MOOD

Managing Obstacles to Improved Outcomes in Depression:

A COLLABORATIVE APPROACH TO IMPROVED CARE

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ABOUT THIS PUBLICATION

MOOD

Managing **O**bstacles to Improved **O**utcomes in **D**epression
A Collaborative Approach to Improved Care

Depression is a significant — and inadequately addressed — health problem in the United States. The literature is replete with studies that document the failure to diagnose and treat depression, the undertreatment of this disorder, and the lack of adequate follow-up in both primary and specialty care.

Numerous challenges to adequate diagnosis and treatment of depression have been identified: fragmentation of the health care system; insufficient time among primary care physicians to detect depression in patients; a tendency among many physicians to avoid making a diagnosis of depression; lack of experienced behavioral health specialists in some regions; social stigma; and cultural, language, and financial barriers to access. Quality-improvement studies have exposed other barriers to optimal care, such as inadequate physician knowledge, disparities in benefits for mental versus physical health services, and lack of patient education.

Some of these barriers are pronounced in certain regions of the United States, resulting in, among other things, practice variation that hinders the delivery of evidence-based, standardized care. At the 2006 MOOD (**M**anaging **O**bstacles to Improved **O**utcomes in **D**epression) symposia, faculty explored these barriers in the context of different populations across the United States. The Chatham Institute convened four panels — in Philadelphia, Atlanta, Chicago, and Los Angeles — to discuss common obstacles to improved outcomes in their respective regions and how specialists, primary care physicians, third-party payers, and patients can collaborate in that regard.

Identification of these diverse barriers to optimal treatment provides multiple opportunities to achieve better outcomes. It is imperative, however, that these interventions be coordinated among various stakeholders to maximize effectiveness and minimize waste of resources. In the first half of this supplement to MANAGED CARE, a primary care physician and a nationally renowned psychiatrist examine opportunities for, and examples of, collaboration — and present two case studies in this context.

In the second half of this publication (beginning on page 12), highlights from the regional symposia are presented with an emphasis on common needs of employers and populations in each area. For example, in the Northeast, where a largely white-collar, educated work force functions in a pressure-packed, competitive environment, use of employee assistance programs is surprisingly low. In the rural South, a lack of providers presents access-to-care issues. Many manufacturers in the industrialized Midwest cope with high health care liability related to union contract requirements, disproportionate levels of disability and unhealthy worker lifestyles, and the cost of providing retiree benefits. A profoundly diverse range of specialized populations renders numerous unique challenges for employers and third-party payers in the West. Corporate medical directors, physicians, and representatives from MCOs present these issues and discuss ways to work collaboratively with providers and patients to overcome these barriers.

This continuing education activity could not have been possible without the participation of the faculty at the live symposia. Though not every faculty member makes a presentation within these pages, The Chatham Institute wishes to express appreciation to each for their contributions to this program. In addition to the people whose bylines appear herein, The Chatham Institute is grateful to Paul Ciechanowski, MD, Faye A. Gary, EdD, RN, R. Andrew Huber, MD, Kristina Katzovitz, MD, and Hyong Un, MD, for their support and input, and for their participation in this dynamic program. We hope the expertise they and the presenters herein share through these pages will be valuable to you in your everyday responsibilities.

SUPPLEMENT TO
MANAGED Care
October 2006

MOOD

Managing **O**bstacles to Improved **O**utcomes in **D**epression

A Collaborative Approach to Improved Care

A CONTINUING EDUCATION ACTIVITY

Based on regional symposia held in June and July 2006
In Philadelphia, Atlanta, Chicago, and Los Angeles

This supplement is supported by an educational grant from Wyeth Pharmaceuticals. The material in this supplement has been independently peer reviewed. The grantor played no role in reviewer selection.

SELF-STUDY CONTINUING EDUCATION ACTIVITY

MOOD – Managing Obstacles to Improved Outcomes in Depression
A Collaborative Approach to Improved Care

Continuing education credit is offered to physicians and pharmacists who read pages 3 through 19 of this publication. Credit will be awarded upon completion of the evaluation form on page 20 and successful completion of the post-test on page 21. Estimated time to complete this activity is 2.0 hours.

Target audience
Medical directors, pharmacy directors, clinical pharmacists, and other appropriate personnel in the managed care and pharmacy benefit management sectors.

Purpose and overview
This comprehensive CME and CPE program explores the burden of depression on patients, employers, and society at large and identifies and addresses barriers to suitable care. The material herein focuses on opportunities for collaboration among primary care physicians, mental health specialists, third-party payers, and patients, to address issues specific to regions of the United States.

Educational objectives
After reading this publication, participants will be able to:

- Summarize the regional epidemiology and disease burden of depression.
- Better recognize and diagnose patients who have depression.
- Identify and address barriers to suitable care.
- Recognize strategies for effective management and treatment of depression.

Accreditation and CE credit statements
The Chatham Institute is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The Chatham Institute designates this continuing medical education activity for a maximum of 2.0 Category 1 credits toward the AMA Physician's Recognition Award. Each physician should claim only those credits that were actually spent in the educational activity.

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Javier I. Escobar, MD, discloses that he owns stock in Johnson & Johnson, Bristol-Myers Squibb, and Pfizer.

The following people disclose that they have no real or apparent conflicts of interest with respect to this activity:

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FACULTY PRESENTATION

Dialogues on Depression Management: The Primary Care and Specialist Perspectives

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DEPRESSION IN PRIMARY CARE

Richard L. Collins, MD

General practitioners are the first line of intervention for most patients with anxiety and depression. Primary care physicians (PCPs), as well as affiliated staff, such as nurses, nurse practitioners, and physician assistants, see patients on a regular basis for a wide range of complaints. Patients with mental health issues may not even be aware that depression can contribute to many of their physical problems, and thus, it falls to their primary medical caretakers to differentiate somatic complaints secondary to depression from the wide range of medical diagnoses with which patients may present. In this way, the PCP has become the *de facto* mental health system and the first line of attack for many patients who suffer from depression.

Epidemiology in primary care setting

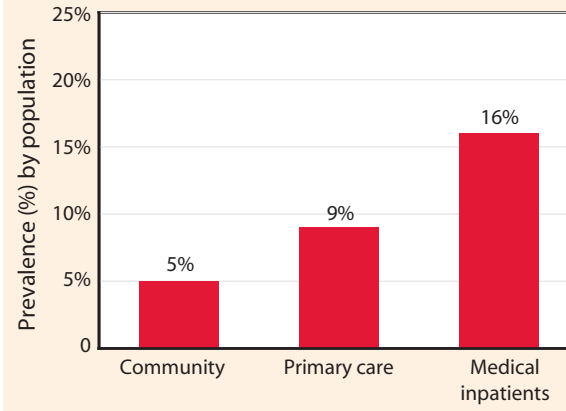
Depression is a more frequent element of primary care visits than had been previously recognized. Most patients' first encounter with the health care system for general medical issues, which may include a component of depression, is at their PCP's office. In addition, depression may be concomitant with chronic diseases or pain disorders under a generalist's care and, if not addressed, can impede response to treatment for the primary disease. The prevalence of major depressive disorder (MDD), generally about 5 percent in the community at large, doubles among patients visiting a primary care practice and more than triples among hospital inpatients (Figure 1). Nearly a quarter of patients seen in the primary care setting have a primary mental disorder, and in 50 to 70 percent of medical outpatients, mental health or psychological issues contribute to the complaints that precipitated their health care visits (Ostun 1995, Thompson 2000, Surgeon General's Report 2001).

Left untreated, depression can lead to lost productivity, impaired quality of life, substance abuse, and even suicide. It is extremely important, therefore, for PCPs to recognize depression. Suicide is a serious and significant concern with depressed patients; available data suggest that more than 75 percent of elderly people who commit suicide visited a PCP in the year before their death (NSSP 2001), and 45 percent of all suicide victims had contact with their PCP in the month before their death (Luoma 2002). Thus, primary care clinicians play a key role in identifying and intervening to prevent severe depression from leading to self-destructive behavior or suicide.

Recognizing patients with depression

The challenge for PCPs is to recognize depression among the complaints that bring patients to the medical office. Physicians who have traditionally responded to complaints of fatigue with a blood test, or palpitations and abdominal pain with Holter monitoring and an echocardiogram, must consider signs of depression when making a differential diagnosis. Clinicians who are focused on diabetes, hypercholesterolemia, or hypertension

FIGURE 1
Prevalence of major depression by setting
Higher rates of diagnosis in recent years parallels rates seen among medical inpatients



SOURCE: KATON 1992

management must learn to take the time to consider the impact these chronic diseases may have on their patients' mental state.

One technique that can be helpful in identifying depression in primary care has come to be known unofficially as the "rule of five." This rule suggests that any patient presenting with more than four symptoms or physical complaints should be considered for evaluation for an underlying mental disorder. Although this method is not a scientifically recognized diagnostic tool, it appears in practice to correlate well with patterns of presentation in MDD. In the primary care setting, at least 69 percent of patients with MDD present with somatic complaints alone (Simon 1999). Furthermore, Kroenke (1994) has found that patients with depression generally have multiple somatic symptoms with no underlying organic pathology in many cases.

Prognosis for depression in primary care

With appropriate diagnosis and intervention, depression can be reversed and most patients returned to normal functioning. Although severe depression may require referral to a psychiatrist, the availability of safe and effective medications, like selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs), has enabled simplified care right in the primary care office without necessitating immediate specialist involvement. In fact, around 65 percent of prescriptions for antidepressants are written by primary care physicians (IMS 2001), and estimates of managed care populations indicated that as many as 75 percent of prescriptions for antidepressants are written by PCPs (Way 1999).

