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 a depressive disorder. You are invited to pose questions or comments during this live discussion for immediate faculty feedback. This activity has been developed as part of the complimentary PI CME 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 today’s 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: Thanks and good afternoon to everybody. Welcome to this Community of Practice Audioconference on clinical depression. The goal of this call is to bring together specialists who are interested in the care of patients with depression to discuss current challenges and advances that pertain to their treatment. Now before I open it up to your questions, I want to first share some of the reasons why activities such as this performance improvement initiative are important and provide you a little background into this particular initiative. For those of you who may not be familiar with performance improvement or PI activities, 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 to improve their practice. There is an increasing acceptance that improving care requires us as healthcare professionals to measure and monitor indicators of quality with the goal of identifying areas where practice falls below established standards and where opportunities for improvement are present. PI CME is one method that helps us accomplish this.

The process of this particular initiative consists of three phases; five CME credits are attached to each phase, and an additional five CME credits are 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 using a standardized data collection form. The
data can either be entered online or submitted by fax 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 activity.

In the next step, or stage B, participants review these results and design a process-based improvement strategy to meet the specific 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 some practical tools and resources.

We recommend that participants implement their improvement plan for at least 90 days before continuing with stage C of the activity by reviewing an additional 25 patient charts. The charts selected for this stage should be for patients who were seen after the clinician started the activity and ideally should include patients who were initially diagnosed after 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 has reviewed this PI activity and accepted it as meeting the maintenance of certification requirements for Performance in Practice, or PIP, or life-long learning programs.

Now that we’ve discussed the framework of PI CME, I’d like to take a few minutes to highlight some of the key challenges in managing clinical depression and share some of the early data we’ve collected with this initiative.

The PI activity was launched about 7 months ago. To date, more than 520 clinicians have registered for the activity, and almost 125 have completed stage A, which is the baseline data collection. So far only 20 clinicians have completed stage C, so we need your involvement and participation to help us get these numbers up. We currently have baseline data from more than 3,100 patient charts from stage A, and more than 500 patient charts from stage C. Although it is still early in the data collection process, particularly considering the number of stage C completers, the data we’ve collected reveals a pretty good indication of a high level of performance improvement. So if you’re just joining, get in there! It really will make a difference.

We developed this activity to focus on three general areas of care for patients with depression: screening with standardized tools, treatment (whether with antidepressants and/or psychotherapy), and patient follow-up (like scheduled appointments, medication adherence, and patient self-management strategies).
Let’s start with the screening results. 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 with acceptable sensitivity and specificity for major depressive disorder (MDD), as defined by the DSM-IV-TR. These questionnaires can be completed in approximately 2 to 10 in a waiting room and, therefore, do not have to take up much time during the office visit. Additionally, patients may not always voice their concerns about their symptoms of depression for a variety of reasons, so an active approach to assessing patients really is one of the best ways to improve recognition.

Looking at the early data from participants in this PI activity, clinicians in stage A said that they assess patients for symptoms of depression about 72% of the time. By stage C, that number had increased to 99%, which is truly outstanding and an honest unit of improvement. As for the tools that were being used, about 15% of the participants used one of the PHQ versions at stage A, and that increased to 42% by stage C. Of course the PHQ-2 is recommended by the prevention task force because of its simplicity. Other screening tools are also available, such as the Beck Depression Inventory-1 or 2 or the QIDS; however, the PHQ was developed for primary care, and the two-item version is by far the shortest and most efficient. If you are having trouble integrating a patient screening tool into your practice, you may find that adding a checklist or a flow sheet may help you remember. You may also find a checklist useful for identifying the DSM-IV criteria, although one of the beauties of the nine-item version of the PHQ is that it covers the core symptoms of depression. I think it is important to remember to engage the patient when determining a treatment strategy and to follow up to ensure that they do get help. We know there are many complicated decisions with regard to choosing the appropriate therapy for your patient, whether it is an antidepressant, which one do you begin with, or psychotherapy, or both. And of course the factors involved in this decision making can be complex and are perpetually changing. For example, you choose a certain medication, but the patient develops significant adverse events, or a patient you thought would be adherent to treatment is not adherent. The participants of the PI activity reported recommending psychotherapy 83% of the time for their patients with depression and antidepressants 92% of the time, so if those were independent, they would be recommending both treatments about 72% of the time. By far most participants reported recommending an SSRI antidepressant—in about 66% of patients; about 25% said they recommended treatment with an SNRI.

