Practice-based depression case management in primary care: a qualitative study on family doctors’ perspectives

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Background. Case management provided by health care assistants (HCAs) is effective in improving primary care for depressive patients. Little is known on the implementation-related aspects of case management performed in small family practices.

Objective. To explore family doctors’ perspectives on clinical and organizational aspects of implementation of case management and perceived practice-related aspects associated with patient care after 1 year’s experience of HCAs providing case management for depressive patients in their practices.

Methods. This qualitative study was nested in a cluster-randomized trial on case management provided by practice-based HCAs for patients with major depression in Germany. We used semi-structured interview guides and performed audio-taped interviews with family doctors. Full transcription and thematic content analysis were carried out.

Results. Twenty-three family doctors were interviewed. The family doctors perceived case management as beneficial to patients and reported that it improved their consultation styles and doctor–patient relationships. They implemented case management elements into their everyday work using ‘concrete’, ‘subsumed’ or ‘progressive’ implementation styles.

Conclusions. Family doctors perceived practice-based case management by HCAs as beneficial for patient care. Different implementation styles may be appropriate, depending on the health care setting, and this requires further evaluation.

Keywords. Common mental disorder, depression, primary health care, qualitative research.

Introduction

Major depression is an important and common mental disorder in family medicine. The joint report of the World Health Organization and the World Organization of Family Doctors states that integrating mental health services into primary care ensures access at affordable costs and minimizes stigma or discrimination.\textsuperscript{1} In Germany, the majority of depressive patients are treated in family practices\textsuperscript{2}, and all family doctors have a basic psychiatric qualification.\textsuperscript{3} However, depression is still claimed to be under-diagnosed and under-treated in family medicine.\textsuperscript{4} Patients with depression are less capable of describing their mental health problems\textsuperscript{5} and contact the health care system with physical rather than psychosocial complaints.\textsuperscript{6}

Collaborative care in depression care improves clinical outcomes.\textsuperscript{7} Collaborative care, which has its theoretical background in the Chronic Care Model, includes interventions such as follow-up and proactive support provided by a multiprofessional team.\textsuperscript{7} Case management is an essential patient-centred element of collaborative care, which is effective in improving symptoms and adherence to medication in primary care depressive patients.\textsuperscript{8,9} It provides a systematic follow-up of patients in order to facilitate the early detection of symptom deterioration or a decrease in medication adherence.\textsuperscript{10–13} Case management can be provided by practice nurses\textsuperscript{14,15} or by health care assistants (HCAs).\textsuperscript{16} The HCAs profession is well established in various primary care systems. In the UK, for instance, ~50% of family practices employ HCAs\textsuperscript{17}, who increasingly carry out the basic clinical tasks traditionally performed by practice nurses.\textsuperscript{18} In Germany, HCAs are well established in family practices and mainly responsible for administrative tasks.
and simple medical procedures, such as blood pressure measurement.\textsuperscript{19} In a cluster-randomized controlled trial, case management provided by practice-based HCAs in small German family practices was effective in improving the symptoms and adherence to medication of patients with major depression.\textsuperscript{20} Although some scientific evidence on the effectiveness of case management provided by HCAs is now available, little research has been done on the implementation-related aspects of case management in family practices.

We here report the results of a study, which is aimed at exploring family doctors’ perspectives on implementation and perceived positive and negative practice-related aspects associated to patient care after 1 year’s experience of HCAs providing case management for depressive patients in their small family practices.

**Methods**

This qualitative study was nested in a large cluster-randomized controlled trial showing positive effects on clinical outcomes of a practice-based case management for patients with major depression.\textsuperscript{20,21} The case management intervention was designed in accordance with the Chronic Care Model, which emphasizes proactive support for the patient by the entire practice team.\textsuperscript{22} Case management was provided by practice-based HCAs, who in general have less professional training than medical assistants or practice nurses, and are mainly responsible for administrative and simple clinical tasks in primary care, such as measuring blood pressure.\textsuperscript{18} They are accountable to the family doctor.\textsuperscript{7}