Although the percentage of Americans treated for depression tripled between 1987 and 1997, with 75 percent receiving antidepressant prescriptions (Olfson 2006), too many patients remain undiagnosed and undertreated. Although frequent interaction with affected patients position PCPs to identify and treat these individuals, the time limitations of today's medical practice — where physicians generally have only a few minutes for each ambulatory visit — makes early and accurate diagnosis difficult. In addition, many patients resist a psychiatric diagnosis, in which case the clinician must take time to explain that depression is not really "something wrong with their head," but that the patient's depressed mood is of a biochemical nature and can be improved with a pharmacologic intervention that addresses a chemical imbalance. Further, the important issue of patient adherence to prescribed therapy — whether medication or adjuvant psychotherapy — is difficult to ensure within the constraints of a primary care practice. It has been reported that as much as 60 percent of primary care patients will discontinue antidepressants within 1 month of starting therapy and few will return for a recommended follow-up visit (Katon 1992, Simon 1992, Lin 1991).

Equally important, the depressed patient might be happy to retrieve a drug prescription, but less willing to accept intervention by a mental health professional. How can a PCP with limited time and daily responsibility to patients with a full range of medical conditions recognize depression hidden among the multiple physical complaints with which patients present? How can the clinician effectively monitor and support drug adherence and follow-up care for depressed patients who resist the depression diagnosis and the psychiatric interventions they need? These are the challenges of mental health care in the primary care setting, and are the ones that we need to address in order to ensure comprehensive and personalized therapy to improve the management of depressed patients in community practices.

Richard L. Collins, MD, FACP, is clinical assistant professor of medicine at the State University of New York (SUNY) School of Medicine in Buffalo. He also is a physician in practice with Buffalo Medical Group. Collins earned his MD at the SUNY School of Medicine in Buffalo. After graduating, he completed his internship at Millard Fillmore Hospital in Buffalo and his residency at Saint Elizabeth's Hospital in Boston. Collins's professional interests are primarily devoted to primary care, smoking cessation, and lifestyle changes. He is the recipient of 10 honors and awards, including the Millard Fillmore Hospital Painton Award for Excellence in Teaching.

THE PSYCHIATRIST'S VIEW OF DEPRESSION

Javier I. Escobar, MD

Psychiatrists acknowledge that depression, whether it is primary depression or depression as a concomitant of underlying disease, is frequently identified first in the primary care setting. Nonetheless, a collaborative model to depression management, using both pharmacologic and psychotherapeutic interventions, has proven benefits that should not be disregarded in the treatment plan for primary care patients with depression.

Impact of depression

Research commissioned by the Washington Business Group on Health (now the National Business Group on Health) indicates that major depressive disorder (MDD) is the most frequent diagnosis associated with absence from the workplace. It is also responsible for more missed days at work (709 per 1,000 employees) than arthritis (504), hypertension (484), asthma (438), or substance abuse (166) (Kessler 2001). The presence of depression

in patients with underlying medical disease significantly increases the costs associated with the primary medical condition. The annual treatment costs for managing diabetes, hypertension, and ischemic heart disease approximately doubles among patients who suffer from concomitant depression; costs for heart failure, allergic rhinitis, migraine, and back pain can nearly triple when depression complicates the picture (Table 1).

The costs associated with depression and its morbidities and disabilities have been estimated at approximately $83 billion annually in the United States (Greenberg 2003)[1]. Of this, 31 percent ($26 billion) is spent on direct medical costs, 62 percent is ascribed to indirect costs, and another 7 percent represents suicide-related mortality in terms of lost wages. This excessive burden highlights the economic benefit to be gained by effectively diagnosing and treating depression in the United States.

TABLE 1

Financial effect of depression on comorbidities

The cost to manage chronic conditions is 2 to 3 times greater in patients with concomitant depression. Data are from a managed care database, expressed in terms of cost per condition, per member per year.

Condition	Annual medical costs per patient without depression ($)	Annual medical costs per patient with depression ($)
Heart failure	2.56	6.74
Allergic rhinitis	3.27	8.46
Asthma	3.73	10.56
Migraine	3.82	15.47
Back pain	11.61	33.25
Diabetes	13.06	27.28
Hypertension	13.38	27.16
Ischemic heart disease	62.40	110.94

SOURCE: OCI 2001

The presentation of depression

Depression in the primary care setting is highly associated with multiple somatic symptoms, and the likelihood of underlying mood disorder correlates with increasing numbers of physical complaints (Figure 2), providing some substantiation of Dr. Collins' proposed "rule of five." In as many as 84 percent of depressed patients, there is no identifiable organic cause for the somatic complaints that bring them to the physician (Smith 1995, Kellner 1985, Mayou 1978). Fifty percent of patients presenting to a primary care setting will be found to have no medical illness, and 20 to 30 percent of patients will have multiple medically unexplained physical symptoms (MUPS) (Panzarino 1998, Escobar 1998, Simon 1999, Üstün 1995). Pain is the most common presentation associated with underlying depression, followed by myocardial infarction, stroke, asthma, and diabetes (Pincus 2001, Schatzberg 2004).

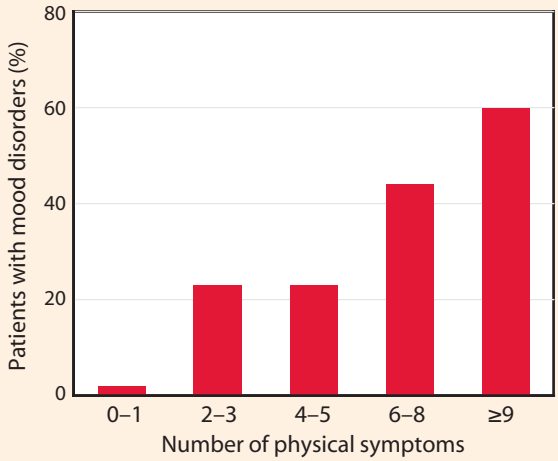
In fact, physical symptoms are one of the most important signs of depression. Symptoms ranging from pain (especially musculoskeletal pain, such as back, neck, and shoulder pain) and headache to gastrointestinal disturbance, chest tightness, fatigue, and appetite or weight changes frequently are markers for underlying depression. Furthermore, pain markers often escalate when one's mood worsens from normal to depression to MDD (Ohayon 2003). Many behavioral symptoms will be

[1] Greenberg (1993) estimated the economic burden for depression in 1990 at $44 billion. Adjusting for inflation, this estimate would be $77 billion in year-2000 dollars. Thus, the $83 billion figure reported in Greenberg's 2003 study of direct and indirect costs in 2000 represents a 7 percent increase when adjusted for inflation.

FIGURE 2

Relation of mood disorders and physical symptoms

The likelihood of a mood disorder correlates with an increased number of physical symptoms[1]



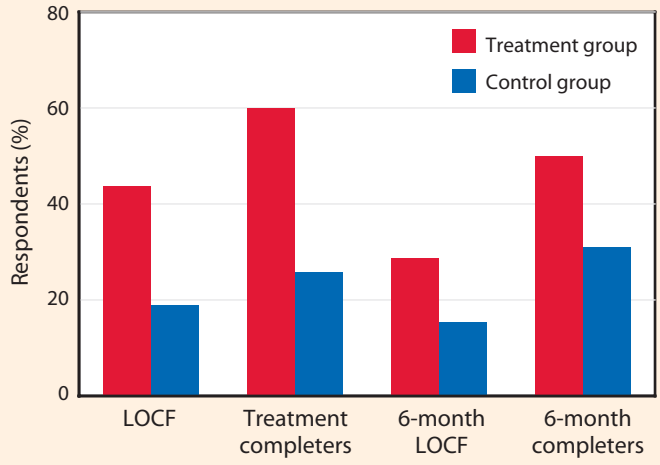
- Patients with depression often present with numerous physical complaints
- As the number of physical complaints increase, so does the likelihood of a mood disorder[1]
- 30% of patients with depression experience depressive physical symptoms for >5 years before receiving the proper diagnosis[2]

SOURCES: [1]KROENKE 1994; [2]LESSE 1983

FIGURE 3

Response to cognitive-behavioral therapy (CBT) in patients with physical symptoms

CBT significantly improves symptoms of somatization disorder in patients with multiple unexplained physical symptoms plus comorbid depression and anxiety



LOCF=Last observation carried forward.
SOURCE: ESCOBAR 2006

evident as well — sadness, loss of pleasure, difficulty concentrating, sleep problems, or feelings of worthlessness — and a diagnosis of depression requires that these be evaluated during ambulatory visits, as well.

Management of depression in primary care

Treatment for comorbid medical illness and depression can present a huge therapeutic challenge. Beckman (2004) has reported that treatments for depression do not necessarily improve somatic symptoms, and treatments targeting physical symptoms only partially relieve depression. This was supported in a recent trial evaluating the effect of depression on pain processing and response to antidepressant therapy in 53 patients with fibromyalgia (Giesecke 2005). In this trial, patients with depression or MDD had elevated neuronal activation in brain regions related to affective but not sensory pain processing compared with controls. Thus, the authors observed distinct sensory and affective components to the pain experience, which respond independently to treatment. Given that antidepressant therapy improves depressive symptoms without effect on pain measures, these data support the need for multiple therapies that target depression and pain for patients with these comorbidities.

Behavioral interventions, such as interpersonal therapy and cognitive-behavioral therapy (CBT), have been shown to be effective at improving depression in patients with physical symptoms (Wells 2000, Simon 2001). Figure 3 illustrates the effect of cognitive-behavioral therapy on improvement in somatic symptoms among 170 patients with somatization disorder and associated depression and/or anxiety (Escobar 2006). In the group that completed CBT treatment, somatization symptoms were less severe and patients were more likely to be "very much" or "much" improved compared with patients treated with standard medical care. CBT also yielded improvements in self-reported functioning and somatic symptoms and a decrease in health care costs. These findings highlight the importance of adjuvant psychotherapeutic intervention in medical patients with unexplained physical symptoms and possible depression.