If you add those numbers, it means that about nine out of ten patients are getting one of these classes of medications. The respondents were rarely prescribing tricyclics, MAOIs, or some of the other antidepressants, but they
were aware of them and recognized their utility for patients who didn’t benefit from first- or second-line newer generation therapies. As we all know, depression is heterogeneous and varied in its presentations; it is very difficult to anticipate a response for a particular patient, so we make our best choice, monitor for response, and move on to our second best choice for that patient if necessary. One reason that treatment does not work is the side effects; as many as 70% of primary care patients cite treatment-emergent adverse effects, including sexual dysfunction, weight gain, and sleep disturbance, as one of the main reasons that they stopped taking antidepressant medication. It is important to monitor patient adherence and to follow up and ask about side effects. With respect to following up with patients, we didn’t see much change between stage A and C. About one-half of the participants reported that they schedule two to three follow-up visits within the first 12 weeks, which normally corresponds to what we call the acute phase of antidepressant therapy. Only about one-third said that they see patients four times or more during that same follow-up period. It does seem that patients attend these follow-up appointments—about one-half of the participants said that their patients attend at least two to three follow-up visits, the majority of which are in-person office visits.

When we asked our PI participants how they monitored adherence, 83% in stage A said they asked patients about adherence, but only 7% said they used a standardized scale to help monitor attendance. By stage C, however, that number had increased to 43%, so using the tools and adherence-monitoring questionnaire we provided seems to have caught on with the participants who went from stage A through C in this activity. That scale, the Medication Adherence Rating Scale (MARS) is provided in the educational resource material for our activity, and its use increased from 16% in stage A all the way up to 45% in stage C. We asked our PI participants how often they screen for suicide risk, and 88% in stage A reported doing so. It’s hard to improve upon that, but we did because 98% said they were doing it at stage C. It’s hard to get much better than 98%, but of course that is one of the most horrific and sobering aspects of depressive illnesses—its association with suicidal behavior—and if we don’t ask, often our patients don’t tell us.

I think one of the areas in which we really did see an opportunity for improvement was in engaging patients in self-help or self-management activities. At stage A or at the pre-intervention, about two-thirds of our respondents (63%) said they were doing this, but by stage C, that number had increased to 93%. Again, I think that by taking ownership for their treatment and their role as active participants in the treatment process, patients will be more satisfied with the treatment outcome and will have a better chance to get better. In conclusion, although I’ve touched on only a few of the many challenges of managing depression, I think we have identified in this PI activity some opportunities for practice improvement and
hopefully will see in the future some better outcomes for our patients. I think we’ll move on to our questions. I have some pre-submitted questions here. I also will invite the operator to let me know if folks have called in to ask live questions, and if so, we can go back and forth. I think you have received call-in information, is that correct operator?

MODERATOR: We do need to provide our participants with how to ask a live question.

DR. THASE: Okay, so please do that.

MODERATOR: Thank you, Dr. To ask a question, please press zero followed by a one on your touchtone phone. Questions will be answered in the order in which they are received. Again you may ask a live question by pressing zero, one now. Please pause to assess whether we receive live questions in queue, and as Dr. Thase said, we will go ahead and share a couple of questions that were submitted by your colleagues. Dr. Thase?

DR. THASE: The first one came from a primary care physician who asked “when should I refer to a psychiatrist?” I think the answer here varies pretty dramatically from physician to physician, from provider to provider. It’s when you feel like you’re in over your head, when you don’t think you have a good grasp on the diagnosis, when the treatments that usually work aren’t working, or when the treatments that usually work are having unusual untoward outcomes. Also, importantly, I think it’s appropriate when psychiatric hospitalization is a consideration because of severity, incapacity, or the degree of suicidality, and I think when patients have psychotic or bipolar subforms of depression, primary care doctors often feel better having a psychiatrist involved. Now all of that said, probably about two-thirds of depressed patients can be managed in primary care, and that’s about the proportion of patients who are being managed in primary care today.

I have a provocative question next: “Do [you] think antidepressants are overprescribed? Should we be referring for psychotherapy first, then using antidepressants when psychotherapy doesn’t work?” Interestingly, antidepressants are both over-prescribed and under-prescribed when we look at service utilization data; a portion of antidepressant prescriptions, maybe as much as one-third, are for people who don’t have conditions for which antidepressants are known to work. Also, in the US population at any given time, about 50% of all the people with depression aren’t receiving any antidepressants. That’s way up from what it was 20 years ago when maybe only 25% of depressed people were getting treated, but in the course of treating more, there has been some imprecision and overtreatment. I think do be judicious with respect to deciding which to start with: psychotherapy or pharmacotherapy. How severely ill is the patient? The more severely symptomatic, the more I lean toward pharmacotherapy. How motivated for psychotherapy is the patient? The more motivated for psychotherapy, the
more likely I am to start with it. And always keep in mind that these
treatments are not incompatible; on average, people who receive both
psychotherapy and pharmacotherapy have higher satisfaction with treatment
and have a better chance of getting well quicker. Operator, do we have
anybody called in yet?

MODERATOR: Not at this time, but as a reminder to our participants, you may ask a
live question by pressing zero, one. Dr. Thase?

