

Chronic Care Assessment and Planning Report

Executive Summary

Prepared for
Blue Hill Memorial Hospital

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**BLUE HILL MEMORIAL HOSPITAL
CHRONIC CARE ASSESSMENT AND PLANNING REPORT**

Executive Summary

Overview

In the summer of 2004, Blue Hill Memorial Hospital (BHMH) contracted the Public Health Resource Group (PHRG) to complete a second follow-up community healthcare needs assessment of its service area. This study builds on the initial and follow-up healthcare needs assessments that PHRG completed for BHMH in 1994 and 1999. Unlike the 1994 and 1999 studies however, the 2004 study focuses more on the status of chronic disease care in the communities served by BHMH rather than on the full spectrum of service needs. In doing so, this study provides information on trends in indicators of chronic disease care—the major issue in both the 1994 and 1999 studies—and on gaps in community services, linkages between primary care providers and community services, and quality improvement initiatives in primary care.

Findings from this assessment can be used for strategic and service line planning, as well as to provide information about the impact of programs developed by BHMH to address the chronic care needs of patients. To complete this study PHRG prepared and analyzed a profile of the health indicators on chronic disease and conducted assessments of community services and practice patterns related to chronic disease care.

The following are edited excerpts from the PRHG report:

We conducted an assessment of availability and integration of community health providers—limited to services that have demonstrated value in prevention and management of patients with chronic conditions. Additionally we conducted a practice assessment and a review of medical records at four sites of Peninsula Primary Care.

From these data we prepared a report describing how the community's health care needs are currently being met by existing resources, what additional resources are needed, and how existing resources can be better linked to primary care practices and patients for prevention, diagnosis and treatment of chronic disease. The opportunities discussed will better meet the needs of the community, improve health status, enhance quality of care and in the end result in a larger proportion of health care revenues remaining with area providers.

Priority Health Issues

In the Blue Hill community there is a widening gap between the rich and the poor. This gap will likely result in differences in the demand for and access to health services. It also raises concern about the level of safety net services available to the apparent growing population who are without adequate health insurance or income to purchase services. The overall demand both chronic disease care and primary care will likely increase in both groups as the population ages, with access more limited in the lower socioeconomic groups.

- Aggressive outpatient management of diabetes should remain a priority in this community, as well as health promotion efforts to reduce lifestyle-related risks for diabetes and other chronic diseases.

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- While cancer indicators are improving, cancer treatment remains a priority health issue in the community. Access to quality treatment services for treatable cancers and cancer prevention services should be strengthened, with an emphasis on smoking prevention and cessation programs, especially those diagnosed with one or more chronic conditions, increased screening efforts, and nutritional education/counseling services.

Community Resource and Linkage Assessment

The community health resource and linkage assessment allowed a thorough analysis of how well the community's health care needs are currently being met by existing resources, what additional resources are needed, and how existing resources can be better linked to primary care practices and patients for prevention, diagnosis, and treatment of chronic disease.

- Our review indicates that the Blue Hill Community has ample services in the prevention, education, and early detection of chronic disease. As in most rural communities with limited resources, the health educators play multiple roles—as behavioral risk factor and disease specific educators. The self-management services, provided through DSMT, SCORE, and the Dietician, are comprehensive for behavioral risk factors and diabetes. **Additional resources for disease specific self-management are indicated due to the ongoing research that links quality care with self-management techniques across all chronic conditions.**
- The *Chronic Disease Self-Management Program*, along with other academic initiatives to develop quality improvement techniques, is comprehensive and tends to reflect an ideal approach in chronic disease interventions. Primary care practices may not have the organizational or financial resources to take part in these initiatives or fully integrate the components into the practice. An article on the impact of an asthma self-management program suggests that a less complex version of these programs may be more efficiently and effectively implemented in a more broad care setting (10). **PCPs, for example, could use self-management protocols already in practice and customize those into patient worksheets or, instead of organizing a formal self-management program, implement self-management instructional sessions with groups of patients.**
- Services specifically for families, children and adolescents are few, although most behavioral and disease specific programs serve all age groups and encourage family participation.
- Because the use of support groups has been shown to vary across illness categories—a study in 2000 demonstrated that individuals with stigmatized diseases (e.g. alcoholism, cancer) were more likely to seek support than those with heart disease (8)—it is important that groups are available to serve the most prevalent diseases within the community. An additional setting for support groups addressing other chronic conditions that is cost-effective and may reach a broad population base is through the Internet—a pilot Internet discussion group for patients with diabetes and their families was positively received as a resource for information exchange and support (9).
- The specialty care services available in the Blue Hill community are not comprehensive and do not meet the needs of patients with chronic conditions. There is no local access

