



Metrics and Outcomes Report

Schizophrenia and Approaches to Recovery

neuroscienceCME Snack

December 13, 2012 – December 13, 2013

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Report Executive Summary

Clinicians find new “optimism” in developing multimodal schizophrenia treatment plans with a goal of “recovery” that does not indicate “failure” when the expected relapse of schizophrenia occurs.

This neuroscienceCME Snack™ activity addressed suboptimal attitudes toward schizophrenia care among clinicians in the Chair Summit target audience, first by reinforcing education from the live meeting for Chair Summit participants and second by extending access to Chair Summit experts on *recovery* as the goal in schizophrenia for clinicians who had not attended the meeting. It also reinforces content from a related Snack activity on improving antipsychotic medication adherence in patients with schizophrenia¹. Level 5 outcomes data reported here were gathered from clinicians (MD/DO/PA/NP) who provide direct patient care for patients with schizophrenia.

Specifically, the activity discusses the operationalized criteria for symptomatic remission for schizophrenia by the Remission in Schizophrenia Working Group (RSWG)¹ and the more recent shift in thinking from remission to the more complex and difficult-to-attain concept of recovery, which includes improved measures of social and occupational functional outcomes, quality of life, and cognitive status.² Content addressed gaps in clinicians’ abilities to work as partners with patients toward a goal of *response, remission, and recovery ... the “three Rs” of schizophrenia treatment*. Overall educational effectiveness, as documented by the findings below, is shown by this clinician’s statement after participating: “Comments on clinician attitude [were] especially helpful”; this clinician also found that the most important information learned from this activity was its “new definition of recovery,” and followed this by a request for future education on “addressing negative symptoms” in schizophrenia.

Top Findings

Achieving this learning objective requires attitudinal change for many clinicians, as documented in the pre-activity needs assessment: “Implement a treatment program that has recovery as a treatment goal for patients with schizophrenia ... a recovery that involves a stepwise progression from response to remission, and then to recovery.” Therefore, to focus clinicians’ attention on the underlying attitudinal change of this objective, this Snack activity called for a specific commitment:

“I commit to including in treatment planning a goal of recovery in at least 40% of the patients with schizophrenia whom I see in the next three months.”

This commitment seeks the ideal outcome for clinicians to work for the goal of recovery in 100% of their patients, while it recognizes that these types of changes typically happen over time and in small increments. Therefore, the initial commitment sought was a 40% increase.

Just after participating in the activity, commitments were strong, at 89.6% (n = 115), but the realities of maintaining this commitment over the course of the outcomes plan year challenged responding clinicians (n = 27) who saw patients with schizophrenia in the previous three months:

- 42.9% of clinicians had included a goal of schizophrenia recovery in treatment planning with *most to all (81% – 100%) of their patients*.
- Another 14.3% planned treatment to achieve recovery in about two third to three quarters (61% – 100%) of their patients.
- The remaining 42.9% seemed to be at a loss for incorporating the goal of recovery into treatment-planning, stating that they had done so with just 1% – 20% of their patients.

¹ Andreasen NC, Carpenter WT Jr, Kane JM, Lasser RA, Marder SR, Weinberger DR. Remission in schizophrenia: proposed criteria and rationale for consensus. *Am J Psychiatry*. 2005;162(3):441-449. PMID: 15741458.

² Emsley R, Chiliza B, Asmal L, Lehloeny K. The concepts of remission and recovery in schizophrenia. *Curr Opin Psychiatry*. 2011;24(2):114-121. PMID: 21285703.

