

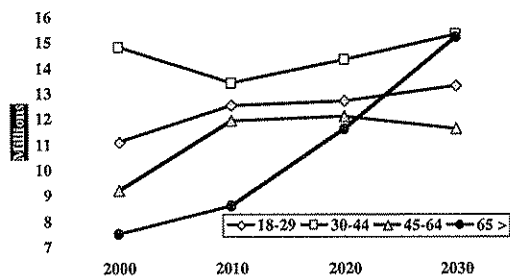
Integration of Mental Health and Primary Health Care for the Older Patient

Stephen J. Bartels, M.D., M.S.
 Professor of Psychiatry and Community and Family Medicine
 Co-Director Dartmouth Center on Aging

Overview

- **Background: Mental Health, Primary Care, and the Older Patient**
- **Outcomes: Integration of Mental Health Services in Primary Care and the Older Patient**
- **Policy Implications for The President's Commission on Mental Health**

Estimated Prevalence of Major Psychiatric Disorders by Age Group



Prevalence of Depression and Other Disorders in Primary Care

Study	Major Depression	All Depression	All Disorders
Hoepfer et al.	5.8%	19.9%	26.7%
Schulberg et al.	----	9.2%	30.3%
Von Korff et al.	5.0%	8.7%	26.5%
Barrett et al.	0.4%	10.0%	26.4%
Coyne et al.	13.5%	22.0%	----
ECA (highest)	3.5% (6mo)	6.5% (6mo)	8.8% (2wk)

Depression Associated with Worse Health Outcomes

- **Worse outcomes**
 - Hip fractures
 - Myocardial infarction
 - Cancer (Mossey 1990; Penninx et al. 2001; Evans 1999)
- **Increased mortality rates**
 - Myocardial Infarction (Frasure-Smith 1993, 1995)
 - Long term Care Residents (Katz 1989, Rovner 1991, Parnelce 1992; Asliby 1991; Shah 1993, Samuels 1997)

Suicide and the Older Patient

- **Older adults: Highest risk of suicide of any age group**
- **70% of elderly completing suicide have seen their primary care physician in the prior month, 40% prior week, 20% same day (Conwell et al., 1994)**
- **Screening all primary care patients impractical... But identification of higher risk patients important**

Primary Care Elderly with Depression, Anxiety, or At-risk Alcohol Use

- 27.5% Report Death Ideation
- 10.5% Report Active Suicidal Ideation
- Greatest Suicidal Ideation: Depression with Anxiety (18%), Poor Social Support
- Suicidal Ideation NOT associated with increased visits to the PCP

Bartels et al., Am J Geriatric Psychiatry 2002, 10:417-427

Quality of Mental Health, Care and the Older Patient

- Fragmentation of the Mental Health service delivery system for older persons
- Primary Care as the “de facto” mental health system of care for the older person

Quality of Mental Health Care for Older Primary Care Patients

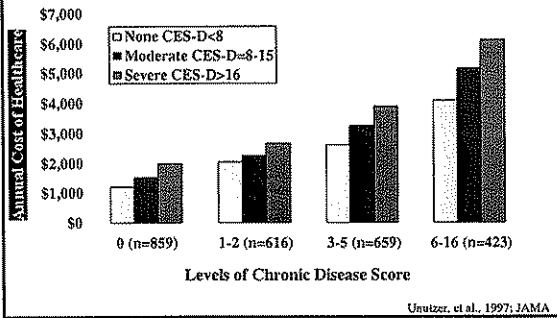
The older primary care patient with depression compared to younger:

- More likely to receive benzodiazepines
- Less likely to receive SSRIs
- Less likely to receive psychotherapy

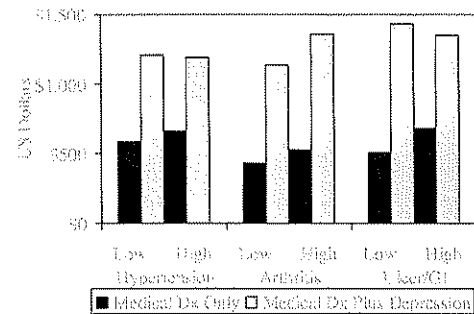
Bartels et al., International J. Psychiatry in Medicine 27 (3):215-231, 1997.

