Skal fastlegen tilby personlig koordinator for eldre personer med moderat eller alvorlig depresjon?

Problem: Eldre med depresjon
Tiltak: Personlig koordinator
Sammenlikning: Vanlig oppfølging
Setting: Primærhelsetjenesten
Perspektiv: Systemnivå (kommunen). Individnivå (helsepersonell, pasient/pårørende)

Bakgrunn: Pasienter med depresjon kan ha vanskeligheter med å følge opp behandlingstiltak iverksatt av helsetjenesten. Opp til 50 % har autoseponert medikasjon i løpet av de fire første ukene etter oppstart. Deprimerte preges av vegring, inaktivitet og initiativløshet. Personlig koordinator er en helsefagarbeider (lege, sykepleier, sosionom, legesekretær etc.), ansatt i kommunehelsetjenesten, som tildeles et spesielt ansvar for å holde kontakt med pasienten og se til at pasienten klarer å følge opp de avtalene som er gjort. Personlig koordinator rapporterer til fastlegen (hvis legen ikke selv tar oppgaven), som har hovedansvaret for behandlingen.

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
PROBLEM	**Is the problem a priority?**	*No* ☐ *Probably No* ☐ *Uncertain* ☐ *Probably Yes* ☐ *Yes* ☒ | *Varies* ☐		Depresjon hos eldre er vanlig og et alvorlig problem. Manglende oppfølging av behandling reduserer muligheten for bedring.

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
BENEFITS & HARMS OF THE OPTIONS	**What is the overall certainty of this evidence?**	☐ No included studies ☐ Very low ☐ Low ☒ Moderate ☐ High	(see evidence table below)	Personlig koordinator inngår i "collaborative care" (samhandling), men effekt av personlig koordinator ("case management") har også effekt alene. Effekten blir sterkere når personlig koordinator integreres i en modell for samhandling i behandling og oppfølging av deprimerte pasienter. Vi kjenner ikke til mulige negative effekter av personlig koordinator.
	Is there important uncertainty about how much people value the main outcomes?	☐ Important uncertainty or variability ☐ Possibly important uncertainty or variability ☐ Probably no important uncertainty or variability ☐ No important uncertainty or variability ☒ No known undesirable outcomes		
	Are the desirable anticipated effects large?	☐ No ☐ Probably No ☐ Uncertain ☒ Probably Yes ☐ Yes ☐ Varies		
	Are the undesirable anticipated effects small?	☐ No ☐ Probably No ☐ Uncertain ☐ Probably Yes ☒ Yes ☐ Varies		
	Are the desirable effects large relative to undesirable effects?	☐ No ☐ Probably No ☐ Uncertain ☐ Probably Yes ☒ Yes ☐ Varies		

Bibliography: Remission, response, adherence [1] Mortality: [2]

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects: Risk with Control	Anticipated absolute effects: Risk difference with Case/care manager (95% CI)
Remission	0 (7 studies) 6-12 months	⊕⊕⊕⊝ **MODERATE**[3] due to inconsistency	**RR 1.39** (1.30 to 1.48)	**Moderate**[1] **350 per 1000**	**136 more per 1000** (from 105 more to 168 more)
Response Depression scales	2000 (5 studies) 6-12 months	⊕⊕⊕⊝ **MODERATE**[3] due to inconsistency	**RR 1.82** (1.68 to 2.05)	**240 per 1000**[2]	**197 more per 1000** (from 163 more to 252 more)
Adherence	5306 (9 studies)	⊕⊕⊕⊝ **MODERATE**[3] due to inconsistency	**RR 1.55** (1.28 to 1.86)	**418 per 1000**	**230 more per 1000** (from 117 more to 359 more)
Mortality	396 (1 study) 98 months[4]	⊕⊕⊕⊝ **MODERATE**[5] due to imprecision	**HR 0.76** (0.57 to 1)	**374 per 1000**	**74 fewer per 1000** (from 140 fewer to 0 more)
Depressive symptoms	4320 (11 studies) 6-12 months	⊕⊕⊕⊝ **MODERATE**[3] due to inconsistency		The mean depressive symptoms in the intervention groups was **0.4 standard deviations lower** (0.6 to 0.2 lower)	

CI: Confidence interval; **RR:** Risk ratio; **HR:** Hazard ratio;