Unfortunately, the limitations of time and resources in a primary care practice make it difficult to provide psychological diagnosis and support to every patient. As a result, depression is missed in about half of affected primary care patients (Callahan 2002) and in those practices where there is an attempt to measure mood disturbances, the tools most often used are not adequately sensitive. Traditional depression inventories like the Hamilton Rating Scale for Depression, Montgomery-Asberg Depression Rating Scale, and Beck Depression Inventory do not include features that recognize most MUPS (Borus 1998, Wells 1989, Coyne 1991, Attkisson 1990). For this reason, a collaborative approach involving both medical and mental health practitioners is a rational paradigm to provide the best of both psychotherapeutic and pharmacologic care for patients with signs and symptoms that may be due to underlying depression (Keller 2000; March 2004).

Third-party payment issues

Despite the fact that the most effective management approach for depression is a combination of antidepressant medications and psychotherapy, many health insurers limit coverage for psychotherapy, putting appropriate mental health care out of the reach of many patients. Health plans may place limits on payment or duration of coverage, and higher deductibles or copayments for psychiatric interventions — all of which can discourage patients from seeking or continuing mental health care. This barrier to effective treatment can be especially challenging if the patient suffers from a concomitant illness that also requires economic outlay, forcing the patient to make difficult choices.

Although health care financing is one that is beyond the scope of patients and clinicians to resolve, it is an important factor in treatment. Payers and human service agencies, therefore, also must participate in and contribute to plans for improving diagnosis, treatment, and

outcomes for patients with depression. Although this may be one of the biggest challenges in bringing mental health care into the primary care setting, several model systems described below are attempting to do that.

Models for addressing mental disorders in primary care

New thinking regarding the management of medical outpatients with unexplained somatic symptoms has been achieving prominence in the literature and in practice over the last 5 years. As a first step, proponents recommend loosening the DSM-IV definition for somatoform disorder so that the purely "mental" traditional explanation makes way for a more functional definition that incorporates the concept of an underlying nervous-system disturbance that can be addressed effectively by antidepressant drugs (Sharpe 2001, Mayou 2005). Further, the new approach would depend on determining a context for the symptoms by exploring the patient's life and experience. It would also integrate basic psychiatric methods into primary care routines to ensure consistent attention to, and awareness of, comorbid mental and physical complaints (Epstein 1999).

The Mind/Body Clinic at Beth Israel Deaconess Medical Center in Boston has started in this direction by offering a comprehensive program of medical care plus relaxation techniques, cognitive restructuring, nutrition, and exercise for patients with somatization disorder (Nakao 2001). This "crossover" model of physical interventions to address depression has proved effective in significantly reducing psychological and physical symptoms among somatizing patients, and may serve as a model for the development of other innovative programs for psychological intervention in primary care.

Ideally, such a program also would include some cost controls and reimbursement considerations that enable consistent and long-term care necessary for the optimal treatment of depression. Several programs designed to integrate psychiatric treatment into primary care routines under the auspices of a managed health care plan have already been initiated around the United States. For instance, the MacArthur Initiative on Depression and Primary Care's RESPECT-Depression (Re-Engineering Systems for the Primary Care Treatment of Depression) program involves a primary care clinician, a care manager, and a mental health professional in depression management. This program is operated in collaborations with Magellan Health Services, Dartmouth University, Duke University, and Blue Cross and Blue Shield of Georgia, and has been shown to improve measures of depression and increase patient satisfaction with care (Dietrich 2004).

The John A. Hartford Foundation has measured the value of a collaborative primary care medical/psychotherapeutic approach in Project IMPACT[2] (Hartford 2004). The team care approach in IMPACT involved 1,801 patients working with PCPs and a depression clinical specialist in a primary care setting for management of depression. The program showed that this model could reduce late-life depression twice as effectively as regular care. The benefits of the 12-month intervention were maintained more than a year later and yielded 107 extra depression-free days over the course of 2 years. Equally important, the program reduced the annual overall health care costs of older diabetics with depression by almost $1,000 per patient (Depression in Primary Care 2006). IMPACT hopes in the near future to promote broad adoption of its model in primary care settings across the country.

Summary

Depression is a major public health problem in the United States and is responsible for an enormous economic burden and loss of productivity and quality of life. In many cases, PCPs are well situated to identify and treat unrecognized depression, but an optimal treatment program often comprises both medical and psychotherapeutic interventions. Many collaborative models that integrate the efforts of PCPs, psychiatrists, behavioral health organizations, and workplace assistance programs are being tested and may prove to be the best direction for improving care for patients with depression.

Looking ahead, improvement in treatment of depression will depend on numerous factors, including educating health care practitioners to recognize silent depression, expanding current collaborative models to cover more of the population, involving MCOs and payers in the development of effective treatment systems, and improving workplace-support programs to encourage more patients to seek appropriate care.

Javier I. Escobar MD, MS, is professor and chairman of the Department of Psychiatry at the University of Medicine and Dentistry of New Jersey–Robert Wood Johnson Medical School. Escobar is recognized as a national leader in academic psychiatry and has been an active teacher and researcher. He was a member of the National Advisory Mental Health Council at the National Institutes of Mental Health and recently worked at NIMH as senior advisor to the director. At NIMH, he led the work group that prepared the NIMH report that addressed mental health disparities. Escobar's research background is primarily in the areas of psychiatric epidemiology, psychiatric nosology, and cross-cultural psychiatry. His most recent work focuses on the somatic presentations of psychiatric disorders in primary care and he leads a developing center funded by NIMH.

[2] Improving Mood – Promoting Access to Collaborative Treatment for late-life depression.

References

Attkisson CC, Zich JM. *Depression in Primary Care: Screening and Detection.* New York: Routledge. 1990.

Beckman TJ. Discussing the depression-pain dyad with patients. *Arch Intern Med.* 2004;164:804–805.

Borus JF, Howes MJ, Devins NP, et al. Primary health care providers' recognition and diagnosis of mental disorders in their patients. *Gen Hosp Psychiatry.* 1988;10:317–321.

Birnbaum HG, Kessler RC, Lowe SW, et al. Costs of attention deficit-hyperactivity disorder (ADHD) in the US: excess costs of persons with ADHD and their family members in 2000. *Curr Med Res Opin.* 2005;21:195–206.

Callahan EJ, Bertakis KD, Azari R, et al. Association of higher costs with symptoms and diagnosis of depression. *J Fam Pract.* 2002;51:540–544.

Coyne JC, Schwenk TL, Smolinski M. Recognizing depression: a comparison of family physicians ratings, self-report, and interview measures. *J Am Board Fam Pract.* 1991;4:207–215.

Depression in Primary Care. «http://www.wpic.pitt.edu/dppc/about.htm». Accessed Sept. 8, 2006.

Dietrich AJ, Oxman TE, Williams JW, et al. Re-engineering systems for the treatment of depression in primary care: cluster randomized controlled trial. *BMJ.* 2004;329:602.

Epstein RM, Quill TE, McWhinney IR. Somatization reconsidered: incorporating the patient's experience of illness. *Arch Intern Med.* 1999;159:215–222.

Escobar JI, Gara M, Interian A, et al. Treatment of patients presenting with unexplained symptoms in primary care. *Neuropsychopharmacology.* 2006;29(suppl 1):S100.

Escobar JI, Waitzkin H, Silver RC, et al. Abridged somatization: a study in primary care. *Psychosom Med.* 1998;60:466–472.

Giesecke T, Gracely RH, Williams DA, et al. The relationship between depression, clinical pain, and experimental pain in a chronic pain cohort. *Arthritis Rheum.* 2002;52:1577–1584.

Greenberg PE, Kessler RC, Birnbaum HG, et al. The economic burden of depression in the United States: how did it change between 1990 and 2000? *J Clin Psychiatry.* 2003;64:1465–1475.

Greenberg PE, Sisitsky T, Kessler RC, et al. The economic burden of anxiety disorders in the 1990s. *J Clin Psychiatry.* 1999;60:427–435.

Greenberg PE, Stiglin LE, Finkelstein SN, Berndt ER. The economic burden of depression in 1990. *J Clin Psychiatry.* 1993;54:405–418.

Gureje O, Simon GE. The natural history of somatisation in primary care. *Psychol Med.* 1999;29:669–676.

Hartford (John A. Hartford Foundation). The IMPACT program: a team approach to depression care that gets dramatic results. 2004. Available online:«http://www.jhartfound.org/pdf%20files/IMPACT.pdf» Accessed Sept. 8, 2006.

Harwood H. *Updating Estimates of the Economic Costs of Alcohol Abuse in the United States: Estimates, Update Methods and Data.* Report prepared by the Lewin Group for the National Institute on Alcohol Abuse and Alcoholism. 2000.

IMS Health, NPA Plus Moving Annual Total (MAT). 2001. In: Lieberman JA. The use of antipsychotics in primary care. *J Clin Psychiatry.* 2003;5(suppl 3):3–8.

Katon W, Schulberg H. Epidemiology of depression in primary care. *Gen Hosp Psychiatr.* 1992;14:237–247.

Keller MB, McCullough JP, Klein DN, et al. A comparison of nefazodone, the cognitive-behavioral analysis system of psychotherapy, and their combination for the treatment of chronic depression. *N Engl J Med.* 2000;342:1462–1470.

Kellner R. Functional somatic symptoms and hypochondriasis: a survey of empirical studies. *Arch Gen Psychiatry.* 1985;42:821–833.

Kessler RC, Greenberg PE, Mickelson KD, et al. The effects of chronic medical conditions on work loss and work cutback. *J Occup Environ Med.* 2001:43:218–225.

Kroenke K, Spitzer RL, Williams JB, et al. Physical symptoms in primary care. Predictors of psychiatric disorders and functional impairment. *Arch Fam Med.* 1994;3:774–779.

Lesse S. The masked depression syndrome — results of a seventeen-year clinical study. *Am J Psychother.* 1983;37:456–475.

Lin EH, Katon W, VonKorff M, et al. Frustrating patients: physician and patient perspectives among distressed high users of medical services. *J Gen Intern Med.* 1991;6:241–246.

Luoma JB, Martin CE, Pearson, JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry.* 2002;159:909–916.

March J, Silva S, Petrycki S, et al. Treatment for Adolescents with Depression Study (TADS) Team. Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) randomized controlled trial. *JAMA.* 2004;18:292:807–820.

