# Shared Decision Making and Depression Treatment in Primary Care

 (1-hour webinar) 11-12-2015

**Quanah Walker:** Today’s webinar is the second in a series titled Reducing Racial Disparities in the Treatment of Depression. Our topic for today is Shared Decision Making and Depression Treatment in Primary Care. We have three subject matter experts with us in today’s webinar:

Vicki Olson, Program Manager for Stratis Health

Dr. Art Wineman and Tasha Gastony from Health Partners and Park Nicollet

My name is Quanah Walker and I’m a manager in behavioral health at HealthPartners. I will be moderating today’s webinar on behalf of the Minnesota Health Plan Collaborative, working to reduce disparities and improve antidepressant medication management. We will have time for questions following the presentation.

 There are a couple of logistical slides that we’ll go through really quickly. The first thing is to call your attention to the Stratis Health website. We have a provider toolkit and that is focused towards primary care providers or other kinds of providers with a goal of helping them have some tools for managing medication and antidepressant adherence.

 The educational objectives for today:

Following this learning activity, participants will be able to:

* Discuss what shared decision making is and at least two of its components.
	+ - Describe how shared decision making can be used for depression treatment in primary care.
		- Explain how to incorporate shared decision making into depression treatment in primary care.

People can get CDUs for this, so we’ll have some instructions at the end about that.

 We have our disclosure policy, our content validation policy and a note about commercial support and, again, the faculty today is listed here.

The planning committee includes Patty Graham, quality consultant at HealthPartners; Marcy Otypka, quality consultant at HealthPartners; Sharon Kopp-Huth from the Park Nicollet Institute and Quanah Walker, LICSW. Again, we worked with the Health Plan Collaborative together on this project. With that, I want to introduce Vicki Olson from Stratis Health to talk about shared decision making.

**Vicki Olson:** Hello, everyone, I’m happy to be here. This is a topic that is kind of near and dear to my heart, so I commend you on working on this topic. The objectives for my very short, brief overview are to define shared decision making and review the SHARE approach. SHARE is an acronym used by the Agency for Healthcare Research and Quality. They have developed a train-the-trainer toolkit on shared decision making and we are currently in the process of doing some national training.

 You’ll notice some of my slides have a different background and those are actually slides that you can get on our website. These are all publically available, the ones that have the AHRQ background to it. I wanted to share a couple websites that will summarize and be good resources for you for shared decision making. Our train-the-trainer workshop is a full day workshop. I get to do this in 15 minutes, so obviously it’s a very quick overview. So let’s spend a little time on definition because I do think people struggle with what shared decision making is and what it isn’t.

 Shared decision making occurs when a healthcare provider and patient work together, so there is a partnership. You need that interaction between the professional. It could be a physician or nurse practitioner. It could be a pharmacist. It could be a nurse expert. It could be a social worker. It depends on the topic and how people organize that.

 Making a Healthcare Decision

 It needs to be a situation where there is actually a decision to be made. So when people talk about patient education, patient education isn’t per se shared decision making. Doing the choosing wisely may, in an encounter, impact utilization, but that’s not the purpose of it. The optimal decision takes into account evidence-based information, so it’s still important and very important to reinforce with providers that this is evidence-based practice. If there is a clear evidence-based solution that may not be the situation for shared-decision making, but often times that’s not the case.

Evidence-based practice is still very important to help the patient understand what the options are. The provider’s knowledge and experience is also important to bring to bear in a situation and then, of course, the patients’ values and preferences is really what we’re trying to highlight as an addition into the decision-making process.

 Why is it Important?

 In many cases the choice isn’t clear, so we need to hear the terminology and reference them to the condition. So the conditions that have been identified is where there might be multiple options, including doing nothing. It is really evidence-based and helping patients understand when those situations occur what the options are is important. Patients may not know that there is more than one treatment option and that one is not clearly superior to the other, so having that discussion can help the patient understand the options and then clarify their own values and preferences.

 Why do Shared Decision Making, What Benefits are There?

 The two that have been shown by research really is the patient experience of care. Of course, with value-based purchasing and value modifier certainly organizations have some incentive for the patient experience of care besides just doing the right thing to reinforce with the patient. The other piece that’s been shown through the literature is adherence to treatment plans, which makes sense. If you’re involved in the decision and you understand you’ve picked a decision that fits with your values and preferences then you would be more compliant with that and, therefore, can help improve the health outcome.

 When?

 Not every encounter is there a decision to be made for treatment decision. It really may be that particular situation arises, although it arises probably more frequently than many realize in the course of getting health care.

 The other piece that they really reinforce in the SHARE training is that it depends on the patient in terms of how they want to be involved. So a patient who really does want to defer to the physician or the provider’s experience and expertise is okay, too, but the idea is that they have that option and the continuum might be from one end to the other in terms of how that patient wants to be involved. Of course, not making a decision is also making a decision.

