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## CME PSYCHCAST

### STRATEGIES FOR IMPROVING ADHERENCE IN THE TREATMENT OF MAJOR DEPRESSIVE DISORDER COLLABORATIVE CARE: *EVIDENCE-BASED MODELS THAT IMPROVE PRIMARY CARE DEPRESSIVE OUTCOMES*

#### AUTHOR

Wayne J. Katon, MD

#### CME COURSE DIRECTOR

James C.-Y. Chou, MD

CME 25

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#### ABSTRACT

It is estimated that 15 million Americans have a depressive disorder, including major depressive disorder, and many of those afflicted do not receive recommended guideline levels of care. Of patients who are correctly diagnosed with depression, a majority of patients do not recover by 4–6 months, often due to discontinuing treatment prior to the initiation of therapeutic effect. It is important for clinicians to understand the factors involved in nonadherence to treatment for the depressive disorders, including presence of residual symptoms, younger age, and less educational attainment. Once clinicians believe a patient is at risk for nonadherence—which is the rule rather than the exception—health care professionals have various techniques available to increase treatment adherence, including communication techniques and other health care interventions.

In this Expert Review PsychCast™, Wayne J. Katon, MD, describes how collaborative care—a health care model that involves not only primary care but also additional health care providers in patient treatment—can be beneficial in improving adherence by providing further patient education and additional screening to ensure that patients remain adherent to antidepressants.



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### Acknowledgment of Commercial Support

Funding for this activity has been provided by an educational grant from Eli Lilly and Company.

### Activity Review Information

The activity content has been peer-reviewed and approved by Susan F. Abbott, MD.

Review Date: November 12, 2009.

### Faculty Affiliation

**Wayne J. Katon, MD**, is professor of psychiatry, director of the Division of Health Services and Epidemiology, and vice chair of the Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine in Seattle.

### Faculty Disclosure Policy Statement

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### Faculty Affiliations and Disclosures

Dr. Katon serves on the advisory boards of Eli Lilly and Wyeth; and has received honoraria from Eli Lilly, Forest, Pfizer, and Wyeth.

CME Course Director **James C.-Y. Chou, MD**, is associate professor of psychiatry at Mount Sinai School of Medicine. Dr. Chou has received honoraria from AstraZeneca, Bristol-Myers Squibb, Eli Lilly, GlaxoSmithKline, Janssen, and Pfizer.

**Susan F. Abbott, MD**, is assistant professor of psychiatry in the Division of Child and Adolescent Psychiatry at Mount Sinai School of Medicine, and Chief of Child and Adolescent Inpatient Psychiatry Units at Mount Sinai Medical Center in New York City. Dr. Abbott reports no affiliation with or financial interest in any organization that may pose a conflict of interest.

### Learning Objectives

At the completion of this activity, participants should be better able to:

- Identify clinically actionable barriers to adherence and formulate treatment plans that address these barriers

### Statement of Need and Purpose

While physicians are routinely trained to recognize symptoms of depression and evaluate side effects of antidepressants, they receive almost no training on assessing nonadherence to antidepressant therapy or considering the factors (ie, nonresponse, adverse events, poor patient insight, etc.) that contribute to nonadherence. Nonadherence to antidepressant treatment in depression is very common and could be considered the single greatest impediment to successful antidepressant therapy. Patients often do not report nonadherence, not realizing that when a physician erroneously believes that a patient has taken the prescribed medications, the physician may make inappropriate medication changes or dosage adjustments which can lead to further complications and worse health outcomes. Unacceptable side effects are often the motivation for discontinuing antidepressant medication. Patient beliefs about the necessity of antidepressants, their understanding of and attitude toward depression as an illness, the frequency of dosing, and patient awareness of the length of treatment course also influence treatment adherence. Physicians would benefit from specific direction regarding fostering effective communication regarding adherence and depression therapy, including tools and techniques for assessing adherence throughout all stages of therapy and creating collaborative relationships with patients.

### Target Audience

This activity is designed to meet the educational needs of psychiatrists.

### Accreditation Statement

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the Mount Sinai School of Medicine and MBL Communications, Inc. The Mount Sinai School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.



### Credit Designation

The Mount Sinai School of Medicine designates this educational activity for a maximum of 2 *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

### To Receive Credit for this Activity

Listen to this Expert Panel PsychCast™, reflect on the information presented, and complete the CME posttest and evaluation on pages XX and XX. To obtain credit, you should score 70% or better. Early submission of this posttest is encouraged. Please submit this posttest by DATE, 2012 to be eligible for credit.

Selected content from this supplement will be available via ePocrates MobileCME in early 2010.