Mayou R, Foster A, Williamson B. Psychosocial adjustment in patients one year after myocardial infarction. *J Psychosom Res.* 1978;22:447–453.

Mayou R, Kirmayer LJ, Simon G, et al. Somatoform disorders: time for a new approach in DSM-V. *Am J Psychiatry.* 2005;162:847–855.

Nakao M, Myers P, Fricchione G, et al. Somatization and symptom reduction through a behavioral medicine intervention in a mind/body medicine clinic. *Behav Med.* 2001;26:169–176.

NSSP (National Strategy for Suicide Prevention). Suicide: Cost to the Nation. Rockville, Md.: U.S. Department of Health and Human Services. 2001. Available online: «http://www.mentalhealth.samhsa.gov/suicideprevention/costtonation.asp». Accessed Sept. 8, 2006.

OCI (Options and Choices Inc.) Unpublished research. 2001.

Ohayon MM. Schatzberg AF. Using chronic pain to predict depressive morbidity in the general population. *Arch Gen Psychiatry.* 2003;60:39–47.

Olfson M, Marcus SC, Druss B, et al. National trends in the outpatient treatment of depression. *JAMA.* 2002;287:203–209.

Ostun TB, Sartorius N (eds). M*ental Illness in General Health Care: An International Study.* New York: John Wiley & Sons. 1995.

Panzarino PJ Jr. The costs of depression: direct and indirect; treatment versus nontreatment. *J Clin Psychiatry.* 1998;59(suppl 20):11–14.

Pincus HA, Pettit AR. The societal costs of chronic major depression. *J Clin Psychiatry.* 2001;62(suppl 6):5–9.

Schatzberg AF. The relationship of chronic pain and depression. *J Clin Psychiatry.* 2004;65(suppl 12);3–4.

Sharpe M, Carson A. "unexplained" somatic symptoms, functional syndromes, and somatization: do we need a paradigm shift? *Ann Intern Med.* 2001;134(9 Pt 2):926–930.

Simon G. Psychiatric disorder and functional somatic symptoms as predictors of health care use. *Psychiatr Med.* 1992;10:49–59.

Simon GE, VonKorff M, Piccinnelli M, et al. Physical symptoms in primary care. Predictors of psychiatric disorders and functional impairment. *N Engl J Med.* 1999;341:1329–1335.

Simon GE, Manning WG, Katzelnick DJ, et al. Cost-effectiveness of systematic depression treatment for high utilizers of general medical care. *Arch Gen Psychiatry.* 2001;58:181–187.

Smith GR, Rost K, Kashner TM. A trial of the effect of a standardized psychiatric consultation on health outcomes and costs in somatizing patients. *Arch Gen Psychiatry.* 1995;52:238–243.

Spitzer RL, Kroenke K, Williams JBW, et al. Validation and utility of a self-report version of PRIME-MD. *JAMA.* 1999;282: 1737–1744.
Surgeon General's Report. Mental Health: Culture, Race, and Ethnicity – a supplement to Mental Health: a Report of the Surgeon General. Rockville, Md.: U.S. Department of Health and Human Services. 2001.
Thompson M. Five giant leaps toward integrating health care delivery and ways to drive organizations to leap or get out of the way. *J Ambul Care Manag.* 2000;23:1–18.
Üstün TB, Sartorius N, eds. *Mental Illness in General Health Care: An International Study.* New York: John Wiley & Sons. 1995.
Way K, Young CH, Opland E, et al. Antidepressant utilization patterns in a national managed care organization. *Drug Ben Trends.* 1999;11:6–11.
Wells KB, Stewart A, Hays RD et al. The functioning and well-being of depressed patients: results from the Medical Outcomes Study. *JAMA.* 1989;262:914–919.
Wells KB, Hays RD, Burnam MA, et al. Detection of depressive disorder for patients receiving prepaid or fee-for-service care: results from the Medical Outcomes Study. *JAMA.* 1989;262:3298–3302.

CASE STUDIES

Depression Management: Applying Skills in the Clinical Setting

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Primary care and specialist providers face different challenges – and often make different choices – when treating a severely depressed patient. To help attendees learn from the experiences of primary care physicians and mental health professionals, and to demonstrate how to incorporate the skills of each, Collins (the internist) and Escobar (the psychiatrist) reviewed two actual cases [the names of the patients have been changed] at the MOOD symposium in Philadelphia. They then advised on their chosen approaches to managing them. Questions from symposium attendees are referred to as *audience*.

CASE 1: "MRS. GONZALEZ"

Mrs. Gonzalez is a 56-year-old Hispanic immigrant who speaks only Spanish. A widowed mother of four, she is overweight and mildly hypertensive but otherwise has no major health problems. Two years ago, she was treated with a low-dose angiotensin-converting enzyme (ACE) inhibitor for complaints of weakness, back and joint pain, headaches, palpitations, and dizziness. The current presentation was precipitated by an extreme mood crisis, marked by agitation, insomnia, crying jags, loss of appetite, and complaints of pains in multiple locations. Her daughter served as translator.

JAVIER I. ESCOBAR, MD: It is difficult to manage patients for whom there are language barriers: it can interfere with our ability to get information and to present recommendations for care.

RICHARD L. COLLINS, MD: This patient came with her daughter, who could speak English.

ESCOBAR: At a subsequent visit, the daughter indicated that the pain had continued, the mother was sleeping poorly, and did not want to leave the house because of her "physical problems." It became clear that Gonzalez probably had a depressive disorder, or at least a common mental disorder in the depression/anxiety spectrum. Whereas in the old days a good physician might have comforted the patient, today the constraints of time and reimbursement mean that most primary care providers can only tell the patient, "I cannot find anything physically wrong with you."

COLLINS: Primary care providers should say to patients such as this, "I think you may be depressed." More often than not, the patient will be thrilled to hear that they are not severely ill, and sometimes they will even

jump at the chance to admit that they have been depressed.

At her next visit, Gonzalez was assessed with PRIME-MD (the Primary Care Evaluation of Mental Disorders; *see discussion that follows) by the office nurse and was found to have significant depression and anxiety symptoms. However, her family refused to accept a psychiatric diagnosis and she remained untreated until she presented to an emergency department for another crisis. The ED physician prescribed an antidepressant and referred her to a bilingual clinic, where the Spanish-speaking nurse practitioner persuaded her to stay on therapy.*

ESCOBAR: The self-administered version of PRIME-MD Patient Health Questionnaire (PHQ) is a validated, convenient instrument for assessing unexplained physical symptoms — as well as symptoms of anxiety, depression, and some other common mental disorders — that can be simply applied in the primary care setting[3]. It is underutilized as a rule and in this case, because it was done, the patient received an accurate diagnosis. The busy physician, however, just gave her a benzodiazepine for sleep with instructions to visit a psychiatric clinic. In our experience, the follow-up visit does not occur in 70 to 80 percent of cases.

COLLINS: Yes, it may be that there is a stigma associated with mental illness, or the patient or family does not believe that physical symptoms are related to a mental disorder. In Latino families, especially, it is often the family group that decides on care for parents rather than the patient alone. In this case, the family decided that Gonzalez did not need psychiatric care and took her to another primary care physician.

ESCOBAR: This sort of doctor-shopping behavior is common among patients who present with multiple unexplained physical symptoms.

COLLINS: Once she was brought to the emergency department, Gonzalez accepted the prescription for an antidepressant, but soon discontinued because it made her feel nauseated.

ESCOBAR: It is quite common for patients to discontinue antidepressant medications within a few weeks of receiving the prescription. Some researchers estimate more than 50 percent of patients will stop without telling their doctor (Simon 1992). This creates a problem for long-term control.

COLLINS: But in this case, a Spanish-speaking nurse practitioner at the clinic was able to persuade the patient to keep trying until she found a medication that was more tolerable. This was key to her successful care. The nurse subsequently scheduled weekly visits, examined the patient, reassured her, and allowed her to talk about such things as stressors, social isolation, and difficulties with immigration. Once the patient was on the right antidepressant and visited the clinic regularly, she improved within 6 to 8 weeks.

AUDIENCE: As Gonzalez adjusts to the changes in her life situation, will reduction or discontinuation of medication be considered?

ESCOBAR: We know very little about how long a patient who has depression needs to be maintained on antidepressants, particularly someone in whom symptoms seem to be related to a number of life contingencies. If you start a patient on effective antidepressant therapy and initiate psychosocial support, I would wait until there is full remission of symptoms (for example, Hamilton Depression Scale <5), until the patient's life situation is stable for at least 3 months, and until there is a family support system in place to try a discontinuation. Then, I would follow her regularly during the transition period, and hopefully the symptoms will not return.

CASE 2: "EVA"

Eva is a 44-year-old, married, white female who lives with her husband, an adopted 2-year-old son, and her mother with Alzheimer's disease. Eva's complaints of chest pain and palpitations yielded no identifiable organic pathology. Alprazolam was prescribed for anxiety, but was discontinued due to drowsiness and disorientation. Months later, complaints of severe headaches, sleeplessness, and fatigue led to referral to a neurologist, but again no organic diagnosis could be made. Upon changing physicians to accommodate a new health care plan, questions about stress revealed her difficult home situation.

COLLINS: Early in my career, I was very distressed by cases like these because the multiple somatic complaints made it difficult to perform an accurate diagnosis. Now, the older I get, the more I rely on the "rule of five" *[see Collins' explanation of this on page 4 – Ed.]* Now I know that these symptoms are quite possibly a manifestation of a mental health disorder.

ESCOBAR: Agreed. That is why Eva was referred to a stress-management program. Here, the psychologist administered some questionnaires, which confirmed that she met the criteria for multiple unexplained somatic symptoms and hypochondriasis. She also exhibited symptoms of mild depression.

COLLINS: Was she prescribed medication?