 Makoul & Clayman did a review of the literature, so these are nine different criteria that came up no matter what shared decision-making framework and there are several of them out there. These were nine consistent traits of shared decision making, so these are kind of good ones when people think they’re doing it but they’re not really doing it or if they want to be reinforced as to is this meeting the criteria of shared decision making. This is kind of a good checklist to look at when you are doing all of these pieces.

 The SHARE approach did a lot of review from experts and review of the literature in terms of deciding the toolbox. At the same time they were doing this, we were actually doing it in Minnesota for the Minnesota SHARE Decision-Making Collaborative and I was very pleased of how reinforcing it was from our work, too. So a few things I’ll just point out.

 The first step is really important. In fact, in Palo Alto they identified patients feel very vulnerable when they’re in a provider situation, so that permission giving and seeking your patient’s participation is a very important first step so that they understand that they can participate in the decision making of what the expectations are, particularly if there are some differences in practice as that changes.

 Step two, exploring and comparing treatment options is where you’ll see decision aids used frequently. So decision aids are not just shared decision making, as you well know, but decision aids can be very helpful, particularly for providing some of that risk, benefit and option information and helping guide the conversation to what might fit best for them. Then the values and preferences are obviously where you’re trying to have a conversation more about what is important to them, reaching a decision and then evaluating it.

 This is actually a handout. You can download this from the AHRQ site and go through an overview of the shared decision making. This is tool number 1. There are actually nine of these and I’m not going through all of them, but these are good handouts and very reinforcing of a lot of the information. Benefits of using decision aids, there is literature to support that work in addition because it does improve the patient’s knowledge of what their options are and help them have more accurate expectations of what the benefits are. Obviously, being more informed leads them to make decisions where they’re both more participatory and also more consistent with what their values are.

 In the SHARE training we do quite a bit of work on having the conversation. For those of you who are familiar with the ICSI conversation model tool, obviously there needs to be more information on how to help them understand, so a big focus on health literacy, health numeracy, teaching back and making sure that they understand and having the cultural awareness obviously with your focus on diversity. It is a skill set of being able to have that conversation, so there are ways and more education and curriculum to help you if you’re interested.

 Tool 2 goes through the five SHARE steps, but it gives scripting so I find it helpful for people to have something really concrete as a starter of what would look different if I was to initiate this conversation in each of these steps. They’re not meant to be prescriptive, but to get conversations going and then, of course, when providers see scripting they tend to do some thinking about what fits the best for their style and practice in conversations.

 Here are a couple resources. This is the SHARE approach on the AHRQ site and then, of course, on the Ottawa site you’ll see a toolkit on shared decision making. We do have a website and we focus our website for Minnesota Shared Decision-Making Collaborative very much on implementation because we found that’s where people were at in terms of a struggle, so you’ll see a list of resources and really how to get it going in an organization. Because you are focused on depression, I just thought I’d give you the link to the depression decision aid.

 A lot of the decision aids are organized by topic area or by question if you’re using the option grids. So when you hear providers say “*oh, I don’t have enough time to do this”*, some of the decision aids can be really helpful because, in a way, they help frame the conversation and make it more efficient so the patient could pick “*this is most important to me”* and might make the decision after going through a couple of the questions. That can help frame the conversation and here’s my resource information if you have any questions.

**Quanah Walker:** Thank you, Vicki. We’re now going to switch over to Art Wineman and Tasha Gastony.

**Art Wineman:** Thank you, Quanah. I’m Art Wineman. I’m from the Family Medicine Department on the HealthPartners side of our medical group. I’m one of our regional medical directors in the Primary Care Division. I’m here with my partner Tasha Gustony, who is from the Department of Family Medicine on the Park Nicollet side and she is also is regional medical director. In those roles, part of what we do is each of us has primary responsibility for behavior health initiatives and for improving care for behavioral problems, including depression, in our respective divisions and that’s enforced.

 It’s interesting. Just a few years ago, she and I were competitors and, fortunately, now we’re partners, which allows us to support and to learn from each other. When this slide talked about successful outcomes start with a stable foundation, if you look at the absolute bottom part of it is our medical groups working together and we have been able to learn from each other, but it’s not just primary care divisions that need to come together.

 What we have found is that to have effective care for depression we also need to work with our behavioral health colleagues, so we’ve collaborated with psychiatry and moved forward to where we’ve developed a uniform protocol that’s shared between behavioral health and primary care that makes care more consistent and better across the entire medical group. Finally, we’re trying other things, such as actually integrating therapists into the primary care area.