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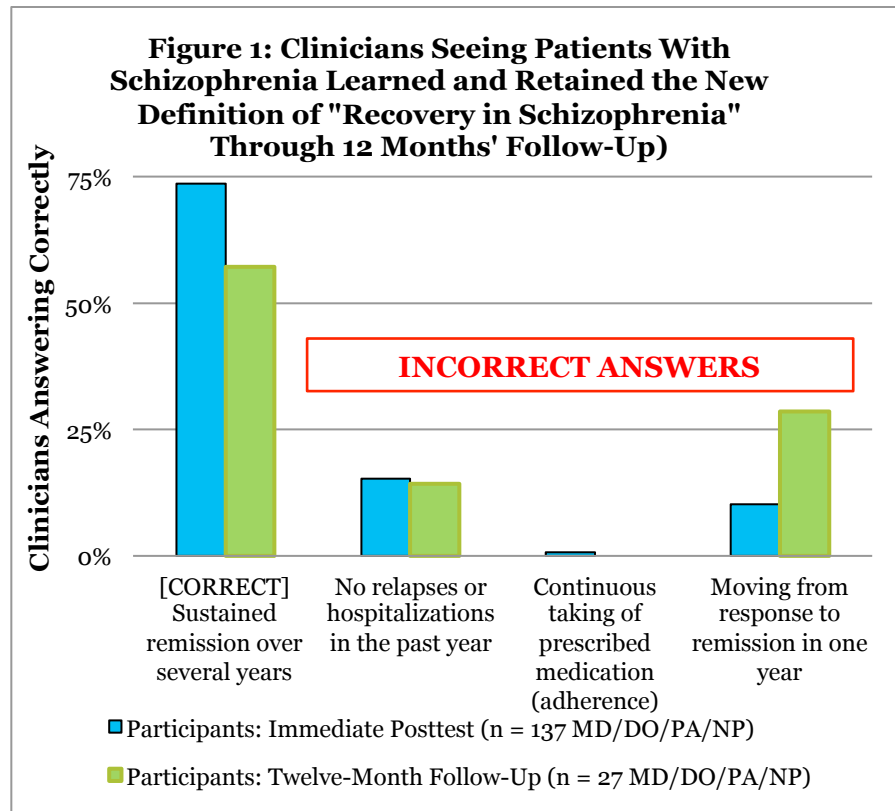
Even with improved “optimism,” considering the difficulty of moving an improved attitude into practice for challenging illnesses like schizophrenia, we should look at the self-rated competence levels that clinicians chose upon registering for the activity: 68.2% of participating clinicians rated their competence in managing schizophrenia as high (or “7” to “10” on a 10-point Likert scale), and another 23.4% estimated moderate competence. And yet, showing that additional reinforcement of attitudinal change is still needed, data gathered in the final outcomes survey one year later had 100.0% of responding clinicians rating their competence as very high: 85.7% of clinicians chose “8” in this follow-up survey, and 14.3% chose “9” (n = 27).

[illegible]

When surveyed up to one year later, clinicians (n = 27) provided clinical examples in which they planned treatment in a way that sought recovery from schizophrenia, including these:

- Matching response to medication
- We assisted the patient with access to appointment by providing an advocate who would call, or visit the patient
- Considered ACT team placement, family involvement, vocational rehab/school
- Address noncompliance and emphasize continuity of care

These patient scenarios show that participants were addressing the *whole* patient's needs through combination therapy, monitoring of adherence, team-based care, therapy adjustment according to treatment response, and family, with a long-term approach to increase the duration of response without relapse. This wholesome model to achieving recovery rests on the foundation that relapse is an expected component of the illness that does not indicate failure to provide care.



Knowledge test data give us another layer of insight into these improved attitudes and practice behaviors to promote recovery in schizophrenia. As shown in Figure 2 (below), clinicians finishing the immediate post-test had knowledge of both (1) treatment strategies they needed about treating to *recovery* and (2) definitions of what “relapse” and “remission” mean in terms of “recovery”: scores on these questions were greater than 90% correct. Despite this operational knowledge, they stopped short of the high benchmark that defines “recovery” (see also Figure 2).

Looking into this more closely, Figure 1 (green bar, n = 27) shows that clinicians who had correctly understood this new definition of recovery then retained their knowledge through one year after participation—more importantly, they correctly defined recovery as “sustained remission over several years” and *not* in terms of the very “relapse” that they learned is an expected part of the illness. Still, additional reinforcement is needed on the concept that moving from response to remission in one year is not sufficient for saying that a patient has achieved “recovery.”