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to physicians or clinics for endocrinology, ophthalmology, or pulmonology, although patients can be referred to larger communities, such as Bangor, to receive these services. **We recommend building relationships with outside medical specialists and organizing hospital-based clinics, such as those already provided for cardiology, in order to increase access for patients in the area (22).**

- Provider linkages are key to integrated primary care. The majority of community agencies and providers have little or no linkages to local primary care physicians. Programs targeted at behavioral risk factors, unless provided through the hospital or through SCORE, do not communicate with PCPs—patients may be seen through these programs without the PCP ever being aware. Other agencies and providers that require a physician referral do not necessarily follow up with patients and may never directly contact the patient’s PCP regarding care. **Within the limits of confidentiality, all community service providers should routinely contact patient/client’s PCPs and provide information regarding the patient/client’s care as standard protocol.**

Developing collaborative relationships between community agencies and providers and PCPs is a new and challenging area and it will take some time to figure out the best approaches and mechanisms to accomplish this, but doing so should improve patient care and health status. Additionally, PCPs may be more likely to refer patients if they are aware of the types and range of services provided in the community, including the credentials and licensure of staff. **Although community agencies and providers should make this information easily available, it is also the responsibility of the PCPs to be up to date on what is available in the community to assist patients in managing their conditions and on what services the patient will receive upon referral.**

Practice Infrastructure Assessment

- A healthcare team is critical for quality improvement; members assist in implementing tools, educating staff, and organizing resources. Although the SCORE nurses play a role in providing patient care, their implementation alone does not constitute a healthcare team, which needs to have capabilities to organize care efforts between multiple levels of care. In addition, practices rarely participate in quality improvement initiatives that relate to clinical care—these programs would teach staff to implement specific tools and methods when providing care. **We recommend that the PPC practices consider the development and implementation of a team and practice based incentives—both will work to improve care by motivating staff to take part in quality improvement efforts.**
- EB guidelines, including protocols, goal setting, and patient barrier review, should be systematic and routine in use. Although providers are responsible for maintaining CME on their own, the practice can assure that all staff are up to date on guidelines and have the most current resources available to them by implementing, for example, monthly inservice sessions about particular conditions.
- The current resources, such as the diabetes flow sheet, are extremely helpful for staff in managing patients with complex chronic diseases—**similar sheets for more conditions should be developed and implemented.** Even though the patient problem list and

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checklists for hypertension and hyperlipidemia are convenient tools to track history, they do not assist in treatment.

- As outlined in a recent study, self-management includes problem solving, decision-making, resource utilization, the formation of a patient-provider partnership, action planning, and self-tailoring (26). **The PPC practices have the community resources and practice staff available that may assist in filling all of these tasks—it is critical that appropriate relationships are developed and maintained by each practice.** Linkages will improve patient access to beneficial programs, for example, a provider may refer a smoking cessation program to his/her patients, but those patients who are scheduled into a class, given contact information and a timetable, and who are followed up with are more likely attend. Patients are also more satisfied, more likely to adhere to treatment, and control their disease more often when a specific disease management protocol is utilized (23).
- Future practice level assessments should include a more in depth analysis of primary care providers linkages with all health care related services and providers, including not only specialists and hospital based programs, but community health initiatives (e.g. Healthy Peninsula Project), support groups and CAM providers.
- Since the practice level assessment was completed, one PPC practice staff member has developed a patient education tracking form that includes the program/provider name, date of scheduled appointments or classes, and multiple follow-up boxes to routinely follow a patient's progress through each program. This tool is meant to maintain contact between the PCPs and particular community services and providers while patients' are involved, assist in getting patients into those programs, and serve as a reminder to follow up with the community services and providers regarding patients' progress.
- The use of disease registries, electronic medical records, and other clinical information systems has been proven to be of substantial use to practices in providing chronic care. These systems allow practices to manage patient care through the use of reminders, educational and self-management resources, and EB protocols, in addition to tracking patients with particular conditions to determine health outcomes and population data. For example, providers will be prompted to schedule appointments for patients with diabetes who are required to have regular intervals of laboratory tests and will be reminded to follow up on self-management tasks and goals.

