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SYLLABUS AND COURSE GUIDE

Release Date: February 23, 2009
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Depression Management in Healthcare Systems: A Team Approach to Care

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LIVE CE: Webcast and Interactive Q&A

Monday, February 23, 2009, 12:00 p.m.–1:00 p.m. ET

FACULTY: Larry Culpepper, MD, MPH
MODERATOR: Rakesh Jain, MD, MPH

This continuing education activity is provided by

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INFORMATION FOR PARTICIPANTS

Statement of Need

The application of a chronic disease model to the management of depression is lagging behind other therapeutic areas owing to system-, provider-, and patient-related barriers. Yet the incorporation of this model can help to improve fragmented care, address gaps between best care and usual care, improve coordination of care, enhance outcomes, and reduce costs.[1] Critical to this model is the implementation of screening tools and a clear understanding of how to read and evaluate these tools in a primary care practice.[2] Communication between the primary care provider and the psychiatrist is vital in order to streamline care, optimize resources, incorporate the latest guidelines and evidence, and avoid overlap that can result in dangerous medical outcomes and increased costs. The involvement of a multidisciplinary treatment team can provide synchronized and coordinated care. A team of providers including the primary care physician, psychiatrist, pharmacist, psychologist, nurse, and case manager, all sharing a common goal for the patient, can ensure that care is optimized by selecting appropriate medication, supporting medication adherence, managing side effects and efficacy issues, and incorporating behavioral and/or psychotherapeutic interventions into the treatment plan when warranted. Research has shown that this team approach indeed improves treatment adherence and recovery.[3] In this neuroscienceCME webcast, faculty will discuss system-wide barriers to improved recognition and management of depression in primary care, and will review both guidelines and the evidence base for using a team-based approach to improve outcomes.

[1] Agency for Healthcare Research and Quality. Screening for depression: systematic evidence review number 6. Rockville, MD. Agency for Healthcare Research and Quality; 2002.

[2] Gilbody S, et al. Educational and organizational interventions to improve the management of depression. *JAMA* 2003;289:3145-3151.

[3] Katon W, et al. Rethinking practitioner roles in chronic illness: the specialist primary care physician and the practice nurse. *Gen Hosp Psychiatry* 2001;23:138-144.

Activity Goal

To identify system-, provider-, and patient-related barriers to coordinated care for patients with depression, and to provide mental healthcare practitioners with strategies drawn from the evidence base and guidelines for developing team-based care to improve outcomes for this patient population.

Learning Objectives

At the end of this CE activity, participants should be able to:

- Improve awareness and response to healthcare systems related barriers to recognition, screening, and coordinated care for patients with depression.
- Integrate a team care approach into practice in order to facilitate involvement of and communication between clinical stakeholders, patients, and their families.
- Increase utilization of established clinical guidelines for primary care treatment of depression.

Target Audience

Physicians, physician assistants, nurse practitioners, nurses, psychologists, social workers, certified case managers, pharmacists, and other healthcare professionals with an interest in mental health.

CREDIT INFORMATION

CME Credit (Physicians)

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Note to Physician Assistants: *AAPA accepts Category I credit from AOACCME, Prescribed credit from AAFP, and AMA Category I CME credit for the PRA from organizations accredited by ACCME.*

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It has been assigned code 6WASUP-PRV-0653. 1.0 contact hours will be awarded upon successful completion.

Note to Nurse Practitioners: *The content of this CNE activity pertains to Pharmacology.*

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Universal Program Number: 376-000-09-004-L01-P (live presentation), 376-000-09-004-H01-P (recorded programs)
Activity Type: knowledge-based

All other clinicians will either receive a CME Attendance Certificate or may choose any of the types of CE credit being offered.

Commercial Support

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To complete your credit request form, activity evaluation, and post-test online, and print your certificate or statement of credit immediately (70% pass rate required), please visit www.neuroscienceCME.com and click on the Testing/Certification link under the Activities tab (requires free account activation). This website supports all browsers except Internet Explorer for Mac. For complete technical requirements and privacy policy, visit www.neurosciencecme.com/technical.asp.

There is no fee for participation in this activity. The estimated time for completion is 60 minutes.
Questions? Please call **877.CME.PROS**.