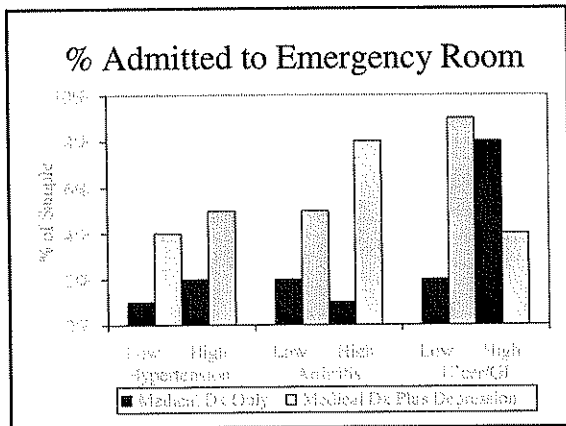
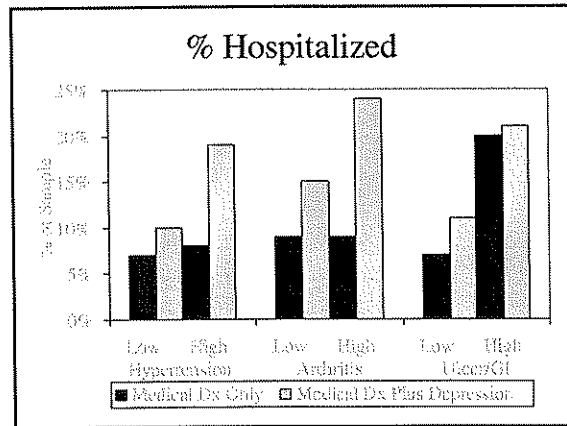
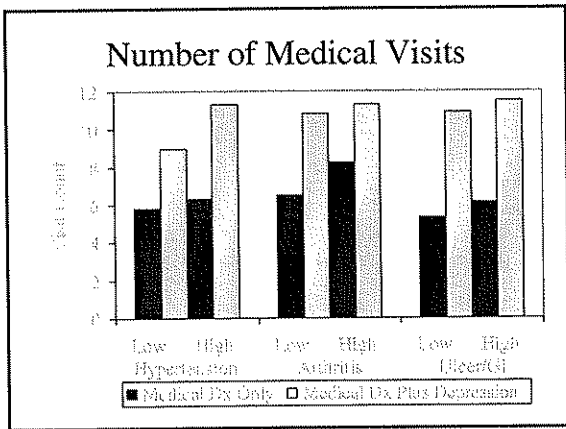
Health Service Use and Costs Associated with Depression for Older Primary Care Patients

Cost of Outpatient Services in Depression



Cost of Prescriptions





Depression as a Costly Chronic Disease

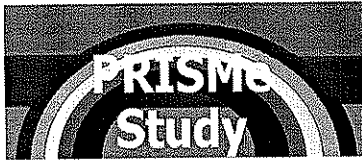
Individuals with these 5 conditions account for 49% of total health care costs, 42% of illness-related lost wages

	Health Care Costs (per capita/total)	Work Loss Costs For Individuals with Condition	Health care and Total Costs for Individuals with Condition
Mood Disorders	3	1	2
Diabetes	4	3	3
Heart Disease	1	5	4
Hypertension	2	1	1
Asthma	5	4	5

- ### Summary of Findings
- Comorbid Depression in Medical Disorders Commonly Affecting Older Patients
 - Greater Use and Costs of Medications
 - Greater Use of Health Services (medical outpatient visits, emergency visits, and hospitalizations)

The Research Question:

What is the Most Effective Way to Organize and Deliver Mental Health Services to Older Persons in Primary Care Settings?



Primary Care Research in Substance Abuse and Mental Health for the Elderly



A Comparison of Two Service Models

- Integrated/Collaborative Care
 - Co-Located
 - Concurrent
 - Collaborative
- Enhanced Referral to Specialty Mental Health and Substance Abuse Clinics
 - Preferred Providers and Facilitated appointments, transportation, payment

Primary Hypotheses

- Engagement Hypothesis
- Participation Hypothesis
- Outcomes Hypothesis
- Cost Hypothesis

Is the Integrated Model More Likely to Result in Engagement in Mental Health Care by Older Persons?