We trained one HCA from each practice who was assigned to the intervention group in two workshops (an 11-hour and a 6-hour workshop). The interactive training included information on depression, communication skills, telephone monitoring and the behavioural activation of the patient.\textsuperscript{23–25} The HCAs contacted the patient by telephone once every 2 weeks in the first 2 months and once a month thereafter over a period of 1 year. They monitored depression symptoms and adherence to medication and encouraged patients to pursue self-management activities using a previously published structured monitoring list known as the ‘Depression-Monitoring-List (DeMoL)’.\textsuperscript{26} The HCAs coded the responses of the patients using a traffic light scheme, with the categorization and visualization of the answers ranging from green (‘normal’ findings) to red (‘alarming’ situation). The results of each interview were reported to the family doctor in a structured manner and depending on urgency. The family doctor was responsible for treatment decisions and provided feedback to the HCA, if necessary. This case management intervention was provided in addition to usual care and did not replace any of the family doctor’s clinical work. The research team did not influence any of the family doctor’s treatment decisions. The practice team received a financial incentive to participate in the study. The study protocol was approved by the institutional review board of Goethe University Frankfurt/Main on 25 April 2005, and participants gave their written consent. We present our results in line with the guidelines for reporting on qualitative research.\textsuperscript{27}

**Study participants and sites**

We interviewed 23 of the 34 family doctors who participated in the intervention group. Eleven family doctors refused to participate because of time constraints. The characteristics of the practices and doctors are shown in Table 1. The family practices were either solo practices or run by a maximum of two doctors. Participants and non-participants were similar in terms of practice characteristics, i.e. panel size and location (data not shown). The family doctors (12 females, 11 males) were between 39 and 64 years old. The family doctors had substantial professional experience (mean of 12.6 years per doctor).

**Data collection**

Based on the Chronic Care Model\textsuperscript{28} and an extensive literature search, we designed an interview guide to explore the doctors’ views on (i) motivation to implement case management in their practices, (ii) perceived new role of the HCA, (iii) experience with the practice team after 1 year of case management, (iv) the doctor–patient relationship, (v) attitudes towards depressive patients. We did not focus on the efficacy of the intervention or whether the intervention was realized in accordance with study protocol. We aimed to elicit positive and negative perceptions on practice-related aspects when implementing such an innovative instrument in a German family practice setting.

Face-to-face interviews were performed by interviewers in the practice setting between August 2006 and March 2007 (trained in qualitative interviewing). The audio-taped interviews lasted 22–45 (mean 33) min and were fully transcribed.

| TABLE 1 Characteristics of family physicians and their practices 
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<td><strong>Location of practice, n (%)</strong></td>
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<td>Rural</td>
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<td>Urban</td>
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<td><strong>Size of practice</strong></td>
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<td>Mean no. of patients per 3 months (SD)</td>
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<td><strong>Family physicians</strong></td>
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<td>Female, n (%)</td>
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<td>Mean age in years (SD)</td>
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<td>Mean no. of working years in the practice (SD)</td>
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Data analysis
The data were analyzed following the principles of qualitative content analysis according to Mayring29 and using Atlas.ti software (version 5.2). Firstly, inductive content analysis with an almost open coding was performed to identify categories that were then discussed within the research team. VK analyzed all the material using the finalized categories. Three authors (JG, CG, VK) looked for similarities as well as for divergent themes in the data with the aim of identifying ‘key aspects’ and finally developing ‘prototypes’ for case management implementation in depression care.

Results
In summary, we explored three major aspects based on the interviews.

Doctor–patient consultations and relationships
Doctors felt case management helped them to react faster to clinical symptom change and any deterioration. They felt more comfortable addressing the subject of depression in a direct manner and developing a proactive structured consultation style with the patient:

In the report [...] the current color codes—when the color codes were bad, that is to say orange or red, then I spoke to them directly. (GP16)

The doctors reported paying more attention to the diagnosis and felt their systematic depression management skills had improved. Moreover, when encountering new patients, they were more aware of heterogeneous depression symptoms:

I also ask new patients more about the symptoms I have, so to say, found out about. Asking standardized questions from a list. That helps me enormously. (GP15)

According to the doctors, their increased competence when talking to depressed patients may have improved the ‘doctor–patient relationship’:

Yes, well, the thing is I start talking about the subject of depression more quickly, and I would also say that I recognize it more clearly, and I definitely have more confidence when dealing with it. (GP07)

The benefits of structured depression management
The doctors noted significant advantages to practice-based case management. It provided timely and comprehensive information on patients’ needs at the point of consultation, which made it easier to manage an increasing number of patients:

Yes, as I said, to get an overview of the process, and in the end it’s just important for me—you know I have between 50 and 120 patients a day, every day of the week. That means I don’t always remember the patient, what his concern is, what her concern is. (GP04)

Doctors reckoned encounters with the patient were more structured, after the HCA had shared the results of the depression monitoring list with them. They felt that they were better able to systematically observe depression symptoms and the course of the illness:

It was just important for me to practically always have a kind of quick overview of the situation and to think about a patient and to see what the current state of events was. (GP12)

Some doctors integrated parts of the depression monitoring tool into their electronic patient records to optimize depression management after the trial was finished.