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# COLLABORATIVE CARE: EVIDENCE-BASED MODELS THAT IMPROVE PRIMARY CARE DEPRESSIVE OUTCOMES

Wayne J. Katon, MD  
Slide Library

## SLIDE 1

### Medical System Barriers to Depression Care<sup>11</sup>

- Infrequent visits
- Total reliance on physician
- Lack of close follow-up
- Lack of time to educate and activate
- Lack of monitoring of adherence and outcomes
- Lack of time to support behavioral changes (ie, exercise, problem-solving, interpersonal behaviors)

## SLIDE 2

### Collaborative Care Model

#### Two New "Team Members"

#### Two Processes

1. Systematic diagnosis and outcomes tracking (eg, PHQ-9 to facilitate diagnosis and track depression outcomes)
2. Stepped Care
  - A) Change treatment according to evidence-based algorithm if patient is not improving
  - B) Relapse prevention once patient is improved

#### Care Manager

- Patient education/self management support
- Close follow-up to make sure patients don't "fall through the cracks"
- Support prescription by PCP
- Brief counseling (behavioral activation, PST-PC, CBT, IPT)
- Facilitate treatment change / referral to mental health
- Relapse prevention

#### Consulting Mental Health Expert

- Caseload consultation for care manager and PCP (population-based)
- Diagnostic consultation on difficult cases
- Consultation focused on patients not improving as expected
- Recommendations for additional treatment / referral according to evidence-based guidelines

PHQ-9=9-item Patient Health Questionnaire; PCP=primary care physician; PST-PC=Problem-Solving Treatment for Primary Care; CBT=cognitive-behavioral therapy; IPT=interpersonal psychotherapy.

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# ***STRATEGIES FOR IMPROVING ADHERENCE IN THE TREATMENT OF MAJOR DEPRESSIVE DISORDER — COLLABORATIVE CARE: EVIDENCE-BASED MODELS THAT IMPROVE PRIMARY CARE DEPRESSIVE OUTCOMES***

## **CME QUESTIONS**

**1. Approximately 35% to 40% of primary care patients prescribed an antidepressant for a new depressive episode do not fill a second prescription for these medications.**

- A. True
- B. False

**2. Depression can affect some patients with medical illness, however, depression is not highly comorbid with other common illnesses, such as diabetes or heart disease.**

- A. True
- B. False

**3. Collaborative care models have been found in a meta-analysis to increase rate of adherence by two fold over the first six months of treatment and to improve depressive outcomes compared to usual primary care for up to 2 years.**

- A. True
- B. False

**4. It is recommended that patients undergo at least three visits during the first 90 days after initially being prescribed an antidepressant, regardless if it is through primary care or specialty care.**

- A. True
- B. False

Fax  
212-328-0600

Mail  
CME Director, *CNS Spectrums*  
333 Hudson Street, 7th Floor, New York, NY 10013

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**ANSWER FORM**

Expert Panel Supplement – Strategies for Improving Adherence in the Treatment of Major Depressive Disorder—Collaborative Care: Evidence-Based Models That Improve Primary Care Depressive Outcomes

**TERMINATION DATE:** XX, 2012

To receive credit, you should score 70% or better (participants will receive certification for their records in approximately 4–6 weeks). Early submission of this posttest is encouraged. Please submit this test by December 1, 2011, to be eligible for credit. If you have any questions about this, or any of our other CME materials, please e-mail CME@mblcommunications.com

Please circle your answers

1. A B      2. A B      3. A B      4. A B

**EVALUATION SECTION** (please provide the information below and print clearly)

1=Minimally, 5=Completely

1. Please rate how well this CME activity met the stated learning objectives:
- A. Recognize the scope of patient nonadherence to antidepressant therapy and its effect on patient outcomes      1 2 3 4 5
  - B. Identify clinically actionable barriers to adherence and formulate treatment plans that address these barriers      1 2 3 4 5
  - C. Review the evidence regarding safety and tolerability of available and emerging agents, and their potential influence on patient adherence      1 2 3 4 5
  - D. Implement communication strategies to assess and promote adherence to antidepressant treatment throughout the course of therapy      1 2 3 4 5

2. Please indicate how well this CME activity met your expectations regarding the following:
- A. Translating clinical information/trial data to patients I see in my practice      1 2 3 4 5
  - B. Providing new information      1 2 3 4 5
  - C. Increased my knowledge and/or skills in delivering patient care      1 2 3 4 5
  - D. Communicated information in an effective, accessible manner      1 2 3 4 5

3. Compared to other CME activities in which I have participated this year, I would rate this activity as:      1=Needs Improvement, 5=Outstanding  
1 2 3 4 5

4. As a result of participating in this educational activity, I will (please check one)  
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 5a. If "no," please explain: \_\_\_\_\_

6. Do you feel these topics should be repeated/updated in future CME activities?      Yes  No   
 6a. If "yes," what suggestions would you make to improve this activity? \_\_\_\_\_

7. Please indicate your three preferred formats for CME activities:  
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