FACULTY BIOS & DISCLOSURES

Larry Culpepper, MD, MPH

Dr. Culpepper is Professor of Family Medicine and the founding Chairman of the Department of Family Medicine at Boston University School of Medicine. Dr. Culpepper also is Chief of Family Practice at Boston Medical Center. He received his MD degree from Baylor College of Medicine and his MPH degree from Boston University.

An active researcher, Dr. Culpepper has conducted federally funded studies of depression and anxiety, otitis media, and school-based and community interventions to improve pregnancy outcomes and to prevent teen pregnancies. Recently, he served as the principal investigator of an AHRQ funded developmental center for patient safety research devoted to the study of problems affecting low income and minority vulnerable populations in ambulatory care settings, and is a co-investigator of the Primary Care Anxiety Project, a study of the course of anxiety disorders in primary care settings. Dr. Culpepper's department operates a large hospitalist inpatient service, obstetric and newborn service, and provides leadership to a network of 15 community health centers involving over one million visits annually. It also is responsible for Boston University's Student Health Service and for the Boston University Medical Center's Occupational Health Service.

He has served as President of the North American Primary Care Research Group (NAPCRG), and Chairman of the Research Committee of the Society of Teachers of Family Medicine (STFM). Dr. Culpepper is a Primary Care Fellow of the federal Health Resources and Services Administration, and has chaired or served as a member of research grant review committees for five NIH and other federal agencies, and has served on six federal expert panels for consensus committees or evidence-based centers. He founded and is the Chairman of the Board of the Rhode Island Public Health Foundation. He is a member of The Depression and Bipolar Support Alliance and the Anxiety Disorders Association of America Scientific Advisory Boards. He is the editor of the *Primary Care Companion to the Journal of Clinical Psychiatry*. In 1997 he received the NAPCRG-STFM Career Research Award, and in 1998 was elected to the Institute of Medicine.

Rakesh Jain, MD, MPH, Moderator

Dr. Jain is Director of Psychiatric Drug Research for the R/D Clinical Research Center at Lake Jackson, Texas.

Dr. Jain attended medical school at the University of Calcutta in India. He then attended graduate school at the University of Texas School of Public Health in Houston, where he was awarded a National Institute/Center for Disease Control Competitive Traineeship. His research thesis focused on alcohol abuse issues. He graduated from the School of Public Health in 1987 with a Masters of Public Health (MPH) degree.

After graduate school, Dr. Jain completed a postdoctoral fellowship in Research Psychiatry with the Gerontology Center of the University of Texas Mental Sciences Institute in Houston. He received the National Research Service Award for the support of the postdoctoral fellowship. After this, he served a three-year residency in Psychiatry at the Department of Psychiatry and Behavioral Sciences at the University of Texas Medical School at Houston as well as a two-year fellowship in Child and Adolescent Psychiatry.

Dr. Jain is currently involved in multiple research projects studying the effects of medications on short-term and long-term treatment of depression, anxiety, pain/mood overlap disorders, and psychosis in adult and child/adolescent populations. He is the author of several articles on the issue of mood and pain conditions. He serves on several Boards focusing on drug development and disease state education. He was recently named "Public Citizen of the Year" by the National Association of Social Workers, Gulf Coast Chapter, in recognition of community and peer education and championing of mental health issues. He was also recently awarded the "Extra Mile Award" by the local school district, in recognition of the service to the children of the school district and consultation to the teachers and counselors. In 2008, at the U.S. Psychiatric Congress, held in San Diego, California, he was the recipient of "Teacher of the Year Award."

Disclosure Declaration

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Dr. Culpepper has disclosed that he serves on the speakers bureaus of Forest Laboratories, Inc., Pfizer Inc., and Wyeth Pharmaceuticals. He also serves as a consultant to AstraZeneca Pharmaceuticals LP, Forest Laboratories, Inc., Eli Lilly and Company, Pfizer Inc., Somaxon Pharmaceuticals, Inc., Takeda Pharmaceuticals North America, Inc., and Wyeth Pharmaceuticals.