STUDY TARGET CONDITIONS

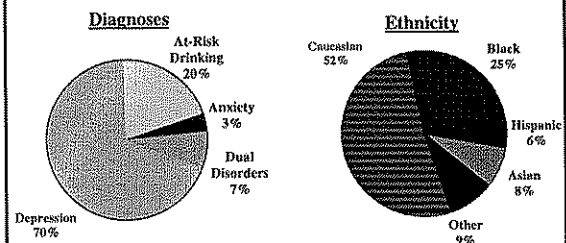
- Major Depression
- Dysthymic Disorder
- Minor Depression
- Depressive Disorder NOS

- Generalized Anxiety Disorder (GAD)
- Panic Disorder
- Anxiety Disorder NOS

- At-risk Alcohol Use

Sample Characteristics (n=2022)

Mean Age: 73.5 ± 6.2
26% Female

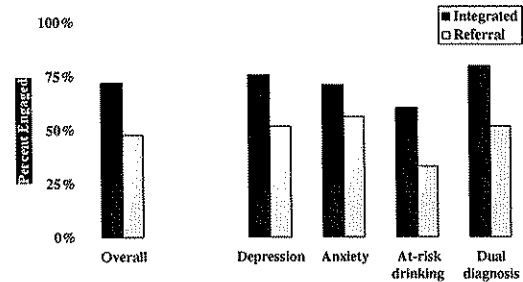


Overall Engagement by Model

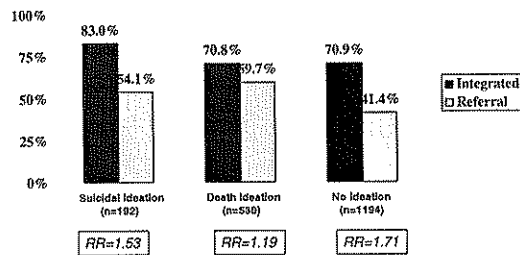
- **Integrated:** 71% (709/999)
- **Referral:** 49% (499/1023)
- **Relative Risk:** 1.45

RR = % engaged integrated / % engaged referral

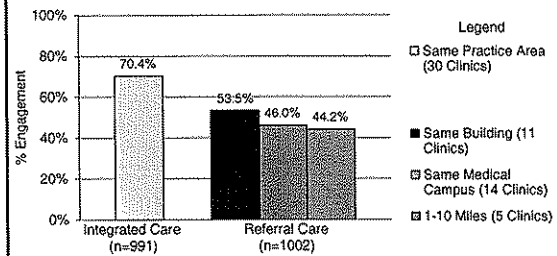
Rates of Engagement in MHSA Care: By Diagnosis/Condition



Rates of Engagement in MHSA Care: By Level of Suicidal Ideation



Physical Proximity between Primary Care Clinic and MH/SA Clinic



*Rates of engagement are significantly different across all four practice arrangements for the total sample ($\chi^2(3)=103.15, p<.001$) and across the three referral practice arrangements ($\chi^2(2)=7.76, p=.02$).

Bartels et al., American Journal of Psychiatry, 161:1455-1462, 2004.