 In addition to the collaboration, in order to be successful with these outcomes we need to understand what’s going on. This tangle is the way many of us see depression and depression care and we need to untangle it if we’re going to do better and part of doing better is understanding what some of the problems are. We know many, many patients, as many as one out of six adults will have major depression at some point during their lifetime and we know that many patients who are depressed come in and are never diagnosed.

 First, many don’t even come in at all, they don’t seek care. Those who do rarely come in saying *“Gee doc, I’m depressed, can you help me with that”*. Usually, we need to tease it out because they present with other complaints and, unfortunately, many times they’re misdiagnosed. So only one-third to one-half of the patients get the diagnosis and then once they do the majority of them don’t end up getting all the care or the appropriate care they need.

 They often don’t fill their prescriptions or make an appointment with the therapist that was recommended that they visit. Even if they start that they don’t follow up or many of them stop taking the medicine whenever it runs out. They finish their first month and they’ll stop or they’ll go for three months and they stop at that point, partly because *well, gee, I’m feeling better, I don’t need any more,* but often it’s because *I’m depressed and it’s too much work or effort*. Part of the difficulty is because we have not involved them in those initial decisions to where we should, they are less likely, as Vicki had said, to follow through with what our recommendations are. It’s particularly hard for people who are depressed.

 Part of our problem that Tasha and I deal with is that although it would be a little more comfortable and maybe easier to send all these patients to a psychiatrist, they’re not out there. Often, when I talk about depression with groups I’ll say “h*ow many of you in this room take care of patients with depression and see patients with depression in your practice*?” and virtually every hand goes up. When I say “*and how many of you have enough behavioral health resources in your community?”* and every hand goes down.

 Like it or not, most depressed patients start in primary care and the majority of them will receive all of their care for this problem through their primary care clinician. The difficulty is that our ability in primary care to provide excellent care for this varies widely and part of that is our ability or inability to do shared decision making and fully engage with patients.

 So for the next steps I’ll pass this to Tasha.

**Tasha Gustony:** Hi, this is Tasha Gostony. I’m here with everybody as stated earlier. Working in a family practice, the tricky part about what we do is often people don’t come in. Sometimes we get lucky, but they often don’t come in presenting with depression alone. Depression gets tangled up in chronic disease and chronic pain. We also deal with the stigma around it and people don’t want to admit that. So learning to recognize what these signs are when they’re tangled in with those other things is important.

 We talk a lot about a screening tool that we do that’s called the PHQ-9 and the screening tool asks questions that are listed here on your screen.

* + - Depressed mood
		- Irritability
		- Decreased interest and pleasure in things

 Often, people come in and say *ah, you know, I get home from work and I used to exercise, but I don’t feel like doing that anymore. I don’t want to hang out with my friends anymore.*

* + - Weight changes, both gain and loss
		- Sleep activities

 They say *well, I’m feeling depressed because I am not sleeping*. The question then really “is are you not sleeping because you’re feeling depressed?”.

* + - Activity changes
		- Fatigue

 Fatigue is common, we see fatigue all the time and more often than not it’s hard to find a reason for the fatigue, such as thyroid disease or anemia or those types of things.

* Guilt and worthlessness

 People feel guilty and worthless, they can’t concentrate at work and they start missing work. Then, of course, number nine, which is

* Thoughts of suicide

 That is the critical piece to make sure we’re asking these patients about.

 I think it’s important if we’re thinking about depression with a patient to screen for that. This is where shared decision making can definitely come into place. You need to validate a patient and how they’re feeling and saying *I understand that you’re feeling really tired and I definitely think we need to check the medical reasons that I may or not be able to fix, but let’s make sure that we don’t have any underlying symptoms of sadness*. Sometimes using the word ‘depression’ is just too harsh because of that stigma, so using words like are you feeling blue, are you feeling sad, those types of things can make that a little bit easier with that patient.

 On the next screen we have the PHQ-9 and we make it a habit if there is a depression diagnosis around their medication we screen with the PHQ-9 frequently with these patients. With Minnesota Community Measurement it’s really important that we’re doing this in the right intervals, but sometimes if you don’t have time there is the PHQ-2, which is two questions. There is some evidence out there to support that maybe every patient at a minimum should have a PHQ-2 offered, so help identify that.

 We have a protocol that has been developed with psychiatry and primary care and it’s built into our electronic medical record. Some of the mistakes we make in primary care is we’ll do a trial of a medication such as, Zoloft, Fluoxetine or something, but we don’t titrate high enough. We get them a little better, but we don’t get them to therapeutic level. So this protocol has helped primary care titrate higher to be more comfortable or to even add a second medication. Maybe they’re on Zoloft, but they’re really tired and maybe Wellbutrin would be helpful. That has helped with that bottleneck into psychiatry.

