Schizophrenia and Approaches to Recovery

neuroscienceCME Snack

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Designed, Analyzed and Prepared By: CME Outfitters, LLC
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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 neuroscience CME 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.

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• Among those clinicians who had difficulty implementing this improved attitude to treatment-planning:
  o Reasons cited were patient-, practice-, or system-related barriers, and the other claimed additional educational need.
  o None claimed “disagreement” with this approach or a lack of “feeling confident” as underlying reasons for these difficulties.

With a new definition of optimal care—seeking recovery—it is not surprising that achievement of the performance measure proved difficult even among clinicians who felt generally competent in managing schizophrenia. One clinician seemed to identify the most important information learned as a kind of permission, or acquiescence, to “accept relapses as part of the illness,” as though this realization allowed a move forward to better care without blame. Several others echoed this sentiment, one naming relapse “not a treatment failure but part of the illness,” and two cited “optimism” as a top take-away message for their practice.

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).

Before participating in the online activity, clinicians listed these and other practice gaps in managing schizophrenia: matching the antipsychotic to the particular response of the patient; treatment of resistant positive and negative symptoms; history of symptom evolution, functional decline, and medication trial; and brief stabilization, noncompliance, and the need for family therapy. The word cloud reflects the 75 most frequent words and phrases that MD/DO/PA/NP learners shared as open-ended “most important information learned” responses related to the concept of treating schizophrenia with a goal of recovery rather than remission, after they participated in the online neuroscienceCME Snack activity.

This word cloud shows that clinicians had embraced new concepts, definitions, and models of care that sought both remission and recovery in schizophrenia—using long-acting/depot formulations and combination/multimodal therapies—with treatment-adjustments earlier if a lack of response was seen. Clinicians had less tolerance for incomplete resolution of positive symptoms, greater interest in cognitive and negative symptoms, and greater optimism as they saw relapse as a part of the illness and not a clinical failure.
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.”
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


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:

<table>
<thead>
<tr>
<th></th>
<th>Estimated Attendance</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enduring Activity Participation</td>
<td>2,000</td>
<td>3,087</td>
</tr>
<tr>
<td>Total Credit Requests</td>
<td>N/A</td>
<td>277</td>
</tr>
</tbody>
</table>

Learner Demographics:

<table>
<thead>
<tr>
<th>Response</th>
<th>Responses (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average years in practice</td>
<td>14 years (n = 277)</td>
</tr>
<tr>
<td>Average number of patients seen per month with schizophrenia</td>
<td>11-15 (n = 277)</td>
</tr>
<tr>
<td>Practice setting</td>
<td>Small-group practice (5%)</td>
</tr>
<tr>
<td></td>
<td>Large-group practice (10%)</td>
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<tr>
<td></td>
<td>Hospital (53%)</td>
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<tr>
<td></td>
<td>Solo practice (22%)</td>
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<td></td>
<td>Managed Care (10%)</td>
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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.

<table>
<thead>
<tr>
<th>Question</th>
<th>Percentage of Overall Learners</th>
<th>n Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>The activity presentation met that stated learning objectives. (Likert scale: 1 = strongly disagree to 5 = strongly agree)</td>
<td>89% (# responding 3-5)</td>
<td>277</td>
</tr>
<tr>
<td>Do you feel the activity was balanced and objective? (Yes/No response)</td>
<td>96% (# responding Yes)</td>
<td>277</td>
</tr>
<tr>
<td>Do you feel the activity was free of commercial bias? (Yes/No response)</td>
<td>96% (# responding Yes)</td>
<td>277</td>
</tr>
<tr>
<td>Do you feel you have benefited from the information received in this activity? (Yes/No response)</td>
<td>89% (# responding Yes)</td>
<td>277</td>
</tr>
<tr>
<td>Do you feel your patients will benefit from the information received in this activity? (Yes/No response)</td>
<td>88% (# responding Yes)</td>
<td>277</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Commitment-to-Change Question</th>
<th>Percentage of Overall Learners</th>
<th>n Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>89% (# responding Yes)</td>
<td>277</td>
</tr>
</tbody>
</table>

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.