Guidelines and Resources for the Depression Nurse Specialist

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Supported by the
Agency for Healthcare Research and Quality

RAND
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Preface

*Partners in Care* is a Patient Outcomes Research Team (PORT) II study, funded by the Agency for Healthcare Research and Quality, formerly the Agency for Health Care Policy and Research (AHCPR). It is a randomized trial to evaluate whether externally designed, evidence-based interventions for improving care for depression can be locally implemented in managed care organizations. The study took place in 46 primary care clinics within six diverse, nonacademic managed care plans in various locations across the United States. It involves 181 primary care providers and 1,356 patients with current depressive symptoms and either 12-month, lifetime, or no depressive disorder.

The materials designed for clinicians, nurse specialists, and psychotherapists to use for the interventions were developed at RAND in collaboration with researchers and clinicians at many institutions, including the VA Greater Los Angeles Healthcare System, Los Angeles, California; the University of California, Los Angeles; Georgetown University; and the University of California, San Francisco. They are published in 7 volumes, along with the patient-education videotape and brochure developed for the *Partners in Care* study.

The interventions for which these materials were developed took place in 1995-2000. The authors recognize that clinics implementing the interventions today would want to update some of the manuals to take into account subsequent advances—for example, in psychotropic medications and in informatics support for documenting case management. However, the approach remains current, and is the basis for a variety of ongoing interventions for depression for adults, adolescents, and older adults.

The Depression Nurse Specialist is critical to the success of the *Partners in Care* quality-improvement programs. The nurse plays a key role in initially assessing symptoms of depression, educating and activating patients, providing feedback on patients' progress to the patients' primary care clinician, helping to implement treatment plans, and monitoring patients to improve their compliance with their treatment regimen. This document, *Guidelines and Resources for the Depression Nurse Specialist*, contains all the information required for the nurse specialist to perform these functions, including flowcharts showing the sequence of the nurse's activities and explicit protocols that provide guidance for the nurse in dealing with patients at various stages and in specific situations. The document also provides all of the forms that the nurse will require to carry out these responsibilities.

The other *Partners in Care* documents are as follows:


Research findings from the Partners in Care study will be of interest to providers, patients, and managed care plans. More information about the study can be found on its web site at http://www.rand.org/organization/health/partners.care/portweb.
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Introduction

Role of the Depression Nurse Specialist

The role of the Depression Nurse Specialist (DNS) is critical to the success of depression care improvement programs. The DNS plays a key role in initially assessing symptoms of depression, educating and activating patients, providing feedback on patients’ progress to their primary care clinician, helping to implement treatment plans, and monitoring patients to improve their compliance with their treatment regimen.

This manual contains all the information required for the DNS to perform these functions. It provides an overview of the DNS’s role, including those responsibilities that are particular to patients receiving either medication or psychotherapy treatment. A series of flowcharts shows the sequence of the nurse’s activities, beginning with the first meeting with the patient and including all follow-up activities. Explicit protocols provide guidance for the nurse in dealing with patients at various stages and in specific situations, including the initial visit and evaluation, follow-up contacts, health status assessments, and activities to prevent relapses.

The manual also provides all of the forms that the nurse will require while performing these responsibilities. Forms include worksheets and index cards for writing up the initial evaluation, and for logging and tracking patients’ progress. A set of frequently asked questions about antidepressants, and their answers, helps the nurse provide reassuring information that patients may need about their treatment.
1. Overview of the Role of the Depression Nurse Specialist

The Depression Nurse Specialist (DNS) is the key to the success of the *Partners in Care* study. The DNS is the first contact for patients referred from the study team. The Depression Nurse Specialist is the only person in the clinic who knows about all of the depressed patients in treatment, and he or she will be able to help patients and primary care clinicians in a number of important ways:

Goals for the Depression Nurse Specialist in both Medication-Enhanced and Psychotherapy-Enhanced Clinics:

1. Increase the efficiency and effectiveness of the patient’s initial primary care evaluation for depression by:
   - Assessing key symptoms of depression
   - Educating and activating patients
   - Giving feedback to the primary care MD/primary care clinician

2. Review and help to implement the treatment plan.

3. Increase patient’s adherence to protocols for treatment.

Responsibilities of the DNS assigned to Medication-Enhanced Clinics:

- *Becomes familiar* with the protocols as presented in the *Medication-Enhanced Clinics: Follow-up Activity Flowchart* for DNS (Figure 2a).

- *Completes* an initial patient assessment visit and a post-initial visit evaluation with assigned patients.

- *Follows patients* who begin medication and helps them to stay in treatment.
  The DNS monitors patient adherence to medications and to follow-up visits and trouble-shoots when problems arise. Some patients will be followed by the DNS for 12 months and some will be followed for 6 months. Patients followed for 12 months are being studied to determine if longer follow-up improves outcomes. **Note:** Patients randomly assigned to 12 month follow-up have an **odd**-numbered Study ID; patients randomly assigned to 6 month follow-up have an **even**-numbered Study ID. To determine if the patient’s Study ID is odd or even, ignore the final Study ID letter, (e.g., Study ID 1006B is **even**-numbered--6 is the final digit).

- *Recontacts patients* who have been **referred to psychotherapy** to assess progress at 8 weeks.
  Patients who are not adhering to therapy, or are not doing well, should be referred back to the MD/primary care clinician for evaluation.
• **Follows patients** not started on treatment (but for whom treatment is indicated).
  DNS will recontact patients at 4 weeks after the initial assessment visit. If no treatment has been started by then, the DNS has the option of recontacting the patient in 8 weeks.

• **Recontacts patients for whom neither medication nor psychotherapy is required.**
  DNS will call patients at 3 months after the initial assessment visit to reassess and educate the patient about depression.

• **Contacts patients who miss visits during the follow-up period.**
  DNS will contact patients, encourage them, and help eliminate barriers to care.

• **Maintains regular communication with patients’ MD/primary care clinicians.**
  Ideally, and whenever possible, the DNS discusses directly with the MD/primary care clinician the patients they share. To facilitate this discussion, the DNS may prefer to set up regular meetings with their primary care clinicians to review all of their shared cases and to discuss how patients are doing.

• **Sets up regular (i.e., weekly) caseload supervision with the study psychotherapist.**
  During these meetings, the psychotherapist may suggest changes in the patient’s regimen. These changes should be discussed with the patient’s MD/primary care clinician.

**Responsibilities of the DNS assigned to Psychotherapy-Enhanced Clinics:**

• **Becomes familiar with the protocols as presented in the Psychotherapy-Enhanced Clinics: Follow-up Activity Flowchart for DNS** (Figure 2b).

• **Completes an initial patient assessment visit and a post-initial visit evaluation with assigned patients.**

• **Provides the patient’s study record to the assigned psychotherapist prior to the first visit so the therapist can take over active follow-up.**

• **Follows patients** not started on treatment (but for whom treatment is indicated).
  DNS will recontact patients at 4 weeks after the initial assessment visit. If no treatment has been started by then, the DNS has the option of recontacting the patient in 8 weeks.

• **Recontacts patients for whom neither medication nor psychotherapy is required.**
  DNS will call patients at 3 months after the initial assessment visit to reassess the condition and educate the patient about depression.

• **Contacts patients who miss visits during the follow-up period.**
  DNS will contact patients, encourage them, and help eliminate barriers to care.
• *Maintains regular communication with patients’ MD/primary care clinicians.*

Ideally, and whenever possible, the DNS discusses directly with the MD/primary care clinician the patients they share. To facilitate this discussion, the DNS may prefer to set up *regular meetings* with the patients’ primary care clinicians to review all of their shared cases and to discuss how patients are doing.

• *Sets up regular (i.e., weekly) caseload supervision with the study psychiatrist.*

During these meetings, the psychiatrist may suggest changes in the patient’s regimen. These changes should be discussed with the patient’s MD/primary care clinician.
2. Initial Telephone Call to Study Patients

The initial telephone call to patients who have been identified by the Partners in Care study team as study patients is very important. At this point, the patient has worked with a number of study personnel and has been screened for depressive symptoms, with a waiting room survey and a structured telephone survey. With this initial telephone call, the DNS initiates the patient’s enrollment in the clinical portion of the study.

**The goals of the call are the following:**

1. Encourage the patient to become actively involved in getting well.
2. Answer any questions or concerns the patient may have.
3. Arrange for a scheduled appointment for an initial education and assessment session prior to the patient’s initial visit with the primary care clinician.

*We suggest that a protocol similar to the one on the next page be used for this initial call.*
1. Introduce yourself
   Good (morning / afternoon / evening), M(r/s), ____________________________.
   I am ____________________, a nurse specialist at the __________________________ clinic.

2. Explain how you obtained the patient's name
   I work with Dr. ____________________, and your name was given to me by
   ______________________ who has spoken with you about our study to improve the treatment of
   depression in primary care.

3. Explain purpose of call (scheduling visit)
   (I would like to know if you have been scheduled/I see that you have been scheduled) to
   come in for a free 45 minute visit with me in the clinic. This will be followed by a brief visit
   with (__________________), your primary care clinician (physician).

4. Explain the nature of the initial visit
   During this visit, I want to talk a little bit more with you about some of the symptoms you
   have been experiencing. The information should help you and your doctor decide about
   whether you need treatment, and if so, what the right treatment is for your symptoms. I
   would also like to give you some information that tells you about our study.²

5. Wait for feedback; if none, continue:
   Do you have any questions at this time?

6. Schedule visit if none has been scheduled
   When would be a good time for you to come to the clinic?
   (Arrange a visit time, ideally coordinating it with the MD/primary care clinician's schedule so
   that the clinician can see the patient immediately after the visit with the DNS. If the DNS is
   not responsible for scheduling appointments, patient's scheduling preferences should be
   given to the appropriate staff person.)

7. Thank patient and provide contact telephone number
   Thank you very much. I look forward to meeting you on __________ (date/time). If you have
   any questions between now and our visit, feel free to call me at ______________________
   (DNS's telephone number).

8. Send a reminder appointment card

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¹ The words of the script itself are in italics.
² Offer to give the patient a Partners in Care "Beyond Depression" videotape if the patient has been designated during study
  enrollment as being at higher risk for major depression. 'Higher risk' is indicated by a score of '5' or higher entered in the
  Symptoms portion of the Initial Visit Worksheet.
During and after the call the DNS:

1. Fills out the Initial Telephone Call Notes (Figure 3a) to create a record of the call.

2. Notifies the patient's MD/primary care clinician of the patient's enrollment by giving the clinician the yellow copy of the Initial Telephone Call Notes form.

3. Logs and tracks the call.

   **Note:** After the Initial telephone call, the DNS enters the patient's name, pertinent contact and appointment dates, and other required information in the study's Register and Activity Summary—ALL Study Patients (Refer to Figure 5a for Medication-Enhanced Clinics and Figure 6a for Psychotherapy-Enhanced Clinics). This form collects the names of up to 10 assigned study patients. We suggest you use the following tracking system to easily follow patients across logs:

   - A Line Number adjacent to each row will be used to track patient information across different study forms. Line Numbers 1-10 are preprinted on page 1 of the Register.

   - Continuation pages for the Register are provided to accommodate patient assignments greater than 10. In the continuation Register, a blank space to enter a Line Number appears on the far left side adjacent to each row. The DNS can record in that space a sequential Line Number, starting with number 11, for each additional patient added to the Register's continuation pages.

   - This Line Number will be copied to other forms, along with other identifying patient information, such as name and Study ID Number, whenever a patient needs to be listed on another study tracking form, for example, a Partners in Care Follow-up Log, or a Partners in Care Beck Depression Inventory (BDI) Tracking Form (Figures 5e and 5f).

   - Detailed information for completing the Register and other study forms appears in Section 5, “Logging and Tracking Patients.”
3. The Initial Visit and Post-Initial Visit Plan

_Initial Visit_

The purpose of the initial visit is threefold:

1. To provide the patient with education about depression, its treatment, and the _Partners in Care_ study.
2. To conduct a clinical assessment and provide feedback to the patient’s MD/primary care clinician.
3. To activate the patient to participate actively in his/her treatment.

_DNS Initial Assessment and Patient Education Protocols_

At the initial visit, the DNS uses the “Are you feeling...tired, sad, angry, irritable, hopeless?” brochure as a guide for the discussion with the patient. The DNS also uses the _Initial Visit Worksheet_ (Figure 3b) to record the results of the assessment and to provide feedback to the MD/primary care clinician.

Appendix A, _Step-by-Step Guide for DNS’s Initial Visit Assessment_, describes the procedure for the assessment in more detail. Appendix B, _DNS Initial Assessment Queries_, describes the kinds of questions to ask to complete the assessment and to fill out the worksheet itself.

Two kinds of patients will be coming to you for assessment—those who have been assessed by the study research team as having a high probability of having major depression, and those whom the team has assessed as having a low to moderate probability of having major depression. The Enrollment Status on the _Clinic Assessment Form_ provided by the study team to the clinic staff indicates which group each patient falls into: ‘5’ indicates the patient is considered at high risk for major depression; ‘1’ means low to moderate risk. The _Partners in Care_ assessment protocol for the DNS provides information that will help him/her to determine whether the patient has a clinical depression (major depression or dysthymia) or a mood change of another kind. Many patients in the low-to-moderate probability group will have minor depression and will not need medications or full psychotherapy. Remember, minor depression patients often do as well with supportive care (such as patient education and problem-solving training) as they do with full treatment, and might not require medications or therapy. Your assessment will help ensure that your practice resources are used as cost-effectively as possible. At the beginning of the patient’s initial assessment, the DNS may wish to emphasize again that the patient’s symptoms of depression _may or may not_ indicate clinical depression needing medication and/or full psychotherapy.

If patients are assessed as _not_ having major depression, it is important that the DNS convey to the patient during the post-visit evaluation that he/she has good news for them—their symptoms of depression do not indicate a clinical depression, but rather a low mood. The DNS should indicate to the patients that he/she and the clinic will be following them to ensure that their symptoms get better, not worse, and that they will need to observe their own moods to assess how they feel. The DNS may want to invite them back for a “booster” education/activation session.

