

Partnerships to Improve the Management of Late-Life Depression in Primary Care

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Acknowledgments

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- Funding: CIHR Meetings, Planning, and Dissemination grant.

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Outline of session

Introduction – 10 minutes (J. McCusker)

- Project goals
- Chronic care model
- Integrated knowledge translation

Review of solutions from project – 20 minutes (L. Van Bussel)

Next steps – 5 minutes:

- Feedback after session

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Introduction: Goals of project

- Funded by CIHR Meetings, Planning, and Dissemination grant
- Identify barriers and potential solutions to implementation of a chronic care model for late-life depression in primary care
 - Phase 1: Conference to develop a working document
 - Phase 2: Refinement of working document
 - Phase 3: Joint preparation of research grant proposal

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Late-life depression in primary care

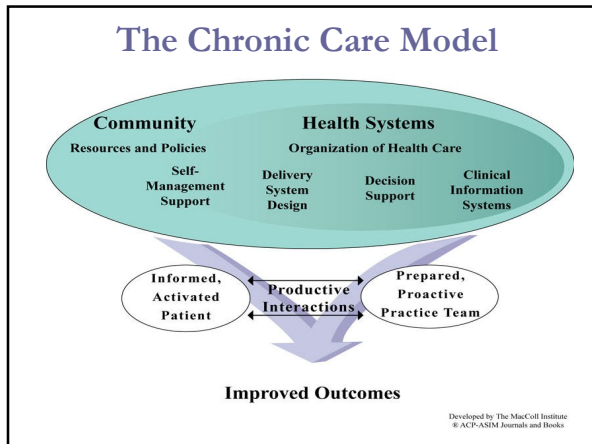
- Prevalent
 - Serious
- Risk factor for mortality and disability
- Chronic and relapsing
- Associated with disability, chronic physical illness, social isolation
- Effective treatments
- Poorly managed

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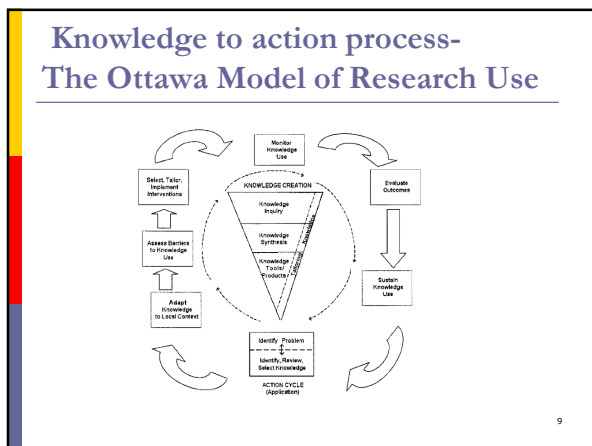
Development of feasible solutions to improve management

- Two conceptual models:
 - Chronic Care Model:
 - Structured approach to identifying solutions
 - Integrated knowledge translation
 - Collaborative partnerships with "knowledge users"

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- ### “Integrated knowledge translation”
- Why?
 - Increase implementation of research evidence
 - Makes research more relevant to practice
 - How?
 - Creating partnerships between researchers and “knowledge user” partners
 - Who?
 - Clinicians, administrators, patients, family members, community agencies, policy-makers, etc.



Approach

- Nominal group technique:
 - Group decision-making
 - Balanced participation
- Standard procedure:
 - Introduction and explanation
 - Silent generation of ideas
 - Sharing ideas
 - Group discussion
 - Voting and ranking

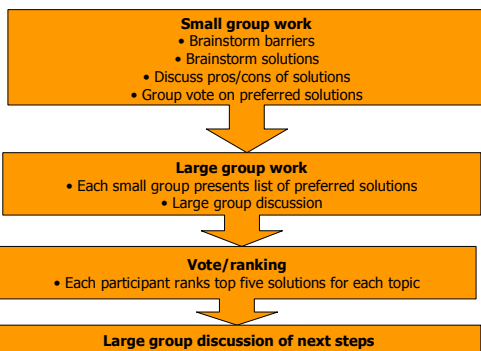
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3 areas identified for discussion at conference

- Case-finding and treatment
- Supported self-management
- Collaboration between primary care and mental health providers

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Plan for the day



Post-conference activities

- Phase 1:
 - Clarification of solutions
 - Ranking and voting on 1) importance, and 2) feasibility.
 - Linkage of solutions to Chronic Care Model
 - Development of working document
- Phase 2:
 - Feedback/ranking on working document from other partners across Canada
- Phase 3:
 - Submission of research grant proposal to CIHR Partnerships for Health System Improvement (PHSI) program

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Solution #1

- Mechanisms should be developed by which family physicians are made aware of what services/programmes are available in the community to help them to manage their older patients with depression and provide supportive care/aftercare (e.g. fitness classes, support groups).

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Solution #2

- Monetary and human resources should be allocated by government health authorities to make collaborative care of depression in seniors easier for health providers to engage in on a regular basis.

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Solution #3

- Professional training should be supplied to health care providers from different disciplines to learn how to engage in and maintain interdisciplinary and interprofessional collaboration in mental health care.

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Solution #4

- A framework for new pathways to access depression care services in non-stigmatized and non-clinical settings should be developed, which would allow patients and caregivers to access services for depression from many settings including: primary care provider, specialist, and community organizations.

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Solution #5

- There should be increased lobbying efforts (by professionals, the public at large, and advocacy groups) to ensure that mental health funding is secured for care at the primary and community care levels.

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Solution #6

- Recovery should be seen as both a process and a goal for management of depression in seniors, which functions to motivate patients, coach and support them in their self-care efforts, and reframes treatment from "getting better" to "working towards a better life"

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Solution #7

- General education on depression (e.g. stigma, risk factors) and the types of services available to manage depression (e.g. community resources) should be supplied to providers, older adults and the general population (especially pockets of the population that may come into contact with older adults such as hair dressers, people who deliver mail, bank tellers).

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Solution #8

- Community-based resources, including peer-support, should be designed or enhanced to support seniors with depression and their families and to work in tandem with hospital/clinic-based mental health services.

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Solution #9

- Mechanisms for direct support of family physicians by mental health teams in managing depressed patients should be provided. This goes beyond informing family physicians about resources available (as in #1), and provides direct, collaborative support on management of specific patients.

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Solution #10

- There should be improved coordination of care and flow of information between family/patient and family physician/care teams.

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Solution #11

- Computerized information system(s) should be implemented to allow the family physician and other health professionals to coordinate information between hospitals, physicians' offices, care teams, in order to increase the informational continuity of care, and to monitor patient treatment and follow-up.

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Solution #12

- Case-finding strategies to identify depressed seniors should be implemented at strategic moments (e.g., when patient makes ER visit, is hospitalized, when clinical condition deteriorates, when patient is assessed for homecare services).

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Next steps

- Return feedback form
 - By June 5
- Vote on revised list of solutions
 - By June 19
- Receive copy of report
 - By June 30

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