

Kristen Donigan
Aug 22, 2006

Family Medicine Community Health Project Identifying Depression in Chronically Ill Patients

Description

On family medicine rotation at Michael Reese Hospital we have the unique experience of providing mental health counseling to patients under the care of Dr. Wendell Carpenter. Once a week we are able to spend the duration of patient visits addressing patients' depression and examining how it affects their lives. We were reminded of the value of the Osteopathic triune approach to patient care and inspired to better address patient's mental health during routine visits to the family medicine clinic. We wanted a time-efficient way of identifying depression in patients who may be overlooked as office visits where the bulk of the time allotted is usually directed at managing chronic illnesses and addressing adherence to treatment regimens.

Goal

Our short term goal was to implement a time-efficient method of detecting depression in chronically ill patients that might otherwise be overlooked. We intended for both patients and physicians to be more mindful of the mental health status of the patient and the role it plays in overall health maintenance and outcomes of treatment regimens. We planned to identify patients with co-morbid depression and chronic illness, offer treatment options and begin a process of monitoring the patient's progress. For the long-term, we hope that the family medicine clinic will continually attempt to evaluate and identify depression in chronically ill patients, and provide treatment and ongoing monitoring for co-morbid depression. Ultimately, by addressing co-morbid depression, we hope to see improvements in discrete measurable health indices such as blood pressure, lipid profiles, blood sugar, and glycosylated hemoglobin.

Rationale

Depression is often comorbid with chronic illness such as diabetes, coronary artery disease, chronic obstructive pulmonary disease and hypertension. (1, 2, 3). Depression negatively impacts patient adherence to treatment regimens such as diet, exercise and consistent use of prescribed medications, with one study finding that depressed patients were three times as likely to be noncompliant. (2) Related to the issue of compliance is that comorbid depression is associated with an increase in overall morbidity and mortality. (1) In the primary setting, time is often spent on specifics of management of chronic problems with often little attention to depression or other psychological problems. (4) There is a need for better screening for depression in primary care, better monitoring of depressed patients, better communication between patient and physician, and education for both patient and physician as to the various presentations of depression and the relationship between depression and chronic disease. (5)

An objective of *Healthy People 2010* was to increase mental health screening in primary care from baseline of 62% in 2000 to 66% by 2010. Similarly, treatment for adults with depression is intended to increase from 58% in 2002 to 64% in 2010. *Healthy people 2010* also notes the importance of increasing state tracking of consumer satisfaction with mental health services and addressing the cultural competence of such services. United States Preventative

Services Task Force (USPSTF) found good evidence that screening improves the accurate identification of depressed patients in primary care settings and that treatment of depressed adults identified in primary care settings decreases clinical morbidity.

The Family Medicine clinic at Michael Reese serves a predominantly African American population (for more information on the population served please see the Community section below). Because African Americans disproportionately suffer from chronic illness such as diabetes and hypertension, the identification, treatment and monitoring of comorbid depression that contributes to increased morbidity and mortality is particularly warranted in this population. Studies have found that both depression and race are related to antihypertensive drug adherence and blood pressure control. (6) The direct effect of symptoms of depression on obesity and hypertension was found to be more significant in African Americans than in whites. (7) Black women are experiencing the brunt of the disparity having rates of hypertension exceeding those of black males and other ethnic groups. (3) African Americans are less likely to be diagnosed with depression (8) and there is a paucity of research about depression in African Americans, particularly in women. (3, 9) African Americans face many obstacles in the recognition and treatment of major depression including clinical presentation with somatization, stigma about diagnosis, competing clinical demands of comorbid general medical problems, problems with the physician-patient relationship, and lack of comprehensive primary care services. African Americans may be frequently underdiagnosed and inadequately managed in primary care. (5) Community based programs for reducing disparities in physical illness may need to address the burden of undiagnosed and untreated depression in order to become optimally effective. (4)

Healthy People 2010 has established the goal of increasing the number of black or African American adults being treated for depression from 42% to 64%. Similar goals include increasing treatment for adults with generalized anxiety disorder, co-occurring substance abuse and mental disorders, improving negative feelings interfering with activities among adults with disabilities, providing sufficient emotional support among adults with disabilities, satisfaction with life among adults with disabilities.

Method

Our method of identifying depression in chronically ill patients is to first identify patients being treated for the following conditions: diabetes, hypertension, chronic obstructive pulmonary disease, and heart disease. We will screen/review medical charts before patients' scheduled appointment. Patients with aforementioned conditions documented in their charts will be given surveys and additional information upon arriving for their appointment and checking in with the receptionist. In addition to the survey, patients will be given information describing the purpose of the questionnaire, informing patients of their right to decline to participate in the survey. Patients that chose to participate will be asked to sign a consent form. The survey provided will be the Beck Depression Inventory II (BDI-II) – a twenty question multiple choice survey. According to an InfoPoems inquiry, there is little evidence to recommend one depression screening survey over the other. (10) We chose the BDI-II as it is brief, easy to score, and (we hope) easily understood by patients. The survey was to be completed, scored and discussed with the patient all in the same office visit. In patients' whose score suggests depression, treatment options will be discussed, including pharmacotherapy, supportive counseling, and exercise. Depressed patients will be encouraged to follow-up with Dr. Carpenter for at least 4 visits, to

monitor their condition. At the completion of the four visits patients will be to retake the BDI II to measure the effect of the attention to the depression.