ESCOBAR: The evidence of efficacy with drug treatment among patients with unexplained physical symptoms is questionable, although it could have been given as

[3] Spitzer (1999) determined that the PRIME-MD PHQ is more efficient to use than the original, clinician-administered PRIME-MD. The original PRIME-MD screening instrument, though validated, is considered by some to be of limited usefulness because of the time it takes clinicians to administer it to patients.

an adjunct. But we have a good number of studies showing cognitive-behavioral therapy (CBT) really works on unexplained physical symptoms, so she was prescribed a 10-session CBT program. This is not psychoanalysis or lifelong therapy; it is given over about a 2-month period.

With CBT, she learned to monitor her physical symptoms and then relate them to her thoughts and emotions. The patient quickly recognized that she often experienced headaches and chest pain after difficult interactions with her son or mother. She was taught progressive muscle relaxation and diaphragmatic breathing to practice daily. Sleep hygiene skills, such as how to regulate her sleep schedule and limit her time in bed to sleep only, helped to alleviate her insomnia. Eva began falling asleep within 30 minutes on most nights.

COLLINS: Was the depression resolved?

ESCOBAR: She learned to challenge her concerns about cardiovascular disease and a brain tumor, and so she experienced substantial improvement in her chest pain and headaches. She realized she did not have a progressive fatal disease. Learning to create the symptoms on her own, running up the staircase to create palpitations or grinding her teeth to create headaches, also helped to remind Eva that her physical symptoms were insufficient proof of a serious physical illness, thus alleviating some of her depression.

In the final CBT sessions, Eva and her therapist developed a relapse-prevention plan, including continuing to use each of the newly acquired skills and continuing to visit her primary care physician every 2 months for checkups.

COLLINS: I assume that it is important that the primary care physician continues to follow the patient and perform brief physical assessments at regular intervals.

ESCOBAR: Yes, these help to reassure her that she is physically healthy.

In the final session with the therapist, Eva reported a significant improvement in her headaches and chest pain, and noted that symptoms of depression had disappeared. Her depression inventory, which is a self-administered scale to assess depressive symptoms, was steady at <5, which means that she had few, if any, depressive symptoms.

AUDIENCE: How do you overcome the barrier of stigma about needing mental health care when the overriding belief is that we should be able to "pull ourselves out of it"?

COLLINS: I explain to patients that the brain is a biochemical puzzle, that they are missing a piece of that, and that treatment will "complete" it. Often, it does.

AUDIENCE: What plan of care or approach would you take if you start with medication and it does not work?

ESCOBAR: There are a number of options for managing these patients. I think what is most underutilized, not only in primary care but also in mental health care, are the nonpharmacologic treatments. Some approaches, including CBT and interpersonal therapy, are extremely effective in the management of depression. These options could be used in primary care and, in fact, have been proven to work in primary care.

AUDIENCE: If a patient still complains of a sleep disorder despite antidepressant therapy, should there be a change in medications?

ESCOBAR: Sleep disturbance is a key symptom of depression. If that symptom is not improved, you need to switch to another agent. Some might not even respond to the second agent and may require a combination, so we must leave our options open and aim for the best outcome.

AUDIENCE: Are the newer dual reuptake inhibitors different than other antidepressants for the treatment of multiple unexplained physical symptom syndrome?

ESCOBAR: These agents work at both the norepinephrine and serotonin receptors in the brain and there is some research showing a higher remission rate compared with selective serotonin reuptake inhibitors. These agents are particularly useful in the case of patients who have both physical symptoms, such as pain, and concomitant depression.

Reference

Simon G. Psychiatric disorder and functional somatic symptoms as predictors of health care use. *Psychiatr Med.* 1992;10: 49–59.

REGIONAL ISSUES IN CARE

PHILADELPHIA/NORTHEAST

Organized Care and Employee Assistance Programs

IMPROVING APPROACHES TO DEPRESSION IN THE WORKPLACE

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Depression is a significant problem in the workplace and costs employers approximately $52 billion a year (Greenberg 2003) in treatment costs, absences, and lost productivity. On average, each patient with depression will be absent 40 workdays per year. In 2005, at DuPont alone, employee health care costs reached $588 million, of which depression was responsible for $17 million.

A study from the University of Michigan Depression Center showed that although Corporate America believes it is effectively addressing depression in the workplace, employees generally disagree. Of the benefits managers, supervisors, and employees with depression who were surveyed (N=950), 86 percent of benefits managers and 76 percent of supervisors felt that their employees could acknowledge their depression and still advance their careers at their companies; only 41 percent of the employees agreed. Interestingly, 65 percent of companies had employee assistance programs (EAPs), but only 14 percent of employees with depression had used them (Carli 2004).

These statistics emphasize the need to improve the approach to depression in the workplace. From my perspective, this means first that employers need to destigmatize depression and to promote mental health wellness. This might involve training managers to recognize the signs of depression, encouraging open communication about depression in the workplace, and supporting EAP initiatives. When EAP case workers act as a liaison between the employee and clinician, they are able to ensure effective referrals, monitor treatment adherence, advise on health plan coverage, and be available to talk if the employee is in crisis (many EAPs provide hot lines for acute problems). Management may also play a role by allowing some concessions to an individual's mental health needs, whether it be accepting time off or changing work circumstances that prove overly stressful.

Encouraging enrollment in a company's EAP and facilitating appropriate communication among all participants can reduce the emotional and economic burden of depression in the workplace.

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THE MBHO'S ROLE IN ORGANIZING CARE

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Managed behavioral health organizations (MBHOs) have the same goals as physicians and employers: to treat and reverse depression with high-quality care in an efficient and effective manner. Organized care and coordinated services are key to improved patient management. Cost is a consideration but is not the goal; MCOs, like health care workers and employers, plan their programs and strategies with outcomes in mind first and finances second.

To do this, we work on several fronts:

Organizing stakeholders. MBHOs coordinate the efforts of employers, health plans, and government agencies with the services of clinicians and treatment programs to ensure that members receive appropriate care of proper intensity and duration. MBHOs serve multiple functions, from administering claims and quality assurance, to data management and ensuring compliance with federal, state, and private regulations.

Coordinating services. MBHO care managers sit at the center of a dynamic process: they receive input from EAPs, physicians, and patients; help with referral decisions (e.g., outpatient care, hospitalization, facility-based programs); coordinate care among all parties; and monitor progress that allows for providing feedback to employers. As experienced clinicians (such as nurses, psychologists, and social workers), care managers add value by administering screening tools, predicting patient trajectory based on normative data, and assisting with adjustment of treatment plans for members.

MBHOs are also focused on prevention. Early detection, for instance, can be achieved by recognizing a family history of depression and then implementing proactive diagnostic or screening programs. We strive for primary prevention by distributing educational materials to employers and families. Relapse prevention improves treatment adherence and makes the care process effective and efficient.

Reducing avoidable expenditure. As noted by Escobar in these pages, the financial advantage of eliminating depression is well established. Goldberg (2001) found that, among working-age men and women, mean annual health care expenditures for patients with depression were more than 4 times those of patients without claims for depression.

Several areas for improvement remain. We need to broaden efforts to reach community practices, improve uptake of evidence-based practices, and increase communication with providers and employers to achieve common goals. These efforts will continue to improve our ability to control the many adverse effects of depression.

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PANEL DISCUSSION

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Richard Collins, MD, and Javier I. Escobar, MD, are introduced previously in this publication. Questions from symposium attendees are referred to as audience.

HYONG UN, MD: Dr. Nardozzi, you represent a managed behavioral health organization [MBHO] that deals principally with psychiatrists and mental health providers. What is your relationship with primary care physicians [PCPs]?

LAWRENCE J. NARDOZZI, MD: Through treatment programs, we attempt to augment their evaluation, recognition, and treatment of depression, anxiety, and other issues, such as substance abuse. We believe there is great opportunity in the primary care setting to recognize and intervene early to address depression.

JAVIER I. ESCOBAR, MD: The President's Commission on Mental Health declared that the current mental health care system is inadequate to serve the needs of most people with mental illness in the United States, particularly due to lack of access to care. Part of the problem is that mental health issues are viewed clinically as separate — and paid for separately — from physical health issues. Progress depends on changing this attitude via better integration of primary care, psychiatric, and MCO needs and improved utilization of employee assistance programs [EAPs]. This is going to take time to achieve, but it is an important goal.

UN: What can primary care physicians do to help increase utilization of EAPs?

RAYMOND R. STROCKO, MD: Most important, physicians should ask patients with depression if their workplace has an EAP, which is a great resource to support the PCP in depression management. Once the PCP and the EAP physician connect, they can work together to get the employee back to work and make sure that the employee adheres to prescribed therapies, and the EAP counselor can follow up on the patient's progress to see how he or she is doing from a work perspective.

UN: I think Dr. Strocko is right — you just have to ask, "Do you have an EAP?" The amazing thing is that a lot of times, employees don't know, despite huge efforts to educate and inform them about the EAP's presence. You might want to refer them back to the company's human resources department for better introduction to the EAP.

AUDIENCE: There is a stigma, too. People don't want to be seen walking into an EAP counselor's office because people will then know something is wrong. It may be helpful to provide a phone number or Web site to help them find off-site services that will help maintain their privacy.

STROCKO: That's a good point, though at DuPont we started our EAP with off-site clinics, and management decided they didn't want our employees driving off site. So now we have EAP counselors right in our medical clinics, so that when an employee comes in, nobody knows who they are going to go see, the doctor, the nurse, or the EAP counselor.

UN: What can an MBHO, an MCO, or an employer do to help PCPs manage depression better?

RICHARD COLLINS, MD: I would recommend three things: collaboration aimed at agreeing on processes to meet each others' expectations; communication among all people involved in the cycle of care; and formulary coverage that enables us to find appropriate and effective treatment for all patients.

ESCOBAR: We need to integrate mental health and primary care treatments, then we must show that this approach improves outcomes. We also need to change the way we educate medical and nursing students to teach them about interviewing skills that bring mental health issues to the surface.

UN *[to Strocko]:* Are there evidence-based data showing that EAPs actually improve outcomes?

STROCKO: Yes, studies have shown that they are cost-effective, and that for every $1 you spend on an EAP you save $3 to $5 (Coshan 1994, HHS 1999, UPMC 1996).