DR. THASE: “Do [you] think group psychotherapy may be beneficial, particularly for
non-English-speaking speaking patients and especially Spanish-speaking
patients?” I know some of the more evidence-based or better-studied
psychotherapy, such as cognitive therapy, has been adapted so that it can be
used in groups and in Spanish-speaking groups. And of course when you are
culturally a minority, c feelings of isolation and disempowerment are common
and do help increase the risk of depression. Direct comparisons of group
psychotherapy and individual psychotherapy give the individual
psychotherapy a small edge in terms of the likelihood of benefit, but when
you take into account that you can treat five, six, or seven patients for the
same cost as one, then the cost effectiveness edge actually goes to group
psychotherapy. That said, when you’re talking about recommending
psychotherapy, ask your patient what seems of interest to him/her, and if you
know of a provider who does a very high level, very useful group that has
good consumer satisfaction ratings, by all means refer to it. If not, getting
people in an effective treatment, whether group or individual, is more
important than worrying about the difference between group and individual.

“Have [you] implemented CBT in my own practice, and what are the
challenges?” I am a card-carrying cognitive behavior therapist. I’m actually
one of the founding fellows of the Academy of Cognitive Therapy. The main
challenge of implementing CBT in a primary care practice is the time required
for training the patient how to use it effectively. Some shorter, less time-
intensive models of CBT exist, including one called “problem-solving
therapy.” Some online adaptations are also available that provide some
benefit for patients who either are unwilling or unable to see a therapist in
person, but I think most primary care docs would say the number one limit is
finding a good reliable person to refer to who takes good care of patients,
communicates, and stays in touch. When you find such a person, you should
nurture that resource and take good care of them.

“What’s the best way to initiate treatment with an SSRI?” Well most of us
have one or two favorites within this six-drug class, whether it’s loxitane,
paroxetine, sertraline, citalopram, S-citalopram, or even fluvoxamine, and we
say to the patient “I want you to take this one. This is my favorite, and I think
it’s a good match for you.” You usually start on the minimum therapeutic
dose, which varies by drug, and give that a couple of weeks at least to work.
If there are untoward effects, side effects, you can reduce the dose or go to
every other day dosing to functionally reduce the dose. Typically if the patient
has good tolerability and no clear response within 2 to 4 weeks, you want to
increase progressively toward the maximum tolerated dose within the
therapeutic range. Most people who are going to get better start to get better
in 4 weeks; if you’ve reached the maximum tolerated dose in 6 to 8 weeks
without clear benefit, it’s time to move on to another drug, whether it’s a
second member of the SSRI class or a different kind of antidepressant.

“What’s [your] best advice for treating a patient who declines antidepressant
therapy for one reason or another?” Well I accept their decision. I want to
know their reasons, and we talk about alternatives—you know, there’s a wide
range of alternatives starting with things like aerobic exercise and yoga, but
most importantly the focused, well-studied forms of psychotherapy. If they’ve
tried one of these alternates and aren’t making headway, I ask them to
reconsider antidepressant medication and schedule them for watchful waiting
and follow-up so that they have an opportunity to keep track of symptoms and
have a chance to talk again about the use of antidepressants. People have a
more positive bias toward psychotherapy or non-medication interventions
than they do for medications, and it really is quite okay to think about non-
medication interventions first. Just don’t lose track of patients, and if the
alternatives aren’t working, get them back in, talk with them about the
medication, and move on to the next one.

MODERATOR: And Dr. Thase, I believe we do have time for two additional
questions before we conclude today.

DR. THASE: “Can [you] speak a little about augmentation with treatment-resistant
depression?” Well, yes, because there are about a half dozen non-
antidepressants that have antidepressant-enhancing effects, including older
medicines such as forms of thyroid hormone and lithium carbonate, some of
the psychostimulants, the not-so-old medications like the anxiolytic
buspirone, and several of the newer second generation antipsychotics. I think
the key thing about picking an augmentation strategy as opposed to a
switching strategy is to ensure that the medication you picked first is well
tolerated because you’re going to continue it; you want to make sure that it
has a favorable tolerability profile and that you are seeing some hint or some
glimmer of response because you want to try to enhance that. I hope this isn’t
an offensive image, but you don’t want to beat a dead horse. If the medicine
is poorly tolerated or you’re seeing no benefit whatsoever, move on to a
different dissimilar medication before thinking about augmentation strategies.
The last question is “why would I think about transcranial magnetic
stimulation as opposed to ECT?” Well ECT involves having a series of
general anesthesias. It has some potential for causing memory dysfunction in
people who may persist for weeks or even months, and so we usually reserve
ECT for people with more incapacitating forms of depression including
psychotic depression. ECT usually is started in the hospital. Transcranial
magnetic stimulation is only about one-half as likely as ECT to work for a
patient with difficult to treat depression, but it can be done on an ambulatory basis, doesn’t require anesthesia, and has no ill effect on memory. I think of transcranial magnetic stimulation as an alternative to yet another trial of medication, whereas I think of ECT as something very, very different.

MODERATOR: Thank you, Dr. Thase.

DR. THASE: I think we’re going to have to wrap up.

MODERATOR: Yes, thank you sir. 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 and Certification program. To date, more than 700 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.