The Community

Reese's Chicago Osteopathic Family Medicine clinic serves the neighborhoods of Chicago's south side primarily Douglas and Oakland, but also the Near South, Armour Square, Grand Boulevard, and Kenwood. According to the Chicago Department of Public Health demographics information, both the Oakland Community and Douglas are predominantly black and described as below twice poverty level. In Douglas, mental disorders not related to drug or alcohol was related was the second leading cause of hospitalization in 2001. In Oakland, mental disorders not related to drugs or alcohol was the number one leading cause of hospitalization in 2001. Similarly, the number one patient diagnosis at Michael Reese in 2001 was mental disorder not related to drugs or alcohol. (11)

Community resources

In addition to Dr. Carpenters services, patients have mental health counseling services available at the following locations: Stickney Public Health District Division of Mental Health, South Central Community Services, Inc. McKinley Interventions Woodlawn, Hyde Park - Woodlawn Center, Jewish Vocational Services, Chicago MH Clinic – Woodlawn, Chicago MH Clinic – Englewood, Chicago MH Clinic - Greater Grand Blvd, Abraham Lincoln Centre, Abraham Lincoln Centre Urban Systems of Care.

Outcome/ Results

In order to involve patients in such a survey, we were required to obtain approval for the project by Michael Reese. Unfortunately time did not allow for the implementation of the project, as we are currently awaiting approval from Michael Reese to begin administering the surveys to patients.

Discussion

Although we were unable to formally survey our patients, I found that during the course of the project development I was more likely to inquire about a patient's mental health status and address depression in patients who may have otherwise not mentioned this aspect of their health. I found value in eliciting this information as most patients seemed to appreciate my interest and were willing to discuss this topic.

One concern with using written surveys is the issue of literacy and language barriers. It is vital that patients understand what they are being asked, however miscommunication and misunderstanding between patient and physician is common, but not always apparent to either party. I also feel it's important to recognize that depression, adherence to treatment regimens and perceived quality of life is multivariable with financial, cultural and educational barriers playing a large role. I also suspect that in some cases patients may be hesitant to immediately take action such as to schedule follow-up appointments with Dr. Carpenter that day as they may need time to absorb the new information presented to them.

I hope that future students on rotation at Michael Reese's Osteopathic Family Medicine Clinic will pick up where we left off. An improvement to our project would be to get other

psychologists involved in the project to expand on the options available to patients, as currently Dr. Carpenter is only able to take patients on Wednesday afternoons. An important aspect of monitoring the effects of our screening project to observe any changes in measurable health indices such as cholesterol or glycosylated hemoglobin in patients that committed to following up with a treatment plan for their depression.

References:

1. Katon WJ, Rutter C, Simon G et. al. The association of comorbid depression with mortality in patients with type 2 diabetes. *Diabetes Care*. 2005 Nov;28(11):2668-72
2. DiMatteo MR, Lepper HS, Croghan TW. Depression is a Risk Factor for Noncompliance with medical treatment. Meta-analysis of the Effects of Anxiety and Depression on Patient Adherence. *Arch Intern Med*. July 24, 2000;160:2101-2107
3. Artinian NT, Washington OG, Flack JM, et. al. Depression, stress, and blood pressure in urban African American women. *Prog Cardiovasc Nurs*. 2006 Spring;21(2):68-75
4. Larson C, Belue R, Schlundt DG, et. al. Relationship between symptoms of depression, functional health status, and chronic disease among a residential sample of African Americans. *J Ambul Care Manage*. 2006 Apr-Jun;29(2)L133-40
5. Das AK, Olfson M, McCurtis HL, et. al. Depression in African Americans: breaking barriers to detection and treatment. *J Fam Pract*. 2006 Jan;55(1):30-9
6. Morris AB, Li J, Kroenke K, et. al. Factors associated with drug adherence and blood pressure control in patients with hypertension. *Pharmacotherapy*. 2006 Apr;26(4):483-92
7. Kabir AA, Whelton PK, Khan MM, et. al. Association of symptoms of depression and obesity with hypertension: the Bogalusa Heart Study. *Am J Hypertens*. 2006 Jun;19(6):639-45
8. Wagner J, Tsimikas J, Abbott G, et. al. Racial and ethnic differences in diabetic patient-reported depression symptoms, diagnosis, and treatment. *Diabetes Res Clin Pract*. 2006 Jun 16 (Epub ahead of print)
9. Carrington CH. Clinical depression in African American women: diagnoses, treatment, and research. *J Clin Psychol*. 2006 Jul;62(7):779-91
10. USPSTF guidelines available at <http://www.ahrq.gov/clinic/uspstfix.htm>
11. Chicago Department of Public Health