A patient's reason for a primary care office visit allows the provider to address immediate issues, but providers should also discuss the patient's chronic conditions with them at these visits—routine review of conditions will allow underlying symptoms and issues to arise and be controlled before becoming more problematic.

Although electronic systems and software are designed to be ideal, many practices may not have the financial resources to implement them. In this case, practices may still maintain a registry of patients within a PC, for example using Microsoft Excel, or in paper format with index cards. Many quality improvement programs suggest marking the cards with colors for particular diseases, so that the practices can easily sort and obtain aggregate information for

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their patients. **We recommend implementing a patient registry for chronic care through the expansion of tools already in place, such as the diabetes flow sheet and SCORE—both have key indicators for best practice outlined for some chronic conditions and can serve as a jumping off point for a registry.**

The Idealized Design of Clinical Office Practice (IDCOP), a three-year initiative organized by the Institute for Healthcare Improvement (IHI) in 1998, sought to reorganize practice procedure along four areas—access, interaction, reliability, and vitality—in an effort to achieve improved levels of performance in patient care, improved access to care, and a reduction in costs. The components of the initiative are similar to the health care organization building blocks of the ICC framework and to the five essential components to providing quality chronic care outlined in this report. The PPC practices will improve the quality of chronic care and improve health outcomes by implementing the suggested recommendations—**organizing a healthcare improvement team, utilizing community resources and staff for management, and developing a patient registry or clinical information system**—similarly to the outcomes of other practices that took part in the IDCOP (29).

Patient Chart Review

Referrals

Referrals to community providers, including both medical specialists and community health programs, are not made often. All patients with chronic conditions should have coordinated, continuous and collaborative care—as outlined in the ICC framework (WHO) and in recommendations for appropriate self-management. Patients with diabetes for example, would greatly benefit from participation in self-management programs (ADEF/DSMT) and patients with COPD need specialized care through a pulmonologist so that all appropriate laboratory tests (e.g. spirometry) are completed and exacerbations controlled.

- **Although referrals should be made at the providers discretion, the PPC practices and patients could improve adherence to best practice guidelines by utilizing all appropriate health care resources.**
- **Referrals to SCORE nurses are also rarely made for all patients at all practices. Because SCORE is a multifaceted program that can monitor and track multiple chronic conditions, including behavioral risk factors, and is easily available by all PPC patients, we recommend that all primary care physicians utilize this resource for all patients in management and follow up.**

Smoking

Smoking status is rarely recorded in patient charts at all practices. And of those who were documented as current smokers, few have received smoking cessation or counseling. Providers need to routinely question patients regarding their smoking use and history all of the time and should utilize the resources in the community to assist in addressing smoking in patients with chronic conditions.

- **We suggest that PPC providers with community resources such as the Healthy Peninsula Project's Free Smoking Cessation classes and the Maine Tobacco Helpline—in addition to SCORE—all easily accessed by PPC patients.**

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End of Life Care

Patients suffering from advanced chronic disease should receive specialized care that includes initiatives to address end of life care. Of the end of life care indicators developed for this report, few are currently being addressed or documented in patient charts by the PPC practices, even though the sample characteristics show that approximately half of all patients are 65 years of age or more.

- **We recommend that the PPC practices work towards addressing end of life care for a larger proportion of patients with chronic conditions by linking with the directors of Hancock County Home Care and Hospice and developing strategies and goals to meet this need.**

Education

Educating patients about their condition, about medications, and regarding self-management is recommended for all chronic conditions and will ultimately lead to improved health outcomes. Island Family Medicine appears to be providing patients with educational information and discussing behavioral risk factors (physical activity and diet regimens) most of the time across conditions. Practice procedure at IFM includes regular office visits specifically for patients with chronic conditions and a mental health provider who provides on site care once per week—both of which may contribute to their high level of adherence to these indicators.