The doctor’s cooperation within the practice team
Family doctors noted that their function within the practice team was reconsidered as a result of the implementation of case management, i.e. symptom monitoring by the HCA increased communication and enhanced cooperation between them. The doctors delegated tasks and refined responsibilities within their practice teams and appreciated the additional clinical information on their depressive patients provided by the HCAs:

Someone else was involved, it’s a kind of team a, doubles team … the health care assistant and I both look after the patient—as it was in this case, yes’. (GP05) and: ‘Yes, the team idea was reinforced by a further aspect—a commonality, a joint project, that we [HCA and family doctor] shared. (GP31)

Particularly the greater exchange of information was regarded as beneficial to the family doctor:

Well, yes, we regularly talked about it, we regularly discussed the patient: “What was he like, how was it on the phone, or how was it overall?” Some patients are very difficult to get through to, or it didn’t work at all. An exchange happened … (GP04)

and:

I think it is simply the relief at not being solely responsible for a depressive patient and relief that the burden is kind of shared by two pairs of shoulders. (GP29)

Family doctors also mentioned some negative effects of case management on their clinical work. These were related to an initial increase in the workload:
Because the health care assistant is tied up and not readily available, and that over a lengthy period of time. (GP07)

Three implementation prototypes of practice-based case management for depression

The family doctors' perceptions of case management were based on a year's experience providing practice-based case management for patients with depression. We identified three major implementation prototypes or styles.

Subsumed implementation. These family doctors implemented case management by integrating parts of the intervention. They relied more on their own long-time professional experience and medical competence. They did not make much use of the structuring elements, such as the systematic monitoring list:

[... ] and [I] didn’t use the questionnaire as rigidly in the end because the patients and I know the thing inside out. [laughs ... ] it is more a summary of what you already know. It has systemized it—I would rather see it like that. Well let me put it like this. As a whole, there are fewer interviews with the patient now [...] and the interviews are shorter. (GP10)

Concrete implementation. Doctors who implemented case management in a concrete or abridged manner showed themselves to be more diligent and conscientious. They appreciated the structured side of case management. Implementation in these practices was focused on regular phone calls by the HCA. Additional innovative treatment in depression management, such as agreeing on specific depression treatment targets, was less often implemented:

That you say, okay, I'll just go down this list and ask certain questions, even if you don’t think all of them are important. I think it’s also good that the assistant asks so schematically, and that certain subjects have been touched upon, and it is surprising that there are certain findings which one would not otherwise have thought of. (GP06)

Progressive implementation. These family doctors implemented practice-based case management for their depressive patients and progressively developed additional features. These innovations were connected to the way the practice team worked, communicated and interacted with one another. For example, as HCAs became more experienced, they received additional clinical tasks in patient care:

Yes, as far as the organization of the practice is concerned, that is to say internally, it did help—it helped demonstrate that there are other jobs the assistant can do. (GP18) and:

Yes, I think one of the most important things was to recruit people that really are depressive—that is to say, I have also adopted the process now. Even now that we have stopped recruiting, I continue to present patients with the PHQ-D questionnaire on a clipboard and say 'just fill this in, you know.' (GP07)

Discussion

This study explored family doctors' perspectives on the introduction of case management for depressive patients within their practices, as has recently been called for.30 Three major aspects emerged: (i) a perceived improvement in consultation style and doctor–patient relationships, (ii) recognized benefits of a structured case management intervention and (iii) a new style of cooperation within the practice team. In our final analysis, we explored heterogeneous styles of case management implementation within the practice.

In general, the family doctor felt an increased awareness of common mental disorders and felt more comfortable addressing sensitive mental health questions. Previous research has indicated that most depressive patients want to be actively addressed with regard to their symptoms so as to better understand and control their situation.31 Furthermore, practice-based case management improved perceived cooperation within practice teams, with responsibilities being reallocated, and the exchange of information and communication improved. However, the initial increase in workload was seen as problematic by family doctors.

