Bridging The Gap Between Primary Care & Psychiatry In The Treatment Of MDD: A Discussion Among Nurses

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Speaker Profiles

Roland Larkin, PhD, NP

Position: Dr. Larkin is a Medical Science Liaison at Otsuka Pharmaceutical Development & Commercialization, Inc. His clinical areas of expertise include serious and persistent mental illness (SPMI), post-traumatic stress disorder (PTSD), and addictions.

Education: Dr. Larkin received his Masters degree and PhD from Columbia University, where his dissertation focused on psychiatric screening and challenges to prison-based mental health research.

Kimberly Lonergan, RN, MSN

Position: Ms. Lonergan is a Senior Medical Liaison Neuroscience at Otsuka Pharmaceutical Development & Commercialization, Inc. Her clinical areas of expertise include critical care medicine, trauma medicine, and gastroenterology.

Education: Dr. Lonergan earned her BSN from Harding University and MSN from Abilene Christian University.

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Position: Ms. Miller is a Family & Psychiatric Nurse Practitioner at SMC Medical Center, Infinite Behavioral Health in Hollywood, FL. Her clinical areas of expertise include family and psychiatric medication assessment and treatment across the lifespan as well as substance abuse disorders in dual diagnosis clients.

Education: Ms. Miller received her BSN from Barry University and MSN from the University of Miami, prior to receiving her PMHNP-BC from the University of Alabama.
This program was developed with the support of Otsuka Pharmaceutical Development & Commercialization, Inc. and Lundbeck, LLC. The speakers are employees or compensated contractors of Otsuka Pharmaceutical Development & Commercialization, Inc.
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Objectives

• Examine prevalence and burden of major depressive disorder
• Identify gaps between primary care and psychiatry
• Discuss potential roles of nurses in collaborative care practices
• Review examples of measurement-based care in major depressive disorder
BURDEN OF
MAJOR DEPRESSIVE DISORDER
Lifetime Prevalence of Major Depressive Disorder

MDD, major depressive disorder; y, years.

• Overall lifetime prevalence of MDD across all ages is 16.6%
Link Between Depression and Other Illnesses

When these rates were compared with subjects without reported mental illness in the past year, the differences in all chronic health conditions were statistically significantly different at the 0.05 level.

Burden of Disease to the Individual

• Physical
  – Major depressive disorder (MDD) is a consistent predictor of the subsequent first onset of a variety of chronic physical disorders, including arthritis, asthma, cardiovascular disease, diabetes, chronic pain, and certain types of cancer

• Financial
  – Incomes of people with MDD are substantially lower than those without depression

• Education
  – MDD is associated with a 60% elevated risk of failure to complete secondary school than otherwise comparable youth

GAPS IN PRIMARY CARE AND PSYCHIATRY
Deppression and Primary Care

- The primary care sector is becoming the *de facto* treatment setting for depression¹
  - It is estimated that patients with depression constitute 5% to 10% of patients seen in primary care clinics
  - Nearly 60% of patients treated for depression in the United States receive treatment in a primary care setting
  - Primary care providers (PCPs) prescribe 79% of antidepressant medications
- Effective treatment in a primary care setting can be impacted by many factors, including¹:
  - The physician’s attitude and comfort in discussing mental health issues
  - Competing demands on the treating physician
  - Patient-specific factors (aversion to treatment, adherence, etc)
- Inadequate treatment of depression negatively impacts interpersonal and family relationships, employment, and quality of life²

Underutilization of Mental Health Services*

Barriers to Care

- **PCPs**: Two-thirds reported that they could not obtain outpatient mental health services for patients due to:
  - Shortages of mental health care providers
  - Health plan barriers to use of mental health services
  - Lack of or inadequate insurance coverage

- **Patients**: Failure to seek care may be caused by:
  - Continuing stigma of mental illness
  - Lack of awareness of treatment options
  - Lack of access to mental health care
    - Lack of insurance or inadequate insurance coverage
    - Shortages of psychiatrists and other providers
    - Fragmentation of service delivery
    - Severe underfunding of community mental health services for Medicaid and uninsured patients

*Based on 2004–2005 Community Tracking Study Physician Survey data.

DISCUSSION
MODELS FOR BRIDGING THE GAP
Polling Question

Are you part of a collaborative care program or system?