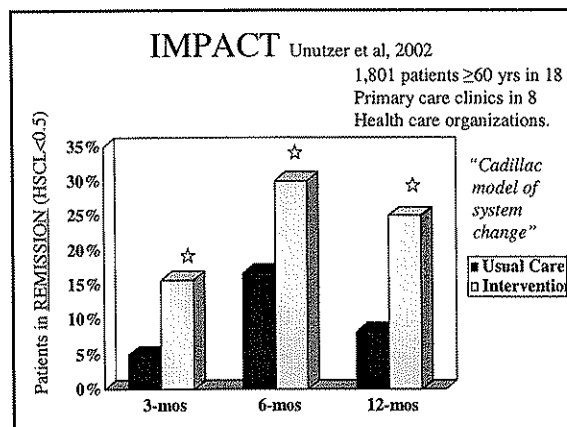
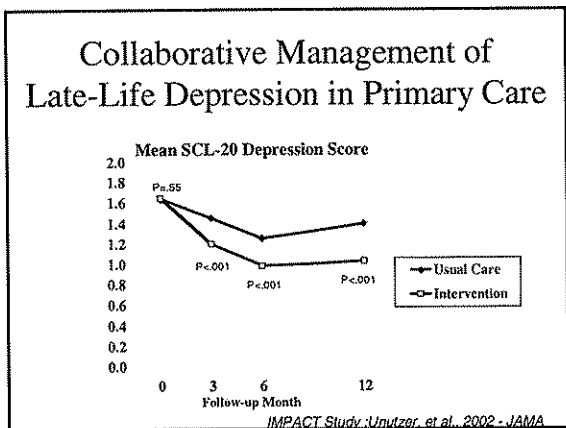
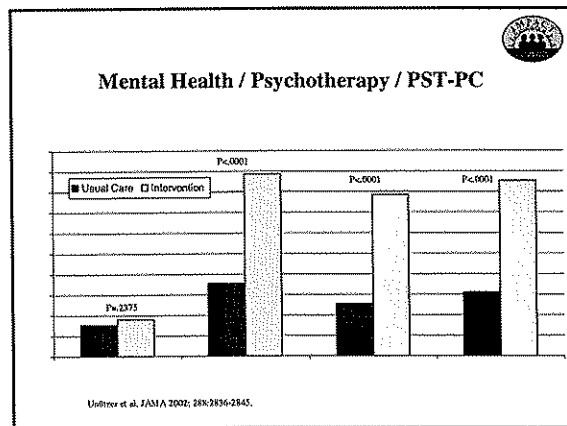
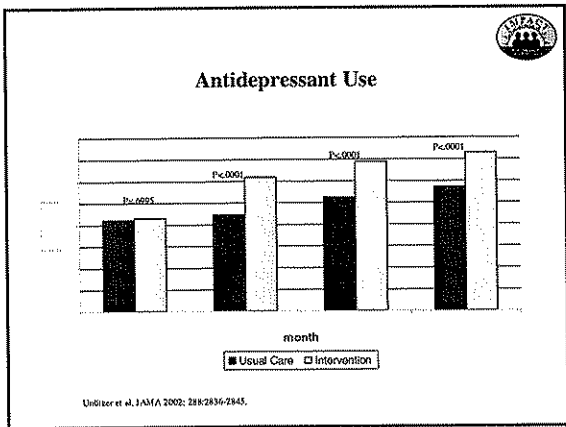
Outcomes

- **Integrated Care (compared to specialty referral) Associated with Greater Engagement in Treatment**
.....Similar Outcomes (*slightly* better for major depression in specialty referral)
- **Are Integrated Services with Depression Care Management (including use of specified treatment protocols) Better than Usual Care?**
 - IMPACT (Hartford Foundation)
 - PROSPECT (NIMH)

The IMPACT Treatment Model

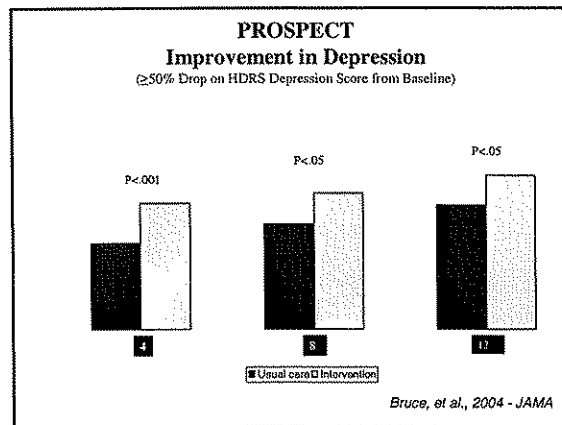


- Collaborative care model includes:
 - Care manager: Depression Clinical Specialist
 - Patient education
 - Symptom and Side effect tracking
 - Brief, structured psychotherapy: PST-PC
 - Consultation / weekly supervision meetings with
 - Primary care physician
 - Team psychiatrist
- Stepped protocol in primary care using antidepressant medications and / or 6-8 sessions of psychotherapy (PST-PC)