Patients assessed at the initial visit as _not_ having major depression should be entered into the “Follow-up Log for Patients Not Requiring Psychotherapy or Medication” (Figure 5d).
There are four complicating conditions that are particularly important to identify during the initial assessment because they have significant effects on treatment choice. These are: alcoholism, mania (characterized by periods of extreme excitement), grief reactions (someone important to the patient died within two months prior to the visit), and pregnancy or breast feeding. Grief reactions and pregnancy or breast feeding are not listed on the assessment form, but it will be helpful to MD/Primary Care Clinicians if these conditions are identified when present.

Another tool that may be helpful for this visit is the SF-12 Health Survey (Appendix C), an instrument that assesses functional status. The DNS is not required to complete this form, but it might provide useful examples of questions to ask when assessing functional status.

If the DNS would like more guidance for following the initial visit protocol, she/he can call RAND to get a copy of a videotaped example of an initial assessment, or can ask her/his nurse expert leader or nursing supervisor to role-play the initial assessment with her (see Training Role-Plays for Initial Assessment and Follow-Up, Appendix D).

The DNS will be able to complete most of the assessment questions on the Initial Visit Worksheet by discussing the “Are you feeling... Tired, Sad, Angry...” brochure with the patient.

During this initial visit, the DNS also administers the Beck Depression Inventory (BDI) (Figure 3o), giving it to the patient to fill out. You may help the patient by reading the Beck to them if needed, but avoid guiding their answers in any way. To score the Beck, simply add up the patient’s responses. A score of 9 or more on the 21-Item Beck generally signifies a significant amount of distress, but may not indicate major depression (e.g., the symptoms may not have lasted long enough). The patient’s score should be recorded on the worksheet.

Providing Feedback to MD/Primary Care Clinicians and Patients

At the end of the initial assessment visit, you should provide the yellow copy of the Initial Visit Worksheet (Figure 3b) to the MD/primary care clinician and the pink copy to the patient. Keep the top copy for the patient’s study record. There is one additional copy; you can give this to other consultants who may see the patient, such as a mental health specialist. Briefly review with the MD/primary care clinician the Initial Visit Worksheet assessment prior to his/her visit with the patient. The MD/primary care clinician should sign the study record copy either before or after the visit.

IT IS VERY IMPORTANT TO GIVE A COPY OF THE INITIAL VISIT WORKSHEET TO THE PATIENT. This is part of the patient activation intervention. In previous studies, providing patients with their records has served to improve physician/nurse/patient interaction.

Be sure the MD/primary care clinician has sufficient blank copies of all the forms called Your Personal Plans (Figures 4a, 4b, 4c and 4d), so that the clinician can provide the patient with the appropriate completed plan(s) at the conclusion of the visit.
**Post-Initial Visit Evaluation**

After the patient sees the MD/primary care clinician, the DNS either visits with or calls the patient to go over the treatment plan. There are four types of treatment plans:

- **Your Personal Plan: Medications** (Figure 4a) - For patients started on antidepressant medications
- **Your Personal Plan: Psychotherapy** (Figure 4b) - For patients started on psychotherapy
- **Your Personal Plan: Watchful Waiting** (Figure 4c) - For patients not started on either treatment
- **Your Personal Plan: Relapse Prevention** (Figure 4d) - For patients who may have already been treated, and require a plan for avoiding relapse. (See Appendix E, *Course of Action for Relapse Prevention*, for information about how to discuss relapse with the patient.)

One or all of these forms may be required for a given patient. Ideally, the MD/primary care clinician will provide the patient with the completed appropriate form(s). If the clinician does not provide these to the patient, the DNS should complete the form(s). One copy is given to the patient and one copy (yellow) to the MD/primary care clinician, and one is kept in the study record.

Ideally, the patient should leave the clinic with copies of the appropriate *Your Personal Plans* (Figures 4a-d). If the patient is not given these forms at the clinic and the post-initial visit evaluation is conducted by telephone, the appropriate *Your Personal Plans* can be mailed to the patient.
4. Assuring Privacy and Confidentiality of Patient Information

Patient information gathered for this study is sensitive and must be regarded as highly confidential. Even the fact that the patient is enrolled in the study should be viewed as private and confidential. All study materials that identify patients by name and/or number must be kept in locked files or secure locations when not in use. Omit (or black out) the patient medical record number from Column C of the study Register and Activity Summary (Figures 5a and 6a) if there is any possibility that this information may be exposed to non-study personnel. Only the DNS should have access to the Register. The patient medical record number also appears in the alphabetical and tracking index cards (Figures 7a and 7b); again, omit the medical record number from these records if there is any chance that the information is not secured. The only other place the medical record number appears is on the Initial Visit Worksheet (Figure 3b), which remains locked as part of the study record when not in use.

It is possible that Partners in Care forms will find their way into patient medical records. If there is a chance that this will occur, the DNS’s should review the medical record after a visit to remove any study forms that have been inadvertently included. MD/Primary Care Clinician (yellow) duplicate copies of forms should either be stored by the physician in his or her own secured or locked file that is separate from the patient’s medical record, or returned to the DNS after use and destroyed if not needed.
5. Logging and Tracking Patients

For ALL Patients:

A key DNS activity for this project is keeping track of study patients. A set of forms has been developed by Partners in Care for this purpose. A list of these forms appears on pages vii and viii of this manual (List of Figures). In addition, the Register and Tracking Logs binder contains all of the forms the DNS will need for the tracking process. The Register and Activity Summary (Figure 5a or Figure 6a) is the form that initiates the DNS logging activity and is the primary form for keeping track of assigned patients. The DNS first uses this form to register the first 10 patients after the Initial Telephone Call, recording the patient’s Study ID, name, medical record number, and date of the initial telephone call. For additional patients, the DNS will use the continuation page, located behind the first page of the Register in the binder. (All registers and follow-up forms have accompanying continuation forms, located behind the first page of the respective form in the Register and Tracking Logs.) For these continuation logs, the DNS will provide a sequential Line Number (located to the left of the patient ID), starting with number 11. (For more information on recording Line Numbers, see page 9). The DNS will also need to fill in the appropriate page number for the form, located on the bottom right-hand corner of each continuation page. Space is also provided in the Register for the dates of the initial assessment visit (Column E), the post-initial assessment visit (Column F), and the type of therapy, if any, the patient was started on at the initial visit (Column G).

For Medication-Enhanced Clinics:

1. Register and Activity Summary (Figure 5a):

   This form provides places to indicate the dates the patient actually started medication and/or psychotherapy (columns H and I). Some patients may not have had treatment prescribed for them or may have declined treatment at the initial visit. In this case, no treatment dates should be entered on the form. However, if a patient begins treatment at a later date, the date treatment started should be recorded on the form at that time.

   **Column J** (End of Follow-up Period) provides space to indicate the date at which the DNS will cease to follow the patient. The follow-up end date is calculated as either 6 months or 12 months from the date of the initial assessment visit. Patients with Study IDs ending in even numbers are followed for 6 months, and patients with Study IDs ending in odd numbers are followed for 12 months. To keep track of patients with different follow-up periods, the study provides a separate follow-up form for patients in each follow-up group. These forms are described in item 2 below.

2. Beck Depression Inventory (BDI) Tracking Form for 12 Month and 6 Month Follow-ups (Figures 5e and 5f, respectively):

   These forms keep track of BDI scores as administered to the patient by either the primary care clinician or the DNS, and enable the study clinicians to quickly review overall progress of patients on medications and spot problems, (e.g., scores are not improving). Patients in the 6 month follow-up program are entered on the BDI Tracking Form for 6 Month Follow-Up Patients. Patients in the 12 month follow-up program are entered on the BDI Tracking Form for 12 Month Follow-Up Patients. The forms provide space for patient Line Number, Study ID, name, and for up to 5 BDI scores and their corresponding dates. If more than 5
BDIs are administered, the additional data can be recorded on a BDI Tracking Form for Information Overflow (separate forms are provided for 6 month and 12 month follow-ups - see Register and Tracking Logs). These overflow forms require transfer of the patient’s name and Line Number and provide space for additional BDI entries (up to 12 total).

3. Follow-up Logs (Figures 5b, 5c and 5d):

Partners in Care provides a set of forms for use in keeping track of DNS follow-up activities:

- Follow-up Log for Patients Started on Psychotherapy Only (5b)
- Follow-up Log for Patients Not Started on Treatment, but for whom treatment has been indicated (5c)
- Follow-up Log for Patients Not Requiring Psychotherapy or Medication (5d)

These logs document patient results relating to his or her treatment or condition as discussed during follow-up phone calls or visits.

The DNS enters names, Line Numbers, and Study ID numbers from the Register and Activity Summary form to the appropriate follow-up log for assigned patients who have been started on psychotherapy only or who have not been started on treatment as a result of the initial assessment visit. The DNS will also record the patient’s telephone number. For each follow-up contact, the DNS records the date of contact and the result of that contact. For ease of recording, there is a set of result codes provided on each of the Follow-up Logs that can be used as shorthand for recording results. For example, if, during the follow-up call, the DNS finds that a patient listed in the psychotherapy only follow-up log has not yet had an initial visit with the psychotherapist, but does have an appointment, the DNS can enter the code for “Initial therapy appointment pending” (‘31’) in the code box that appears in the form. Comments can be added as needed.

4. Index Cards (Figures 7a and 7b):

Partners in Care sent each DNS two sets of index cards and a card file box. One set was for recording contacts and ID information about each study patient assigned to the DNS. These cards should be filed alphabetically. The second set of cards was for tracking patient follow-up progress. These cards are designed to work as a tickler file, reminding the DNS of each patient’s follow-up schedule. We provided 3 tabbed alphabetical dividers, 12 tabbed month dividers, and a “this week” tab divider, to assist in setting up the file system. The following system is suggested:

**Setting up the file box**

- Set up an alphabetical section using the three alphabetical tab dividers, and a date section using the month dividers.
- Place a “this week” tab in front of the date dividers as a reminder of the calls or visits that are scheduled for the current week. (You may wish to indicate the dates of the current week on a post-it tape flag.) Review the cards each week and place those who have contacts scheduled for that week behind this tab divider.
Creating the index cards

- **For ALL clinic patients:** The DNS fills out a Patient Index Card and places it in the alphabetical section of file box. She/he also fills out a Tracking Card and may wish to catalogue it according to the instructions outlined below.

- **For patients started on medications or medications plus psychotherapy:** The DNS enters the dates for patient calls or visits on the tracking card as she/he schedules them. The card is placed behind the month divider during which the DNS expects to make the next follow-up contact. When this contact is complete, the DNS replaces the card behind the next appropriate month divider.

- **For patients started on psychotherapy only:** The DNS places the tracking card behind the month divider corresponding to the date during which the 8 week follow-up evaluation (telephone or in-person) is scheduled. When the follow-up is discontinued, and the results are recorded in the appropriate follow-up log, the card can be removed from the date section of the card box.

- **For ALL patients not started on treatment:** The DNS places the tracking card behind the month divider corresponding to scheduled date of the next follow-up contact (i.e., about four to six weeks after the initial visit). When the follow-up is discontinued and the results are recorded in the appropriate follow-up log, the card can be removed from the date section of the card box.

**For Psychotherapy-Enhanced Clinics:**

1. **Register and Activity Summary (Figure 6a):**

   In addition to the information logged on this Register at the initial phone call, this form provides places to indicate the date of the initial assessment visit (Column E), the date of the post-initial visit assessment (Column F), and the type of therapy started at the initial visit (Column G). The type of therapy started on (prescribed) is coded as “P” for Psychotherapy only, “B” for Both psychotherapy and medications, and “N” for No treatment started on at the initial visit. If either “P” or “B” is circled, the DNS should then enter the scheduled date of the initial psychotherapy appointment (Column H), the actual date of the initial psychotherapy appointment (Column I), and the date that the DNS gave the study record to the therapist (once the psychotherapist has been identified) (Column J). For those patients who are not started on any treatment at the initial visit, no treatment dates should be entered in columns H, I, and J. However, if, at a later time, the patient begins psychotherapy with a study therapist, the DNS should enter that information in columns H, I, and J as appropriate. Also, patients who are not started on any treatment at the initial visit should be recorded on the appropriate follow-up log. Detailed information about this log follows below.

2. **Follow-up Logs for Patients Not Started on Treatment (Figures 6b and 6c):**

   The Follow-up Log(s) for Patients Not Started on Treatment are designed to collect information on activities related to study follow-up protocols for patients who, at the initial visit, have not started on any treatment either because none has been prescribed or because none is indicated. The DNS copies the patient’s name, Line Number, and Study ID number from the Register and Activity Summary to the follow-up log. The DNS also records the patient’s telephone number. For each follow-up contact, the DNS records the date of the contact and the result of that contact. For ease of recording, there is a set of result codes
provided on the *Follow-up Log* that can be used as a shorthand method for recording results. For example, if, during the follow-up call, the DNS finds that a patient started treatment with a health care provider outside of the study clinic, she/he can enter the code for "Started treatment at outside clinic" ('5') in the code box that appears in the form. Comments can be added as needed.

3. *Set of Index Cards, Card File Box, and Alphabetical Dividers* (Figures 7a and 7b):

These materials were provided to help the DNS maintain an alphabetical list of study patients, enabling her/him to find key information easily. It is recommended that the DNS fill *out an index card for each patient*. *Even though the DNS will not be following all patients*, she/he may need access to certain information on a particular patient.
6. Protocols for Follow-Up Visits

For Medication-Enhanced Clinics:

A. Protocol for Patients Started on Medication

Patients who begin antidepressant medications require continuous follow-up care for the duration of their treatment. Some of the follow-up visits can be conducted by telephone, but some must be done in person. Both the DNS and the primary care clinician are involved in the patient's care, and they should maintain regular communication. In addition to responding to feedback from the DNS about patient problems, the primary care clinician must see the patient at intervals during acute phase and continuation phase treatment. (See Clinician Guide to Depression Assessment and Management in Primary Care.)