[1] Remission rate taken from control group remission rate in review of de Maat of studies on elderly with depression.
[2] Response rates in case management and control group stated. Five studies with 3218 patients. Absolute numbers not stated.
[3] Included studies are heterogeneous, including complex and simple interventions, which indicate that not only effect of case manager is analysed. Statistically significant and substantial heterogeneity identified (I^2 = 88·3% for depressive symptoms,)
[4] Range 0.8-116 months follow up
[5] Few events and wide CI

Link to evidence profiles

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
RESOURCE USE	**Are the resources required small?**	*No* ☐ · *Probably No* ☒ · *Uncertain* ☐ · *Probably Yes* ☐ · *Yes* ☐ · ***Varies*** ☐		Tiltaket krever opplæring og organisering av veiledningsgrupper for personlige koordinatorer.
	Is the incremental cost small relative to the net benefits?	*No* ☐ · *Probably No* ☐ · *Uncertain* ☐ · *Probably Yes* ☒ · *Yes* ☐ · ***Varies*** ☐	Vi har ikke funnet kost-nytte analyser for personlig koordinator, men tilbudet inngår i modell for samhandling (collaborative care). En oppdatert systematisk oversikt konkluderer med at collaborative care er kostnadseffektivt.	
EQUITY	**What would be the impact on health inequities?**	*Increased* ☐ · *Probably increased* ☐ · *Uncertain* ☐ · *Probably reduced* ☒ · *Reduced* ☐ · ***Varies*** ☐		Tilbudet om personlig koordinator er et "flatt tilbud" som skal tilbys alle pasienter med moderat til alvorlig depresjon. Vi kjenner ikke dokumentasjon om effekt på sosial ulikhet, men vi vil anta at tiltaket vil kunne utjevne forskjeller ved at pasienter som har mindre ressurser vil bli bedre fulgt opp, mens pasienter med gode ressurser og støtte i familien vil kunne klare dette bedre uten slik hjelp.
ACCEPTABILITY	**Is the option acceptable to key stakeholders?**	*No* ☐ · *Probably No* ☐ · *Uncertain* ☐ · *Probably Yes* ☒ · *Yes* ☐ · ***Varies*** ☐		Anbefalingen støttes av to brukerorganisasjoner og sju profesjonelle organisasjoner
FEASIBILITY	**Is the option feasible to implement?**	*No* ☐ · *Probably No* ☐ · *Uncertain* ☐ · *Probably Yes* ☒ · *Yes* ☐ · ***Varies*** ☐		Anbefalingen krever først og fremst organisering, og tenkes å inngå i den personlige koordinatorens øvrige arbeid. Det er relativt få innbyggere over 65 år som vil ha behov for tjenesten, fordi det først og fremst er pasienter med moderat og alvorlig depresjon som skal ha tilbudet.

Balance of consequences	Undesirable consequences *clearly outweigh* desirable consequences in most settings	Undesirable consequences *probably outweigh* desirable consequences in most settings	The balance between desirable and undesirable consequences *is closely balanced or uncertain*	Desirable consequences *probably outweigh* undesirable consequences in most settings	Desirable consequences *clearly outweigh* undesirable consequences in most settings
	☐	☐	☐	☒	☐

Type of recommendation	We recommend against offering this option	We suggest not offering this option	We suggest offering this option	We recommend offering this option
	☐	☐	☐	☒

Recommendation (text)

Vi anbefaler

Fastleger bør gi pasienter med moderat til alvorlig grad av depresjon tilbud om regelmessig kontakt i form av møter eller telefonkontakt med en personlig koordinator med ansvar for oppfølging av pasienter med depresjon, som et supplement til fastlegen.

Justification

Anbefalingen om en personlig koordinator er et tiltak av lav intensitet der utpekt helsepersonell i organisasjonen (kommune, bydel, legesenter) får i oppgave å følge opp pasienter med moderat til alvorlig depresjon, som et supplement til fastlegen. Det er ikke spesielle krav til profesjonelle kvalifikasjoner til denne personen, men oppgaven krever opplæring og noe veiledning. Det er dokumentasjon av moderat kvalitet for at dette tiltaket bedrer behandlingsresultatet for pasienter med depresjon, sikrer at pasienter tar antidepressiver som anbefalt, og reduserer mortalitet. Utfordringen er mest av organisatorisk art. Utover dette oppfatter vi tiltaket som rimelig og lite ressurskrevende. Anbefalingen gjelder personer med moderat til alvorlig depresjon, og disse utgjør ikke så stor gruppe i en kommune eller fastlegepraksis. Når tilbudet er på plass vil også andre grupper kunne ha nytte av tilbudet.