Dr. Jain has disclosed that he receives research support from Abbott Laboratories, Addrenex Pharmaceuticals, Inc., Aspect Medical Systems, Inc., Forest Laboratories, Inc., Eli Lilly and Company, and Pfizer Inc. He serves on the speakers bureaus of Cyberonics, Inc., GlaxoSmithKline, Jazz Pharmaceuticals, Eli Lilly and Company, Pfizer Inc., Shire Pharmaceuticals, and Takeda Pharmaceuticals North America, Inc. Dr. Jain serves as a consultant to Addrenex Pharmaceuticals, Inc., IMPAX Laboratories, Inc., Eli Lilly and Company, and Shire Pharmaceuticals.

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The slides that are presented in this activity are available for download and printout at the neuroscienceCME website: **www.neuroscienceCME.com.** Activity slides may also be obtained via fax or email by calling **877.CME.PROS**.

Abbreviation List

CAGE	A 4-item self-report screening tool for alcohol abuse
GAD-7	Generalized Anxiety Disorder-7 Scale
HAM-D	Hamilton Depression Rating Scale
HSCL-20	Hopkins Symptom Checklist-20
IMPACT	Improving Mood Promoting Access To Collaborative Care Treatment Study
PATHWAYs	A Randomized Trial Of Collaborative Care In Patients With Diabetes And Depression
PCP	Primary Care Physician
PHQ-9	Patient Health Questionnaire-9
PROSPECT	A Randomized Controlled Trial Of A Depression Treatment Program For Older Adults Based In Primary Care
QIDS	Quick Inventory Of Depressive Symptomatology
SCL-20	Symptom Checklist-20
STAR*D	Sequenced Treatment Alternatives To Relive Depression Study

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Depression Management in Healthcare Systems: A Team Approach to Care

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Moderator:
Rakesh Jain, MD, MPH

Director, Adult and Child
Psychopharmacology Research
R/D Clinical Research, Inc.

Rakesh Jain, MD, MPH
Disclosures

- **Research/Grants:** Abbott Laboratories; Addrenex Pharmaceuticals, Inc.; Aspect Medical Systems, Inc.; Forest Laboratories, Inc.; Eli Lilly and Company; Pfizer Inc.
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- **Stockholder:** None
- **Other Financial Interest:** None
- **Advisory Board:** None

Larry Culpepper, MD, MPH

Professor and Chairman
of Family Medicine

Boston University Medical Center

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The course guide for this activity includes slides, disclosures of faculty financial relationships, and biographical profiles.

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Depression Management in Healthcare Systems: A Team Approach to Care

Supported by an educational grant from Wyeth Pharmaceuticals

Learning Objective 1

Improve awareness and response to healthcare systems-related barriers to recognition, screening, and coordinated care for patients with depression

Learning Objective 2

Integrate a team care approach into practice in order to facilitate involvement of and communication between clinical stakeholders, patients, and their families

Learning Objective 3

Increase utilization of established clinical guidelines for primary care treatment of depression

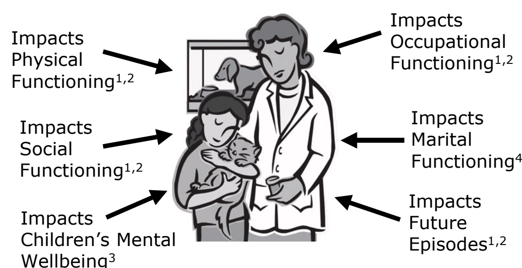
Global View of Depression—Impact on Society

A Major Cause of Disability Worldwide

Rank	1990	2020 (Estimated)
1	Lower respiratory infections	Ischemic heart disease
2	Perinatal conditions	Unipolar major depression
3	HIV/AIDS	Road traffic accidents
4	Unipolar major depression	Cerebrovascular disease
5	Diarrheal diseases	Chronic obstructive pulmonary disease

Murray CJL, Lopez AD, eds. *The Global Burden of Disease*. Boston: Harvard University Press; 1996.

Remission Is Important



1. Sobocki P, et al. *Int J Clin Pract* 2006;60:791-798.
2. Keller MB. *JAMA* 2003;289:3152-3160.
3. Weissman MM, et al. *JAMA* 2006;295:1389-1398.
4. Bromberger JT, et al. *J Nerv Ment Dis* 1994;182:40-44.