For those visits that do not require an in-person visit, a telephone visit can be scheduled if neither the DNS nor the primary care clinician is able to meet with the patient. One week prior to the scheduled phone call, the DNS should send the patient a reminder letter, a Beck Depression Inventory (BDI) form, and a self-addressed stamped envelope. The letter should request that the patient return the completed BDI form to the DNS before the scheduled phone call. If the DNS does not receive the Beck form from the patient, she/he should ask the patient about his/her depressive symptoms (specifically, those bolded on the visit worksheets) during the phone call. Additionally, the patient should also be asked about his/her alcohol use. The eight most critical times for follow-up visits, with time zero being the date of initiation of antidepressant therapy, are listed below within the 3 phases of treatment.

NOTE: It is important to remember that patients started on antidepressants are to be followed by the DNS for either 6 months or 12 months. At the end of the patient's assigned follow-up period, follow-up by the DNS should be terminated (within a few weeks), regardless of the phase of treatment the patient is in. The patient might still be in acute phase or s/he might be well into maintenance phase. Regardless of the phase of treatment, the DNS is no longer responsible for the patient's follow-up care. The primary care clinician will continue his/her care for the patient, but the protocol for the patient's care will return to the usual practice for that clinic. The DNS and primary care clinician should develop a plan for coordinating that transition. Additionally, the DNS should be aware of the patient's follow-up termination date as she/he schedules appointments. The patient also needs to be informed of the transition.

Acute Phase Therapy

Goal: Ensure Full Treatment and Symptom Remission

One week follow-up: (This visit can be done by telephone by the DNS). Assess the patient's initial tolerance of the regimen, readjust if necessary, and reinforce continued use of medications. Discuss barriers to taking medications as prescribed. The 1 Week Follow-up Telephone Call Worksheet (Figure 3d) should be used to document and distribute the results of this visit.
Two week follow-up: The goals of this visit are similar to those of the one week visit. Since the patient recently started antidepressants, it is important to again assess the patient’s initial tolerance of the regimen, readjust if necessary, and reinforce continued use of medications. The 2 Week Follow-up Telephone Call Worksheet (Figure 3e) can be used to document and distribute the results of this visit.

4 to 6 week follow-up: Assess response to medication, and consider readjustment if the patient is not improving at all. Use the 4-6 Week Follow-up Visit Worksheet (Figure 3f) to document and distribute the results of this visit.

10 to 12 week follow-up: Assess whether the patient is completely or nearly symptom-free, and readjust or change medications if not. If medications are readjusted, more visits may be necessary. If the patient has not improved, consider adding psychotherapy to the patient’s regimen or getting a psychiatric consultation. If the patient is symptom-free, s/he has completed the acute phase therapy and enters the continuation phase therapy. (Note: In this case, skip the 16 week follow-up visit and proceed to the protocol for continuation phase therapy. The patient’s next follow-up visit should be in approximately 2-3 months). Use the 10-12 Week Follow-up Visit Worksheet (Figure 3g) to document and distribute the results of your visit. If the patient is not symptom-free, schedule a 16 week follow-up.

16 week follow-up: This visit is intended only for those patients who are still experiencing symptoms at the 10 - 12 week visit. If the patient is symptom-free at this visit, s/he enters the continuation phase of treatment. (Proceed to the continuation phase protocol.) If the patient still has depressive symptoms, consultation with the primary care clinician or psychiatrist is advised. Use the 16 Week Follow-up Visit Worksheet (Figure 3h) to document and distribute the results of this visit. If other acute phase visits are needed, the 20+ Week Follow-up Visit Worksheet (Figure 3i) can be used to record the results of these visits.

Continuation Phase Therapy

Goal: Prevent Relapse (See Appendix E: Course of Action for Relapse Prevention)

Once the patient is free of symptoms and has returned to a reasonably good level of functioning, the goal of treatment shifts from relief of acute symptoms to prevention of recurrences or relapses of depression. To help patients prevent a recurrence or relapse, each patient should receive relapse prevention education and then be followed up about every 3 months. Patients should continue medications for 4 to 6 months after becoming symptom-free.

Relapse prevention education should occur at a time when the patient has achieved a complete remission from depression. Relapse prevention should be reinforced at the end of the continuation phase, which may last anywhere from 3 to 6 months after starting acute treatment.

In most cases, this education should be conducted in person. If such a session cannot be arranged, the DNS may want to consider mailing the Your Personal Plan: Relapse Prevention (Figure 4d) to the patient and scheduling a telephone session to discuss this plan.
3 months into continuation phase therapy: (Continuation phase typically begins between 8 and 12 weeks after initiation of acute phase therapy and only when the patient has achieved complete remission.) Assess patient for continued adherence to medications and look for signs of relapse. (See Clinician Guide to Depression Assessment and Management in Primary Care.) The 3 Month Continuation Phase Visit Worksheet (Figure 3j) should be used to document and distribute the results of this visit.

6 months into continuation phase therapy: (6-Month follow-up patients with even-numbered IDs will now have reached the end of their study-related follow-up care.) Assess patient for relapse. If patient is doing well, and if s/he has not had more than two prior episodes of depression, stop medications. If the patient has had more than two prior episodes, he or she has a 70-90% chance of having another episode, and maintenance therapy is recommended. In this case, continue the antidepressant indefinitely (see Maintenance Phase Therapy below). Use the 6 Month Continuation Phase Visit Worksheet (Figure 3k) to document and distribute the results of this visit.

9 months into continuation phase therapy: (Only 12-Month follow-up patients with odd-numbered IDs are still being followed by the DNS at this point.) For patients no longer on medications, assess for relapse, emphasize patient self-monitoring of symptoms, and return to as-needed visits. Use the 9 Month Continuation Phase Visit Worksheet (Figure 3l) to document and distribute the results of this visit.

Maintenance Phase Therapy

Goal: Prevent Relapse

Every three months for the duration of antidepressant therapy, the patient should be re-evaluated for depressive symptoms, new problems, or side effects. Use the Maintenance Visit Worksheet (Figure 3m) to document and distribute the results of this visit.

B. Protocol for Patients Started on Psychotherapy

The DNS should schedule an 8-week follow-up evaluation (telephone or in person) with the patient. If s/he still has significant depressive symptoms that meet criteria for major depression, the DNS may want to ask the MD/primary care clinician or study psychiatrist whether or not antidepressants are indicated. The date and results of the telephone or in-person evaluation should be recorded on the appropriate patient follow-up log. At times, the DNS may want to make contact with other mental health providers, such as a patient's psychotherapist, but this should be done only with the patient's explicit permission.

C. Protocol for Patients Not Started on Any Treatment - Treatment Indicated

For patients not started on treatment but for whom treatment is indicated because they have clinical depression, your goal is to assist the patient in getting treatment. For these patients, we recommend that a telephone follow-up call be scheduled for about 4 weeks after the initial visit. The date and results of this call should be recorded in the Follow-up Log for Patients Not Started on Treatment - Treatment Indicated (Figure 5c).
During the 4 week follow-up call, the DNS:

- asks how the patient is doing overall
- asks about the 9 symptoms of major depression
- asks if the patient is getting any treatment for depression
- checks if the patient has any further questions about his/her symptoms or treatment options. The DNS may be able to answer these questions directly or she may need to consult with the MD/primary care clinician or the study psychiatrist.
- schedules a follow-up visit to the MD/primary care clinician for the patient if the patient is willing.
- provides her name and number to the patient in case the patient would like to ask questions about treatment at a later time.
- re-contacts once more at 8 weeks if the patient is still depressed and not willing to see the MD/primary care clinician.
- returns to the protocol for follow-up visits for patients started on medication if the patient starts on medication at a later date.

D. Protocol for Patients Not Requiring Psychotherapy or Medications

A number of patients who are depressed at the initial visit may not require medications or psychotherapy because they do not have a clinical depression. For these patients, your goal is to educate and reassess in 3 months to see if symptoms have worsened. Record date of call and results in the Follow-up Log for Patients Not Requiring Psychotherapy or Medication (Figure 5d).

During the 3 month follow-up call, the DNS:

- asks how the patient is doing overall
- asks about the 9 symptoms of major depression
- reinforces education provided at the initial visit
- provides her/his name and number to the patient in case the patient would like to ask questions about treatment at a later time.

For Psychotherapy-Enhanced Clinics

A. Protocol for Patients Started on Psychotherapy

If a patient decides to start psychotherapy with a study psychotherapist, the DNS does not follow that patient. The DNS gives the patient’s study record to the study psychotherapist and the therapist is then responsible for follow-up. If a problem arises, the DNS might receive calls from a patient or a psychotherapist. If this happens, the DNS may need to consult with the primary care clinician, the patient’s psychotherapist, and/or the expert leader psychotherapist as appropriate.
B. Protocol for Patients Started on Medication

If a patient starts on medications, the DNS is not responsible for following the patient. However, if the patient later decides to start psychotherapy with a study psychotherapist, the DNS provides the therapist with the patient’s study record, at that time.

C. Protocol for Patients Started on Psychotherapy and Medications

When a patient chooses at the initial assessment to start both psychotherapy (with a study psychotherapist) and medications, the DNS gives the patient’s study record to the study psychotherapist. The therapist is then responsible for follow-up. If there is a problem, the DNS might receive calls from a patient or a psychotherapist. If this happens, the DNS may need to consult with the primary care clinician, the patient’s psychotherapist, and/or the expert leader psychotherapist as appropriate.

D. Protocol for Patients Not Started on Any Treatment - Treatment Indicated

For patients not started on treatment but for whom treatment is indicated because they have clinical depression, your goal is to assist the patient in getting treatment. For these patients, we recommend that a telephone follow-up call be scheduled for about 4 weeks after the initial visit. The date and results of this call should be recorded in the Follow-up Log for Patients Not Started on Treatment - Treatment Indicated (Figure 5c).

During the 4 week follow-up call, the DNS:

- asks how the patient is doing overall
- asks about the 9 symptoms of major depression
- asks if the patient is getting any treatment for depression
- checks if the patient has any further questions about his/her symptoms or treatment options. The DNS may be able to answer these questions directly or she may need to consult with the MD/primary care clinician or the study psychiatrist.
- schedules a follow-up visit to the MD/primary care clinician for the patient if the patient is willing.
- provides her name and number to the patient in case the patient would like to ask questions about treatment at a later time.
- re-contacts once more at 8 weeks if the patient is still depressed and not willing to see the MD/primary care clinician.
- returns to the protocol for follow-up visits for patients started on medication if the patient starts on medication at a later date.
E. Protocol for Patients Not Requiring Psychotherapy or Medications

A number of patients who are depressed at the initial visit may not require medications or psychotherapy because they do not have a clinical depression. For these patients, your goal is to educate and reassess in 3 months to see if symptoms have worsened. Record date of call and results in the Follow-up Log for Patients Not Requiring Psychotherapy or Medication (Figure 5d).

During the 3 month follow-up call, the DNS:

- asks how the patient is doing overall
- asks about the 9 symptoms of major depression
- reinforces education provided at the initial visit
- provides her/his name and number to the patient in case the patient would like to ask questions about treatment at a later time.
7. Maintenance Phase Treatment and Relapse Prevention

For Medication-Enhanced Clinics

We know from prior research that, without active treatment, 50% of patients with one prior episode of major depression will have a relapse within two years. Patients with 2 or 3 prior episodes have a 70 or 90% chance of relapse, respectively. Research has also shown that full doses of antidepressants (i.e., the doses that resulted in the initial remission of symptoms) significantly reduce the risk of relapse for up to 5 years. In some patients, such maintenance treatment may be required indefinitely. However, despite the benefits and necessity of long-term medication therapy, we also know that up to 50% of patients with chronic illnesses have difficulty taking their medications as prescribed. Therefore, it is important to discuss the necessity of the medications, anticipate problems, and develop a strategy for the patient should problems arise.

The goals of the relapse prevention visit are to:

1. Increase adherence to maintenance antidepressants.
2. Educate the patient and his/her significant other(s) about the early-warning signs of depression.
3. Make a relapse prevention plan, which outlines how patients can prevent a recurrence of depression and what to do in case they do experience further symptoms of depression (see Appendix E, Course of Action for Relapse Prevention).

During this visit, DNS:

- reviews the patient’s course up to now (i.e., what was the course of depressive symptoms and treatment up to now).
- reviews risk factors for relapse: 2 or more prior episodes of major depression, dysthymia (chronic depressive symptoms for 2 years or more), or residual depressive symptoms.
- prepares a written relapse prevention plan using Your Personal Plan: Relapse Prevention as a guide. Whenever possible, it is important to involve a spouse or significant other in making this plan.
- reviews the rationale for continuing medication and encourages the patient to do so.
- reviews any concerns about continuing medications and anticipates potential barriers to long-term antidepressant treatment.
- discusses early-warning signs of depression.
- discusses future clinic or telephone follow-up visits.
- reminds the patient that both she/he and the MD/primary care clinician are available in case the patient has any questions or concerns about recurring depressive symptoms or treatment for depression.
8. Caseload Supervision
(For Medication-Enhanced Clinics ONLY)

Depending on the size of her/his assigned clinic(s), the DNS may have a caseload of up to 100 patients in various stages of treatment. This can be a busy job, and it is important that the DNS has good clinical supervision and back-up available at all times in case of an emergency.

The DNS and study psychiatrist should meet once per week to review the caseload of study patients and assist with difficult cases or problems. Additionally, both the DNS and the primary care clinician should have 24-hour access to telephone consultation from a psychiatrist in case either encounters an emergency with a depressed patient.
In the *Partners in Care* quality improvement programs, most of the forms that follow in this manual were used in quadruplicate: for the nurse, the primary care physician, the patient, and the file. Purchasers of this manual have permission to duplicate these forms for purposes of implementing the *Partners in Care* approach. Forms may also be ordered in quadruplicate from RAND—see the price list (www.rand.org/organization/health/pic.products).
Partners in Care

DNS FLOWCHART FOR PATIENT IDENTIFICATION AND INITIAL ASSESSMENT

SECOND STAGE SCREENING
Data collector conducts a structured diagnostic interview, identifies patients to DNS if they meet criteria for depression or dysthymia. Every patient identified will go on DNS’s Register & Activity Summary Form.

