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Crossing the bridge – A prospective comparative study of the effect of communication between a hospital based consultation-liaison service and primary care on general practitioners' concordance with consultation-liaison psychiatrists' recommendations

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ABSTRACT

Objective: Concordance with consultation-liaison (CL) psychiatrists' recommendations by general practitioners (GP) has hardly been studied systematically. We studied if telephone calls or written notes from a hospital based CL-service to GPs, whose patients were treated on medical-surgical wards, can improve GP-concordance, as compared to the usual communication pathway by standard discharge letters written by hospital physicians, and if higher GP-concordance improves outcomes of depressive and anxious symptoms.
Methods: 116 inpatients of a general hospital referred to a CL-service with depression and anxiety were allocated to three groups of communication pathways between CL-service and GPs: (1) A telephone call (TC) by CL-psychiatrists with GPs, (2) a copy of the psychiatric consultation report (CR) was handed out to patients, (3) GPs received standard discharge letters of the hospital physicians (communication as usual, CAU). Six weeks after the CL-episode, patients were phoned at home and asked about implementation of recommendations by their GP's. The Hospital Anxiety and Depression Scale (HADS) was used to monitor anxious and depressive symptoms.
Results: GP-concordance was highest in the TC group, followed by the CR group with significant improvements in medication and psychotherapeutic recommendations compared to CAU. Higher concordance was associated with a significant greater decrease in HADS depression scores but not anxiety scores after 6 weeks.
Conclusion: Telephone communication between CL-psychiatrists and GPs improve GPs' concordance with psychiatric recommendations. This easy-to-implement intervention takes about 10 min time but prevents loss of information. It may enhance quality of GPs' mental health care and lead to improved outcomes.
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1. Introduction

Depression and anxiety are major risk factors for adverse outcomes in patients with comorbid medical illness [1,2,3]. Dysfunctional illness perceptions and behavior lead to reduced quality of life and increasing health care costs [4]. A major task of CL-services in general hospitals is to diagnose hitherto unknown mental disorders and initiate treatment, thus improving care for both physically and psychiatrically ill patients [1]. For most of these patients, the CL-psychiatric consultation is their first contact with a mental health specialist [5]. CL-services in general hospitals could therefore be referred to as "filters" for mental health care.

As any consultation can only be effective if the patient's physician implements the recommendations, "concordance" or "adherence", as physician compliance is called in the CL-literature, is paramount to achieve effectiveness of CL-psychiatric interventions. While it is known that general hospital consultees' concordance with inpatient CL-recommendations is weak [6], the even more likely possibility of loss of information during transfer to GPs after discharge has rarely been studied [7]. GP's play a crucial role in providing mental health care worldwide. For instance, in a country like Germany, about 75% of outpatients with mental health problems are treated in primary care [8].

Thus, we examined the effectiveness of different ways of communicating recommendations from inpatient CL-services to GPs. In a 3-armed study we compared two ways of intensified communication (telephone call, consultation report) against communication as usual (CAU). The hypotheses were: (1) A telephone call to the GP, or handing out a written CL-report to the patient by the CL-psychiatrist, leads to higher GP-concordance than routine discharge letters (CAU) alone. (2) Telephone calls lead to higher GP-concordance than written handouts. (3) Higher GP-concordance leads to a greater reduction of depressive and/or anxious symptoms.

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To our knowledge, this is the first prospective comparative study to investigate effectiveness of different ways of communication from inpatient psychiatric CL-services to GPs.

2. Method

2.1. Sample and setting

The study was conducted from March 2004 until December 2005 at the university affiliated inner city general hospital “Königin Elisabeth Herzberge” (KEH), Berlin that has a catchment area of about 240,000 inhabitants. The hospital has 360 medical-surgical and 130 psychiatric beds. Referral rates to the psychiatric CL-service are about 5%, i.e. an annual workload of about 960 inpatient consultations. A psychiatric resident, a CL-nurse and a senior consultant staff the service. In addition, residents and consultants of the psychiatric department perform consultations as needed. Consultation reports are routinely documented with the hospital's computerized documentation system, “Nexus/Medicare ®”.

2.2. Inclusion and exclusion criteria

All patients referred to the CL-service from the departments of internal medicine, neurology and surgery for depressive and/or anxious symptoms were screened for the following inclusion criteria: diagnosis of a depressive episode (F3X), adjustment disorder (F43.2), or anxiety disorders (F40, F41) made by the CL-service according to ICD-10 criteria [9], and patients' ability to give informed consent.