PROSPECT

- USUAL CARE vs. INTERVENTION:
- Clinical Algorithm for Geriatric Depression Consisting of Citalopram or IPT (based on patient preference)
- Depression Care Manager: Social Workers, Nurses, Psychologists in Primary Care: Depression recognition, guideline based treatment, monitoring of response to treatment, follow-up



PROSPECT Depression Specialist with Treatment Algorithm

- Practices with Depression Specialist Using Treatment Algorithm for Depression had Greater Reduction in Depression Compared to Usual Care Practices
- However, Better Outcomes Only For Major Depression, Not for Minor Depression

Bruce, et al., 2004 - JAMA

Conclusions: Integrated Mental Health Services in Primary Care

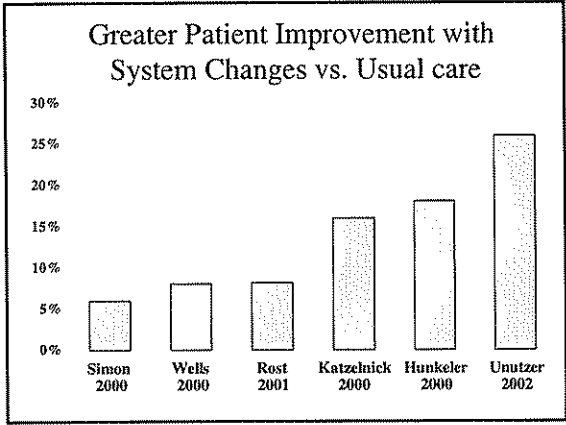
- Better engagementsimilar outcomes compared to referral care (perhaps slightly less effective for major depression)
- Better engagement and outcomes compared to usual care.....especially with care management, standardized screening and outcome tracking, and treatment protocols

Summary of 1st & 2nd Generation Studies

- Multiple component interventions
- Lectures &/or distributing guidelines do not change behavior nor outcomes
- Adding patient tracking with a care manager significantly improves outcomes
- Including a mental health specialist in an integrated treating or consulting role improves outcomes the most

Effectiveness Studies of Depression in Primary Care

	Tx Guidelines	Case Mgmt Screening	Patient Ed.	Physician Ed.	Tracking Systems	Tx Coord.	MH Spec.	Effective
Schulberg	+	+	+	+	+	+	++++	Yes
Mynors-Wallis	+	+	+	+	+	+	+++	Yes
Katon	+	+	+	+	+	+	++	Yes
Katzelnick	+	+	+	+	+	+	++	Yes
Rost	+	+	+	+	+	+	+/-	Yes
Hunkeler	+	+	+	+	+	+	+/-	Yes
Simon	+	+	+	+	+	-	-	Yes
Simon	+	+	+	+	+	-	-	No
Callahan	+	+	+	+	-	-	-	No
Goldberg	+	+	+	-	-	-	-	No
Dowrick	+	+	-	-	-	-	-	No