 If I refer at 50 milligrams of Zoloft to psychiatry because they’re a little bit better but not quite there and they see psychiatry and psychiatry titrates to 100 that could have been handled in primary care. Again, the shared decision making gets built in here because it’s asking that patient you know you’re feeling better, but are you feeling as good as you want to and are you willing to consider increasing that dose of medication.

 Just as important in this piece with the shared decision making is medications works great, but often times our mood is driven by our thought process and that’s where therapy comes in. Some people want to start with therapy because they don’t want to be on medications, they want to start with diet and exercise. That’s all wonderful and it works great. The important piece there is to make sure you’re doing that follow up.

 Sometimes I work with patients and I say we could do a month trial on medication and see how it works. I’m not going to make you take it in a month if you don’t like it, but maybe it makes a difference. You’ve got everything to gain and nothing to lose. Sometimes I say let’s try the therapy first, let’s see what happens. Let’s follow up in a month and see how you’re feeling. Those are opportunities where you’re engaging the patient to participate in their care.

 Here’s an example in our electronic medical record of the protocol. We have the protocol built into it so you can refer to it if you have questions. We have the notes that’s built into this. You can see we have the initiation of Wellbutrin as an example in this slide and Zoloft, so it helps make it clear how you titrate those medications.

Built into this protocol we also have instructions about titration because if you’re telling a patient that has depression you’re going to start with half a tablet for one week and then in one week you’re going to increase it to two are they likely going to remember that, so we make sure we put that in our after-visit summary.

Plus, we also know that they’re aware of the side effects of the medications because we don’t want them to feel like we’re giving them something and then they don’t have that awareness.

 I am going to pass it back to Art so he can review their protocol.

**Art Wineman:** We’ve been fortunate because Park started this work back in 2012 and we’re starting to catch up to them, but we did the same thing that they did, which was met with our behavioral health folks. Even to take a step back from what Tasha said, this is the pathway that we share with all of our clinicians and, frankly, I will sometimes share this with a patient. We use the PHQ-9 not to make a diagnosis of depression, but to tell us we need to be thinking about it and to help us with the criteria so we use our own clinical judgment and knowledge base. Yes, they have major depression or no, they don’t.

 The PHQ-9 score also helps to decide what are the alternatives that we should be offering to the patients. The one highlighted here, for example, if somebody scores 10 to 19 and who is diagnosed with major depression needs to do a number of things or could do a number of different things, but they’re not going to do it on their own and slow to getting fully engaged, but they’ve got the decision to make on what the best approach to care would be.

 This is the key. We need to engage our patients and, frankly, what shared decision making is meant to do is give one more way to fully engage with a patient. We know the patients who are engaged in their care will have better outcomes and a better overall experience. That’s true with depression just as it is with any other medical condition or behavioral health condition that we treat.

 In depression, it’s interesting because we have tended to find that shared decision making has been adopted a little bit more easily in some of the procedurally-oriented specialties. If what you’re doing is deciding I’m going to have this surgery or not or choosing between two different procedures, it’s fairly easy to say here’s Option A, here’s Option B. Take a look at these materials and tell me what you want to do.

 Much of nonsurgical medical care is much less clear and much more fuzzy and you would think initially that that would be the case for depression and it turns out that it’s not. Although depression is a challenge to treat, in fact, some of the decisions that need to be made are relatively clear and that’s where you can pull the patient in.

 What I’d like to talk about and give you some examples of over the next couple slides are some of the scripting that I use with patients as we do this and then talk about some of the choices they have. The classic choice for patients with this diagnosis was do you want to be on medication or do you want to go see a therapist and we now have some other options, including some that are online that Tasha will be telling you about.

 The first thing for any patient, however depressed they are, is that there are things they can do for themselves, but unless we engage them and help them make the decision to do that it won’t happen. Actually, I’ll take a step back. Vicki had said that education while important is not shared decision making and that’s true, but particularly in depression if you don’t do the education you can’t get the decisions made at all. Part of it is that with particular cohorts of patients, those from certain ethnic or national groups, there are particular stigmas or other misconceptions attached to this.

 So the first place that I start with anyone, but particularly for the folks who come in with that mindset is depression is a disease. It’s a disease like high blood pressure or heart disease or diabetes and just like those, it’s not your fault. So you’re not a bad person or a weak person because you’re feeling depressed. When you get depressed there are changes in the chemicals in your brain, that’s why medication can help. If it’s a problem of not being strong enough or being too weak-willed, medications wouldn’t make any difference.

The first thing to understand is that this is a disease, but there are certain things you can do to help it get better and you need to be part of making that decision so I’ll take whatever time it takes for you to get the education. Sometimes it’s easy, sometimes thats the majority of that first visit.