- **Practices will benefit from one another if procedures that work to improve health outcomes are shared—we recommend that all PPC practices regularly communicate to determine procedures that may assist in improving adherence to these best practice indicators.**

Influenza Vaccinations

Patients diagnosed with CHF, diabetes, and COPD are encouraged to have an influenza vaccination once per year during the fall. Avoiding illness will help reduce the number of possible exacerbations for those with COPD.

- **We recommend that all PPC staff track all patients with CHF, diabetes, and/or COPD who have not had an influenza vaccination in the past year.**

Hyperlipidemia and Hypertension

- **Address and document a follow up when LDL values and/or blood pressure measurements, for hyperlipidemia and/or hypertension respectively, are elevated. Patients do not need to have a full office visit, but could follow up with a practice nurse or through SCORE to address test elevations.**

Congestive Heart Failure (CHF)

- **Complete left ventricular ejection fractions (LVEF) for all CHF patients once every two years.**

Diabetes

- **Collaborate with PPC staff, including SCORE nurses, to help manage the LDL values of patients with diabetes and set a goal of less than 100 mg/dL.**
- **Increase the number of patients who have a documented foot examination at every office visit.**

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Obesity

- **Increase the number of patients diagnosed with obesity that have documented BMI values and waist circumference measurements—both are easily obtained and can be determined by a medical assistant or nurse prior to meeting with a physician.**
- **Develop goals with patients and actively follow-up and monitor patients' progress to improve weight loss and management.**

Chronic Obstructive Pulmonary Disease

- **Increase the number of patients who receive spirometry testing and clearly document and date test results.**

Major Depression

- **Systematically diagnose patients using the current DSM-IV TR criteria; document all indicators, including those symptoms that the patient has and those that he/she does not.**
- **Educate all patients on medications for major depression about the side effects and possible problems, and provide an informational fact sheet to all patients regarding their condition.**

APPENDIX H

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2004-5 CHART REVIEW FOR BEST PRACTICE IN CHRONIC CARE

	Total	BHFM ¹	BFM ²	CCHS ³	IFM ⁴
TOTAL COUNT	123	54	21	21	27
< 18	3%	4%	5%	0%	4%
18-44	17%	15%	24%	5%	26%
45-64	31%	44%	33%	10%	19%
65 +	49%	37%	38%	86%	52%
Male	45%	46%	43%	57%	33%
Female	55%	54%	57%	43%	67%
GENERAL INDICATORS:					
Weight (last visit)	93%	91%	95%	95%	96%
Blood pressure (last visit)	97%	96%	95%	100%	96%
Review of medications (last visit)	80%	83%	81%	81%	74%
SMOKING:					
Discussion of smoking status (last visit)	16%	24%	24%	5%	4%
Current smokers	26%	37%	38%	5%	11%
Current smokers receiving smoking cessation or counseling	50%	40%	63%	100%	67%
END OF LIFE CARE:					
Advanced Directive	13%	7%	14%	24%	15%
Discussion regarding end of life care	7%	0%	14%	14%	7%
Referral: Hospice Program	0%	0%	0%	0%	0%
MANAGEMENT (SPECIFIC INDICATORS):					
HYPERLIPIDEMIA	24% (29)	30% (16)	24% (5)	19% (4)	15% (4)
Fasting lipoprotein / LDL (past year)	100%	100%	100%	100%	100%
Elevated Fasting lipoprotein / LDL (past year)	55%	69%	80%	0%	25%
Plans and/or evidence of a follow up fasting lipoprotein	81%	82%	75%	NA	100%