SCREENING
Data collector identifies depressed patient using a brief questionnaire.

INITIAL PHONE CALL
DNS calls patient to arrange a back-to-back visit with him/herself and primary care clinician.

INITIAL DNS VISIT
(45 minutes)
Assessment • Education • Activation • Feedback to primary care clinician

INITIAL PRIMARY CARE CLINICIAN VISIT
(15 minutes)
Diagnostic evaluation • Management plan • Decide on appropriate stage of RX • Start on treatment if required: antidepressant medication and/or psychotherapy

POST-VISIT EDUCATION
(10 minutes—may be by telephone)
Clarify any questions • Address potential barriers to treatment

If patient is in a medication-enhanced clinic,
Refer to Medication-Enhanced Clinics: Follow-up Activity Flowchart for DNS, Figure 2a

If patient is in a psychotherapy-enhanced clinic,
Refer to Psychotherapy-Enhanced Clinics: Follow-up Activity Flowchart for DNS, Figure 2b
Partners in Care

Medication-Enhanced Clinics:
FOLLOW-UP ACTIVITY FLOWCHART FOR DNS

POST-VISIT EDUCATION
(10 minutes—may be by telephone)
DNS clarifies any questions and addresses any potential barriers to treatment

If medication or medication plus psychotherapy is prescribed, DNS reviews personal plan with the patient, sets up initial follow-up visit with the doctor/primary care clinician, and begins follow-up as described below.

If psychotherapy is prescribed, DNS reviews personal plan with the patient, sets up an appointment with a therapist and a follow-up visit with the doctor/primary care clinician, and recontacts in 8–10 weeks. If in active therapy, DNS discontinues follow-up. If out of therapy or doing poorly, DNS recontacts primary care clinician.

PATIENTS NOT STARTED ON TREATMENT

If patient does not require psychotherapy or medication, DNS recontacts in about 3 months for education and reassessment.

If treatment is indicated but not prescribed because of patient barriers, DNS encourages treatment and, if possible, sets up a follow-up visit/call with him/herself and the doctor/primary care clinician in about 3–4 weeks to reassess.

Follow-up Visits/Phone Calls by DNS and Primary Care Clinicians
1 week  2 weeks  4–6 weeks  8–10 weeks  16 weeks*  20+ weeks* (acute phase)
Every 3 months thereafter
until 6 or 12 month follow-up completed (continuation phase)

DISCUSS:
• Compliance with medication plan  • Barriers to adherence  • Depressive symptoms
• Level of functioning  • Side effects  • Questions/concerns
• Need for psychiatric referral (e.g., not improving after 8 weeks)

*16 week and 20+ week follow-up are only for patients who are still symptomatic.
Partners in Care

Psychotherapy-Enhanced Clinics:
FOLLOW-UP ACTIVITY FLOWCHART FOR DNS

POST-VISIT EDUCATION
(10 minutes—may be by telephone)
DNS clarifies any questions and
address any potential barriers
to treatment

If medication is prescribed,
DNS reviews personal plan
with the patient, sets up initial
follow-up visit with the
doctor/primary care clinician,
and discontinues follow-up.

If psychotherapy or psychotherapy
plus medication is prescribed, DNS
reviews personal plan with the patient,
sets up an appointment with the study
CBT therapist and a follow-up visit with
the doctor/primary care clinician and
discontinues DNS follow-up.

PATIENTS NOT
STARTED ON
TREATMENT

If patient does not
require psychotherapy
or medication, DNS
recontacts in about 3
months for education
and reassessment.

If treatment is
indicated but not
prescribed because
of patient barriers,
DNS encourages
treatment and, if
possible, sets up a
follow-up visit/call with
him/herself and the
doctor/primary care
clinician in about 3–4
weeks to reassess.
Partners in Care

INITIAL TELEPHONE CALL NOTES

(See suggested script in Guidelines and Resources for the Depression Nurse Specialist, Section 2)

Patient Name: ________________________________ Study ID: __________
Primary Care Clinician: __________________________ Tel. No: (____) ________
Depression Nurse Specialist: ______________________ Tel. No: (____) ________

Patient Questions
1. ____________________________________________
2. ____________________________________________
3. ____________________________________________

Scheduled Patient Visits

Initial Depression Nurse Specialist visit
Date of visit: __/__/__ Time of visit: ____:____ am / pm

Initial MD visit
Date of visit: __/__/__ Time of visit: ____:____ am / pm

Was patient given depression nurse specialist's telephone number?

Record of Calls ☑

__/__/__ Notes: _____________________________________________________________
 (date)

__/__/__ Notes: _____________________________________________________________
 (date)

__/__/__ Notes: _____________________________________________________________
 (date)

Notes
_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

Recorded by: ____________________________ Phone number: (____) ________
Reviewed by: ____________________________ (Signature of MD/Primary Care Clinician)
Partners in Care

INITIAL VISIT WORKSHEET
Refer to Appendices A and B in Guidelines and Resources for the Depression Nurse Specialist.

To: (Primary care clinician) ________________ Today’s date: ___/___/____

Mr./Ms. _____________________________ (Study ID ______, MR# ________________) has been identified by the Partners in Care study team to have symptoms of depression. She attended an initial educational session on ___/___/____ and (has / has not) received the video tape and educational brochure in (English / Spanish). Refer to step-by-step guide for Depression Nurse Specialist’s initial visit assessment (Appendix A) and Depression Nurse Specialist initial assessment queries (Appendix B) in Guidelines and Resources for the Depression Nurse Specialist.

List 2 questions for the doctor or primary care clinician:
1. ________________________________________________
2. ________________________________________________

Symptoms (Check all that apply, then circle the symptom that bothers the patient the most)

- Sad or empty
- Thoughts of suicide or self-harm
- Loss of interest
- Sleep disturbance (sleeps _____ hrs/night)
- Poor concentration
- Appetite/weight change (+ / - ____ lbs.)
- Poor energy
- Physical agitation or slowness
- Worthless/guilty
- Period of over-excitement
- Anxiety
- Sees/hears things not apparent to others
- Hopelessness/poor future
- Drug misuse/abuse
- Drinks alcohol (type(s) ______ drinks/day _____)

Family history of depression
- Somatic/Other symptoms: (list)

NOTE: The patient meets DSM-IV major depression criteria IF at least 5 of the 9 symptoms shown in the outlined box are present nearly every day for 2 weeks or more, and one of these symptoms is marked by a ✦ ✦. (Dysthymia has fewer/milder symptoms and lasts for 2 years or more.)

Other Indicators for Depression: (check all that apply)

- Beck score: ______
- Activities affected: □ social □ personal □ family □ work/school
- Patient last felt good ___ (wks / mos) ago
- # bed days last month ______
- # restricted days last month

Treatment:

a. Patient treated for depression in the past? □ Yes □ No Treated currently? □ Yes □ No

a.1 Any of these treatments? (✓ if yes)
- Psychotherapy □ Yes □ No
- Medication □ Yes □ No
- Electro-Convulsive Therapy □ Yes □ No

a.2 Was/is treatment helpful? □

b. Patient wants:
- medication □
- psychotherapy □
- no strong preference

c. Patient is opposed to:
- medication □
- psychotherapy □
- no strong opposition

Current Medications

List both prescription & non-prescription medications
(Circle medications which may interact significantly with antidepressants)

1. ____________________________ 4. ____________________________
2. ____________________________ 5. ____________________________
3. ____________________________ 6. ____________________________

Social Situation

Stressors: ____________________________

Social support: ____________________________

Assessed by: ____________________________ Phone number: (____) ____________________________

Reviewed by: ____________________________ (Signature of MD/Primary Care Clinician)

Healthform.2–02/00
**Figure 3c**

**Partners in Care**

**POST-INITIAL VISIT EVALUATION**

**Patient Name:** ____________________________  
**Study ID:** __________________

**Primary Care Clinician:** __________________  
**Tel. No.:** (__) _________

**Depression Nurse Specialist:** __________________  
**Tel. No.:** (__) _________

This post-initial telephone call was with__________________________ on __/__/_____ (date)

**Patient Questions**

1. ____________________________
2. ____________________________
3. ____________________________

**Patient Handouts**

*Patient received:*

- [ ] Your Personal Plan: Medications
- [ ] Your Personal Plan: Psychotherapy
- [ ] Your Personal Plan: Watchful Waiting
- [ ] Your Personal Plan: Relapse Prevention

**Depression Phase of Patient** *(at time of post-initial visit evaluation)*

<table>
<thead>
<tr>
<th>Phase</th>
<th>Follow-up</th>
<th>Next Visit</th>
<th>Handouts/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Acute</td>
<td>Call next week</td>
<td>2 weeks</td>
<td>- Your Personal Plan: Medications</td>
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<td></td>
<td></td>
<td></td>
<td>- Your Personal Plan: Psychotherapy</td>
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<td></td>
<td>- Other Your Personal Plans as appropriate</td>
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<td></td>
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<td></td>
<td>- Beck score &gt;9</td>
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<tr>
<td>[ ] Continuation</td>
<td>Call next week</td>
<td>3 months</td>
<td>- Your Personal Plan: Relapse Prevention</td>
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<td>- Other Your Personal Plans as appropriate</td>
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<td>- Beck score &lt;9</td>
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<tr>
<td>[ ] Maintenance</td>
<td>Call in 1 month</td>
<td>3 months</td>
<td>- Your Personal Plan: Relapse Prevention</td>
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<td>- Other Your Personal Plans as appropriate</td>
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<td></td>
<td>- Consider continuing/starting antidepressants</td>
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<td>- has completed acute phase medications AND 6 months of</td>
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<td>continuation phase medications OR</td>
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<td>- has completed psychotherapy AND has had two or more</td>
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<td></td>
<td></td>
<td></td>
<td>prior episodes of major depression</td>
</tr>
</tbody>
</table>

➢ Next Primary Care Follow-up Appointment: __/__/___  
With: ____________________________

Assessed by: ____________________________  
Reviewed by: ____________________________  
Phone number: (__) ____________________  
(Signature of MD/Primary Care Clinician)
Partners in Care
1 WEEK FOLLOW-UP TELEPHONE CALL WORKSHEET

Patient Name: ____________________________ Study ID: ____________

This follow-up telephone call was with __________________________ on __/__/__

Attempted Calls: __/__/__  Notes: ________________________________________
  (date)

 __/__/__  Notes: ________________________________________
  (date)

 __/__/__  Notes: ________________________________________
  (date)

Problems or Concerns with Treatment
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Improvement Status
a. Patient is feeling: (check one) □ better than before
       □ worse than before

b. If patient is worse, is s/he considering suicide or self-harm?
       □ Yes  □ No

Medications
a. List current medications: Taking as prescribed? Side effects/Concerns
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Next Primary Care Follow-up Appointment: __/__/__  With: ________________________

Recorded by: ____________________________  Phone number: (____) ____________
Reviewed by: ____________________________  (Signature of MD/Primary Care Clinician)
Partners in Care

2 WEEK FOLLOW-UP TELEPHONE CALL WORKSHEET

Patient Name: ______________________________ Study ID: ______________

This follow-up telephone call was with __________________________ on ___/___/___

Attempted Calls: ___/___/___ Notes: ________________________________________

___/___/___ Notes: ________________________________________

___/___/___ Notes: ________________________________________

Problems or Concerns with Treatment

____________________________________________________________________________

____________________________________________________________________________

Improvement Status

a. Patient is feeling: (check one) ☐ better than before ☐ worse than before

b. If patient is worse, is s/he considering suicide or self-harm? ☐ Yes ☐ No

Medications

a. List current medications: Taking as prescribed? Side effects/Concerns

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

b. Is patient in psychotherapy? ☐ Yes ☐ No

If Yes, does patient attend every session? ☐ Yes ☐ No

Name of therapist: __________________________ Phone number: (___) ______________

Next Primary Care Follow-up Appointment: ___/___/___ With: __________________________

Recorded by: __________________________ Phone number: (___) ______________

Reviewed by: __________________________ (Signature of MD/Primary Care Clinician)

ORIGINAL – STUDY RECORD  YELLOW – MD/PRIMARY CARE CLINICIAN  PINK – PATIENT  GOLDENROD – OTHER

Healthform.5 – 02/00

47
Partners in Care
4-6 WEEK FOLLOW-UP VISIT WORKSHEET

Patient Name: ___________________________ Study ID: ________________

This follow-up visit was □ in person  □ by telephone with ______________________ on ___/___/___

Problems or Concerns
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Symptoms (Check all that apply, then circle the symptom that bothers the patient the most)

□ Sad or empty  □ Thoughts of suicide or self-harm  □ Somatic/Other symptoms: (list)
□ Loss of interest  □ Sleep disturbance (sleeps ___ hrs/night)
□ Poor concentration  □ Appetite/weight change (+ / - ___ lbs.)
□ Poor energy  □ Physical agitation or slowness
□ Worthless/guilty  □ Periods of over-excitement
□ Anxiety  □ Sees/hears things not apparent to others
□ Hopelessness/poor future  □ Drug misuse/abuse
□ Drinks alcohol (type(s)) ___________________________ drinks/day ___
________________________________________________________________________________________
________________________________________________________________________________________

Improvement Status

a. Beck score: _____  b. (check one) □ > 9, no improvement  □ > 9, some improvement  □ < 9
(If no improvement, consider changing medications or adding psychotherapy or psychiatric consultation)

Social Situation

Stressors: _________________________________________________________________
Social support: ___________________________________________________________
________________________________________________________________________

Treatment

a. List current medications: ____________________________________________
   □ Yes  □ No
   ____________________________________________
   □ Yes  □ No
   ____________________________________________
   □ Yes  □ No
   ____________________________________________
   □ Yes  □ No
   ____________________________________________

b. Is patient in psychotherapy? □ Yes  □ No
   If Yes, does patient attend every session? □ Yes  □ No
   Name of therapist: ___________________________ Phone number: (___) __________

> Next Primary Care Follow-up Appointment: ___/___/___ With: ___________________________

Assessed by: ___________________________ Phone number: (___) __________
Reviewed by: ___________________________ (Signature of MD/Primary Care Clinician)
Partners in Care
10-12 WEEK FOLLOW-UP VISIT WORKSHEET

Patient Name: ___________________________  Study ID: __________________

This follow-up visit was □ in person  □ by telephone with ______________________ on __/__/____ (date)

Problems or Concerns

________________________________________________________________________

________________________________________________________________________

Symptoms (Check all that apply, then circle the symptom that bothers the patient the most)

☐ □ Sad or empty  ☐ □ Thoughts of suicide or self-harm
☐ □ Loss of interest  ☐ □ Sleep disturbance (sleeps ____ hrs/night)
☐ □ Poor concentration  ☐ □ Appetite/weight change (+ / - ____ lbs.)
☐ □ Poor energy  ☐ □ Physical agitation or slowness
☐ □ Worthless/guilty  ☐ □ Periods of over-excitement
☐ □ Anxiety  ☐ □ Sees/hears things not apparent to others
☐ □ Hopelessness/poor future  ☐ □ Drug misuse/abuse
☐ □ Drinks alcohol (type(s) ______________________ drinks/day ____)

☐ □ Somatic/Other symptoms: (list)

________________________________________________________________________

________________________________________________________________________

Improvement Status

a. Beck score: _____  b. (check one)  □ > 9, no improvement  □ > 9, some improvement  □ < 9

(If no improvement, consider changing medications or adding psychotherapy or psychiatric consultation)

Social Situation

Stressors: ________________________________________________________________

Social support: __________________________________________________________

Treatment

a. List current medications: ________________________________________________

   ________________________________________________

   ________________________________________________

   ________________________________________________

   ________________________________________________

Taking as prescribed?