 We know that for all patients who have depression there are some things that will help, whether it’s mild or more severe and I’ll say this to patients, as well. There are things you can do to help yourself, but it’s only a part of it. For example, we know that there are chemicals in the brain that will help you feel happier and feel better. There are natural products that are like some of the drugs people take to make themselves feel happier, but they’re a lot safer and they’re inside you.

 Some of them are called endorphins and one of the ways that you can get those chemicals higher in your brain and feel happier is to exercise. Is there an exercise you like to do? Many patients will say yes, many others will say no. Some look at me like I’m crazy. Then if there is, if they say yes, I say are you doing that now and almost all depressed patients will say no because part of depression is withdrawing and it takes more effort just to do normal day-to-day activities.

 So I will say to them this would help you and it doesn’t take a lot. Just walking three or four times a week can make a big difference, but do you know what the absolute best exercise is to improve your mood. They’ll guess walking, swimming or jogging or something and I say it’s a trick question because the answer is the best exercise is whatever one you’ll do. If you like to run, that’s a great exercise for you. If you don’t and right now I don’t because my knees won’t let me, it’s a bad exercise for you.

 So is there one that you would like that you think you might want to do. Most of them, unless they’re more severely depressed, will come up with something and then okay, let’s talk about that. How much are you doing now and by the time I see you back in a few weeks what do you think you could change. Is there something you would pick? A lot pick walking. I’ve had people pick dance, which is really kind of good because it has other benefits.

 By getting them involved in making this specific decision and by helping them to set an action plan that they choose you can really go further forward with this. I know of one patient who chose as their action plan for exercise that they would drive past the gym and look at it once a day. I said that’s what you can do? They said yes. I said great, let’s do that. Two weeks later they came back and said you know, I’ve been looking at it, I think I ought to go in and talk to them. Over time, they built up and they did, but it wasn’t me saying what are you going to do it’s them helping to make the decision on which way to go. If I say to them I think you should walk, will you do that? They’ll all say yes and they won’t do it. It has to be something that comes as part of their decision making.

 Similar to that, that’s physical, but there is also a social component to this. We know that patients who maintain social contacts with family and friends tend to have improvement in their mood, but again, part of depression is that patients withdraw. So if a patient has withdrawn they won’t get that benefit, they’re mood will go down. Similar to exercise I’ll say are there people you like to spend time with, people that make you feel better about yourself. Often, they’ll say one or two and I’ll say tell me who that would be. I would say how much time have you spent with them recently and again the answer is very often well, not that much.

 Again, because that’s part of the depression so we set up an action plan on that. You really like your cousin, could you and your cousin get together sometime in the next two weeks. Would you set that as a goal for yourself? Or is there another person or another way you’d like to get out there. That’s why I mention dance can be good because that also gets you out among other people.

 Again, it’s not me telling them what to do, it’s them making the decision, but it’s nice to get the question out there and to see what they say. First, because if they actually say it then they’re committing to it in their mind and it’s more likely to happen. The second is every once in a while you have to say that may not be the best. I really enjoy going out with my buddies and having a 12-pack of beer on Friday night. Well, probably not the best choice for treating your depression and we would talk about that. Hopefully, by then I would already have done my initial screening questions.

 Finally, enjoyable activities. Part of what we do in primary care is we treat a lot of different things, including musculoskeletal problems. One of the comments I use with those patients is there’s an old joke about a fellow who says *doctor, doctor, it hurts when I do this* and the doctor says *don’t do it*. Everybody that’s on this call I’m sure knew that. Every mother I’ve said that to knows that answer and I would bet that three-quarters of adolescent males have no clue what I’m getting at.

 The reason I bring that up here is when you’re looking at depression it’s exactly the opposite. Instead of saying if it hurts don’t do it, you say if it helps you feel happier and better do it. So I will say that to them and I’ll sometimes even use that joke and say this is the opposite. Are there things that you like to do that make you happy and, unless they’re severely depressed, there are usually at least one or two they can come up with. Again, I’d say are you doing those and often the answer is no. Well, what does that tell you? It’s nice for them to be able to say *gee, maybe I should do more of it*. Right thought.

 Now, it is interesting when you do this. Sometimes, particularly those here in Minnesota, need to give our patients permission to do fun things. It’s part of our heritage as a state and some of the Norwegian background going way back. Sometimes they say I don’t have time, I have to work, that’s where I’ll point out that patients who are depressed can’t be as productive and if they could treat themselves well here they’ll actually do better in the workplace. So sometimes you work it through, but again it’s letting the patient come up with the conclusions and helping the patient to decide for themselves what they’d like to try.

