CONSENSUS RECOMMENDATIONS FOR IMPROVING ADHERENCE, SELF-MANAGEMENT, AND OUTCOMES IN PATIENTS WITH DEPRESSION

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Consensus Statement

I. Patient Care

A. Utilize rating scales to assess initial symptoms

1. Examples
   a. PHQ-9
   b. QIDS-SR$_{16}$
2. Use for screening, diagnosis, and monitoring of progress
3. Use to educate patient about diagnosis and symptoms of MDD
   a. Full range of MDD symptoms
   b. Mind/body connection

B. Assess prior history (can be done by other allied health care professionals)

1. Patient personal history
2. Family history (can be destigmatizing)
3. Use of alcohol/drugs
4. Trauma history (domestic violence, early trauma, trauma as adult)

C. Assess patient readiness to change, and beliefs/expectations about illness, treatment, stigma, etc.

1. Tailor discussion/education accordingly

D. Provide educational materials (books, videotapes, pamphlets, Web sites, etc.)

1. Use a multi-step approach
2. Emphasize symptoms and diagnosis in initial materials
3. Highlight benefits of effective treatment (eg, fewer symptoms and better functioning)
4. Present options for effective treatment (eg, pharmacotherapy, psychotherapy, and exercise)
5. Address monitoring long-term outcomes and side effects in later materials

E. Encourage patient questions and reinforce doctor/patient relationship

1. Establish partnership (agree on roles/responsibilities for each)
2. Set goals jointly
3. Encourage contact when needed (if symptoms worsen or side effects occur)

F. Engage family, spouse, and other sources of support

1. Share initial patient education materials with family (eg, watching video at home)
2. Bring in family with patient to participate in educational programs
3. Recommend Web sites
4. Use symptom rating scale for initial screening/diagnosis

G. Develop and implement patient-centered treatment plan, recognizing that the patient's decisions and actions are crucial to successful treatment and self-care

1. Involve patient in choice and formulation of plan
2. Prioritize patient's choices for treatments and goals
3. Provide information on expected duration of treatment
   a. Tailor information to patient
   b. Agree on minimum duration of treatment (eg, 9 months) before reevaluation
4. Provide brief evidence-based messages
   a. Antidepressants are not addictive
   b. Medication should be taken daily
   c. Allow 2–4 weeks for full effects to occur
   d. Side effects may occur, but often resolve in 1–2 weeks
   e. Continue medication, even if symptoms improve or resolve
   f. Check with doctor before discontinuing medication
   g. Think of depression as a chronic, recurrent illness (like asthma)
   h. Engage in pleasant activities
5. Educate patients about coping with short-term side effects
   a. Establish action plan (do not stop medications, call if troublesome adverse events occur, etc.)
   b. Discuss longer-term side effects with continued treatment (sexual dysfunction and weight gain)
   c. Monitor progress, using brief side effect rating scale (eg, FIBSER)
   d. Continue education
6. Use rating scale to monitor functioning before asking about symptoms
   a. Use 0–10 functioning scale, if possible
   b. Determine how much function has been recovered (eg, 20%, 60%)
7. Use rating scale to monitor improvements in symptoms
   a. Patients like to see progress over time
   b. Helps focus visit on symptoms/recovery of functioning
8. Provide method for tracking involvement in pleasant activities
   a. Ask what pleasant activities patient engaged in prior to depression
   b. Help patient plan to engage in these activities
   c. Encourage participation in pleasant activities/exercise (can improve patient adherence to treatment)
9. Develop/implement relapse prevention plan
   a. Describe prodromal symptoms (early warning signs)
   b. Discuss long-term side effects
   c. Indicate dose of medication that should be maintained
   d. Use validated rating scale(s) for monitoring symptoms (eg, PHQ-9, QIDS-SR$_{16}$, etc.) and functional outcomes (eg, SDS), tailored to patient and "target symptoms"
   e. Agree on action plan in the event of relapse

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II. Guideline Implementation and Practice Redesign