☐ Yes  ☐ No

☐ Yes  ☐ No

☐ Yes  ☐ No

☐ Yes  ☐ No

☐ Yes  ☐ No

☐ Yes  ☐ No

Side effects/Concerns

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

b. Is patient in psychotherapy?  □ Yes  □ No

If Yes, does patient attend every session?  □ Yes  □ No

Name of therapist: __________________________ Phone number: (____) _________

Next Primary Care Follow-up Appointment: __/__/____ With: ______________________

(If acute phase completed, next contact is 3 month continuation visit. If not, next contact is 16 week follow-up)

Assessed by: __________________________ Phone number: (____) _________

Reviewed by: __________________________ (Signature of MD/Primary Care Clinician)

ORIGINAL — STUDY RECORD  YELLOW — MD/PRIMARY CARE CLINICIAN  PINK — PATIENT  GOLDENROD — OTHER

Healthform.7 – 02/00
Partners in Care
16 WEEK FOLLOW-UP VISIT WORKSHEET

Patient Name: ____________________________ Study ID: _______

This follow-up visit was □ in person □ by telephone with ____________________________ on ___/___/___
(date)

Problems or Concerns

__________________________________________________________________________

__________________________________________________________________________

Symptoms (Check all that apply, then circle the symptom that bothers the patient the most)

□ Sad or empty □ Thoughts of suicide or self-harm □ Somatic/Other symptoms: (list)
□ Loss of interest □ Sleep disturbance (sleeps ____ hrs/night) ____________________________
□ Poor concentration □ Appetite/weight change (+ / - ____ lbs.) ____________________________
□ Poor energy □ Physical agitation or slowness ___________________________________________
□ Worthless/guilty □ Periods of over-excitement _________________________________________
□ Anxiety □ Sees/hears things not apparent to others _____________________________________
□ Hopelessness/poor future □ Drug misuse/abuse ________________________________________
□ Drinks alcohol (type(s) ______________ drinks/day ___) _______________________________

Acute Phase Status

a. Beck score: ______ b. (check one) □ > 9, no improvement □ > 9, some improvement □ < 9
(If still in acute phase, consider changing meds or adding psychotherapy or psychiatric consultation)

Social Situation

Stressors: ____________________________

Social support: ____________________________

Treatment

a. List current medications: Taking as prescribed? Side effects/Concerns

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

b. Is patient in psychotherapy? □ Yes □ No

If Yes, does patient attend every session? □ Yes □ No

Name of therapist: ____________________________ Phone number: (___) ________

➢ Next Primary Care Follow-up Appointment: ___/___/___ With: ____________________________
(If acute phase completed, next contact is 3 month continuation visit. If not, next contact is 20 week follow-up)

Assessed by: ____________________________ Phone number: (___) ________
Reviewed by: ____________________________ (Signature of MD/Primary Care Clinician)

ORIGINAL – STUDY RECORD YELLOW – MD/PRIMARY CARE CLINICIAN PINK – PATIENT GOLDENROD – OTHER

Healthform.8 – 02/00

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Partners in Care

20+ WEEK FOLLOW-UP VISIT WORKSHEET
Use for symptomatic acute phase patients
Week Number: _____

Patient Name: _______________________________ Study ID: ________________

This follow-up visit was □ in person  □ by telephone with ______________________ on ___/___/____ (date)

Problems or Concerns

___________________________________________________________________________

___________________________________________________________________________

Symptoms (Check all that apply, then circle the symptom that bothers the patient the most)

□ Sad or empty □ Thoughts of suicide or self-harm □ Somatic/Other symptoms: (list)

□ Loss of interest □ Sleep disturbance (sleeps ____ hrs/night)

□ Poor concentration □ Appetite/weight change (+ / - ____ lbs.)

□ Poor energy □ Physical agitation or slowness

□ Worthless/guilty □ Periods of over-excitement

□ Anxiety □ Sees/hears things not apparent to others

□ Hopelessness/poor future □ Drug misuse/abuse

□ Drinks alcohol (type(s) ______________________ drinks/day ____)

Acute Phase Status

a. Beck score: _____

b. (check one) □ > 9, no improvement □ > 9, some improvement □ < 9

(If still in acute phase, consider changing meds or adding psychotherapy or psychiatric consultation)

Social Situation

Stressors: ________________________________________________________________

Social support: _____________________________________________________________

Treatment

a. List current medications: Taking as prescribed? Side effects/Concerns

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

b. Is patient in psychotherapy? □ Yes □ No

If Yes, does patient attend every session? □ Yes □ No

Name of therapist: ______________________________ Phone number: (___) _________

Next Primary Care Follow-up Appointment: ___/___/____ With: ______________________

(If acute phase completed, next contact is 3 month continuation visit. If not, next contact is 20+ week follow-up)

Assessed by: _____________________________________________ Phone number: (___) _________

Reviewed by: _____________________________________________ (Signature of MD/Primary Care Clinician)

ORIGINAL – STUDY RECORD YELLOW – MD/PRIMARY CARE CLINICIAN PINK – PATIENT GOLDENROD – OTHER

Healthform.9 – 02/00

55
Partners in Care
3 MONTH CONTINUATION PHASE VISIT WORKSHEET

Patient Name: ___________________________ Study ID: ____________

This continuation visit was ☐ in person ☐ by telephone with ______________________ on __/__/____

Problems or Concerns
__________________________________________________________

Symptoms (Check all that apply, then circle the symptom that bothers the patient the most)
☐ ❖ Sad or empty ❖ ☐ Thoughts of suicide or self-harm ☐ Somatic/Other symptoms: (list)
☐ ❖ Loss of interest ❖ ☐ Sleep disturbance (sleeps ____ hrs/night)
☐ ☐ Poor concentration ☐ Appetite/weight change (+ / - ___ lbs.)
☐ ☐ Poor energy ☐ Physical agitation or slowness
☐ ☐ Worthless/guilty ☐ Periods of over-excitement
☐ ☐ Anxiety ☐ Sees/hears things not apparent to others
☐ ☐ Hopelessness/poor future ☐ Drug misuse/abuse
☐ ☐ Drinks alcohol (type(s) ______________________ drinks/day _____)

Relapse Status
a. Beck score: _____  b. (check one) ☐ > 9, worse than before ☐ = 9, same or some improvement ☐ < 9
   (If patient is relapsing, strongly consider psychiatric consultation)

Social Situation
Stressors: ____________________________________________________________
Social support: _______________________________________________________

Treatment
a. List current medications: Taking as prescribed? Side effects/Concerns
   __________________________________________ □ Yes □ No
   __________________________________________ □ Yes □ No
   __________________________________________ □ Yes □ No
   __________________________________________ □ Yes □ No
   __________________________________________ □ Yes □ No
   __________________________________________ □ Yes □ No
   __________________________________________ □ Yes □ No
   __________________________________________ □ Yes □ No

b. Is patient in psychotherapy? □ Yes □ No
   If Yes, does patient attend every session? □ Yes □ No
   Name of therapist: ___________________________ Phone number: (____) ______________________

  c. Has patient been given Your Personal Plan: Relapse Prevention? □ Yes □ No

➢ Next Primary Care Follow-up Appointment: __/__/____ With: _________________________________

Assessed by: ___________________________ Phone number: (____) ______________________
Reviewed by: ___________________________ (Signature of MD/Primary Care Clinician)

ORIGINAL — STUDY RECORD YELLOW — MD/PRIMARY CARE CLINICIAN PINK — PATIENT GOLDENROD — OTHER

Healthform.10-02/00 57
Partners in Care
6 MONTH CONTINUATION PHASE VISIT WORKSHEET

Patient Name: ______________________________ Study ID: ________________

This continuation visit was ☐ in person ☐ by telephone with ______________ on __/__/_____ (date)

Problems or Concerns

________________________________________________________________________

Symptoms (Check all that apply, then circle the symptom that bothers the patient the most)

☐ ☐ Sad or empty ☐ ☐ Thought of suicide or self-harm ☐ ☐ Somatic/Other symptoms: (list)

☐ ☐ Loss of interest ☐ ☐ Sleep disturbance (sleeps ___ hrs/night)

☐ ☐ Poor concentration ☐ ☐ Appetite/weight change (+/ - ___ lbs.)

☐ ☐ Poor energy ☐ ☐ Physical agitation or slowness

☐ ☐ Worthless/guilty ☐ ☐ Periods of over-excitement

☐ ☐ Anxiety ☐ ☐ Sees/hears things not apparent to others

☐ ☐ Hopelessness/poor future ☐ ☐ Drug misuse/abuse

☐ ☐ Drinks alcohol (type(s): __________________________ drinks/day ___)

Relapse Status
a. Beck score: ____ b. (check one) ☐ > 9, worse than before ☐ > 9, same or some improvement ☐ < 9
(If patient is relapsing, strongly consider psychiatric consultation)

Social Situation
Stressors:

Social support:

Treatment
a. List current medications:

________________________________________________________________________

☐ Yes ☐ No

________________________________________________________________________

☐ Yes ☐ No

________________________________________________________________________

☐ Yes ☐ No

________________________________________________________________________

☐ Yes ☐ No

________________________________________________________________________

☐ Yes ☐ No

________________________________________________________________________

☐ Yes ☐ No

b. Has patient been given Your Personal Plan: Relapse Prevention? ☐ Yes ☐ No

➢ Next Primary Care Follow-up Appointment: __/__/____ With: ________________________

Assessed by: ______________________________ Phone number: (____) ________________
Reviewed by: ______________________________

(Signature of MD/Primary Care Clinician)

ORIGINAL = STUDY RECORD YELOW = MD/PRIMARY CARE CLINICIAN
PINK = PATIENT GOLDENROD = OTHER

Healthform.11 –02/00
Partners in Care

9 MONTH CONTINUATION PHASE VISIT WORKSHEET

Patient Name: ____________________________ Study ID: ____________

This continuation visit was ☐ in person ☐ by telephone with ___________________________ on ___/___/___ (date)

Problems or Concerns

________________________________________

Symptoms (Check all that apply, then circle the symptom that bothers the patient the most)

☐ ☐ Sad or empty ☐ Thoughts of suicide or self-harm ☐ Somatic/Other symptoms: (list)
☐ ☐ Loss of interest ☐ Sleep disturbance (sleeps ___ hrs/night)
☐ ☐ Poor concentration ☐ Appetite/weight change (+/- ___ lbs.)
☐ ☐ Poor energy ☐ Physical agitation or slowness
☐ ☐ Worthless/guilty ☐ Periods of over-excitement
☐ Anxiety ☐ Sees/hears things not apparent to others
☐ ☐ Hopelessness/poor future ☐ Drug misuse/abuse
☐ ☐ Drinks alcohol (type(s) ___________________ drinks/day ___)

Relapse Status

a. Beck score: ______  b. (check one) ☐ > 9, worse than before ☐ > 9, same or some improvement ☐ < 9
   (If patient is relapsing, strongly consider psychiatric consultation)

Social Situation

Stressors: ____________________________________________

Social support: ____________________________________________

Treatment

a. List current medications: Taking as prescribed? Side effects/Concerns
   ____________________________________________ ☐ Yes ☐ No
   ____________________________________________ ☐ Yes ☐ No
   ____________________________________________ ☐ Yes ☐ No
   ____________________________________________ ☐ Yes ☐ No
   ____________________________________________ ☐ Yes ☐ No

b. Has patient been given Your Personal Plan: Relapse Prevention? ☐ Yes ☐ No

Next Primary Care Follow-up Appointment: ___/___/___ With: ____________________________

Assessed by: ____________________________ Phone number: (___) __________________
Reviewed by: ____________________________ (Signature of MD/Primary Care Clinician)

ORIGINAL – STUDY RECORD  YELLOW – MD/PRIMARY CARE CLINICIAN  PINK – PATIENT  GOLDENROD – OTHER
Healthform.12 –02/00

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Partners in Care

MAINTENANCE VISIT WORKSHEET

Patient Name: __________________________ Study ID: __________

This maintenance visit was ☐ in person ☐ by telephone with __________________________ on __/__/____ (date)

Problems or Concerns

________________________________________________________

Symptoms (Check all that apply, then circle the symptom that bothers the patient the most)

☐ ☐ Sad or empty ☐ Thoughts of suicide or self-harm ☐ Somatic/Other symptoms: (list)
☐ ☐ Loss of interest ☐ Sleep disturbance (sleeps ____ hrs/night)
☐ ☐ Poor concentration ☐ Appetite/weight change (+ / - ____ lbs.)
☐ ☐ Poor energy ☐ Physical agitation or slowness
☐ ☐ Worthless/guilty ☐ Periods of over-excitement
☐ ☐ Anxiety ☐ Sees/hears things not apparent to others
☐ ☐ Hopelessness/poor future ☐ Drug misuse/abuse
☐ ☐ Drinks alcohol (type(s) ______________________ drinks/day ____)

Relapse Status

a. Beck score: ______  b. (check one) ☐ > 9, worse than before ☐ > 9, same or some improvement ☐ < 9

(If patient is relapsing, strongly consider psychiatric consultation)

Social Situation

Stressors: __________________________________________________________

Social support: ______________________________________________________

Treatment

a. List current medications: Taking as prescribed? Side effects/Concerns

___________________________________________________________________ ☐ Yes ☐ No
___________________________________________________________________ ☐ Yes ☐ No
___________________________________________________________________ ☐ Yes ☐ No
___________________________________________________________________ ☐ Yes ☐ No
___________________________________________________________________ ☐ Yes ☐ No

b. Has patient been given Your Personal Plan: Relapse Prevention? ☐ Yes ☐ No

Next Primary Care Follow-up Appointment: __/__/____ With: __________________________

Assessed by: __________________________ Phone number: (____) __________
Reviewed by: __________________________ (Signature of MD/Primary Care Clinician)

ORIGINAL – STUDY RECORD YELLOW – MD/PRIMARY CARE CLINICIAN
GENERAL – OTHER

Healthform.13 –02/00

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Partners in Care
MD/RN STUDY RECORD NOTES

Use one form per visit/contact, as needed.
Place in chronological order in patient’s study record.