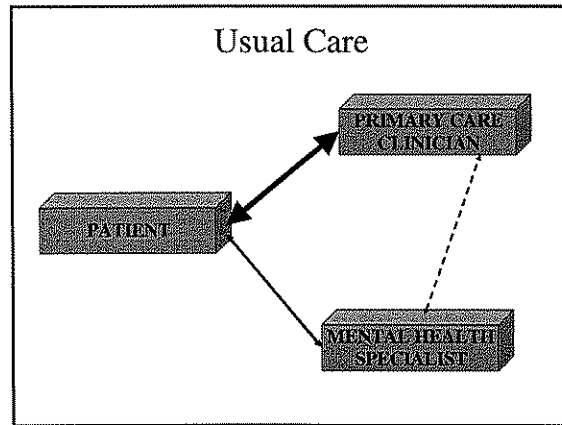
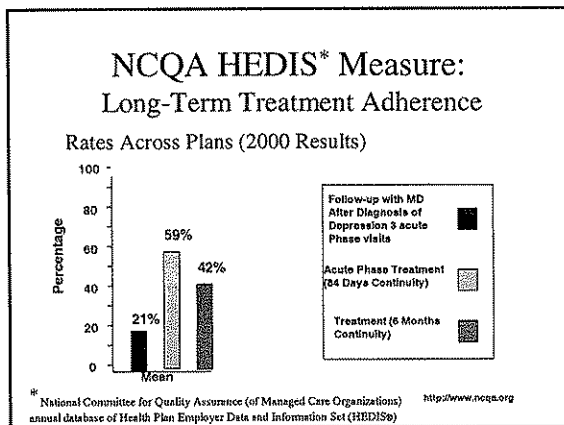
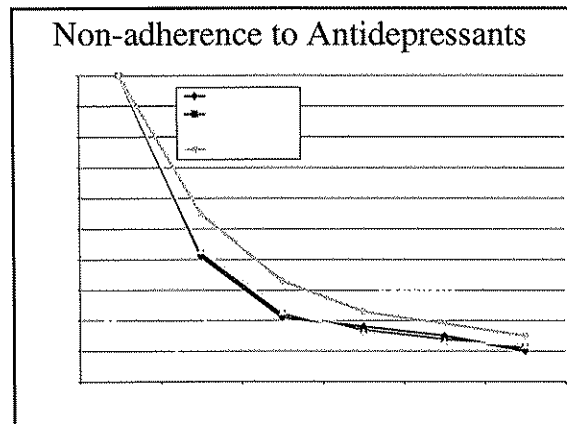
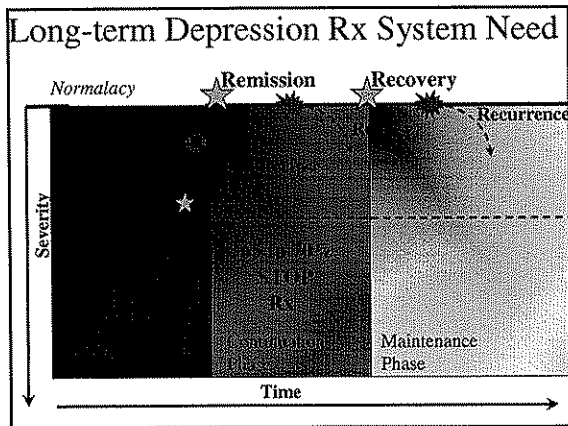
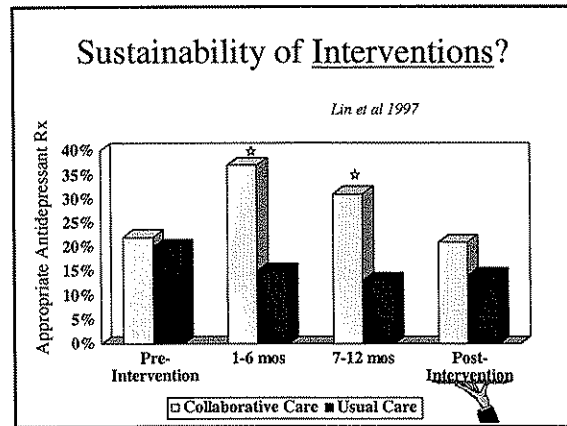


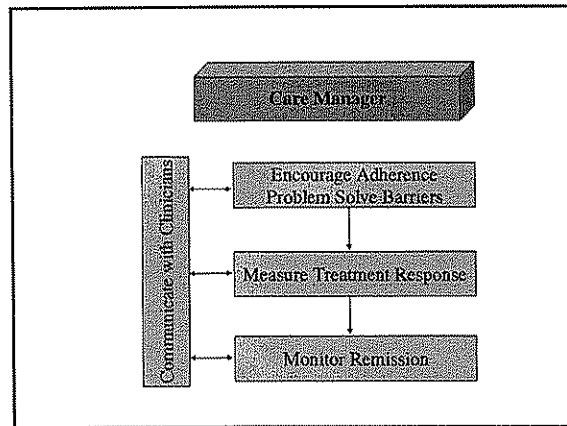
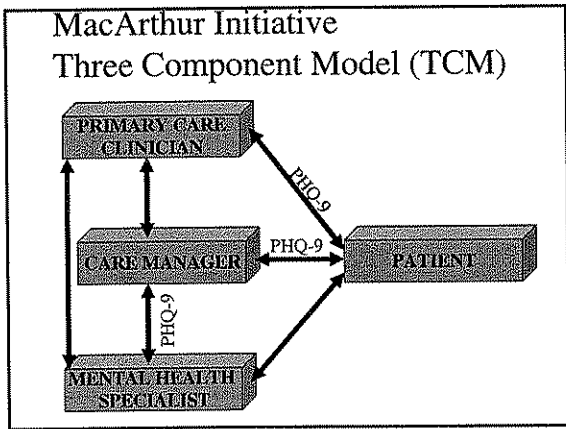
Summary of 1st & 2nd Generation Studies

