This activity was sponsored by Med-IQ and developed in collaboration with the National Committee for Quality Assurance (NCQA).

Performance Improvement Strategies in Clinical Depression

Community of Practice Audioconference

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MODERATOR: Welcome to the Clinical Depression Community of Practice Audioconference with faculty expert, Dr. Michael Thase. This activity is sponsored by Med-IQ and developed in collaboration with the National Committee for Quality Assurance. I am Olivia, your moderator for today's discussion. This audioconference is being recorded; however, resale of the content is prohibited.

During today's call you will have an opportunity to discuss methods for overcoming practice-related barriers in the management of clinical depression, including implementing screening strategies, optimizing therapy regimens, and assessing treatment adherence. We will review nationally recognized quality measures that can aid in enhancing clinical practice performance and improving the care of patients with a diagnosis of depressive disorder.

You are invited to voice questions or comments during this live discussion for immediate faculty feedback. This activity has been developed as part of the complimentary PI initiative, Performance Improvement Strategies in Clinical Depression, for which Dr. Thase has served as faculty chair. Additional details about this initiative will be discussed during this audioconference.

I am pleased to now introduce Dr. Thase. Dr. Thase is Professor of Psychiatry and Chief of the Mood and Anxiety Disorders Section of the Perelman School of Medicine at the University of Pennsylvania. Dr. Thase?

DR. MICHAEL THASE: Good morning and welcome to this community of practice audioconference. The goal of this call is to bring together specialists who are interested in the care of patients with depression and to discuss current challenges and advances in the care of these patients.

Before we get to your questions, I want to share some reasons why programs such as this performance improvement initiative are so important and provide you with a bit of insight about the current state of depression care. For those of you who may not be familiar with performance improvement or PI programs, this is an AMA-approved CME format in which clinicians work on improving their individual performance by completing two stages of retrospective patient data collection and implementing a plan for improvement into practice. There is an increasing acceptance that improving care will require us as healthcare professionals to measure and monitor indicators of quality with the goal of identifying areas where current practice falls below established standards and where opportunities for improvement are present. PI CME is one method to help us accomplish this.

This process consists of three stages, and five CME credits are available for each stage, with an additional five credits available to clinicians who complete the entire activity for a total of 20 credits.

In the first step, or stage A, participants perform a retrospective analysis of

25 patient charts by completing a standardized data collection form for each chart. The data can either be entered online by the participant or their designee or faxed to Med-IQ and entered by a staff member. Once all data from the chart review have been entered, participants receive a summary of their practice patterns relative to those of their peers enrolled in the program and any other peer-based or national standards, when available.

In the next step, or stage B, participants review these results and design a process-based improvement strategy to meet the needs of their practice. To help develop a plan, clinicians may read a complimentary, certified CME implementation guide that outlines the current evidence base and treatment guidelines and provides practical tools and resources.

We recommend that participants implement their improvement plan for at least 90 days before continuing with stage C of the program by reviewing an additional 25 patient charts. The charts selected for this stage should be for patients who are seen after the clinician started the program and ideally should include patients who were initially diagnosed since the clinician put his/her improvement strategy into place. At the conclusion of stage C, participants receive a summary of their current practice patterns relative to their earlier practice patterns, those of their peers, and national standards, and they can assess whether any change has occurred in their practice performance. The American Board of Psychiatry and Neurology, or the ABPN, has reviewed this PI activity and accepted it as meeting the maintenance of certification requirements for Performance in Practice, or PIP, and life-long learning programs.

Now that we have discussed the framework of PI CME, I would like to take a few minutes to highlight some of the key challenges in managing clinical depression and share some of the early data that we have gathered through this PI program.

We developed this PI initiative to focus on three general areas of care for patients with clinical depression: screening and standardized tools, treatment (whether it be with antidepressants and/or psychotherapy), and patient follow-up (like scheduled appointments, medication adherence, and patient self-management plans).

The PI program launched about 4 months ago. To date, more than 400 clinicians have registered for the program, and almost 50 have completed stage A, which is the baseline data collection. We currently have baseline data for almost 1,400 patient charts. Although it is still very early in the data collection process, the baseline data are refreshing in that we've seen a pretty high level of performance among the participating physicians for most of the measures. However, there is still room for improvement in some areas.