A. Utilize treatment algorithms/guidelines

1. Use systematic approach (eg, TMAP, STAR*D, IMPACT) manual
2. Follow basic principles[1-3]
   a. Use measurement-based care
   b. Actively participate in patient education
   c. Follow up with an appropriate number and frequency of visits
   d. Monitor symptoms with standard scales
   e. Monitor side effects with standard scales (eg, FIBSER)
   f. Adjust treatment intensity until remission is achieved
   g. Monitor and aggressively treat residual symptoms
   h. Use critical decision points to ensure optimized pharmacotherapy
3. Implement programs effectively
   a. Employ telephone contacts as part of monitoring system
   b. Follow a decision-support plan (eg, algorithm or supervision by psychiatrist)
   c. Use allied health professionals (eg, nurses, pharmacists, social workers) who are supervised by treating physician
   d. Document long-term progress (computer-based/paper-based)
      1) Develop treatment registries (eg, depression registries), a necessity for population-based care
      2) Use clinical information system(s)
      3) Use standard (written/hard copy) measures
   e. Identify high-risk patients for:
      1) Comorbidities
   a. Physical: chronic pain, diabetes mellitus, heart disease, etc (patients with these disorders may be selectively screened in primary care practice)
   b. Psychiatric: anxiety, substance abuse, bipolar disorder, psychotic MDD*
      2) Suicidality*
      3) Previous history of treatment failure or chronicity*

1. Delineate referral criteria (from PCP to psychiatrist and from psychiatrist to PCP, psychopharmacologist, psychologist, or substance abuse specialists)
   a. From PCP to psychiatrist:
      1) Patients with persistent depression, in spite of depression and medical treatment in primary care
      2) Psychiatric comorbidities (eg, bipolar, anxiety, psychotic disorders)
      3) Patient needs specialty treatment such as cognitive-behavioral therapy, family therapy, Alcoholics Anonymous,
      4) Suicidality*
   b. From psychiatrist to PCP: when to refer patient to general medical specialist (ie, most patients who have achieved significant decreases in depression, are on stable treatment regimens, or have significant medical comorbidity)
   c. Keep PCP updated on patient's progress

III. Health Care System Change

A. Promote and participate in quality improvement efforts (underway in US) (eg, implement/improve HEDIS criteria)

B. Provide incentives

1. To patients through third-party payers
2. To caregivers through third-party payers (some systems successfully bill for quality improvement efforts; a "pay for quality" movement is evolving)

IV. Online Resources

IMPACT
http://impact-uw.org/tools.html

MacArthur Initiative on Depression and Primary Care
http://www.depression-primarycare.org/

Depression in Primary Care: Linking Clinical and System Strategies (The Robert Wood Johnson Foundation)
http://www.depressioninprimarycare.org/

*STAR*D*
http://www.edc.gsph.pitt.edu/stard/index.html

Institute for Healthcare Improvement (The Robert Wood Johnson Foundation)
http://www.ihi.org/B. Provide stepped care

Improving Chronic Illness Care (The Robert Wood Johnson Foundation)
http://www.improvingchroniccare.org

Comparative Effectiveness of Second-generation Antidepressants in the Pharmacologic Treatment of Depression. (Agency for Healthcare Research and Quality)
www.effectivehealthcare.ahrq.gov/reports/final.cfm.

*These patients require more intensive treatment up front (ie, combination treatments: adding augmenting medications, pharmacotherapy + psychotherapy) and more careful monitoring for residual symptoms (eg, anxiety, pain, irritability)

PHQ-9=9-item Patient Health Questionnaire; QUID-SR16=16-item Quick Inventory of Depressive Symptomatology–Self-Report; MDD=major depressive disorder; FIBSER=Frequency, Intensity, and Burden of Side Effects Rating scale; SDS=Sheehan Disability Scale; TMAP=Texas Medication Algorithm Project; STAR*D=Sequenced Treatment Alternatives to Relieve Depression; IMPACT=Improving Mood—Promoting Access to Collaborative Treatment; PCP=primary care physician; HEDIS=Health Plan Employer Data Information Sheet.

1. 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.
2. Trivedi MH, Rush AJ, Gaynes BN et al. Maximizing the adequacy of medication treatment in controlled trials and clinical practice: STAR*D Measurement-Based Care. *Neuropsychopharmacology.* In press.
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