- Multiple component interventions
- Lectures &/or distributing guidelines do not change behavior nor outcomes
- Adding patient tracking with a care manager significantly improves outcomes
- Including a mental health specialist in an integrated treating or consulting role improves outcomes the most

3rd Generation Depression System Change Interventions

	IMPACT	RESPECT	PRISM	PROSPECT
Change	Depression Specialist	TCM	Integrated Mental health	Depression Specialist
Care Mgmt	On-site	Off-site	N/A	On-site
Patient Education	Yes	Yes	Variable	Yes
Psychiatric supervision	Face to face	Telephone	N/A	Face to face
Psychotherapy supervision	Telephone	N/A	N/A	Face to face
Rx algorithm	Yes	No	No	Yes





Two Question Screen U.S. Preventive Services Task Force *Ann Intern Med* 2002;136:760-4

Over the past 2 weeks, have you:

- Felt little interest or pleasure in doing things?
- Felt down, depressed, or hopeless?

PHQ-9

Spitzer R, et al. *Validation and utility of a self-report version of PRIME-MD: the PHQ Primary Care Study.* *JAMA* 1999; 282: 1737-1744

Kroenke K, et al. *The PHQ-9: validity of a brief depression severity measure.* *Journal of General Internal Medicine* 2001; 16: 606-613