 That’s frankly, a conversation I try to have with all my depressed patients to some extent. Now, I’ve taken a long time with this, it actually only takes a minute or two to go through this and I usually just pick one of these as an action plan to start for the first time.

 The other question that patients really have to decide is, unless it’s so mouthed that we don’t really need to move forward, is patients with moderate depression we tend to recommend the current guidelines of either pharmacotherapy or psychotherapy and patients with more severe depression we tend to recommend both. This is one that is absolutely perfect for shared decision making because it’s like do you want this surgery or that surgery.

 Giving a choice like this makes it more likely patients will, in fact, chose one or the other and then follow through. It’s like when I see little kids and I’m looking in their ears and I say which ear do you want me to look in first? They are much happier when they get to make the choice because it gives them some control.

 Part of it here and the majority of my patients probably in my experience have not wanted to go to see what many of them characterize as a ‘shrink’. They see more stigma attached by going to talking with the “crazy doctor” and we have a tendency in our society, unfortunately, to think if you’ve got a problem you take a pill. But that can work for us here because that will tend to make patients think a pill will help which, in fact, many times it can.

 On the other hand, I occasionally get patients who say *I don’t want to take any medications, I’ve had bad side effects in the past,* or *I’m scared of medicines,* or *I’m already on too many* or *they cost too much money* and so instead of medication they’d choose to talk to a counselor. Many of them, if they’re oriented this way, have already spoken with counselors before so much more wanting to consider this.

 So what I do when I sit down with a patient as part of this is I’ll say you really have two good choices in terms of treatment for this and both work and they probably work about equally well. You can have medication or you can go to talk to a counselor or, if you want, you can do both. Now, part of the benefit of medicine is it works a little bit faster overall. Part of the benefit of counseling is it tends to work longer. If you go off medicine you don’t lose the things that you get from counseling, but either one would work.

 If you choose medicine, the one I’m going to recommend based on the protocols is called fluoxetine. That’s the one you’ve probably heard as Prozac and most patients prefer this. I think it’s because it doesn’t have a lot of side effects and if you have to pay for your medication it’s now generic so it doesn’t cost as much.

 The side effects, there are lots of minor ones. It might make you a little nauseated or a little bit light headed. For some people it makes it a little bit harder for them to go to sleep, others it will make sleepy. If it makes you sleepy you take it at bedtime, if it makes you awake you take it in the morning. Those other side effects tend to go away over the course of a week or two, so if you just continue it it will help.

 A few people take this and they find that they lose interest in sexual activity, but a lot of folks who are depressed don’t feel like having sex because they’re depressed and so this can help, in many cases much more than it would hurt. If it does cause that problem, we can deal with that.

 On the other hand, talking to a therapist you can go to and they can work through many things. Not just your depression, but some of the other issues that you may be having and teach you ways that you can use this for the next several years. What would you like to do?

 Now, beforehand I’ve already taken a history before this, *Is there anybody in your family who has had depression* or *have you ever had depression before?,* and when I get to this that’s one more point where I’ll pull them in and say *have you been depressed before, have you been given a medicine, did it work*? If the answer is *yeah, it worked pretty well*. *Did you have those side effects?* *No.* That’s where you start.

 If they have a family member who has been on a medicine and they did well with it, again, I would go that way. If that’s not that case I’ll often say *is there a medicine that you’ve heard of that you would be interested in talking about* because lots of them see, unfortunately, commercials on TV that push them one way or another. If they come in saying that stuff I saw on TV, that Cexella, Celexa or something like that, that looked really good. Probably because the girl that was in the commercial was pretty, I don’t know.

 In that case, though, if they say I’d like to try that, it depends what it is. The ones who come in and say how about that Abilifi stuff? Well no, we don’t start there. More often what I get is you know my buddy down at the station was on that Celexa and he did really well with it.

 Part of the reason we do that is, again, if they can be involved in that decision. First, there is a placebo effect. If they think it’s going to work it’s more likely to work. Second, they’re more likely to remain adherent with the recommendation and work through some of those minor side effects which will tend to go away. So making a partner in this decision will improve adherence and increase the likelihood of good outcomes.

 I guess at this point I’d like to pass this back to Tasha because I know you’ve got your own scripting that you use in your own words of course. Anything else to add?

**Tasha Gostony:** You know, that was actually pretty good. I’d have to say that I might have actually learned something today, as well. It is very true that you have to be a partner in the patient’s care and asking them what they’re willing to do or what they think about is really important. That’s true for treating any condition or leading groups of people. You really have to bring them along.

 What I’m going to move to, since I don’t have a lot to add to that, is the psychotherapy aspect of this. That can get very tricky for people and so there are some things that we’ve been working on. Sometimes you’re working with patients and you’ve gone down this path Dr. Wineman has talked about. You’ve talked about exercise and things like that and maybe they’re even on medications, but you just can’t quite break that barrier for patients and that’s where we get into that thought process.