UN *[to Nardozzi]:* How do care managers work with patients' PCPs in your programs?

NARDOZZI: The PCP is the hub of care, but the care manager keeps the PCP informed of what is occurring in the behavioral health network, whereupon the physician can recommend changes or suggest new therapies.

References

Carli T. Is Depression a Roadblock to Career Success? A Study of Depression in the Workplace. Presented at: University of Michigan Depression Center, March 22, 2004. Available online: «http://www.med.umich.edu/opm/newspage/2004/depressionsurvey.htm». Accessed Sept. 13, 2006.

Coshan M. An EAP can be part of the solution. *Canadian Business Rev.* 1992 Jun 22.

Goldberg RS, Steury S. Depression in the workplace: costs and barriers to treatment. *Psychiatr Serv.* 2003;54:682–687.

Greenberg PE, Kessler RC, Birnbaum HG, et al. The economic burden of depression in the United States: how did it change between 1990 and 2000? *J Clin Psychiatry.* 2003;64:1465–1475.

HHS (U.S. Department of Health and Human Services). Employee Assistance Programs. Fact Sheet. 1999. Available online: «http://workplace.samhsa.gov/WPResearch/EAP/FactsEAPfinal.html». Accessed Sept. 13, 2006.

UPMC (University of Pittsburgh Medical Center). Research cited in "Cost-benefit ratio for EAPs is substantial." EAP solutions: date unknown. Available online: «http://www.eapsolutions.com/managers/pdf/cost-benefit.pdf». Accessed Sept. 13, 2006.

ATLANTA/SOUTH

Lack of Access in Rural Regions

EMPLOYERS – A PARTNER IN COLLABORATIVE CARE?

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The workplace is a site of changing demographics. With flexible schedules, two-working-parent families, working moms with children, adults caring for elderly parents — not to mention all the stress that modern technologies such as cell phones, Blackberries, and videoconferencing place on workers' time and privacy — there is a new face to the working adult today. One outcome is an increased rate of mental health problems in the workplace. It has been estimated that 72 percent of adults with a mental illness work (HHS 2005). In 2003, 8.2 percent of full-time employed adults experienced a mental illness, and 50 percent of workers with major depression and/or anxiety disorders experienced absences from, or impairment in, the workplace (Finch 2005).

As a major employer in the United States, with 8,800 employees and 3,300 covered retirees plus dependents, the Coca-Cola Company is concerned with health care costs in general and total costs related to depression in particular. In our family of employees, mental health disorders are responsible for only 3.2 percent of direct medical costs, but pharmacy costs for psychostimulants and antidepressant medications are the fourth highest category of net paid health care expenses — and the second highest in volume. Additionally, slightly more than 7 percent of short-term disability cases are due to mental health issues and represent nearly 10 percent of all missed work days, and average 36 missed days per affected employee. The indirect costs are difficult to measure, but they have a major effect on the company.

Many employers are reducing benefits to streamline costs, but to poor results. The National Comorbidity Survey Replication found that only 12.7 percent of individuals treated in the general medical sector, and only 43.8 percent treated in the specialty mental health sector, receive even minimally adequate treatment for mental health complaints (Wang 2005). Limiting coverage, discouraging hospitalization, dependence on day programs for depression care, and relying on medications alone to treat this disease carry a risk for inadequate or uneven quality of care and high relapse rates among workers.

I would like to propose that employers be part of the collaborative care model for depression management. Whether it be as consultant on performance or attendance issues, or as a reference source on disability policy and benefits, corporate human resources contacts can provide important information to assist physicians and health care organizations in depression care, as well as assist with return-to-work transitions for employees with depression. Only through teamwork and collaboration can we hope to battle this debilitating disease.

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A HOLISTIC APPROACH TO TREATMENT

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Most MCOs are moving toward an integrated model in which behavioral medical health strategies are merged. United Behavioral Health, a managed behavioral health organization (MBHO), in conjunction with its partner in medical health care, UnitedHealthcare, manages depression through professional integration of nurses, psychiatrists and psychologists, social workers, primary care physicians (PCPs), and what we call behavioral health care advocates. This format is designed to ensure that no aspect of care is overlooked. For instance, we encourage behavioral health consultations early in the care routine, so an elderly patient who has been admitted to the

hospital following a heart attack has a psychiatric consult shortly after admission. In today's world, consults are often delayed and patients languish without needed depression care because no psychiatrist is immediately available.

This brings us to the important issue of access. As a behavioral health care organization, it is our responsibility to ensure the quality of care (see box, below). Specialty services may be difficult to schedule, particularly in remote or rural settings. It may be difficult to get a psychiatric consult on a Friday, leaving the patient to remain in the hospital unnecessarily over the weekend. Or, it might be difficult to find an open nursing home bed, requiring a family to scurry to place the patient wherever it can. If a member cannot find the appropriate resource, UBH is there to ensure quick access. It behooves us to ensure immediate care, lest costs increase because of extended hospitalizations or failure of long-term disease control.

Some of our most promising initiatives include our holistic approach to depression and our Depression Management Programs (DMPs).

Our holistic health approach focuses on coordinating care across medical and behavioral settings, as well as treating depression as a major factor in such medical illnesses as diabetes. Depression negatively affects diabetes therapy, for instance, by causing noncompliance, poor glucose control, and missed appointments.

DMPs address the need for standardized post-discharge care and special interventions for patients at highest risk for rehospitalization. By treating patients with the same attention and detail as we would a post-surgical patient, we achieve better outcomes than observed with standard care. We also would like to see psychiatrists and social workers integrated into more primary care practices and groups, particularly in more isolated settings, to remove the PCP's burden of educating patients about depression.

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MBHO care manager's role

Care managers use their influence to ensure quality care and manage cost through:

- Collaboration and coordination with care providers
- Assurance of rapid and effective treatment
- Endorsement of best-practices procedures
- Making care goal-focused to achieve successful outcomes
- Provision of care in the most appropriate and least restrictive environment

PANEL DISCUSSION

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PETER AUPPERLE, MD: How can we make certain that all patients get good access to integrated treatment for depression and other comorbid conditions?

JOEL AXLER, MD: We need to make it easier to get a consult with a psychiatrist, social worker, or psychologist on the behavioral health side. This goal might benefit greatly from ensuring that some of the models of collaborative care presented in this program are widely initiated. If there were more opportunity to see a therapist and a medical clinician in one visit, it would encourage better diagnosis and improved compliance with treatment.

PAUL CIECHANOWSKI, MD: It might also be valuable to integrate a standard 1-minute screening tool into visits at all care points. When a patient arrives with elevated hemoglobin A_{1c} or congestive heart failure, we have an automatic resource that checks for concomitant depression. At the University of Washington, we have psychiatrists in all our medical clinics — women's health, the heart center, the diabetes clinic — so that patients with depression have an immediate resource and there is no stigma about it.

AUPPERLE: What do you see as the challenges or issues to moving forward with integrated care?

FAYE A. GARY, EDD, RN: I think the IMPACT model[4] *[see Escobar, page 7]* looks attractive, but logistically, it wouldn't work in a small office in a rural setting. Using care managers or having a mental health practitioner in the clinic isn't practical. The American model of medicine still involves practices of 3 to 5 doctors.

CIECHANOWSKI: There are variations, though, such as care-worker home visits and telephone consultations. Greg Simon, MD, MPH, [Group Health, Seattle] is looking at collaborative care models that use telephone visits, and we have a Centers for Disease Control and Prevention grant for a study in which our social workers visit epilepsy patients in their homes. IMPACT did show that at 24 months there was a cost offset: It was worth putting the extra $500 into a case

[4] Improving Mood — Promoting Access to Collaborative Treatment for Late Life Depression. See «http://impact-uw.org».

manager because 2 years later it was cost-effective (Unützer 2004).

AUPPERLE: We need to think outside the box. In Alabama, where there are few child psychiatrists, University of Alabama–Birmingham is offering telepsychiatry for children in cooperation with rural community mental health centers. This is a novel idea that tailors treatment to patient needs and yet may be more cost effective than bringing in full-time child psychiatrists.

GARY: To make any resource effective and useful, health literacy must be addressed. We must also begin to reflect on the social determinants of health care. The stress of trying to make a living and also to have any kind of quality of care is a major issue for many people living in poor rural settings, and we should consider those challenges in planning health care initiatives for isolated communities.

References

Finch RA, Phillips K. Center Prevention & Health Service. An Employer's Guide to Behavioral Health Services. Washington: National Business Group on Health. 2005.

HHS (U.S. Department of Health and Human Services). Substance Abuse and Mental Health Services Administration. Overview of findings from the 2004 National Survey of Drug Use and Health (Office of Applied Studies). HHS publication no. SMA 05-4061. Rockville, Md.: Center for Mental Health Services, HHS, 2005.

Unützer J, for the IMPACT investigators. Improving care for late-life depression. Findings from the IMPACT study: improving mood – promoting access to collaborative treatment for late-life depression. Available online: «http://impact-uw.org/ImpactPoster2004.pdf». Accessed Sept. 13, 2006.

Wang PS, Lane M, Olfson M, et al. Twelve-month use of mental health services in the U.S.: results from the National Comorbidity Survey Replications. *Arch Gen Psychiatry.* 2005;62:629–640.

CHICAGO/MIDWEST

Unions and Collective Bargaining

THE CHALLENGES OF A HIGH-RISK WORKPLACE

WILLIAM B. BUNN III, MD, JD, MPH
Vice President, Health, Safety, and Productivity
International Truck and Engine
Chicago

International Truck and Engine provides insurance coverage to 12,000 U.S. employees, as well as to 40,000 retirees and nearly 50,000 dependents. Our population is predominantly male and primarily older, averaging around 45 to 50 years of age, making cardiovascular disease and cancer major health care issues, but depression ranks with these for its impact productivity and absenteeism.