3-Component Model of Depression Care
MacArthur Project

Lee PW, et al. *J Am Board Fam Med* 2007;20:427-433.

Learning Objective 1

Improve awareness and response to healthcare systems-related barriers to recognition, screening, and coordinated care for patients with depression

System-Related Barriers to Optimized Care for Depression[1,2]

- Interruptions in treatment
- Low frequency of contacts
- Lack of individualized care
- Total reliance on physician
- Lack of time to educate and activate
- Lack of time to support behavioral change
- Lack of monitoring of adherence and outcomes
- Compensation
- Confidentiality
- Lack of parity/carve-outs

1. Katon WJ. *Gen Hosp Psychiatry* 2003;25:222-229.
2. Druss B, Rosenheck R. *Psychiatr Serv* 1997;48:71-75.

Provider-Related Barriers to Optimized Care for Depression

- Primary Care
  - Knowledge
  - Time
  - Attitudes
  - Concepts/language/data
  - Tools: e.g., PHQ-9, QIDS, GAD-7, CAGE
  - Variable practice and measurement patterns
- Psychiatry
  - Time
  - Delay to first diagnosis
  - Patient access to care
  - Misdiagnosis

Compensation | Confidentiality | Communication

Katon WJ. *Gen Hosp Psychiatry* 2003;25:222-229.

Patient-Related Barriers to Optimized Care for Depression

- Partial or nonadherence
- Poor follow-through
- Low motivation
- Lack of knowledge
- Stigma, personal and family issue
- Privacy concerns
- Lack of resources and time
- Preferences for certain treatments, and for care by PCP
- Access to care

Katon WJ. *Gen Hosp Psychiatry* 2003;25:222-229.

Learning Objective 2

Integrate a team care approach into practice in order to facilitate involvement of and communication between clinical stakeholders, patients, and their families

High Quality of Care for Depression Requires Two Levels of Change

- Improvements at the practice level
  - Identifying and developing systems for care
    - Establishing patient registry
    - Defining consultant relationships
    - Developing “tool set”
    - Training team
- Improvements in the process of individual patient care

Elements Required to Improve Care

- Evidence-based strategy for screening and measuring severity and treatment response
- Evidence-based approach to actively managing treatment to attain remission
- Skilled case manager
- Collaborative relationship with psychiatric colleague(s)

Ideal Treatment Team
Primary Care

- In-practice resources
  - Care manager for:
    - Basic chronic care management
      - Phone contact with patients
      - Tracking no-shows
      - Ongoing symptom assessment
- Community/referral resources
  - Psychiatrist for:
    - Difficult psychiatric diagnoses
    - Consultation on medication
    - Patient evaluation
  - Substance abuse program
  - Therapist (psychologist, psychiatrist, psychiatric social worker, psychiatric nurse)
  - Nurse practitioner
- Family members

Ideal Treatment Team
Psychiatry

- Need an extended network including, where appropriate:
  - Substance abuse program
  - Psychotherapist
  - Dementia day care
  - Protective services
  - School psychologist, et al.
  - Family members

Continuity of Care

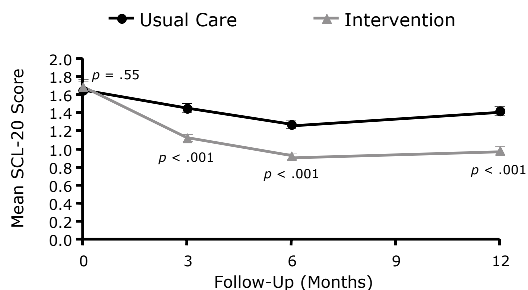
- Need to improve access and outcomes for referral
- Both PCP and psychiatrist need to stay involved after discharge
  - High rates of suicide in depressed patients within 30 days of discharge
- Both PCP and psychiatrist are responsible for patient after discharge and need to coordinate care
- Communication barriers exist related to confidentiality
- Mental health carve-out system makes continuity of care difficult

Involvement of Allied Health Professionals

- IMPACT[1], PROSPECT[2], PATHWAYS[3] studies
- Outcome differences between intervention and usual care patients approaching levels seen in collaborative care (i.e., 30% differences) telephone and/or visits with nurses and other allied health professionals
- Improved patient outcomes from 40% in usual primary care to over 70%
- Outcomes: 6 of 8 trials have shown effectiveness:
  - Improvement from 40% in usual care to 55-57%

Katon WJ. *Gen Hosp Psychiatry* 2003;25:222-229.
Katon W, et al. *Arch Gen Psychiatry* 1996;53:924-932.
Katon W, et al. *JAMA* 1995;73:1026-1031.

