Improving care for patients with depression: A collaborative project with primary care and community pharmacy

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Background: In northern regions in Ontario there are unique challenges which serve as barriers to treating patients with mental health disorders. These include: low health care provider-to-population ratios, travel time to reach service providers, higher hospital readmission rates, and local demand for services.[i]
The purpose of this project was to improve quality of care for patients with depression by collaboratively implementing best practices.

Objective: A demonstration project was undertaken to design and test a collaborative practice model to implement evidence-based practice to improve outcomes for patients with depression in two northern communities, Sudbury and Espanola. The model for delivering care is aligned to Health Quality Ontario's Quality Standard (QS) for Major Depression, which consists of a concise set of statements based on evidence and expert consensus.[ii] We found that translating the QS into practice in a collaborative environment supports better patient outcomes.

Methods: The practice model was designed by a team of physicians from two primary care offices and community pharmacists from six pharmacies and was grounded in a patient's experience receiving care in the community.[iii] The team reviewed the statements within the QS and identified the highest impact areas for a joint primary care practitioners and community pharmacist intervention. The two statements were:

- Statement #5: Adjunct Therapies and Self-Management: People with major depression are advised about adjunctive therapies and self-management strategies that can complement antidepressant medication or psychotherapy.
- Statement #6: Monitoring for Treatment Adherence and Response: People with major depression are monitored for the onset of, or an increase in, suicidal thinking following initiation of any treatment. People with major depression have a follow-up appointment with their health care provider at least every 2 weeks for at least 6 weeks or until treatment adherence and response have been achieved. After this, they have a follow-up appointment at least every 4 weeks until they enter remission.

In the practice model that was developed, primary care providers asked patients to follow-up with their community pharmacist every two weeks to monitor adherence to therapy (statement 6) and to reinforce education on adjunct therapies (statement 6) until the 6 week follow-up appointment. Community pharmacists established the preferred method of communication with the primary care teams.
Throughout the project period, a rapid-cycle plan-do-study-act (PSDA) approach was applied. Improvements and modifications to the project were implemented based on feedback from participants and observations from the project team at regular intervals. The measurement plan included patient

experience (outcome measure) and provider experience (balancing measure). A toolkit that includes resources and templates was developed to assist with implementation and is available on OH-Quality's Quorum website to facilitate broader knowledge translation.[iv]

Results: The project occurred from February 1st, 2019 to December 31st, 2019. Pharmacists followed-up with 30 patients every 2 weeks as per the HQO Quality Standard until the 6 week follow-up with primary care. Education was provided to each patient on adjunct supports, the most common were sleep and physical activity. A total 14 participants completed the patient experience survey. Of the respondents, 13 patients reported they felt supported and would recommend this model to friends and family. Of the five providers that completed the balancing measure survey, 4 reported they felt the collaboration between providers was beneficial to patients and would recommend the project to colleagues. Community pharmacists reported that many were able to sustain this model and embed this into their practice. Key enablers to this were establishing new relationships with primary care providers and adapting staffing to allow pharmacists to engage in more direct patient care activities. Of the 30 patients, pharmacists identified drug related problems in 13 patients and completed a pharmaceutical opinion in 10 patients.[v]

Conclusions: A model was established between primary care and community pharmacists to implement evidence-based standards in practice to improve care for patients with depression. Pharmacists were well-positioned to provide follow-up and monitoring in the community. A similar approach may be taken for other Quality Standards that would benefit from provider collaboration. Larger studies that build on this approach may further identify the impact on patient and system outcomes.

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