Subgroup considerations

Implementation considerations

Tiltaket kan organiseres i en fastlegepraksis i form av at annet helsepersonell I praksisen kan ta denne oppgaven, som supplement til fastlegens oppfølging.

Monitoring and evaluation

Research priorities

Evidence profile Skal personlig koordinator tilbys eldre personer med moderat eller alvorlig depresjon?

Author(s): Aakhus/Flottorp
Date: 2013-07-18
Question: Should case/care manager be used for depression in the elderly?
Settings: Primary care
Bibliography: Adherence: Gensichen, PsycholMed 2006. Improvement: Gensichen, PsycholMed 2006 Mortality: Gallo, BMJ 2013.

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Case/care manager	Control	Relative (95% CI)	Absolute		
Remission (follow-up 6-12 months)												
7	randomised trials	no serious risk of bias	serious[1]	no serious indirectness	no serious imprecision	none	-[2]	-	RR 1.39 (1.3 to 1.48)	-	⊕⊕⊕O MODERATE	CRITICAL
								35%[3]		136 more per 1000 (from 105 more to 168 more)		
Response (follow-up 6-12 months; assessed with: Depression scales)												
5	randomised trials	no serious risk of bias	serious[1]	no serious indirectness	no serious imprecision	none	456/1000 (45.6%)[4]	240/1000 (24%)[4]	RR 1.82 (1.68 to 2.05)	197 more per 1000 (from 163 more to 252 more)	⊕⊕⊕O MODERATE	CRITICAL
Adherence												
9	randomised trials	no serious risk of bias	serious[1]	no serious indirectness	no serious imprecision	none	1581/2936 (53.8%)	990/2370 (41.8%)	RR 1.55 (1.28 to 1.86)	230 more per 1000 (from 117 more to 359 more)	⊕⊕⊕O MODERATE	CRITICAL
Mortality (follow-up median 98 months[5])												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[6]	none	79/214 (36.9%)	68/182 (37.4%)	HR 0.76 (0.57 to 1)	74 fewer per 1000 (from 140 fewer to 0 more)	⊕⊕⊕O MODERATE	CRITICAL
Depressive symptoms (follow-up 6-12 months; measured with: Depression scales ; Better indicated by lower values)												
11	randomised trials	no serious risk of bias	serious[1]	no serious indirectness	no serious imprecision	none	2214	2106	-	SMD 0.4 lower (0.6 to 0.2 lower)	⊕⊕⊕O MODERATE	CRITICAL

[1] Included studies are heterogeneous, including complex and simple interventions, which indicate that not only effect of case manager is analysed. Statistically significant and substantial heterogeneity identified (I2 = 88·3% for depressive symptoms,)
[2] The seven studies had a total of 4584 patients. The number of patients in each group is not stated, and not the number/rate of remission.
[3] Remission rate taken from control group remission rate in review of de Maat of studies on elderly with depression.
[4] Response rates in case management and control group stated. Five studies with 3218 patients. Absolute numbers not stated.
[5] Range 0.8-116 months follow up
[6] Few events and wide CI

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References

[1] Gensichen J et al. Case management to improve major depression in primary health care: a systematic review. Psychol Med 2006;36:7-14.

[2] GalloJJ et al. Long term effect of depression care management on mortality in older adults: follow-up of cluster randomized clinical trial in primary care. BMJ 2013;346:f2570.

Definitions for ratings of the certainty of the evidence (GRADE)**

Ratings	Definitions	Implications
⊕⊕⊕⊕ High	This research provides a very good indication of the likely effect. The likelihood that the effect will be substantially different* is low.	This evidence provides a very good basis for making a decision about whether to implement the intervention. Impact evaluation and monitoring of the impact are unlikely to be needed if it is implemented.
⊕⊕⊕○ Moderate	This research provides a good indication of the likely effect. The likelihood that the effect will be substantially different[4] is moderate.	This evidence provides a good basis for making a decision about whether to implement the intervention. Monitoring of the impact is likely to be needed and impact evaluation may be warranted if it is implemented.
⊕⊕○○ Low	This research provides some indication of the likely effect. However, the likelihood that it will be substantially different[4] is high.	This evidence provides some basis for making a decision about whether to implement the intervention. Impact evaluation is likely to be warranted if it is implemented.
⊕○○○ Very low	This research does not provide a reliable indication of the likely effect. The likelihood that the effect will be substantially different[4] is very high.	This evidence does not provide a good basis for making a decision about whether to implement the intervention. Impact evaluation is very likely to be warranted if it is implemented.

*Substantially different: large enough difference that it might have an effect on a decision

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