Clinicians (MD/DO/PA/NP) Learn About Treatment Strategies for Achieving Recovery in Schizophrenia, But the New Definition of Recovery Needs Reinforcement (vs. Relapse Count and Remission)

Post-Test Question and Correct Answer

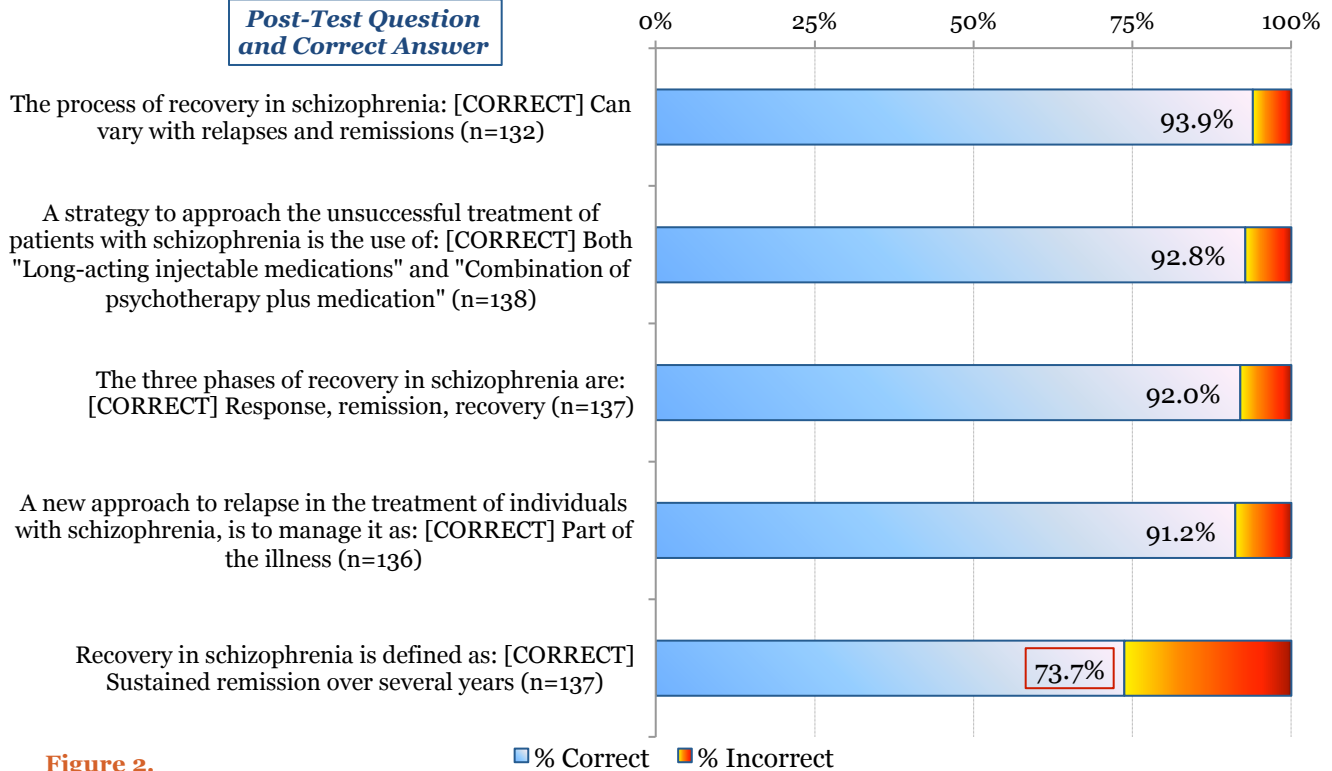


Figure 2.

Educational Activity Impact

Clinicians in the Chair Summit target audience grappled with the new and demanding benchmark of treating schizophrenia with the goal of “recovery.” About three quarters of participating clinicians learned and mastered this concept, retaining functional use of this new definition as “sustained remission over several years” through educational outcomes assessment at one year. Nearly all clinicians could define how the expected relapses of schizophrenia did and did not affect their clinical success with treating this challenging disease. This success and the advanced models of recovery presented by faculty produced new attitudinal competence and even “optimism” among clinicians answering immediate and long-term outcomes surveys.

The self-assessed gaps identified in the pre-activity survey was addressed by the activity, as evidenced by (1) the word cloud of “most important information learned” statements gathered just after the activity and (2) patient scenarios and practice changes that participants described in one-year outcomes surveying. These clinicians are ready for in-depth education on specific cases, negative and cognitive symptoms, and maintaining adherence for a longer duration of “well” periods between relapses that they now allow as an expected component of the illness and not a failure.