Mean SCL-20 Depression Score

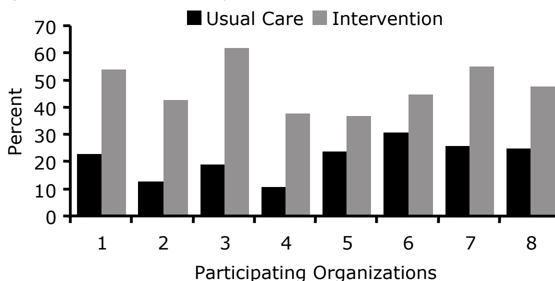


Unützer J, et al. *JAMA* 2002;288:2836-2845.

IMPACT

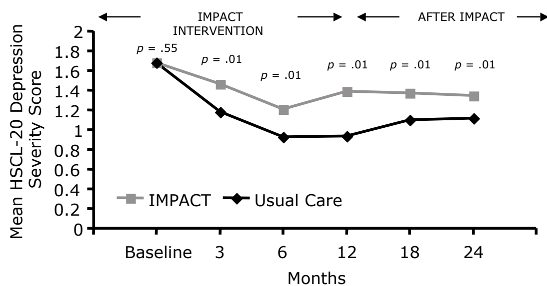
Findings Robust Across Diverse Health Care Organizations

(≥ 50% reduction in depression from baseline at 12 months)



Unützer J, et al. *JAMA* 2002;288:2836-2845.

Effects Persist Even 1 Year After the Program Ends



Hunkeler EM, et al. *BMJ* 2006;332:259-263.

Learning Objective 3

Increase utilization of established clinical guidelines for primary care treatment of depression

Guidelines for Assessing and Managing Depression in Primary Care

- Institute for Clinical Systems Improvement Guideline
  http://www.icsi.org/guidelines_and_more/gl_os_prot/behavioral_health/depression_5/depression_major_in_adults_in_primary_care_4.html
- MacArthur Foundation Depression Collaborative Guidelines
  http://depression-primarycare.org

Assessment Tools for Depression

Scales for Clinical Practice

- QIDS-C/QIDS-SR[2]
  - 16-item scale; practical; can be self-administered by clinician or patient
  - ***Remission: ≤ 5***
- Patient Health Questionnaire-9 (PHQ-9)[3]
  - Based on 9 DSM-IV diagnostic criteria; patient administered
  - ***Remission: ≤ 4***

Research Rating Scales

- HAM-D[1]
  - 17- or 21-item scale; lengthy in clinical practice
  - ***Remission: HAM-D-17 ≤ 7***
- Montgomery-Åsberg Depression Rating Scale (MADRS)[1]
  - 10-item scale; commonly used in antidepressant trials
  - ***Remission: ≤ 10***

DSM-IV = Diagnostic and Statistical Manual of Mental Disorders, 4th ed.

1. Trivedi MH. *Prim Care Companion J Clin Psychiatry* 2004;6:12-16.
2. Trivedi MH, et al. *Psychol Med* 2004;34:73-82.
3. Kroenke K, et al. *J Gen Intern Med* 2001;16:606-613.

Outcomes Measurement in Depression

- "Psychiatry is the only medical discipline in which quantified measurements of outcome are not the standard of care"[1]
- Routine use of standardized scales can improve outcome[1]
- More than 50% of psychiatrists in two studies reported *never* using standardized measures to assess outcome[2,3]
- Less than 12% report routinely using these scales[2,3]
- Brief self-report scales are inexpensive, easy to use, reliable, and valid measures for use in clinical practice[1]

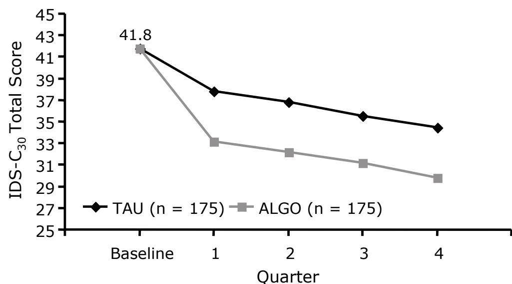
1. Zimmerman M, et al. *Prim Psychiatry* 2008;15:67-75.
2. Gilbody S, et al. *Br J Psychiatry* 2002;180:101-103.
3. Zimmerman M, McGlinchey JB. *J Clin Psychiatry* (in press).