As a unionized workplace, we provide generous health coverage. Therefore, we depend on high productivity to sustain competitiveness. Depression, however, has a negative effect on productivity and can lead to high rates of disability and absenteeism. Further, our workers tend to have substantial musculoskeletal problems because of the heavy labor involved in making trucks, and depression is a frequent concomitant, delaying recuperation and lengthening the term of disability. Our employees also tend to be smokers and overweight, and have a higher-than-average rate of substance abuse. Although our employee assistance program (EAP) shows rates of diagnosed depression around 4 percent — lower than the national 1-year prevalence of about 10 percent (Kessler 1994) — a recent review of our pharmaceutical claims indicated that 21 percent of covered individuals were taking antidepressant or antianxiety medication. Our union agreement does not allow us to transfer benefit costs to the individual, making for a substantial outlay for the company.

The EAP at International is utilized by 16 percent of our workers. Participation in the EAP is strongly encouraged for its improved outcomes and known cost savings. Our plan provides eight counseling visits at no charge, and all services are integrated with onsite health care staff. There is also an EAP coordinator at each site, and a mental health care professional visits weekly to provide services at no charge and to make referrals for long-term care — a service requested by the union and one that is proving to be very successful. Finally, we encourage employees to take advantage of a yearly health-risk appraisal, which includes a depression assessment, to try to help workers who may have depression receive care.

These initiatives helped International reduce corporate health care costs by 30 percent. In the future, we hope to gain a better understanding of barriers to, and methods of, improving adherence to antidepressant therapy.

William B. Bunn III, MD, JD, MPH, is medical director and director of health workers' compensation, disability, and safety for Navistar International Transportation Corp., in Chicago. He also is associate professor of preventive medicine at Northwestern University Feinberg School of Medicine. Bunn's primary professional interests are health care management and international health issues.

REDUCING BARRIERS TO ACCESS

LAWRENCE M. WEINSTEIN, MD, ABHM
Senior Vice President, Medical Affairs
Hythiam Inc.
Los Angeles

MBHOs, the business arm of the mental health care industry, provide services to employers, government,

and third-party payers, and contract with health care providers for high-quality, affordable care. This industry was designed initially to oversee processes of care; today, MBHOs ensure provider quality, are fiscally responsible for coverage, and provide external accountability — that is, ensure that programs meet expectations of federal, state, and private monitoring organizations.

Care management is one of the most important MBHO services. This function includes treatment oversight, 24-hour consultation, provider referrals, and coordination of care between patients and providers, employers, and agencies. The system has undergone substantial refinement since its initiation. Some agencies have developed sophisticated multitiered referral systems that use scoring cards and quality indicators to determine the best provider with the most reasonable price for a particular member's needs. In addition, toll-free phone access systems have been upgraded in accordance with National Committee for Quality Assurance and Joint Commission on Accreditation of Healthcare Organizations standards. In the past, callers might have waited 15 or 20 minutes, with callers transferred to multiple departments before contact was made with the appropriate person; improvements have meant fewer transfers and faster appropriate contact.

The most recent change in behavioral health care programs involves integration of medical and mental health coverage. Until recently, MCOs with large memberships carved out mental health benefits. Today, the trend is reversing so that medical and behavioral treatments can be addressed in sync. This approach improves service coordination and should improve the outcome of multifactorial illnesses like depression.

Despite these advances, there is still room for improvement (see box, right). There is a need to promote population-based prevention, early detection, and relapse-prevention strategies that increase therapeutic adherence and follow-up. MBHOs must adapt their systems to accommodate overlap between medical and psychiatric definitions of disease; a new model that is being developed will endorse medical management with psychotherapeutic interventions and life-coaching programs (e.g., assistance with bill paying, health care appointments). We must also individualize programs for practice variations while adopting evidence-based practices to achieve maximum results. The goal is to stratify care, based on quality indicators, to achieve standardized outcomes.

Prior to joining Hythiam in August, Lawrence M. Weinstein, MD, ABHM, was a medical director at PacifiCare Behavioral Health and, previously, at Magellan Behavioral Health. Weinstein earned his undergraduate degree at Kiev Medical Institute in Kiev, Ukraine, and his MD at Ross University School of Medicine, in New York.

Outstanding needs in health care management

- Respond to variability in practice (regional, cultural, and economic factors)
- Improve adoption of evidence-based practices
- Train providers in evidence-based practices
- Routine measurement of outcomes
- Variability in provider outcomes

PANEL DISCUSSION

STEVEN R. PESKIN, MD, MBA, MODERATOR
Chief Medical Officer
MediMedia USA
Yardley, Pa.

Participants Faye A. Gary, EdD, RN, and Paul Ciechanowski, MD, are introduced previously in this publication. Kristina Katzovitz, MD, is medical director of Elmhurst Physician-Hospital Organization, in Elmhurst, Ill.

STEVEN R. PESKIN, MD: What broad advice would you give to primary care physicians (PCPs) regarding working with employee assistance programs [EAPs] and interacting with major payer organizations?

KRISTINA KATZOVITZ, MD: I suggest that people with depression work closely with their EAPs. EAP counselors are informed about the limitations of mental health benefits and the challenges of copayments, and can provide services or referrals within the framework of the plan. They also are aware of the patient's functionality at work and are helpful at getting the patient to a functional status where he or she can do the job.

PESKIN: What issues pertinent to diagnosing or managing depression are common to the Midwest?

KATZOVITZ: We have some major airlines — United, American — that are either based in, or have major operations in, this city. That means we deal with two important and unique challenges: First, airlines compose a volatile industry, with cycles of hirings and layoffs that can contribute heavily to worker anxiety and depression. Second, this industry is unionized, adding another layer of guidelines to the collaborative care model — which may not be an issue in other settings.

WILLIAM B. BUNN III, MD, JD, MPH: Yes, there's a sense of both management and union being involved in many decisions, including health care. The good news is that the union offers additional behavioral support systems, which may not be available to employees of nonunionized industries. The challenge is that we have to consider union demands in addition to expectations of employers and MBHOs in delivering health care and achieving outcomes.

PESKIN: How can we best support the care of people with depression?

BUNN: At International, immediately upon diagnosis, we have a care manager call the individual or a family member to review special needs for home care. We offer significant life-support systems, so if the individual needs home care, eldercare assistance, or legal support, for instance, we help to find that service.

PESKIN: What are some potentially cost-effective ways of addressing recidivism and frequent readmissions?

LAWRENCE M. WEINSTEIN, MD: That is a big problem, and often it involves comorbid chemical dependence. Current treatment programs are based on a psychosocial approach, but success has been limited. Hythiam has created a predictive-modeling system where care managers reach out and consistently engage patients and families or whomever is influential in the member's life, because we know depression is a family disease and group intervention is paramount. This makes for a costly program, but the alternatives — untreated depression, untreated chemical dependency, or a combination of the two — is even more costly.

FAYE A. GARY, EDD, RN: Individuals with mental illness frequently self-medicate, so a thorough assessment is key to identifying underlying substance abuse. If you want to consider a model that works, the U.S. Department of Veterans Affairs offers a combination of day treatment, drug therapy, recreation, organized follow-up, and education about depression. Patients receive assistance in activities of daily living, like shopping, money management, and dealing with tensions at home. It is a complete program that keeps people out of the hospital.

PESKIN: Is there an effective, patient-friendly way to tell an individual that his or her chief physical complaints are psychological in origin?

KATZOVITZ: There's no way, on a first visit, to tell a patient "There's nothing wrong." You have to do some tests, and by the second or third visit, you might be certain there is no underlying physical cause for symptoms. At that point, I would ask a patient, "Are you having any stress in your life?" This opens the door to talk about how stress can cause symptoms. It's a matter of developing a rapport and gaining trust. It's an art.

Reference

Kessler RC, McGonagle KA, Zhao S, et al. Lifetime and 12-month prevalence of DSM-III psychiatric disorders in the United States: results of the National Comorbidity Survey. *Arch Gen Psych.*1994;51:8–19.

Los Angeles/West

Cultural Diversity and Special Populations

(Presentation begins at the top of the next column)

IMPROVING THE EFFECTIVENESS OF INTERVENTIONS

Chalmers H. Armstrong III, MD
Medical Director
The Motion Picture Industry Health Plan
Studio City, Calif.

The Motion Picture Industry Health Plan covers about 110,000 lives, including actively working professionals, family members, and retirees. Because of its capriciousness, the motion picture industry tends to have a more substantial problem with depression than is seen in other fields. Drugs, too, are more prevalent among employees in the film industry. For many years, we addressed these problems with a costly and random approach, sending members indiscriminately to detoxification programs and wilderness challenges. But this relatively disorganized approach to mental health management gave way a few years ago to involvement in a managed behavioral health organization (MBHO).

The film industry brings double the normal rate of patients to outpatient care for chemical dependency and triple the norm for inpatient detoxification. The indirect costs to the industry are huge, contributing as much as 75 to 80 percent of total expenditures: excessive turnover, training of new employees, absenteeism, and *presenteeism,* a term used to describe people who come to work but who are sufficiently disengaged so as not to contribute full capacity to their workload. Depression also has a negative effect on coworkers, who must pick up the workload lost to presenteeism or absenteeism and, as a result, may experience loss of morale. Further, depression is the third-leading cause of long-term disability and the fifth-leading cause of short-term disability, contributing significantly to employer costs and lost productivity.

Among the many barriers to effective intervention for depression are the stigma of mental illness, patients' fears of medication, lack of information about resources, such as employee assistance programs (EAPs), and work productivity — meaning, in this case, a poor match between employee and job description. Some employees who dislike their position will become depressed, and some will benefit from a new position that better suits their temperaments. We must also consider the challenges that managed care contributes to the mix: It may be difficult for members to figure out the system, they might be put off by calling a toll-free number to speak with a stranger, or they may bristle at screening questions they need to answer before they can reach a clinician.

With primary care physicians (PCPs) serving as the center of care for most depressed individuals, it is important that PCPs recognize depression, provide pharmaceutical intervention, as needed, and refer to an appropriate professional for long-term care, with sufficient plan cov-

erage to ensure optimal outcomes. Making a more easily accessed and patient-friendly process for mental health diagnosis and care is a key to reducing depression and the costs to employers related to this disease.