Informing Future Educational Needs

More work needs to be done, to solidify the new definition and goal of recovery in schizophrenia: most clinicians could operationalize the definition, appreciate the new model, apply depot medication and adjunctive psychotherapy strategies to achieving it, and not let “relapse” indicate a “failure” on their part. Yet despite these successes, one quarter of participating clinicians could not operationalize the definition of “recovery” for their patients. Continuing education to reinforce gains made in introducing a new clinical concept, paired with education on clinicians’ requests for treating the whole patient (see below), will help clinicians developing treatment plans for patients with schizophrenia consider more

angles for functional status improvement and social/work successes for real recovery, not just symptomatic remission.

Illustrating the benefits of serialized, reinforcing education at the live Chair Summit meeting and the two related neuroscience CME Snacks on psychosis, one clinician asked for future education on “helping patients to accept depot medication as a treatment strategy,” and another said that a top practice message was to “treat adherence as part of illness.” Other requests for future education included the following: “an update on depot neuroleptics and more information on cognitive treatments for schizophrenia”; “if clozapine refused, other psychopharm[acological] strategies for schizophrenia that is not entering remission”; “addressing negative symptoms”; “more details about cognitive remediation”; several items regarding drug therapy, interactions, and dosing; and care for special populations, regarding “injectable meds for pregnant women,” “late onset schizophrenia,” and “childhood schizophrenia.”

Voice of the Patient

This activity led clinicians to consider negative symptoms that affect patients’ quality of life and achievement of *recovery* in schizophrenia—and they requested additional CME to address this educational need. If the goals of both, related CME Snack activities become part of routine clinical attitudes *and* behaviors toward schizophrenia, early treatment with good medication adherence to prevent relapse and support recovery from schizophrenia will improve patient outcomes.

Activity Information and Participant Demographics

Activity Title: Schizophrenia and Approaches to Recovery

Activity Target Audience: Physicians, pharmacists, and other health care professionals who manage patients with a diagnosis of schizophrenia

Activity Dates: December 13, 2012 – December 13, 2013

Faculty: S. Charles Schulz, MD, and John Lauriello, MD

Learning Objective:

- Implement a treatment program that has recovery as a treatment goal for patients with schizophrenia ... a recovery that involves a stepwise progression from response to remission, and then to recovery.

Attendance Information:

	Estimated Attendance	Attendance
Enduring Activity Participation	2,000	3,087
Total Credit Requests	N/A	277

Learner Demographics:

	Responses (n)
Average years in practice	14 years (n = 277)
Average number of patients seen per month with schizophrenia	11-15 (n = 277)
Practice setting	Small-group practice (5%) Large-group practice (10%) Hospital (53%) Solo practice (22%) Managed Care (10%)

Participant Evaluation Data and Feedback

The following information represents a compilation of data collected via all participant evaluations at the conclusion of the activity as well as data regarding learners' initial commitment-to-change (CTC) based on the content presented. CTC statements are designed based on activity learning objectives and impact the design of the six-week and six-month surveys.

Question	Percentage of Overall Learners	n Value
The activity presentation met that stated learning objectives. (Likert scale: 1 = strongly disagree to 5 = strongly agree)	89% (# responding 3-5)	277
Do you feel the activity was balanced and objective? (Yes/No response)	96% (# responding Yes)	277
Do you feel the activity was free of commercial bias? (Yes/No response)	96% (# responding Yes)	277
Do you feel you have benefited from the information received in this activity? (Yes/No response)	89% (# responding Yes)	277
Do you feel your patients will benefit from the information received in this activity? (Yes/No response)	88% (# responding Yes)	277
Commitment-to-Change Question	Percentage of Overall Learners	n Value
Will you include in treatment planning a goal of recovery in at least 40% of your patients with schizophrenia whom you see in the next three months?	89% (# responding Yes)	277

Sample of participant comments:

- Comments related to clinician attitude hit home and were especially helpful.
- Excellent activity.
- Excellent discussion of importance of cognitive rehabilitation and psychotherapy approaches balanced by concerns of moving patients to these programs.
- Excellent learning material.
- Good presentation.
- I feel like this activity has helped me to better understand schizophrenia and how to treat and help my patients.
- It is as lively as one might hope. I have no criticism.
- Nice learning format.
- Very good presentation. It provoked thoughtful approaches to managing this disorder.