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Discussion of physical activity and/or diet regimen (past year)	88%	91%	75%	NA	100%
(at least one of the following) Evidence of efforts to change diet and/or efforts at weight reduction and/or prescription of statins	88%	91%	75%	NA	100%
Referral (referred to and seen by): SCORE	28%	38%	20%	0%	25%
HYPERTENSION	32% (39)	39% (21)	24% (5)	38% (8)	19% (5)
Blood pressure (most recent) or Blood pressure (last visit)	100%	100%	100%	100%	100%
Elevated Blood Pressure (past year)	67%	76%	80%	75%	0%
Plans and/or evidence of a follow up blood pressure	62%	56%	75%	67%	NA
On hypertensive medications	92%	94%	75%	100%	NA
Declined hypertensive medications	4%	0%	0%	17%	NA
Referral (referred to and seen by): SCORE	13%	19%	20%	0%	0%
CONGESTIVE HEART FAILURE	20% (24)	22% (12)	19% (4)	14% (3)	19% (5)
Etiology indicated	79%	92%	100%	33%	60%
Hospitalization (past three years) with primary/secondary discharge diagnosis of CHF or other cardiac cause	54%	67%	25%	33%	60%
Left Ventricular Ejection Fraction (LVEF, past two years)	46%	25%	75%	0%	100%
Fasting lipoprotein / LDL (past year)	46%	25%	100%	33%	60%
Influenza Vaccination (past year)	33%	25%	0%	67%	60%
Discussion of physical activity and/or diet regimen, and/or Inquiry regarding Patient compliance with medical regimen and/or restricted sodium diet	67%	58%	50%	67%	100%
Discussion regarding daily monitoring of weight	13%	17%	25%	0%	0%
Evidence of communication among team members providing care	88%	92%	100%	67%	80%
ACE Inhibitors or ARBs	42%	33%	50%	33%	60%
Statins	13%	8%	25%	0%	20%
Other (Beta-blockers, Digoxin or other Inotropes, Diuretics)	83%	75%	100%	67%	100%
Referral (referred to and seen by): SCORE	17%	8%	25%	0%	40%
TOTAL COUNT	123	54	21	21	27

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	Total	BHFM¹	BFM²	CCHS³	IFM⁴
DIABETES	21% (26)	24% (13)	19% (4)	14% (3)	22% (6)
Hospitalization (past three years) with primary/secondary discharge diagnosis of diabetes and/or its complications	38%	31%	25%	67%	50%
Office visit in the past three months	85%	85%	75%	100%	83%
Discussion of physical activity and/or diet regimen (past year)	73%	77%	75%	0%	100%
Recorded physician inquiry regarding patient compliance with medical and/or diet regimen	85%	85%	100%	33%	100%
Evidence of weight loss or management (+/- 5 lbs.)	62%	62%	75%	67%	50%
Influenza Vaccination (past year)	50%	31%	75%	100%	50%
Foot exam (last visit)	31%	38%	25%	0%	33%
Evidence of a dilated eye exam, discussion, or referral to an Ophthalmologist	50%	38%	75%	100%	33%
Fasting lipoprotein / LDL (past year)	85%	85%	100%	100%	67%
LDL < 100 mg/dL	32%	27%	25%	67%	25%
Fasting blood sugar within past 3-6 months	85%	77%	100%	100%	83%
HgbA1c	85%	85%	100%	100%	67%
Patients with elevated HgbA1c (past year; > 6.9)	68%	64%	50%	100%	75%
Follow up office visit within four months after elevated HgbA1c	67%	43%	50%	100%	100%
Microalbumin (past year)	62%	38%	100%	100%	67%
Hypoglycemic Medications:					
Oral agents	54%	54%	75%	33%	50%
Insulin	15%	8%	25%	33%	17%
No medications listed	38%	46%	25%	33%	33%