Patient Name: ____________________________
Primary Care Clinician: ______________________
Depression Nurse Specialist: ____________________

Study ID: __________________
Tel. No: (____) __________

Visit/Contact

____/____/____
(date)

(check one)
☐ Telephone
☐ In person

Notes

__________________________

__________________________

__________________________

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__________________________


Recorded By: ____________________________
Reviewed By: ____________________________

Phone number: (____) __________
(Signature of MD/Primary Care Clinician)

ORIGINAL – STUDY RECORD
YELLOW – MD/PRIMARY CARE CLINICIAN
PINK – PATIENT
GOLDENROD – OTHER

Healthform.14 -02/00

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**YOUR PERSONAL PLAN: Medications**

**Patient Name:** ____________________________ **Study ID#:** ____________________________

**CONTACT/APPOINTMENT INFORMATION**

Primary Care Clinician: ____________________________ **Tel. No:** (____)______________

Depression Nurse Specialist: ____________________________ **Tel. No:** (____)______________

> **Next appointment:** Date ____/____ Time: ____:____ am/pm (circle one)

**YOUR MEDICATION SCHEDULE**

<table>
<thead>
<tr>
<th>Name of medication: ____________________________</th>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; Take ____ tablet(s) of ____ mg every morning/evening for ____ days</td>
<td><strong><strong>/</strong></strong></td>
<td><strong><strong>/</strong></strong></td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; Take ____ tablet(s) of ____ mg every morning/evening for ____ days</td>
<td><strong><strong>/</strong></strong></td>
<td><strong><strong>/</strong></strong></td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; Take ____ tablet(s) of ____ mg every morning/evening for ____ days</td>
<td><strong><strong>/</strong></strong></td>
<td><strong><strong>/</strong></strong></td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt; Take ____ tablet(s) of ____ mg every morning/evening for ____ days</td>
<td><strong><strong>/</strong></strong></td>
<td><strong><strong>/</strong></strong></td>
</tr>
</tbody>
</table>

**NOTE:** The medication is started at a low dose to give your body time to adapt. If you are having side effects, you can stay at a lower dose for a little longer and then increase the amount. **Remember:** It may take a few weeks before you experience the medication’s full effect, so don’t get discouraged.

**IMPORTANT!!!**

DON’T STOP THE MEDICATION BEFORE CALLING YOUR DOCTOR

**SYMPTOMS TO MONITOR**

☑ If you are having this symptom:

- Anxiety attacks
- Aches and pains
- Problems with sleep
- Trouble thinking, concentrating, or deciding
- Decreased or increased appetite
- Feeling slowed down or sped up/jittery
- Feelings of worthlessness or guilt
- Wishing you were dead or thinking about suicide
- Feeling depressed or sad
- Loss of interest or pleasure
- Nervousness or tension
- Fatigue or loss of energy
- Others: ____________________________

**YOUR QUESTIONS/CONCERNS**

Bring this form to your next visit. Record any questions, problems, or concerns you may have about your current treatment here:

1. ____________________________

2. ____________________________

3. ____________________________

**ORIGINAL – STUDY RECORD**
**YELLOW – MD/PRIMARY CARE CLINICIAN**
**PINK – PATIENT**
**GOLDENROD – OTHER**

Healthform.15 –02/00

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INFORMATION ABOUT ANTIDEPRESSANT MEDICATIONS

How do antidepressants work?

Both life stresses and medical problems can deplete the amount of chemical messengers in the nervous system that maintains the balance in how you feel emotionally and physically. This chemical imbalance results in some of the common symptoms of depression such as sleep and appetite problems, loss of energy, loss of concentration, and increased sensitivity to pain. Antidepressant medications help restore a normal balance of these chemical messengers, which helps to relieve emotional and physical symptoms.

Antidepressants can take up to 6 weeks to work. It usually takes one to four weeks until people start feeling better emotionally and physically. The improvement may be gradual, and oftentimes family members or friends may notice a difference in how you are doing before you do. Your sleep and appetite may improve first, then your mood and energy. Negative thinking may take some more time to decrease.

Once you are feeling better, do not stop the medication right away. Your doctor may recommend taking the medication for six to nine months or longer to prevent a relapse of the depression.

How to find an antidepressant that works for you?

Scientific studies show that antidepressant medications do not differ in the percentage of patients that get better. However, different medications are effective for different people, and the side effects of the medications differ. Some medications also cost more than others. Your doctor can help you decide which medication may be best for you.

About 70% of patients will get better after 4 to 6 weeks on an antidepressant medication. By working together, you and your doctor can decide during that six-week period whether the medication you started is the right one for you. If you need to switch to another antidepressant because of side effects or because you are not significantly improved after six weeks, chances are still excellent that you will improve on this second medication.

What about side effects?

Some people may experience side effects when taking antidepressant medications. While these side effects can be annoying, they are rarely dangerous to your health. They usually occur in the first few weeks and then gradually decrease as your body adapts to the medication. Because of these early side effects, patients sometimes feel a little worse before they start getting better and may give up too soon. If you have side effects that are bothering you, discuss these with your doctor. Your doctor will help you determine if these side effects will decrease over time or if you should decrease or switch your medication.

Some of the side effects that can occur with antidepressants:

- nausea
- headaches
- jitteriness
- weight gain
- diarrhea
- insomnia
- sedation
- urinary hesitancy
- dizziness
- rapid heart rate
- temporary difficulty in achieving orgasm
- blurred vision
- dry mouth
- constipation
- other: ________________

Remember:

- Antidepressants are not addicting or habit forming. They do not make people ‘high’, and they do not lead to serious withdrawal symptoms once you stop them.
- Take the medications daily.
- Keep track of side effects and problems and discuss them with your physician.
- Do not stop the medication before talking with your doctor.
Partners in Care

YOUR PERSONAL PLAN:
Psychotherapy

Patient Name: ____________________________ Study ID: _________________

CONTACT INFORMATION

Primary Care Clinician: ____________________________ Tel. No: (___) _____________
Depression Nurse Specialist: ____________________________ Tel. No: (___) _____________
Psychotherapist: ____________________________ Tel. No: (___) _____________

YOUR NEXT APPOINTMENTS

With Primary Care Physician: Date ___/___/___ Time: ___:___ am / pm (circle one)
With Psychotherapist: Date ___/___/___ Time: ___:___ am / pm (circle one)

SYMPTOMS TO MONITOR

☑ if you are having this symptom:

☐ Anxiety attacks ☐ Wishing you were dead or thinking about suicide
☐ Aches and pains ☐ Feeling depressed or sad
☐ Problems with sleep ☐ Loss of interest or pleasure
☐ Trouble thinking, concentrating, or deciding ☐ Nervousness or tension
☐ Decreased or increased appetite ☐ Fatigue or loss of energy
☐ Feeling slowed down or sped up/jittery ☐ Others: __________________________
☐ Feelings of worthlessness or guilt

YOUR QUESTIONS/CONCERNS

Bring this form to your next visit. Record any questions, problems, or concerns you may have about your current treatment here:

1. ____________________________________________
2. ____________________________________________
3. ____________________________________________
Partners in Care

YOUR PERSONAL PLAN:
Watchful Waiting

(For patients not started on medication or psychotherapy treatment plan)

Patient Name: ______________________ Study ID: ____________

CONTACT INFORMATION

Primary Care Physician: ______________________ Tel. No.: (____) ________
Depression Nurse Specialist: ______________________ Tel. No.: (____) ________
Psychotherapist: ______________________ Tel. No.: (____) ________

YOUR NEXT APPOINTMENTS

With Primary Care Physician: Date ___/___/___ Time: ____ : ____ am / pm (circle one)
With Depression Nurse Specialist: Date ___/___/___ Time: ____ : ____ am / pm
With: ______________________ Date ___/___/___ Time: ____ : ____ am / pm

SYMPTOMS TO MONITOR

☑ if you are having this symptom:

☐ Anxiety attacks
☐ Aches and pains
☐ Problems with sleep
☐ Trouble thinking, concentrating, or deciding
☐ Decreased or increased appetite
☐ Feeling slowed down or sped up/jittery
☐ Feelings of worthlessness or guilt

☐ Wishing you were dead or thinking about suicide
☐ Feeling depressed or sad
☐ Loss of interest or pleasure
☐ Nervousness or tension
☐ Fatigue or loss of energy
☐ Others: ______________________

YOUR QUESTIONS/CONCERNS

Bring this form to your next visit. Record any questions, problems, or concerns you may have about your current treatment here:

1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________

ORIGINAL – STUDY RECORD    YELLOW – MD/PRIMARY CARE CLINICIAN    PINK – PATIENT    GOLDENROD – OTHER

Healthform.17 – 02/00  75
YOUR PERSONAL PLAN:
Relapse Prevention

Patient Name: ___________________________ Study ID: ____________

CONTACT INFORMATION

Primary Care Physician: ___________________ Tel. No: (___) ____________
Depression Nurse Specialist: ______________ Tel. No: (___) ____________
Psychotherapist: ________________________ Tel. No: (___) ____________

PERSONAL WARNING SIGNS

1. _______________________________________
2. _______________________________________
3. _______________________________________

STRESSFUL LIFE EVENTS AND HOW TO MINIMIZE THEM

Event: __________________ How to minimize: __________________

Event: __________________ How to minimize: __________________

Event: __________________ How to minimize: __________________

MEDICATIONS

Name of antidepressant: __________________ Dose: __________

Take medication until: __/__/____

Questions: Call your primary care clinician or your depression nurse specialist.
(See Contact Information, above)

WHAT YOU SHOULD DO IF SYMPTOMS OF DEPRESSION RECUR

1. ______________________________________
2. ______________________________________
3. ______________________________________

Reviewed by: _____________________________ (Signature of MD/Primary Care Clinician)

ORIGINEAL – STUDY RECORD    YELLOW – MD/PRIMARY CARE CLINICIAN    PINK – PATIENT    GOLDENROD – OTHER

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77
### Partners in Care
**MEDICATION-ENHANCED CLINIC**

**REGISTER AND ACTIVITY SUMMARY**
**ALL STUDY PATIENTS**

#### Depression Nurse Specialist:

**Clinic:**

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<tr>
<th>Line #</th>
<th>Study ID (ODD &amp; EVEN)</th>
<th>Patient Name Last, First</th>
<th>Medical Record No.</th>
<th>Enter Dates</th>
<th>Type of Therapy Started on Initial Visit* (circle one)</th>
<th>Enter Dates</th>
<th>Patient Started Psychotherapy†</th>
<th>Patient Started Medication‡</th>
<th>End of Follow-up period (6 or 12 months after Initial Visit)</th>
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* M = Medication or medication plus psychotherapy; if 'M' circled, enter dates as appropriate in Columns H & I.

† P = Psychotherapy only; if 'P' circled, enter date as appropriate in Column H.

‡ N = None; if 'N' circled, enter line number, Study ID and name of patient on Follow-up Log for Patients Not Started on Treatment (Healthform.21 –02/00). If patient begins treatment at a later date, enter dates as appropriate in Columns H & I.

§ If patient has not started on this treatment, leave blank.
### Partners in Care
#### MEDICATION-ENHANCED CLINIC
#### FOLLOW-UP LOG
FOR PATIENTS
STARTED ON PSYCHOTHERAPY ONLY*

**Notes:**

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* Record information on patients for whom psychotherapy only (i.e., no medication) has been prescribed as treatment. *Reminder:* Transfer Line Number from Register (Healthform.19 –02/00).

The patient should be contacted 8 to 12 weeks after the initial assessment visit to see if therapy is working. If the patient has not adhered to therapy regimen, or if therapy is not working, consult with the primary care clinician. *This form provides additional spaces for optional contacts.*
**Suggested Result Codes**
21 Made appt. w/ primary care clinician
22 Started on depression medication
23 Initial therapy appointment pending
24 Started CBT therapy at this clinic
25 Started treatment at outside clinic
26 Patient considering treatment
27 Depression improved
28 Refused treatment
29 Unable to contact after repeated attempts
30 Other - Specify

---

**Partners in Care**
**MEDICATION-ENHANCED CLINIC**
**FOLLOW-UP LOG**
**FOR PATIENTS**
**NOT STARTED ON TREATMENT – TREATMENT INDICATED**

---

**Depression Nurse Specialist:** [Name]

**Clinic:** [Name]

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* Record information on patients for whom treatment is indicated, but who were not started on treatment at time of initial visit. **Reminder:** Transfer Line Number from Register (Healthform.19 -02/00).