Let's start with screening. Even though the US Preventive Services Task Force recommends that all patients be screened for depression, it has been reported that only about one-third of primary care physicians ask their

patients about depression symptoms. Several self-administered screening instruments are currently available, all with acceptable sensitivity and specificity for major depressive disorder (MDD), as defined in the DSM-IV-TR. These questionnaires can be completed in approximately 2 to 10 minutes in a waiting room and, therefore, need not take much time during the office visit. For various reasons, patients may not always voice their concerns about their symptoms of depression; therefore, an active approach to assessing patients is a central component of managing depression.

Looking at the early baseline data submitted by the participants in the Med-IQ PI program, clinicians appear to assess patients for the symptoms of depression about 72% of the time and record the results in the patient's chart about 94% of the time. About 15% of the participants use the PHQ-2 or PHQ-9 tool. Almost 40% of the respondents say they use the DSM-IV criteria as a screening tool.

Other tools, such as the Beck Depression Inventory-1 or 2, the QIDS, the Zung self-rating depression scale, and the CES-DR, are also used, but not very often, no more than 6% of the time. Although all of these screening methods are similarly effective for detecting depression, the PHQ-9 is actually the tool that most closely follows the DSM-IV criteria for depression.

If you have trouble remembering or finding time to screen each of your patients, checklists or floor sheets may help you remember to ask patients about any symptoms they may be experiencing. Once you have screened a patient and confirmed a diagnosis according to the DSM-IV criteria, it is important to recommend management strategies, either pharmacologic, nonpharmacologic, or both Pharmacotherapy and psychotherapy are equally effective in gaining response and remission, but they are substantially more effective when used in combination, sometimes with response rates as high as 80% or 85% in some studies.

In the PI program, clinicians reported recommending psychotherapy for 83% of their patients. Antidepressants were prescribed for 92% of their patients. As many as 70% of the primary care patients cited treatment-emergent adverse effects, primarily sexual dysfunction, weight gain, and sleep disturbance, as the main reason for discontinuing an antidepressant medication, so it is important to monitor patient adherence as well as side effects through follow-up visits. This process can be improved by using standardized assessment tools. With regard to following up with patients, approximately one-half of the respondents said they scheduled 2 to 3 follow-up visits within the first 12 weeks, the acute treatment phase, when prescribing antidepressants.

We asked PI participants to report whether they monitor adherence to therapy and, if so, how they do it. About 90% of the respondents said they ask patients about adherence, whereas only 10% said they use a standardized tool to assess adherence. The use of an objective tool can help assess

adherence more accurately than the subjective method, such as patient self-reporting.

The Medication Adherence Rating Scale, or the MARS, was provided as one of the educational resources for this program, but other tools, such as the Antidepressant Adherence Scale and the Drug Attitude Inventory, can be used to measure adherence in your patients.

Another area in which there is more than a little room for improvement is asking patients to identify self-management goals. Just about 70% of respondents said they were doing this. These self-management goals can include things like taking medications regularly, being honest with their physician about side effects, keeping a journal, exercising, and getting adequate sleep; of course, once these goals are documented, it is important to follow up with patients to see whether they are making progress toward their goals.

I have only touched on the surface of a few of many challenging aspects of managing clinical depression. This program has been helpful in identifying the areas in which we can improve the care we provide for our patients with depression.

Now I would like to open it up to you for comments and questions about challenges in depression care and/or strategies for improving the management of our patients. We will begin with questions that we have received in advance by e-mail, but please feel free to let the operator know if you have a question you would like to address this morning.

OLIVIA: Thank you, doctor. At this time we will begin the question and answer session. To ask a question, please press zero followed by a one on your touchtone phone. Questions will be answered in the order they are received. Again, if you would like to ask a live question, please press zero followed by a one now. Please pause to assess whether we received live questions in queue. While we pause, Med-IQ received several questions in advance for this audioconference. At this time, Dr. Thase will share a few questions that were submitted by your colleagues.

DR. THASE: What is the simplest way to diagnose depression? I honestly think the simplest way is to have the PHQ filled out in the waiting room beforehand, and those results will reveal any diagnostic symptoms. During the office visit, you then must confirm that these symptoms are indeed present, that they have been present almost every day, and that they have a significant impact on the patient. You then do a review of systems, consider other possibilities that might be masquerading as depression, and go from there.

If your practice is set up with a two-phase screener, it requires that a patient select “yes” to either the depressed mood or the loss of interest item of the PHQ-2; you would then proceed to the PHQ-9. However, screening scales are not used to make the diagnosis. You only follow up on screening scale results

with your in-person interview. You need about 5 or 10 minutes to go through the criteria and to at least briefly consider some of the alternative points in a differential diagnosis.