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Referral: (referred to and seen by)					
ADEF/DSMT programs	38%	38%	50%	33%	33%
Dietician or Nutritionist	19%	15%	25%	0%	33%
SCORE	27%	38%	25%	0%	17%
OBESITY	28% (34)	30% (16)	19% (4)	14% (3)	41% (11)
Height (past year)	53%	25%	50%	67%	91%
BMI (past year)	47%	44%	50%	67%	45%
Weight (last visit)	97%	100%	100%	100%	91%
Waist circumference (past year)	32%	38%	0%	67%	27%
Pulse measurement at last visit	94%	94%	100%	100%	91%
Discussion of behavioral risk factors (smoking status, physical activity, diet) and/or Discussion of physical activity and/or diet regimen (past year)	85%	94%	50%	67%	91%
Readiness to lose weight assessed	59%	69%	50%	33%	55%
Evidence of managed food and activity diary and/or goals discussed	56%	69%	25%	67%	45%
Evidence of weight loss or management (+/- 5 lbs.)	47%	38%	50%	100%	45%
Weight loss therapy (dietary, physical activity or behavioral therapy)	62%	75%	25%	67%	55%
BMI >= 30	67%	58%	100%	100%	67%
BMI 25-29.9 and greater than 2 risk factors (HTN dx, smoker, high LDL, impaired fasting glucose, family hx of premature CVD, Males >=45yrs, Females >=55yrs)	5%	0%	0%	0%	17%
High risk waist circumference (Men > 40" and Women > 35") and greater than 2 risk factors	5%	0%	0%	0%	17%
Referral: (referred to and seen by)					
Dietician or Nutritionist	15%	13%	0%	0%	27%
SCORE	50%	50%	50%	67%	45%

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	Total	BHFM¹	BFM²	CCHS³	IFM⁴
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)	20% (25)	26% (14)	19% (4)	14% (3)	15% (4)
Hospitalization (past three years) with primary/secondary discharge diagnosis of pulmonary disease	32%	50%	0%	0%	25%
Spirometry (past year)	16%	14%	50%	0%	0%
Referral to pulmonary rehabilitation or to a pulmonologist	100%	100%	100%	NA	NA
Influenza Vaccination (past year)	40%	21%	0%	100%	100%
Physical activity tolerance assessed and/or Discussion of a physical activity regimen	20%	21%	50%	0%	0%
Two or more office visits (past year)	92%	100%	75%	67%	100%
Received COPD education	48%	21%	75%	67%	100%
Evidence of communication among patient's health care providers	80%	79%	75%	67%	100%
Medications:	0%	0%	0%	0%	0%
Short-acting anticholinergics	32%	43%	25%	33%	0%
Long-acting anticholinergics	8%	14%	0%	0%	0%
Inhaled glucocorticosteroids	24%	21%	25%	0%	50%
Home oxygen	24%	21%	25%	0%	50%
Current smoker	33%	33%	100%	NA	0%
Referral: (referred to and seen by)					

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Pulmonary Rehabilitation	12%	0%	50%	0%	25%
Pulmonologist	12%	14%	25%	0%	0%
SCORE	16%	29%	0%	0%	0%
MAJOR DEPRESSION	23% (28)	20% (11)	29% (6)	14% (3)	30% (8)
Documented use of DSM-IV TR criteria	18%	0%	17%	0%	50%
Patients with five or more symptoms (one must be anhedonia or depressed mood-first two)	29%	55%	17%	0%	13%
Discussion regarding the onset and severity of symptoms	75%	91%	33%	67%	88%
Discussion regarding the degree of functional impairment in social and/or occupational settings	54%	55%	33%	67%	63%
Discussion regarding current drug or alcohol use	32%	36%	33%	0%	38%
Discussion regarding suicidal ideation	29%	64%	0%	0%	13%
Comorbid medical condition(s) (Diabetes, Cardiac Disease, Cancer, Obesity and/or Stroke)	43%	36%	0%	100%	63%
Previous psychological episodes or concurrent conditions assessed	39%	27%	33%	33%	63%
Evidence that information about major depression been discussed and/or provided	57%	45%	33%	33%	100%
Patients taking medication for Major Depression	86%	91%	83%	67%	88%
Educated on side effects and compliance issues	63%	60%	40%	0%	100%
Evidence that the patient has been on the same treatment for at least 6 months	83%	80%	60%	100%	100%
Referral:					
Psychotherapy referral discussed and/or Referred to a psychologist or psychiatrist	29%	27%	17%	0%	50%
Patients with comorbid medical condition(s) and/or Patients with previous psych episodes or concurrent conditions	38%	0%	0%	NA	75%
SCORE (referred to and seen by)	25%	27%	17%	0%	38%

¹Blue Hill Family Medicine

²Bucksport Family Medicine

³Castine Community Health Services

⁴Island Family Medicine