About 4 weeks after the initial assessment visit, the patient should be contacted for reevaluation and to encourage treatment. If patient is still depressed and not willing to see the primary care clinician, consider recontacting in another 4 weeks. If treatment is started, record date(s) as appropriate in columns H and/or I of the Register and Activity Summary--ALL Study Patients (Healthform.19 -02/00). This form provides additional spaces for optional contacts.
### Partners in Care

**MEDICATION-ENHANCED CLINIC**

**FOLLOW-UP LOG**

**FOR PATIENTS NOT REQUIRING PSYCHOTHERAPY OR MEDICATION**

---

**Suggested Result Codes**

21 Made appt. w/ primary care clinician  
22 Started on depression medication  
23 Initial therapy appointment pending  
24 Started CBT therapy at this clinic  
25 Started treatment at outside clinic  
26 Patient considering treatment  
27 Depression improved  
28 Refused treatment  
29 Unable to contact after repeated attempts  
30 Other - Specify

---

**Figure 5d**

**Notes:**

---

**Depression Nurse Specialist:**

<table>
<thead>
<tr>
<th>Line #</th>
<th>Study ID (ODD &amp; EVEN)</th>
<th>Patient Name</th>
<th>Tel No</th>
<th>[Date of Contact]</th>
<th>Results</th>
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</table>

* Record information on patients for whom treatment has been neither indicated nor prescribed. **Reminder:** Transfer Line Number from Register (Healthform.19 -02/00).

About 3 months after the initial assessment visit, the patient should be contacted to reassess or educate. If the depression has worsened, notify the primary care clinician. **This form provides additional spaces for optional contacts.**
### Partners in Care
**MEDICATION-ENHANCED CLINIC**

**BECK DEPRESSION INVENTORY (BDI) TRACKING FORM**

**12 MONTH FOLLOW-UP PATIENTS**

**(ODD-Numbered Study IDs)**

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<th>1st Date</th>
<th>1st BDI Score</th>
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*Reminder:* Transfer Line Number from Register (Healthform.19 - 02/00).
Partners in Care
MEDICATION-ENHANCED CLINIC

BECK DEPRESSION INVENTORY (BDI) TRACKING FORM
12 MONTH FOLLOW-UP PATIENTS (for information OVERFLOW+)

(ODD-Numbered Study IDs)

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| + +    | Continue to record scores on this form for patients who have been given the BDI more than 5 times.
* Transfer Patient Line Number and Study ID from the page of the BDI Tracking Form on which the patient was originally listed (Healthform.23a-02/00).
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*Reminder: Transfer Line Number from Register (Healthform.19 –02/00).
### Partners in Care

**PSYCHOTHERAPY-ENHANCED CLINIC REGISTER AND ACTIVITY SUMMARY ALL STUDY PATIENTS**

### Depression Nurse Specialist: ____________________

### Clinic: ____________________

<table>
<thead>
<tr>
<th>Line</th>
<th>Study ID (ODD &amp; EVEN)</th>
<th>Patient Name</th>
<th>Medical Record No</th>
<th>Enter Dates</th>
<th>Type of Therapy Started on Initial Visit (circle one)</th>
<th>Patients Started on Psychotherapy</th>
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*P = Psychotherapy only; if ‘P’ circled, enter dates as appropriate in Columns H, I & J.

B = Both psychotherapy and medications; if ‘B’ circled, enter dates as appropriate in Columns H, I & J.

N = None; if ‘N’ circled, enter patient’s name on *Follow-up Log for Patients Not Started on Treatment* (Healthform.21 –02/00). If patient begins psychotherapy at a later date, enter dates as appropriate in Columns H, I & J.

---

Healthform.25 -02/00
### Suggested Result Codes

1. Made appt. w/primary care clinician
2. Started on depression medication
3. Initial therapy appointment pending
4. Started CBT therapy at this clinic
5. Started treatment at outside clinic
6. Patient considering treatment
7. Depression improved
8. Refused treatment
9. Unable to contact after repeated attempts
10. Other - Specify

---

**Partners in Care**

**PSYCHOTHERAPY-ENHANCED CLINIC**

**FOLLOW-UP LOG**

for patients

**NOT STARTED ON TREATMENT – TREATMENT INDICATED**

---

### Depression Nurse Specialist:

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<tr>
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<th>Tel No</th>
<th>Date of Contact</th>
<th>CODE</th>
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<th>Date of Contact</th>
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### Clinic:

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*Record information on patients for whom treatment is indicated, but who were not started on treatment at the initial visit. Reminder: Transfer Line Number from Register (Healthform.19 - 02/00).*

About 4 weeks after the initial assessment visit, patient should be contacted for reevaluation and to encourage treatment. If the patient is still depressed and not willing to see the primary care clinician, consider recontacting in another 4 weeks. If psychotherapy is started, record date in the Register and Activity Summary–ALL Study Patients (Healthform.19 - 2/00). This form provides additional spaces for optional contacts.
**Suggested Result Codes**
51 Made appt. w/primary care clinician  
52 Started on depression medication  
53 Initial therapy appointment pending  
54 Started CBT therapy at this clinic  
55 Started treatment at outside clinic  
56 Patient considering treatment  
57 Depression worsened  
58 Refused treatment  
59 Unable to contact after repeated attempts  
60 Other - Specify

---

**Partners in Care**  
**PSYCHOTHERAPY-ENHANCED CLINIC**  
**FOLLOW-UP LOG**  
for patients  
**NOT REQUIRING PSYCHOTHERAPY OR MEDICATION** *

---

**Depression Nurse Specialist:**

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<th>Date of Contact</th>
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* Record information on patients for whom treatment has been **neither indicated nor prescribed**. **Reminder:** Transfer Line Number from Register (Healthform.19 –02/00).

About 3 months after the initial assessment visit, the patient should be contacted to reassess or educate. If the depression has worsened, notify the primary care clinician. **This form provides additional spaces for optional contacts.**
**Partners in Care**

**TRACKING CARD FOR PATIENTS ON MEDICATION**

(See reverse for Acute and Continuation/Maintenance Phases)

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<tr>
<th>Patient Name: ___________________________</th>
<th>Phone: (_<strong>)</strong>________</th>
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<tr>
<td>Emergency Contact: ______________________</td>
<td>Phone: (_<strong>)</strong>________</td>
</tr>
<tr>
<td>Primary Care Clinician: __________________</td>
<td>Phone: (_<strong>)</strong>________</td>
</tr>
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<td>Medical Record No: ______________________</td>
<td>Study ID: _____________</td>
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### ASSESSMENT

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<th>on meds?</th>
<th>in psychotherapy?</th>
<th>BDI administered?</th>
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<tbody>
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<td>Initial Visit</td>
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<td>Post-Initial Visit Evaluation</td>
<td><em><strong>/</strong></em>/___</td>
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<tr>
<td>Last Follow-up Scheduled</td>
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*Check box if completed*

*Healthform:29 -02/00*

### Front

| Patient Name: ___________________________ | Study ID: ___________________________ |

### ACUTE PHASE

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<th>Date Scheduled</th>
<th>on meds?</th>
<th>in psychotherapy?</th>
<th>BDI administered?</th>
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<td>2 Week Visit / Call</td>
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<td>4-6 Week Visit / Call</td>
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<td>10-12 Week Visit / Call</td>
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<td>16 Week Visit / Call*</td>
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<td>___ Week Visit / Call*</td>
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### CONTINUATION/MAINTENANCE PHASE

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*Only if patients are still symptomatic*

*Back*
Appendix A

STEP-BY-STEP GUIDE FOR DNS INITIAL VISIT ASSESSMENT

1. **Set up this visit**
   - The visit follows the researcher’s evaluation, indicating that patient felt sad, tired, or less interested in daily activities.
   - The visit is to help the doctor/primary care clinician by identifying key issues that need to be discussed or that the patient wishes to discuss, and by helping the patient to understand what kinds of issues may be most important to the doctor/primary care clinician.
   - The DNS may not be able to listen to all of the patient’s concerns in this visit, but by finding out some things ahead of time she/he makes it possible for the patient to better articulate his or her issues to the doctor/primary care clinician. The nurse will follow up again after the visit to help clear up any remaining issues.
   - *For Medication-Enhanced Clinic Nurses Only*: The DNS will assist the patient during treatment if the doctor/primary care clinician decides that treatment is indicated.

2. **Educate the patient. Know about the key issues regarding depression by reviewing the patient education brochure. Assess whether the patient has the following:**
   - Current symptoms suggestive of depression. (If yes, find out for how long, administer a Beck Depression Inventory, go over DSM IV criteria listed in patient brochure, assess suicidality, somatic symptoms, etc.)
   - A history of depression or treatment for depression
   - Coexisting psychiatric or psychosocial problems that may cause depressive symptoms (list medications, ask about thyroid problems)
   - Impaired social, personal, family, or work functioning
   - Low social support or highly involved family/friends who may need to be taken into account
   - Strong pre-existing treatment preferences or oppositions

3. **Identify at least two questions that the patient would like to ask the doctor/primary care clinician.**
4. Write down your findings on the Initial Visit Worksheet (*Figure 3b*). Give the pink copy to the patient and give the yellow copy to the MD/primary care clinician. Put the original in the patient’s study record.
   - Note any incomplete assessments by writing a “?” on the form in the appropriate location.
   - Ask the patient, “How comfortable do you think you will be talking to your doctor/primary care clinician about your feelings?”

*Rules for the Visit* (the same rules are used in patient activation studies)

During the initial visit
- **you must not** advocate for the patient; you want to get the patient to advocate for him/herself
- **you must not** provide information that is outside the domain of depression and its symptoms

For any but the most basic questions, refer the patient to other sources of information. You may say to the patient, for example:
  - ”That's an excellent question, and its something the doctor/primary care clinician will want to know that you are concerned about.”
  - ”That's something we deal with in the brochure, let me show you....”
Appendix B

DNS INITIAL ASSESSMENT QUERIES

The initial nurse assessment is guided by an understanding of the key features of depression, but follows the nurse’s judgment about which areas to explore in detail during the limited time available. The following probes may be useful in framing questions to gather information required by the Partners in Care Initial Visit Worksheet (Figure 3b). Numbering for the probes follows the order on the Worksheet.

Questions for the Doctor: Pick up key questions as the interview progresses. Ask the patient what he/she most wants to ask the doctor at the end of the interview, and be prepared to feed back earlier questions to the patient as possible targets if the patient cannot tell you in answer to your direct request. You should list at least two questions.

1. Symptoms

To assess for sadness: How much of the time over the past month have you felt downhearted and blue? Did you feel so down in the dumps that nothing could cheer you up?

To assess for mania: Have you ever had a period of four or more days when you were so happy or excited that you got into trouble, or your family or friends worried about you, or a doctor said you were manic? Have you ever had a period when you were much more active than usual, or felt that you hardly needed to sleep at all but did not feel tired or sleepy?

To assess for suicidality: Do you ever have thoughts of wishing you were dead? Have you actively thought of killing or hurting yourself? What have you thought of doing? Have you tried anything?

To assess for somatic symptoms: Look especially for stomach or intestinal complains (abdominal pain, constipation); musculoskeletal pain (back pain, shoulder/neck pain); palpitations; dizziness/lightheadedness; weakness.

To assess for alcohol or drug use: Do you drink any alcohol? What is the most that you ever drink at one time? How much do you usually drink per day? Per week? Do you ever feel the need to cut down? Annoyed by criticism of your drinking?
2. Activities Affected

To assess social, personal, family, and work activities, and bed or restricted activity days: Does the person participate in social and community activities (religious, family, friends)? Has social activity decreased from the past? Does the person have difficulty performing family responsibilities? Does the person have trouble fulfilling job responsibilities? Does the person have days when s/he doesn’t get out of bed (bed days)? Does the patient have days when s/he cuts down on the things s/he usually does for half a day or more (restricted days)?

3. Treatment Preferences

To assess for treatment preferences: Ask the patient whether he/she would have objections to being treated with psychotherapy or medications if the doctor/primary care clinician felt that one or the other of these would be helpful. Ask whether the patient has a strong preference for one or the other.

4. Stress

To assess for stress: Consider losses (deaths, separation or divorce, recent surgery, new health problems in self or significant others, children leaving home); job loss or change; moving; past history of physical or sexual abuse; childbirth.

5. Social Support

To assess for social support: How many friends or relatives do you see or hear from at least once a month? Which friends or relatives do you have the most contact with? Do you talk to any of these people about private matters? Do you usually ask any of them for advice on private matters?
Appendix C

SF-12 HEALTH SURVEY (Modified Scoring)

INSTRUCTIONS: This questionnaire asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by circling one answer. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is: (Circle One)
   Excellent........................................1
   Very good.....................................2
   Good...........................................3
   Fair............................................4
   Poor............................................5

The following items are activities you might do during a typical day. Does your health limit you in these activities?

   Yes, Limited Yes, Limited No, Not
   A Lot A Little Limited
   (Circle One Number on Each Line)

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.......................... 3 2 1

3. Climbing several flights of stairs......................... 3 2 1

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

   (Circle One Number on Each Line)

   Yes No

4. Accomplished less than you would like ............ 2 1

5. Were limited in the kind of work or other activities............................................ 2 1
Appendix C (continued)

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? (Please answer YES or NO for each question.)

(Circle One Number on Each Line)

6. Accomplished less than you would like? .......... 2 1

7. Didn't do work or other activities as carefully as usual? ........................................... 2 1

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(Circle One)

Not at all.......................... 1
A little bit .......................... 2
Moderately ......................... 3
Quite a bit .......................... 4
Extremely .......................... 5

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How often during the past 4 weeks.