A. Yes, I am currently involved
B. I have been involved in the past but am not currently
C. No, I have never been involved
Advancing Integrated Mental Health Solutions (AIMS)

Case Study Considerations: AIMS\textsuperscript{1,2}

- The AIMS Center was created to help organizations develop collaborative care in the management of patients with depression and comorbid medical conditions\textsuperscript{2}

Potential elements for depression care:

- AIMS identified the following 5 important elements for effective, evidence-based depression care\textsuperscript{3}
  1. Collaborative care
  2. Depression care managers
  3. Designated psychiatrists
  4. Outcome measurement
  5. Stepped care

Collaborative Care Model

Collaborative care is an approach to care that may include the following:

1. Care manager: works with the patient and the PCP to help develop a unified approach to care of the patient
2. Patient education and support, including goals and a specific action plan
3. Monitoring of treatment adherence and outcomes
   - Cases are identified and patient progress monitored through the use of instrument screening
4. Coordinating office visits to a PCP and/or a mental health specialist

References:
Advancing Integrated Mental Health Solutions (AIMS) Collaborative Care Team Structure

- **Primary Care Provider**
- **Care Manager**
- **Psychiatric Consultant**
- **Other Behavioral Health Clinicians**
- **Substance Treatment, Vocational Rehabilitation, Collaborative Mental Health Care, Other Community Resources**
- **Patient**

**New Roles**

**Legend**
- Infrequent Interaction
- Frequent Interaction


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Collaborative Care vs Usual Care in Depression

• A systematic review of 79 randomized controlled trials of depression or anxiety found that collaborative care was more effective than usual care in terms of¹:
  – Depression outcomes
  – Antidepressant use
  – Mental health quality of life
  – Physical health quality of life
  – Patient satisfaction post-intervention

• A study evaluating a primary care-based, collaborative care intervention for depression and chronic illness reported improved depression and medical outcomes (eg, cholesterol, blood pressure) compared to usual care²

• A survey assessing attitude after implementation of collaborative care in primary practice reported improved perceptions regarding burden of time required for depression care³
  – Attributed to support provided by care manager
  – Use of a screening tool (Patient Health Questionnaire-9 [PHQ-9]) was identified as assisting in communication

DISCUSSION
PATIENT-REPORTED OUTCOME SCALES
Polling Question

Which of the following rating scales does your practice currently use?

A. Patient Health Questionnaire-9
B. Clinically Useful Depression Outcome Scale
C. Quick Inventory of Depression Symptomatology—Self-Report
D. World Health Organization-5 Well-Being Index
E. None
Assessing Vital Signs in Clinical Practice

• **Measuring medical vital signs**¹
  – Body temperature
  – Blood pressure
  – Pulse
  – Respiration rate

• **Measuring psychiatric vital signs**¹
  – Depression (depression scales)

• **Update of the 2009 United States Preventive Services Task Force recommendation on screening for depression in adults**²
  – Recommends screening for depression in the general adult population (aged ≥18 years)

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Patient-reported Outcome Scales

Practical, standardized tools designed to be systematically used for screening and monitoring depression in clinical practice with minimal administrative burden\(^1\)

- Identify MDD
- Monitor symptoms / adverse events
- PROS: Assess & Reassess
- Foster rapid evidence-based interventions

MDD, major depressive disorder; PROS, patient-reported outcome scales.
Measurement-based Care in Practice: Utilization of Brief and Easily Implementable Patient-reported Outcomes Scales

Patient-reported outcomes scales (PROS) have documented psychometric properties of reliability and validity\(^1\)–\(^3\):

- Clinician-rated symptom scales are longer and may be impractical to use in clinical practice\(^4\)
- Measurement-based care (guided by rating scale assessments) in patients with MDD has been associated with significant improvements in remission and response rates versus usual treatment\(^5\)

Examples of PROS include:

- Quick Inventory of Depression Symptomatology—Self-Report (QIDS-SR)\(^1\)
- Patient Health Questionnaire-9 (PHQ-9)\(^2\)
- Clinically Useful Depression Outcome Scale (CUDOS)\(^3\)


Note: non-US study (China).
DISCUSSION
Summary

- MDD is a serious, chronic, disabling illness affecting hundreds of millions of individuals worldwide\(^1\)
- MDD manifests in both psychiatric and medical settings\(^2\)
- Nurses are trusted professionals who can help integrate treatment and bridge the gap between primary care and behavioral health\(^3\)
- Use of integrated treatment, collaborative models, and evidence-based scales may facilitate improved outcomes\(^4–6\)

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