In this study, 'structuring' depression diagnostics and care seemed to be a clinically relevant factor in family doctors' perceptions, as it might have led to a systematic assessment of patients' symptoms and needs. This is in contrast to research reporting that Family doctors are often reluctant to a systematic approach in depression diagnostics and care, i.e. for the elderly patients.32 Family doctors often assume, for instance, that their patient consultations may lack 'the human element', when using structured monitoring questionnaires.33 The need of structuring care delivery in primary care will increase due to the high numbers of patients that family doctors have to care for in their practice.30

In our study, family doctors noted that specific tasks in patient care were shifted from the family doctor to the HCA, which may have increased the overall competence of the team. This is in line with other research on case management interventions in primary care.11,30,34 Finally, our explorative results support...
research findings that indicate that case management improves communication between practice team and patients. However, the outcome of shifting tasks and implementing case management may differ over countries as for example in the USA and the UK, the practice teams are bigger and practice nurses have both a different role and another educational background than in German GP practices.

Family doctors demonstrated heterogeneous implementation styles of case management in daily practice. Family doctors with a more ‘progressive’ implementation style made successful use of practice-based case management for other chronic diseases as well. Practice-based case management has not only proved to be effective in improving mental health but also in cases of heart failure and arthritis. In studies on heart failure, it was shown that family doctors feel that important ‘role changes’ occur within the practice team—the HCA in particular is seen as taking on more responsibility within the team and acquiring more in-depth knowledge. Family doctors that had a ‘concrete’ implementation style benefited most from structuring their work and receiving regular feedback on treatment results. The effects of a structured feedback approach were also shown in a Cochrane review on audit and feedback. Family doctors with a ‘subsumed’ style of implementation might have benefited less from case management since they are more committed to their own long-time professional experience than to any innovations. This reluctance to integrate external measures into daily practice is in line with research on the hurdles involved in the implementation of guidelines. However, research findings on doctors’ guideline adherence report also appropriate reasons for ‘non-adherence’.

Limitations to this study need to be considered in interpreting our results. We were not able to interview all eligible family doctors of the intervention group. We afforded only 68% of the doctors, those how were ready to participate in a time-consuming interview. Although other qualitative techniques such as hermeneutic phenomenology may look deeper into phenomena or enable theories building to be developed from qualitative data like Grounded Theory, and content analysis provides a reasonable understanding of the phenomena being studied. It represents a first pragmatic approach to describe and explore experiences and perceptions in family medicine. In combination with other (i.e. quantitative) data, this method may provide a better understanding of complex situations and questions in health care.

Implementing innovative approaches in different health care settings has to take into account that medical professions are heterogeneous in terms of qualifications. In 2009, German major health plans started to fund systematic telephone monitoring provided by HCAs. These financial incentives have led to a broader implementation of the intervention. In other countries, where HCAs are not established in family practices, other professions with more advanced professional training may provide case management, which may led to other implementation styles than presented. Furthermore, innovations which are either generated by bottom up innovation or those innovations which are implemented whole sale with or without incentives by local authorities who control the budget or structure of health services might differ from this intervention which was implemented with a clinical study.

In the current debate on health reform, the discrepancy between the supply of family doctors and the demand for primary care is evident. Family practices must increase their patient capacity without reducing either the quality of care or adding to the workload. Therefore, case management as a way of dealing with high volume is fundamental to many enhanced systems of depression care being proposed around the world. The family doctor may no longer be able to see all patients, whereby shifting tasks within the practice team is an efficient way of dealing with increased volume. Further research is needed to evaluate the extent of clinical patient care that can be provided by HCAs in the future. This study sheds light on the challenges of task transfer in the primary care team. The family doctor may act ‘as a leader’ of a well-trained, high performance primary care team.

Conclusions

Family doctors perceived the implementation of practice-based case management for depression as beneficial to patient care, and highly valued the ‘structured’ approach and active involvement of HCAs in inpatient care. Altogether the case management approach was appreciated and should be implemented more widely while taking into account that case management might increase the overall workload of the practice team and thus the implementation style varies. Practice-based case management may contribute to quality in depression management and may lead to more ‘productive’ contacts for patients.

The study protocol was approved by the institutional review board of Goethe University Frankfurt/Main on 25 April 2005.

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Declarations

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References