Exclusion criteria were: severe organic brain syndromes, severe language problems, if a telephone follow-up interview was not possible, and if no GP was available.

2.3. Implementation of the study and informed consent

Department heads, consultants and residents of the referring departments were informed about the study. Patients were informed and handed out a study information sheet by the CL-psychiatrists. They were asked to give written informed consent including authorization of the CL-service to review their discharge letters and conduct a telephone follow-up interview with their GP.

2.4. Ethics

The Study protocol and the patient information sheet were approved by the KEH Ethics Committee.

2.5. Supervision

All CL-psychiatrists received a training workshop about the study design, an update on ICD-10 diagnostic criteria for depression and anxiety disorders [9], the “Practice guidelines for treatment of depression in primary care” [10], and the “Guidelines for treating panic disorders in primary care” [11]. Both guidelines formed the basis for the respective CL-psychiatric recommendations. The principal investigator and director of the CL-service (R.B.) provided regular supervision for the CL-psychiatrists.

2.6. Algorithm and allocation to the study groups

The study schedule is shown in Fig. 1. Instead of using computer generated random numbers we allocated the patients to the study groups in chronological order of their referral- a so-called “pseudo-randomization”. Group allocation and communication of the respective patient's study group to the CL-psychiatrists was the task of the principal investigator.

2.7. Study interventions in the different groups

In all of the 3 study groups, as is the usual practice, CL-psychiatrists discussed diagnoses and recommendations with patients and medical staff on the wards, and in all cases the attending hospital physicians received written CL-reports directly after the consultation. The 3 study groups were:

TC (“telephone call”): CL-psychiatrists phoned the GPs within 5 days after the consultation to communicate their recommendations. In addition, GPs were asked which way of information they prefer: telephone calls, written CL-reports, or routine discharge letters.

CR (“consultation report”): Patients were given copies of the consultation report right after the consultation and asked to pass them on to their GP at their first visit after discharge.

CAU (“communication as usual”/control group): It was left to the discretion of the treating physician to include recommendations of the psychiatric consultation into the discharge letter to any extent they felt necessary.

2.8. Data collection at baseline (T0)

Each CL-episode was documented with a modified version of the “European Quality Assurance Documentation System for CL” (EuroQA-CL). It contains socio-demographic and psychopathological patient-data, and procedural features of the consultation. A version of EuroQA-CL was used in the ECLW-study [12].

The “Hospital Anxiety and Depression Scale” (HADS, German version) was used to measure emotional distress at follow-up. This self-rating questionnaire was developed for medically ill patients and has been widely used in CL-studies. It scores anxious and depressive symptoms separately [13]. The ranges are: normal (0–7), mild (8–10), moderate (11–14) and severe (>15).

2.9. Telephone follow-up interviews 6 weeks after initial consultation (T1)

At T1 patients were phoned at home by the principal investigator (R.B.), given they had been discharged. If not, they were excluded from the study (drop-out). Follow-up at T1 consisted of a structured telephone interview, asking patients if their GPs had implemented the CL-recommendations as documented in the EuroQA-CL at T0, and an assessment of depressive and anxious symptoms with the HADS.

2.10. Areas of CL-recommendations

To measure GP-concordance we defined five different areas of CL-recommendations: (1) medication recommendations, (2) psychotherapeutic recommendations including supportive talks by the GP, (3) psychosocial interventions, (4) diagnostic action, (5) referral to specialist psychiatric outpatient treatment.

During the telephone interviews at T1, questions for each of the five areas allowed for a detailed assessment whether GP's had implemented the respective recommendation.

2.11. Operationalization of implementation

Operationalization of implementation follows Popkin's proposal how to measure concordance [14]. For every recommendation four levels were possible: (1) “Fully implemented” – e.g. the GP prescribed the recommended or an equivalent drug (Sertraline instead of Citalopram) in the recommended or, respectively, the effective dosage. (2) “Partially implemented” – e.g. GP the prescribed the recommended drug, however, in an insufficient dose or, a tricyclic antidepressant was prescribed instead of an SSRI. For instance, if the GP made an immediate referral without trying to treat depression in primary care, we considered this as “partially implemented” in those cases where the CL-recommendation was “refer to psychiatric specialist outpatient treatment if no

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