OLIVIA: Thank you, Dr. Thase. At this time there are no questions in queue, so would you please continue with another pre-submitted question?

DR. THASE: When you prescribe antidepressants in any given situation, do they all have equal efficacy? And how do I go about picking a particular antidepressant for an individual patient? Differences in efficacy from the most effective to the least effective approved antidepressant are roughly 7% to 10%; in many clinical situations, for example common outpatient practice or a primary care outpatient practice, the potential differences in efficacy may be even smaller. For this reason, it is generally recommended that you select antidepressants based on their safety and ease of use first, so a medication such as an SSRI is often an appropriate choice because it can usually be initiated at a therapeutic dose, is available in generic form, and has a good safety profile. Other potential first-line antidepressants beyond the SSRIs are the SNRIs and bupropion. In my own practice, I kind of have a hierarchy of ease of use; I reserve the more difficult to use antidepressants, the tricyclics, and the most difficult to use antidepressants, the MAOIs, for patients who haven't responded to at least several trials with the more tolerable or safer newer-generation antidepressants.

OLIVIA: Thank you, doctor. Again as a reminder to our participants, you may ask a live question by pressing zero one on your telephone keypad. Dr. Thase, will you please continue with additional submitted questions?

DR. THASE: Sure. Any pearls for differentiating between a major depressive episode and bipolar depression? And what is the best way to deal with the depressed phase of bipolar illness? The bipolar depression can look exactly like major depression, and they have the same diagnostic criteria. If you are going to make a differentiation, it is most likely going to be based on the patient’s history, so you should ask about mood swings. You should ask about periods of unusually increased drive, energy, and enthusiasm. Obviously, has the patient ever been hospitalized? Some epidemiologic and clinical characteristics are somewhat more common in bipolar depression, for example, a family history of bipolar disorder is more common in bipolar depression and an early age of onset, ie, before age 25 or, even more striking, before age 20, is more common in bipolar disorder. Patients with reverse vegetative features such as overeating or oversleeping are somewhat more likely to fall within a bipolar spectrum. If you have not seen any of those and you prescribe an antidepressant and the patient gets worse rather than better (particularly if they get worse in the sense of more agitation, racing thoughts, increased libido, or poorer sleep, especially with a decreased need for sleep), those treatment-emergent symptoms are highly suggestive of bipolar depression.

Then, if you have diagnosed bipolar depression, the current consensus is that unless the patient has a very clear and well-established history of having done quite well without mood cycling on antidepressants, you would start a mood stabilizer before you would consider antidepressants. There are great differences in terms of practice preference of which mood stabilizer should be started. Lithium, of course, is the old standard. The divalproex, or Depakote, is the more commonly used modern antimanic mood stabilizer, but for bipolar depression many psychiatrists opt for lamotrigine or brand name Lamictal because it does seem to have somewhat more preferential bipolar depression effects.

Lastly, several of the second-generation antipsychotics are used as monotherapies to treat bipolar depression with quite good evidence that quetiapine, whether the original form or the extended release form, is an effective treatment for bipolar depression.

OLIVIA: Please continue, sir.

DR. THASE: How do you manage weight gain when patients go on antidepressants? If the weight gain is a concern, of course, I will not prescribe an antidepressant that is associated with a greater risk of weight gain; I would put those antidepressants, including mirtazapine and the tricyclic antidepressants, on the shelf for as long as necessary. Among the SSRIs, paroxetine may be associated with a somewhat greater weight gain than the others, so I will put that a little further back in line. I will tell patients that there is a small and idiosyncratic risk of weight gain over time and that the best way of monitoring for this effect is to establish a weight chart by simply tracking their weight once a week or every other week.

One nice thing is that my scale works as well as the scale in the finest office of the best endocrinologist, so you really can see antidepressant-induced weight gain coming. If you see patients begin to gain weight, say on the order of 2 or 3 kilograms over the course of a month or slower, you counsel them about this risk, look for changes in activity level or changes in the eating patterns, and see whether you can put the trend to a halt. If you cannot put the trend to a halt, then I believe you have a heart-to-heart talk with the patient and consider changing the antidepressant.

The antidepressants with the least risk of weight gain are bupropion by far, followed possibly by vilazodone, and I say possibly only because we don't yet have extensive years of experience with this newer medication.

OLIVIA: Thank you, and again as a reminder to our participants, you may ask a question by pressing zero one. Dr. Thase?