(Circle One Number on Each Line)

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>A good bit of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
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</table>

9. Have you felt calm and peaceful? ...................... 1 2 3 4 5 6

10. Did you have a lot of energy? ........................... 1 2 3 4 5 6

11. Have you felt down-hearted and blue? ............... 1 2 3 4 5 6

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

(Circle One)

All of the time........................... 5
Most of the time ........................ 4
Some of the time ........................ 3
A little of the time ..................... 2
None of the time ........................ 1

Maximum Score = 40
Appendix D

TRAINING ROLE-PLAYS FOR INITIAL ASSESSMENT AND FOLLOW-UP

Case 1

Initial visit

Mrs. D. is a 28-year-old married Caucasian mother of a seven-month-old baby boy. She did well immediately after the birth of the baby but now presents with five months of fatigue and poor energy. Even when the baby sleeps at night, she often wakes up around 3 am and has a difficult time going back to sleep. During the day, she can't concentrate and feels like she gets nothing accomplished.

She feels inadequate as a mother because she has a difficult time comforting the baby, who has had a lot of colic and crying spells.

She used to work in a marketing firm and had considered returning to work after 3 months, but now she feels that she cannot go back because she feels that nobody can adequately comfort the baby. She feels guilty about this because it will be very difficult for the couple to support their current lifestyle on her husband's income only.

She stays at home most of the day and has not seen many of her family and friends, who have offered to help with the baby.

Her husband has been trying to help as much as he can, but he has a significant amount of stress at work and the couple has been arguing more than they used to - usually over “little things.”

She denies feeling depressed, but her husband says that she has been extremely emotionally labile, irritable, and crying multiple times a day.

1 week telephone follow-up

Mrs. D. has been taking sertraline 50 mg po qam for 1 week. She has not noticed much difference in her mood but has shared her diagnosis of depression with a friend of hers who had been successfully treated with an antidepressant in the past. She has managed to take the medication every morning but has had “upset stomach,” mild nausea and diarrhea on four mornings. This reminds her of being morning sick with the baby, and she is somewhat discouraged by this. She has not been breastfeeding the baby, because of the antidepressant, and a number of people have warned her that this may cause the baby to have more colic or develop food allergies later on.

8 week follow-up

Mrs. D. is feeling significantly better. She is sleeping better, her mood is improved, and she doesn't cry as easily as she used to. She has started to go out and meet friends, and she has joined a play group with her son. She is still undecided if she should go back to work. She is still taking sertraline 50 mg and doesn't have any more side effects. She wonders if she should discontinue the medication at this time.
Case 2

Initial visit

Mr. B. is a 40-year-old African-American man who is the vice-president of a small software development company. Over the last year, he has developed symptoms of chest pain. His cardiac work-up including treadmill and angiogram have been normal, and he is frustrated about the fact that nobody has been able to find out what is wrong.

He states that he has been under a lot of stress at work because his company is going through a major financial restructuring. He works late hours, and his wife is resentful because he has not spent much time with his family. He has not seen any of his friends and has essentially stopped pursuing his hobbies such as playing golf.

Over the last year, he has had significant problems with his sleep. He often lies awake at night worrying about his business. During the day, he has low energy and cannot concentrate well. He is much more irritable than he used to be.

He denies feeling depressed and focuses on the fact that he experiences repeated episodes of rapid heart beat, sweating, dizziness, and shortness of breath - usually associated with his chest pain.

1 week telephone follow-up

Mr. B. has been taking imipramine - initially 50 mg po qhs and for the last 2 days 100 mg po qhs. He has slept better for the past three nights but feels even more tired during the day. He did take a short walk during his lunch hour two days ago and found that his chest pain actually decreased during the walk.

2 week clinic follow-up

Mr. B. has been taking imipramine 150 mg po qhs. His sleep at night is significantly improved, but he still complains of significant daytime sedation, dry mouth, and constipation. A few nights ago, on his way home from work, he had another episode of chest pain, this time associated with blurred vision, and he is quite concerned about this.
Case 3

Initial visit

Mrs. S. is a 74-year-old Hispanic mother of three grown children. She presents with complaints of extreme fatigue and constipation over the past year. Her children are concerned that she has cancer because she has lost 30 pounds in the past year, and her appetite is poor.

She has been sleeping poorly because she has been caring for her husband, who had a stroke two years ago and is bedridden. He is frequently incontinent and calls for her at night. She has considered placing him in a nursing home but just cannot bring herself to do this.

Mrs. S. herself has significant medical problems. She has a long history of hypothyroidism, for which she is on replacement hormones. She has hypertension and coronary artery disease, and she had a 3-vessel coronary bypass operation four years ago.

When asked about prior episodes of depression, her daughter states that she had a severe depression after the birth of her second daughter, which required an inpatient admission and treatment with electroconvulsive therapy. She has bad memories of this episode and does not wish to see a psychiatrist because of this.

She denies currently feeling depressed but says that she has been crying frequently, often “for no good reason.” She has stopped going out to see her friends because she feels she cannot leave her husband. Even when her children come over to help care for the husband, she does not feel like doing anything.

1 week follow-up

Mrs. S. was given a prescription of sertraline 25 mg po qhs but has not gone to fill the prescription. She cries on the telephone and states that she does not want to become dependent on a medication. She focuses on problems with her husband's incontinence and calling at night.
Appendix E

COURSE OF ACTION FOR RELAPSE PREVENTION

1. Review the course of depression up to now and address the following:
   • depressive symptoms
   • impact of the depression on the patient’s ability to function at home and at work
   • current treatment(s) and treatment(s) tried before
   • questions about treatment(s)

2. Review risk factors for relapse:
   • 2 or more prior episodes of major depression
   • dysthymia: chronic depressive symptoms for 2 years or more
   • residual depressive symptoms (patient is not completely back to baseline)

   Remind the patient that these are risk factors for relapse of depression. We know from prior research that, without active treatment, 50% of patients with one prior episode of major depression will have a relapse within two years. Patients with 2 or 3 prior episodes have a 70 or 90% chance of relapse, respectively.

   **Patients who have such risk factors should stay on full-dose antidepressants for at least 2 years.**

   **Patients who don’t have these risk factors should stay on antidepressants for 6-9 months after they achieve remission** to prevent a recurrence of the same episode of depression. After that, they can be tapered off medication over a week to a month and should monitor themselves for a recurrence of depressive symptoms. You should also contact them one more time at 3 months to make sure that they have not relapsed off the medication.

3. Review the rationale for continuing medication and encourage the patient to do so.

   Research has shown that full doses of antidepressants (i.e., the doses which resulted in the initial remission of symptoms) significantly reduce the risk of relapse. In one study, 80% of those on antidepressants stayed free of depression for 3 years compared to only 20% of those taking a placebo. For some patients, medication maintenance treatment may be required indefinitely.

   Besides staying on medications, there are a number of other things patients can do to prevent a relapse of depression, and you will spend the rest of the session working on this.

   Get a sense of what might motivate the patient to stay on long-term medication. Reinforce the patient’s motivation to do so as much as possible.
Be careful not to sound like you are trying to control the patient’s behavior. Be empathic. Try to understand the patient’s perspective and concerns. You may want to point out that the primary care provider and you want to help prevent a relapse, but it is up to the patient to continue in treatment. “This is a decision you have to make yourself.” Let the patient know that you believe he or she can make some changes or take actions that will significantly reduce their risk of relapse and give them more control over their health. If you sense resistance, carefully explore what may be difficult for the patient at this time.

4. **Review any concerns about continuing medications and anticipate potential barriers.**
   - Start out with neutral question such as, “I wonder how you feel about taking your antidepressant medication long term?”
   - Point out that up to 50% of patients with chronic medical illnesses have difficulty taking their medications as prescribed.
   - Ask patients to generate a list of pros and cons of staying on medication long term, and to weigh these against the risks and benefits of stopping antidepressants. Patients may have a significant number of concerns about the long-term use of antidepressants, and it is important to address these as much as possible. (See Appendix F, *Commonly Asked Questions Regarding Antidepressants*.)

5. **Discuss early-warning signs of depression.**
   Patients and significant others can learn to recognize such early-warning signs and get help before relapses become severe.

   Common early-warning signs include changes in sleep, appetite, or energy level, loss of interest in usual activities, irritability or withdrawal from others. These early-warning signs differ from patient to patient. Patients or significant others may remember early signs of depression from their most recent episode of depression.

   In many cases, spouses or significant others may notice such warning signs before a patient does, and it can be very helpful to involve them in monitoring for such signs.

6. **Make a relapse-prevention plan.**

   It can be very discouraging to experience a recurrence of depressive symptoms. If patients detect these symptoms early on, however, it may be easier to prevent a severe relapse.

   Encourage patients to think positively about seeking additional help for depressive symptoms. Seeking such help should not be seen as a sign of failure, but as a positive step (i.e., “I am doing something to take care of myself”).
A relapse-prevention plan for the patient includes early-warning signs and a plan for what to do if you or a significant other notices such symptoms. The plan can include:

- discussing the situation with a close friend/relative
- making sure you are taking the medication as prescribed
- considering stressful life situations (problems at work, in one's family, etc.) which may lead to an exacerbation of depressive symptoms
- contacting the depression nurse specialist
- contacting the primary care provider or a psychotherapist who has been helpful in the past

See Your Personal Plan: Relapse Prevention (Figure 4d)

7. Discuss future clinic or telephone follow-up contacts.
Tell the patient that you would like to schedule a telephone follow-up appointment every three months to make sure s/he continues to do well. During these visits, you will review depressive symptoms and see if the patient is still on treatment to prevent a relapse.

Let the patient know that you will be in contact with their primary care provider to let them know how patients are doing.

Schedule the first follow-up call 3 months after the relapse-prevention visit. Encourage the patient to call you earlier if he or she has any questions from the relapse-prevention session or after s/he has had an opportunity to think about the session, discuss it with significant others, and to review the educational materials and the videotape.

8. Remind patients that both you and the primary care providers are available and how you can be reached.

- Take the medication every day
- Do not stop the medication before talking with your primary care provider
- Continue the medication even if you are feeling better
Appendix F

COMMONLY ASKED QUESTIONS REGARDING ANTIDEPRESSANTS

1. I have a problem with pain. How can an antidepressant help with this?
   - Antidepressants have been shown to be successful (even in the absence of major depression) in a number of pain conditions such as diabetic neuropathy, post-herpetic neuralgia, and phantom limb pain.
   - Antidepressants may help restore normal sleep and ‘reverse’ this cycle.

2. I have a lot of stress in my life. How can an antidepressant help with this?
   - Life stress can cause or worsen the symptoms of depression. The depression can then worsen the impact of such stressors and your ability to cope with them. Treating the depression can help some patients break out of this vicious circle.

3. Are antidepressants addictive?
   - No. Antidepressants are not habit-forming or addictive. They do not produce a ‘high’ feeling, but slowly increase the amount of certain chemicals in the brain over a number of weeks.
   - Some people have been taking antidepressants continually for up to 30 years without any significant (physical or psychological) adverse effects.

4. My problem is anxiety or panic attacks, not depression. How can antidepressants help?
   - In many cases, anxiety is a by-product of depression. Once the depression lifts, the anxiety improves as well.
   - Antidepressant medications are the most effective medical treatments for many anxiety disorders, including panic disorder and generalized anxiety disorder.

5. My problem is inability to sleep. How can an antidepressant help with this?
   - In many cases, poor sleep is a by-product of a major depression. Once the depression lifts, the sleep improves as well.
   - Antidepressants can help restore normal sleep, even in people who do not have major depression. They are advantageous over other sleeping pills in that they are not habit-forming, and they usually do not impair concentration or motor performance.

6. How long will it take the medications to work?
   - It usually takes from one to six weeks for patients to start feeling better. In many cases, sleep and appetite improve first. It may take a little longer for your mood and energy to improve and your negative thinking to decrease.
   - If the depression has not improved after 4 to 6 weeks, you may need an increase in the dose or a change to another antidepressant.
7. How long will I have to take the medication?
   • Once you are completely recovered from your depressive episode, you should stay on the medication for another 6 months to prevent a relapse.
   • Some patients who have had previous depressive episodes or are otherwise at high risk for a recurrence should be kept on ‘maintenance’ antidepressants for longer periods of time.

8. Are there any dangerous side effects?
   • Side effects from antidepressants are usually mild. You should ask your doctor what to expect and what to do if you have a problem.
   • In many cases, your body will get used to the medication and you won’t be bothered with the side effect for long. In other cases, your doctor may suggest that you lower the dose, add another medication, or change to another antidepressant. If used properly, there are no dangerous or life-threatening side effects.

9. Is it safe to take antidepressants together with alcohol or other medications?
   • In general, antidepressants can safely be taken with other medications. You should let your doctor know exactly which other medications (including over-the-counter medications) you are taking so that he/she can make sure that there are no problems.
   • Antidepressants can increase the sedating effects of alcohol. Be careful to avoid excessive alcohol intake while on these medications.

10. What should I do if I miss the medication one day?
    • Don’t ‘double up’ and take the dose you forgot. Just keep taking your medication as prescribed each day.

11. Can I stop the medication once I am feeling better?
    • No. You would be at high risk for a relapse and may experience some temporary withdrawal symptoms. After one episode of depression, there is a 50% risk of recurrence. After two episodes, the risk goes to 70%; and after three episodes, the chances are 90% that you will have a recurrence if you stop using the medication. In most cases, you should continue the medication for at least 6 months after you and your doctor agree that your recovery is complete.
    • **DON’T STOP THE MEDICATION BEFORE DISCUSSING IT WITH YOUR PHYSICIAN.**

12. How do antidepressants work?
    • Antidepressants help restore the correct balance of certain chemicals called neurotransmitters in critical regions of the brain.

13. Will I get better?
    • With adequate treatment, between 50 and 80% of patients will have a complete recovery.
    • Should you not respond to the first antidepressant treatment you try, there is an excellent chance that you will respond favorably to another antidepressant.