers were encouraged to elicit preferences and to follow them as a strategy to enhance compliance. In QI-MED, the nurse specialist provided monthly follow-up assessment and adherence support. In QI-THERAPY, the psychologist provided individual and group cognitive behavioral therapy for 12 to 16 sessions. Usual care clinic patients and providers were not informed of the diagnosis of depression; however, they were aware of the patients' participation in the study and the clinic medical director received the practice guidelines and the quick reference guide for clinicians [1].

Main outcome measures. Treatment preferences, patient characteristics, and use of depression treatments were assessed at baseline and at 6 months by patient self-report using the patient assessment questionnaire. Patients were considered to have received preferred treatment if they preferred medication at baseline and reported having received an antidepressant, or if they preferred counseling at baseline and reported having at least 1 specialty mental health counseling visit.

Main results. 742 participants fulfilled the selection criteria and wanted treatment for depression at baseline. Their mean age was 44 years. 74% were female, 59.9% white, 27.8% Hispanic, and 6.3% African American. 54.3% had an education beyond high school, and 50.6% had anxiety disorder as comorbidity. For patients not receiving care at baseline, the QI interventions increased rates of entry into depression treatment compared with usual care (adjusted percentage, 50.0% \pm 5.3 and 33.0% \pm 4.9 for interventions versus 15.9% \pm 3.6 for usual care; $F = 12.973, P < 0.001$). Patients in intervention clinics were more likely to receive the treatments they preferred compared with those in usual care (adjusted percentage, 54.2% \pm 3.3 and 50.7% \pm 3.1 for interventions versus 40.5% \pm 3.1 for usual care; $F = 6.034, P < 0.003$); however, in all clinics less than half of patients preferring counseling reported receiving it.

Conclusion. QI interventions that support patient choice can improve the likelihood of patients receiving preferred treat-

ments. Patient treatment preference appears to be related to likelihood of entering depression treatment, and patients preferring counseling may require additional interventions to enhance entry into treatment.

Commentary

There is general consensus that the management of depression in primary care could improve, not only through better screening but also through better treatment interventions. Quality improvement programs at the clinic level seem to positively impact these problems and, perhaps, improve clinical outcomes. The authors of this study focus on patient preferences. The results showed that the likelihood of patients receiving their preferred treatment was not great. Only about half of the intervention patients received their preferred treatment.

This study is a subsequent analysis of previously published data that concluded that depression QI programs in managed primary care practices improve quality of care, mental health outcomes, and retention of employment by depressed patients [2]. However, the study also reported relatively low probabilities with regard to use of treatments, even in the intervention group. For example, only 50.9% of QI patients and 39.7% of controls at 6 months had counseling or used antidepressant medication at an appropriate dosage; the results were similar at 12 months (59.2% versus 50.1%) [2].

The methodology used in this study has some weaknesses. For example, the diagnosis of depression was not provided in the usual care group; this lack of formal screening and recognition of depression gave the intervention group

an unfair advantage. The short follow-up (6 months) does not allow for observation of the usual decline that occurs after educational interventions. The different levels of randomization and intervention (cluster level) and evaluation of the outcome (patient level) was appropriately considered using logistic regression models.

Application for Clinical Practice

In general, quality improvement processes are powerful tools that should be used to identify problems in the health care system and to implement and assess new interventions so as to better serve patients' needs and obtain relatively good, cost-effective outcomes. For patients with symptoms of depression, primary care providers should evaluate and seriously consider treatment preferences as a means to improve patient's adherence to recommended therapy and to improve clinical outcomes.

—Review by Pedro J. Caraballo, MD

References

1. Depression Guideline Panel. Depression in primary care. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research; 1993. Clinical practice guideline no. 5.
2. Wells KB, Sherbourne C, Schoenbaum M, et al. Impact of disseminating quality improvement programs for depression in managed primary care: a randomized controlled trial [published erratum appears in JAMA 2000;283:3204]. JAMA 2000; 283:212–20.

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