 We have a fabulous program called Beating the Blues that is being rolled out to all of our employees, it also is available as a free opportunity for our patients and it’s easy to use and very simple. The online program of Beating the Blues is a form of something called Cognitive Behavior Therapy and it is the only evidence-based therapy that is proven to be effective.

Basically, what it is is just changing the thought process about how you’re looking at something. You can be running late for work or a meeting and sitting in traffic and you can make a choice at that moment. I can get really angry at the people that aren’t driving fast enough, the person that had an accident on the side of the road, the person that has a flat tire or I can look at this as an opportunity to breathe. I’m going to be late regardless of whether I’m angry or not.

 The reason that the online therapy is good is we see patients constantly in the clinic. They maybe don’t have the financial resources for therapy. They have a stigma about going to therapy. They have a hard time finding a therapist that they like. So the online option allows them to use it on their own time through their own resources, they just need a phone, a tablet or a computer. So there’s one way to do therapy.

 Sometimes when I ask patients I say you have options here. You’re not feeling great, medication or therapy and you never know. I think the one thing listening to Dr. Wineman is not to approach it with judgment or make assumptions about what a patient is going to choose. Bringing them in to that shared decision making and letting them decide is really the key, so Beating the Blues is one option. So Beating the Blues, here’s an example of what it looks like online.

 Is shared decision making practical?

 I think Art already pointed out that it absolutely is practical and in the long run it’s going to save a lot of time down the road. Getting buy in from your patients is critical and I think that what you’re going to see is patients with depression improved much better, but I think you’re going to see some improvement in the chronic diseases around it, as well. I don’t have any specific studies to state about that and I’m sure they’re out there, but I think if you have a motivated patient because they’re making that choice in their care and managing their depression you’re going to see improvements in diabetes, blood pressure, weight loss, etc., etc.

 So getting in more depth about how we are improving therapy is patients are more apt to do therapy if we embed therapy in the primary care. The primary care relationship is critical and patients will often say they have a trust in you. If you say I have a therapist working right down the hall in this building, you know where it is, they’re familiar with it, they’re more apt to follow through. Plus, the therapist can be giving us feedback about how the patient is doing in an easier fashion than when they live across the city. So we are embedding therapists within primary care and we’re doing that both at Park Nicollet and HealthPartners and recognizing how important this is nationally.

 Another way here, back to Art.

**Art Wineman:** It’s interesting. Part of the reason that Tasha and I are moving this back and forth is our respective organizations are doing things differently. They’re much further ahead in integrating the therapist into their clinics, which I think is had a lot of success. On our side, we were part of what’s called the Diamond Project, which I assume many people on this telephone call are familiar with - Depression Improvement Across Minnesota Offering New Directions - and the key there, is with the use of depression care managers.

 These are people that we have brought in and they may be nurses, social workers, they may be other folks. Their primary job is to maintain contacts between the patients and the clinicians and between primary care and Behavioral Health. So if we refer somebody to a depression care manager within a few days they’ll contact the patient and say “*Hi! Dr. Wineman asked me to give you a call. I think he let you know I’d be calling. I just wanted to touch base and see how you’re doing. Were you able to get that prescription that he gave you? How are you feeling, any problems with that?* Just in general, *what are you thinking about what he told you the other day*.” After they visit, *I’ll give you a call in other week and we’ll see how you’re doing.*

 They’ve built a relationship and build the trust, they certainly get the patient’s input and it depends on what they’re looking for. They don’t actually call it shared decision making, but in fact that adheres very close with that spirit because they are constantly getting feedback from the patients in terms of how things are going and what they would or would not want to do.

 The other thing they do is help coordinate the care between myself as a primary care clinician and our behavioral health colleagues so that if I’m not having success with a patient and I need some additional assistance or suggestions that will come closer. Again, it’s not always easy for me to get hold of a psychiatrist and this is a great way to tap into their expertise without my having to set time aside from my schedule or his or hers to do that.

 Now, our problem with depression care managers is, for us at least, they’re a limited resource and they are very valuable when we use them, but we don’t have enough for everybody. So we thought, at first, why don’t we just use them for all our patients with PHQ-9s who are at 20 or above, those with severe depression? That would have worked really well if the depression care managers didn’t have to sleep and were 37 hours in a day. So we’ve had to limit it even further there, but we still try to choose those patients who are going to benefit the most from that.

 This is a part of it, too. This is, again, a way to keep engaged. The biggest difficulty that I find with patients after the diagnosis is actually getting in touch with them and having them come in and realizing they are depressed. After that, the next big difficulty is not losing them to follow up because if you’re depressed it’s hard to follow through with things, whether it’s medication or making it to your appointments. Once patients don’t follow through they feel ashamed and then they’re less likely to come back.