Measurement-Based Care (MBC)

- A means of assisting the spread of evidence-based care for MDD
- Includes the following elements:
  - Standard assessments of depressive symptoms, medication side effects, and patient adherence
  - Uses a multi-step decision tree for MDD
  - Consistent patient follow-up
  - Feedback to assist clinical decision-making
  - **IT IS NOT** a substitute for clinical judgement
  - STAR*D shows MBC may lead to greater remission rates in patients with chronic depression

Trivedi MH, et al. *Am J Psychiatry* 2006;163:28-40.

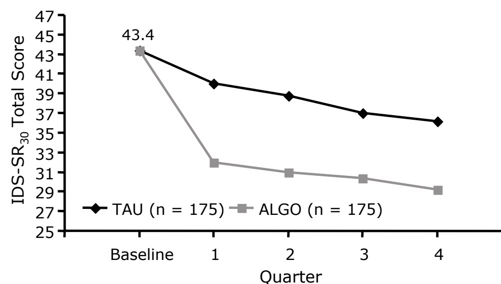
Clinician Ratings of Depressive Symptoms in Algorithm-Based vs. Usual Care



Adjusted mean symptoms for all patients according to the 30-item Inventory of Depressive Symptomatology–Clinician-Rated scale (IDS-C_{30}) during 12-month algorithm-guided treatment (ALGO) compared with treatment as usual (TAU) (N = 350).

Trivedi MH, et al. *Arch Gen Psychiatry* 2004;61:669-680.

Patient Self-Report of Depressive Symptoms in Algorithm-Based vs. Usual Care



Adjusted mean symptoms for all patients according to the 30-item Inventory of Depressive Symptomatology–Self-Report scale (IDS-SR_{30}) during 12-month algorithm-guided treatment (ALGO) compared with treatment as usual (TAU) (N = 350).

Trivedi MH, et al. *Arch Gen Psychiatry* 2004;61:669-680.

Clinical Connections

- Recognize that barriers exist in system, for providers, and even with patients
- Develop a plan to address key barriers, and include a treatment team to help with ongoing care of patients
- Improve communication with other providers, such as psychiatrists, so they can participate in treatment planning and follow-up
- Measure, measure, measure

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Lee PW, Dietrich AJ, Oxman TE, Williams JW Jr, Barry SL. Sustainable impact of a primary care depression intervention. *J Am Board Fam Med* 2007;20:427-433.

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Sobocki P, Ekman M, Apren H, Runeson B, Jonsson B. The mission is remission: health economic consequences of achieving full remission with antidepressant treatment for depression. *Int J Clin Pract* 2006;60:791-798.

Trivedi MH. The link between depression and physical symptoms. *Primary Care Companion J Clin Psychiatry* 2004;6(suppl 1):12-16.

Trivedi MH, Rush AJ, Crismon ML, et al. Clinical result for patients with major depressive disorder in the Texas Medication Algorithm Project. *Arch Gen Psychiatry* 2004;61:669-680.

Trivedi MH, Rush AJ, Ibrahim HM, et al. The Inventory of Depressive Symptomatology, Clinician Rating (IDS-C) and Self-Report (IDS-SR), and the Quick Inventory of Depressive Symptomatology, Clinician Rating (QIDS-C) and Self-Report (QIDS-SR) in public sector patients with mood disorders: a psychometric evaluation. *Psychol Med* 2004;34:73-82.

Trivedi MH, Rush AJ, Wisniewski SR, et al. Evaluation of outcomes with citalopram for depression using measurement-based care in STAR*D: implications for clinical practice. *Am J Psychiatry* 2006;163:28-40.

Unutzer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA* 2002;288:2836-2845.

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