DR. THASE: When should a patient be referred to a psychiatrist instead of continuing to be treated in the primary care setting? I think whenever you feel like you are in over your head is honestly when you should do it. Many primary care prescribers will kind of quickly or automatically refer patients

who have bipolar depression, who have psychotic features, who are strongly suicidal for whom hospitalization is a concern, and for whom the standard useful, good, first- and second-line medications haven't worked, ie, patients with so-called treatment-resistant depression.

OLIVIA: Please continue.

DR. THASE: When changing medicines, do you taper the dose to switch directly if you are going to stay within the same class? If you taper, what is the best way to do it? I taper quickly when switching within a class or when switching between medicines that are closely related, such as SSRIs and SNRIs; by quickly I mean that if the dose can be quartered or decreased by one-third, I will do, say, 3 or 4 days at each of those decrements so that the patient will be off of the ineffective medication within a week.

If the dose can simply be halved, I will do 4 days on half-dose and then stop. I will typically begin the newer medicine at the minimum therapeutic dose, unless the medicine I am tapering is fluoxetine, which has an incredibly long and slow auto taper. In that case, if possible, I will start the patient on a half-dose of the new medicine and continue that half-dose for a week or 2 before increasing it.

OLIVIA: Thank you, sir; let’s conclude with two final questions.

DR. THASE: After remission, if a patient has a recurrent attack of anxiety or depression, for example say they have had three attacks in the last 8 years, how long should the SSRI be continued or how long should the antidepressant be continued? The questioner wrote attack, but let’s substitute the word “episode” so we are all on the same wavelength here. So this would be a period of more than 2 weeks with symptoms that were interfering daily with the patient’s life.

Any time you initiate treatment with an antidepressant, you want to do it with the ground rule that if it works and works well, you are going to recommend staying on it for at least 8 or 9 months. Over the course of those 8 or 9 months, you look at the quality and the completeness of the recovery. If the patient has a full and complete recovery with little side-effect baggage toward the end of this period of continuation treatment, you should have a heart-to-heart talk about the pros and cons of long-term treatment. Most practice guidelines today would recommend indefinite maintenance therapy for someone who had experienced three prior episodes of illness; however, for some patients with very distant and infrequent episodes, the idea of getting off the medicine and taking a wait-and-see approach trumps the idea of staying on the medicine for prophylaxis.

Our final question: if zolpidem has been added to the antidepressant for insomnia, how long can it be continued after remission and should it be tapered slowly from the 10-milligram dose? Generally, we recommend that sedative hypnotic medicines used as adjuncts for antidepressants should be

limited to the first 2 or 3 months of therapy, if possible. Evidence suggests that you have at least a 50/50 chance that if the insomnia was associated with the depression, the insomnia will remit as the depression remits. However, there are patients who have a history of antecedent insomnia, and sometimes longer-term treatment is necessary.

Regarding longer-term treatment with the GABA-A selective agents or the more conventional benzodiazepine sedative hypnotics, we don't know whether they truly have sustained benefit indefinitely or whether they simply reinforce pill-taking behavior because of discontinuation or withdrawal symptoms the night the patient stops the medication. So I would say try, from the outset, to say that this is a short-term prescription. Do your best to taper the patient off of it if they have required a large dose, 10 or 15 milligrams, of zolpidem; certainly, you can taper by reducing the pill strength for one visit, in-between. If the anxiety persists, I think you are on firmer ground talking with the patient about alternates to habitual sedative hypnotic use, including cognitive behavioral therapy for insomnia or even considering a change in antidepressants if you have some reason to think that the antidepressant may be causing or worsening the insomnia.

OLIVIA: Thank you, Dr. Thase. This concludes today's Clinical Depression Community of Practice Audioconference, which has been sponsored by Med-IQ, developed in collaboration with the National Committee for Quality Assurance, and supported by an educational grant from Lilly USA, LLC.

This activity is part of the complimentary PI CME series, Performance Improvement Strategies in Clinical Depression. This series has been approved by the American Board of Psychiatry and Neurology as a performance in practice and CME program, which are part of the overall American Board of Psychiatry and Neurology maintenance of certification program.

To date, more than 380 clinicians have enrolled in this PI initiative to assess their current practice patterns and improve their processes of care in clinical depression. To learn more about this complimentary CME series or to start today, please visit www.PI-IQ.com/depression. Thank you for your time and commitment to improving the care of patients with depression.