 Even if they come back they come back for their ankle sprain or for the cold, but we don’t think to ask them about their depression because they’re here for my ankle hurts or sneezing and coughing. So what we have done and, again, this started first on the Park side and they’ve spread it to us, just like a good disease, is that every patient who has depression on their problem list will get a PHQ-9 done at every single visit. Think about what you do with patients with high blood pressure. If somebody with hypertension comes in you will always get a blood pressure, even if their last three were normal. Even if they’ve been doing well with their depression, we still want to make sure that they’re continuing to do well.

 The way that we’ve been able to do that in the organization is with the electronic medical record. Now, we, like most of you, have a love-hate relationship with our record, which is EPIC, which is really, really good except when it’s not. We use that to give us the best practice work. We use it to tell us which patients have a history of depression. We use it to give us the best practice work saying it’s time to do something, including getting this. When we know that we need to speak to them about depression we can do it at that face-to-face visit, we can call them, we write them a letter or we can do it electronically through something that we’ve called My Chart.

 Part of the way we’ve been able to do that is through a registry. We have found, again like most of you probably have, that if we’re doing population health work the best way for us to keep track of a patient is through a registry. We use our registry to determine which patients need outreach based on their PHQ-9 scores and what kind of treatment. We use the PHQ-9 as a proxy of are they still involved with us. If we don’t have one over the past two months we contact them and, frankly, we can do it very quickly.

 At the beginning of each month now we have one of our depression care managers batch all those people who need to have this done if they’re online with our My Chart and they send one mass email to them saying “*Hi, Mr. Smith. We’re just checking to see how you’re doing”* and Mr. Smith will hopefully fill out the PHQ-9 as it comes along electronically, send it back and then we can use that to determine how aggressive we need to be at further follow up. If we don’t get them that way we’ll call them and if we don’t get them that way we’ll send them a letter and then we address their ongoing care plan based on that response.

 This is what our registry looks like. We really like it, it’s so much better. It used to not be very user friendly. The one we got was one called Reporting Workbench from EPIC, which was terrible. It was just better than any other that was out there. We’ve been able to modify it to this, so our nurses go on this and they look at this. If it’s a green dot they’re up to date, if it’s yellow it’s coming up, red you need to contact us. That makes it very easy to use and it’s allowed us to continue to remain engaged with our patients, which again is the key to the shared decision making.

**Tasha Gastony:** So to wrap this up, here are our take home points.

* As you’ve heard in multiple stories, partnership is key for patients in primary care and between providers and patients, between primary care and behavioral health and between organizations, as well.
* Use every opportunity to engage with patients about how they’re doing.
* Get that PHQ-9 whenever you can so that you can have those touch bases.

 Through feedback our patient partners have stated that they love the outreach. They love to know that somebody is out there that cares and is out checking on how they’re doing.

* Behavioral activation, get them involved in making the decisions.

 For me to tell a patient that you’ll love running and it will make you feel better when they hate it isn’t going to work, but ask them what it is that they love to do. I thought that was great about the hobbies and things. If you love to knit and that makes you feel good, then you should knit. Knit all you want.

* Use your electronic medical records; make it work for you.

 Then the other options:

 Discuss medications versus counseling. Do you need one, do you need the other do you both and then if it’s a time limitation or it’s stigmas we also have Beating the Blues.

 Finally, just remember collaboration. To collaborate means that success is built on relationships. That’s it.

**Quanah Walker:** So now I think we have a couple of minutes and if anyone on the phone has some questions we’re going to go ahead and un-mute the phones and we’re going to allow you to ask a question of Vicki, Art or Tasha.

 So maybe we can assume that there are no questions from anyone on the phone. Okay, I think we’ll go into our closing comments.

 So here is the contact information for Art Wineman and Tasha Gastony. This will also be posted on the Stratis Health website. We want to call your attention to a couple of additional webinars. The next one we’re going to have is in February 2016 and Dr. Georgi Kroupin from HealthPartners Center for International Health will be talking about medication adherence and depression care among immigrants and refugees. So look for some information about that to come out.

 We also had our past webinar in July 2015, Cultural Awareness in Mental Health Care. That’s also posted on the Stratis Health website. You can get CEUs if you follow this link here and then take the survey. You can access the CEUs and give us some feedback. So please remember to complete that evaluation. We will be posting the slide deck and the recording of this webinar on the Stratis Health website and have a wonderful rest of your day. Thanks.

**Tasha Gastony:** You will be emailing out this link.

**Quanah Walker:** Yes. This link will be emailed out to everyone that signed in, as well. Thank you.