Chalmers H. Armstrong III, MD, is medical director of the Motion Picture Industry Health Plan, which insures individuals in the motion picture and television industries. He graduated from the U.S. Military Academy at West Point, N.Y., in 1962, and from medical school at the University of Miami, in 1976. Previously, Armstrong was in private practice in California and practiced as a family physician at the Motion Picture and Television Hospital and Health Clinic.

PANEL DISCUSSION

STEVEN R. PESKIN, MD, MBA, MODERATOR
Chief Medical Officer
MediMedia USA
Yardley, Pa.

Participants Faye A. Gary, EdD, RN, Lawrence M. Weinstein, MD, and Javier I. Escobar, MD, are introduced previously in this publication. Michael K. Ong, MD, PhD, is assistant professor of medicine in residence at the University of California–Los Angeles Department of Medicine.

STEVEN R. PESKIN, MD, MBA: Dr. Armstrong mentioned the need for an "easily accessed and patient-friendly" diagnosis process. How big an issue is access today?

FAYE A. GARY, EDD, RN: Ready access is key to depression diagnosis, management, and community perception. Bernice Pescosolido, PhD, at Indiana University, has done a great deal of work evaluating access to care, using the impact of state hospital closings to follow the progress of patients, families, health care workers, and the public following the loss of care systems. She also has studied differences in care and outcomes among depressed individuals with large support networks versus those with poor access to health services. Her work can be a good resource for information on this topic.[5]

LAWRENCE M. WEINSTEIN, MD: The American Psychiatric Association also is a great resource for issues related to points of access, as are the American Holistic Medical Association and Association of Integrated Health Web sites.

JAVIER I. ESCOBAR, MD: The National Institute of Mental Health Web site can be helpful, not only on the biological side, but also in the area of the practice of health care services. You might wish to refer the Depression in Primary Care site[6] as well.

PESKIN: How often should a PHQ-9[7] or a similar type of instrument be administered and reported in the patient's record?

MICHAEL ONG, MD, PHD: I don't think there have been formal recommendations for use of these tools in general practice, although some PCPs are doing yearly screening with some patients. The important thing to keep in mind is that if you are going to screen for depression, you need to make sure it is be treated appropriately. Further, some of these measures have been validated for the purpose of following patients, so you might also use them to check whether patients are responding to treatment.

PESKIN: What about the lack of cultural, religious, and racial sensitivity that have been questioned in these screening tools?

ESCOBAR: These are self-rating instruments. If the test forms have been translated for non-English-speaking patients into their native languages, those translations must be done by people who understand the nuances of those languages. In addition, when possible, the patient should complete the form with the help of a nurse or social worker who is familiar with the language, so that meaningful data can be extracted from it.

ONG: Many of these instruments have been validated in different ethnic groups, but if you decide to use one, be sure it makes sense for your patient population. Also, keep in mind that many patients — particularly here in Southern California [with its large Spanish-speaking population] — are not necessarily going to be at the same reading level.

ESCOBAR: When properly done, these tools work very nicely, though, at least in the case of our Spanish-speaking population.

GARY: Another issue we need to address is the need to provide *culturally competent* care. The book *In the Best Interest of the Nation* is about the urgent need to educate a diverse work force in psychiatry, in primary care, in psychology, and in nursing … in fact, in all of health care. To address some of these issues about culture, we have to ensure a culturally, religious, and regionally diverse work force and place health care workers where they would best serve our communities.

PESKIN: It also has been argued that *DSM-IV* may not be an accurate diagnostic tool in some patients because of its failure to specify differences based on race, culture, religion, and socioeconomic background.

ESCOBAR: With *DSM-V,* which is scheduled for release in 2011 or 2012, you will find that the issue of culture in diagnosis is becoming very important. Given the multicultural nature of our patient populations, it will look at issues that differ among African Americans, Latinos, recent immigrants, and other populations.

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[5] See «www.indiana.edu/~alldrp/members/pescosolido.html».

[6] See «www.depressioninprimarycare.org».

[7] The PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire. See «www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9».

CONTINUING MEDICAL EDUCATION ASSESSMENT/EVALUATION/CERTIFICATE REQUEST

MOOD – Managing Obstacles to Improved Outcomes in Depression
A Collaborative Approach to Improved Care

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Credit will be awarded upon successful completion of assessment questions (70 percent or better) and completion of program evaluation. If a score of 70 percent or better is not achieved, no credit will be awarded and the participant will be notified.

EXAMINATION: Place an X through the box of the letter that represents the best answer to each question on page 21. There is only ONE correct answer per question. Place all answers on this form:

	A.	B.	C.	D.	E.	F.
1.	☐	☐	☐	☐		
2.	☐	☐	☐	☐	☐	☐
3.	☐	☐	☐			
4.	☐	☐	☐	☐	☐	
5.	☐	☐	☐	☐	☐	
6.	☐	☐	☐	☐		
7.	☐	☐	☐	☐	☐	
8.	☐	☐				
9.	☐	☐	☐	☐		
10.	☐	☐	☐	☐		
11.	☐	☐	☐	☐	☐	
12.	☐	☐	☐	☐	☐	

PROGRAM EVALUATION

So that we may assess the value of this self-study program, we ask that you please fill out this evaluation form.

1. Have the objectives for the activity, below, been met?

Summarize the regional epidemiology and disease burden of depression. ☐ Yes ☐ No

Better recognize and diagnose patients who have depression. ☐ Yes ☐ No

Identify and address barriers to suitable care. ☐ Yes ☐ No

Recognize strategies for effective management and treatment of depression. ☐ Yes ☐ No

(evaluation continues next column)

2. Was this publication fair, balanced, and free of commercial bias?
☐ Yes ☐ No

If no, please explain: _____

3. Did this educational activity meet my needs and contribute to my personal effectiveness? Please indicate your level of agreement:

Strongly agree.....5
Agree.....4
Neutral.....3
Disagree.....2
Strongly disagree.....1

Did it improve my ability to:

Treat/manage patients?
5 4 3 2 1 N/A

Communicate with patients?
5 4 3 2 1 N/A

Manage my medical practice?
5 4 3 2 1 N/A

Other _____
5 4 3 2 1 N/A

4. Effectiveness of this method of presentation:

Excellent	*Very good*	*Good*	*Fair*	*Poor*
5	4	3	2	1

5. What other topics would you like the activity to address? _____

6. Comments _____

CONTINUING EDUCATION POST-TEST

MOOD – Managing Obstacles to Improved Outcomes in Depression
A Collaborative Approach to Improved Care

Please tear out the combined answer sheet/evaluation form on page 20. On the answer sheet, place an X through the box of the letter corresponding with the correct response for each question. There is only one correct answer to each question.

1. **The first line of therapeutic intervention for most patients with depression and anxiety is:**
   a. A psychiatrist.
   b. A primary care physician.
   c. A social worker.
   d. An employee assistance program.

2. **Proven strategies for effective treatment and management of depression include:**
   a. A collaborative approach between medical and mental health practitioners.
   b. Initiation of cognitive-behavioral therapy.
   c. Initiation and management of antidepressant medications.
   d. Reduction in workplace stress.
   e. All of the above.
   f. Answers a, b, and c.

3. **Among patients with diabetes, hypertension, or ischemic heart disease, annual treatment costs:**
   a. Double with concomitant depression.
   b. Multiply by 4 with concomitant depression.
   c. Multiply by 6 with concomitant depression.

4. **Employee assistance programs can:**
   a. Function as a liaison between employee and clinician to ensure effective referrals.
   b. Advise employees about their coverage terms.
   c. Monitor treatment adherence.
   d. Provide crisis counseling.
   e. All of the above.

5. **In recent years, new thinking regarding the management of patients with unexplained somatic symptoms has surfaced and seeks to:**
   a. "Loosen" the definition of somatoform disorder to incorporate concept of a nervous-system disorder that can be treated with antidepressants.
   b. Determine the cause of symptoms based on a patient's life experience.
   c. Integrate basic psychiatric methods into primary care routines.
   d. All of the above.
   e. None of the above.

6. **What percentage of patients seen in the primary care setting have a primary mental disorder?**
   a. Nearly 10 percent.
   b. Nearly 25 percent.
   c. Nearly 33 percent.
   d. Nearly 50 percent.

7. **Primary functions of a managed behavioral health organizations include:**
   a. Care management and coordination between patients and providers, employers, and agencies.
   b. Administration of programs aimed at prevention and relapse prevention.
   c. Facilitation of quick access to care.
   d. All of the above.
   e. Answers a and c.

8. **Pain is the most common presentation associated with underlying depression.**
   a. True.
   b. False.

9. **The John A. Hartford Foundation's Project IMPACT showed that a primary care/psychiatric collaboration could:**
   a. Reduce late-life depression twice as effectively as regular care.
   b. Ensure adherence to antidepressant therapy.
   c. Prevent suicide among elderly patients.
   d. Bridge gaps in cultural barriers to care.

10. **The validated instrument PRIME-MD PHQ, is:**
    a. Self-administered by patients to assess symptoms of anxiety and depression.
    b. Self-administered by patients to assess symptoms of anxiety, depression, and unexplained physical symptoms.
    c. Administered by primary care practitioners to assess symptoms of anxiety and depression.
    d. Administered by primary care practitioners to assess symptoms of anxiety, depression, and unexplained physical symptoms.

11. **Barriers to effective treatment and/or management of depression include:**
    a. Limitations of time in primary care practices.
    b. Limits on payment or duration of coverage.
    c. Provider/patient language differences.
    d. Life stresses not immediately obvious.
    e. All of the above.

12. **Which of the following are significant employer concerns in various regions of the U.S.?**
    a. Lack of access in rural areas.
    b. Low EAP utilization.
    c. Aging, unhealthy, unionized work forces.
    d. Populations with high prevalence of specific disorders or cultural barriers to care.
    e. All of the above.