Sensitivity = 73%

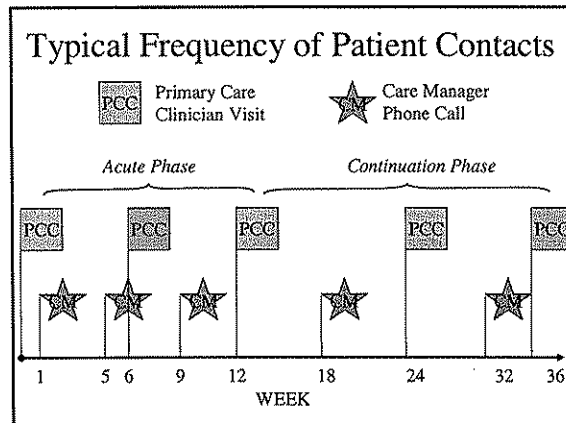
Specificity = 94%

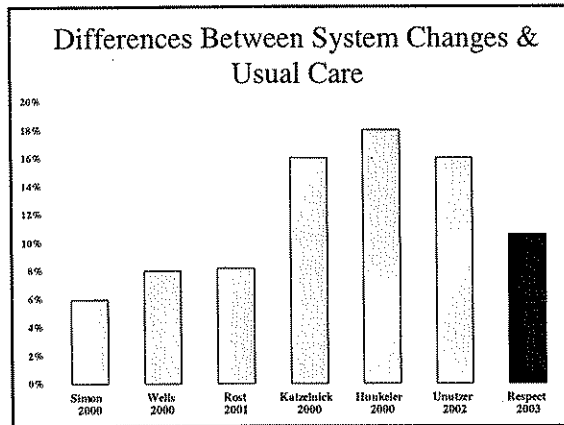
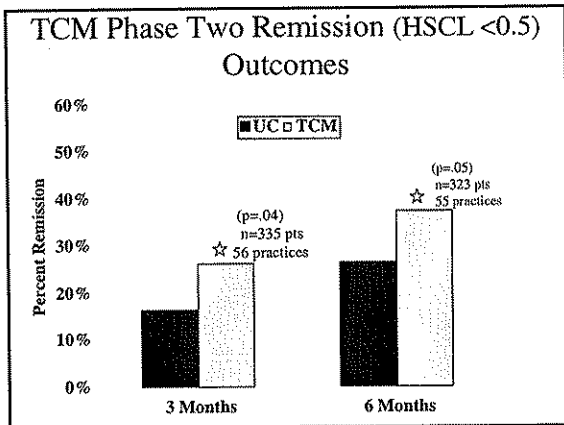
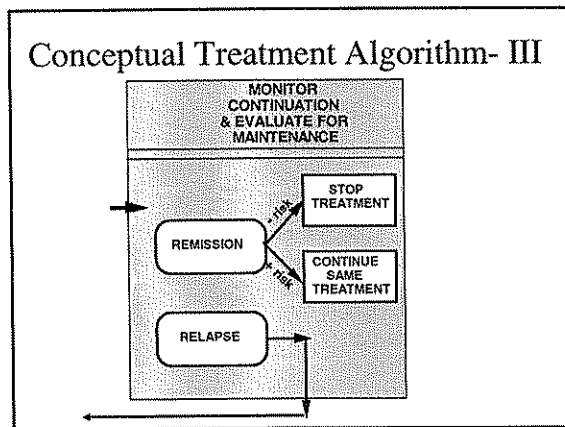
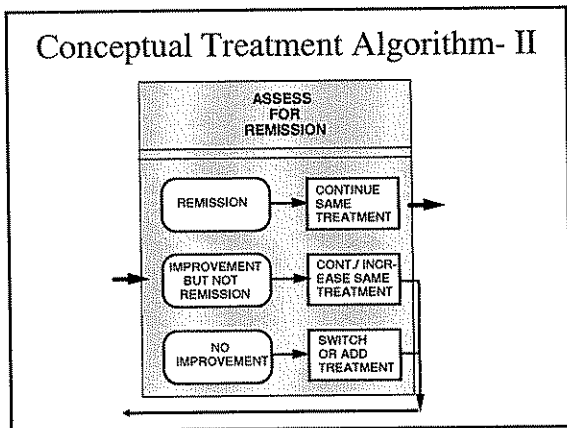
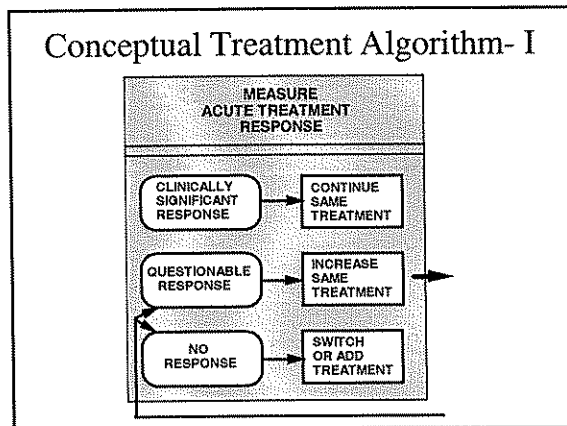
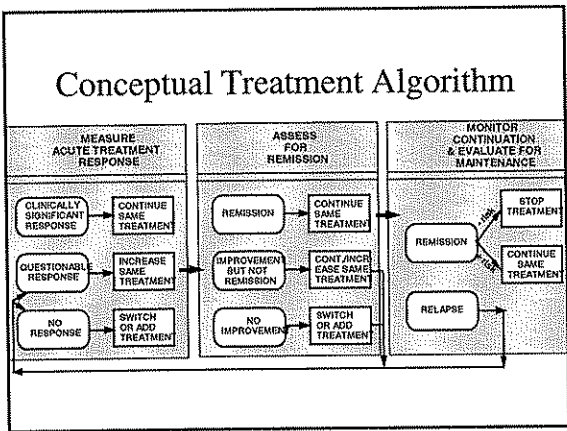
Correlation between PHQ self-report and psychiatrist interview = .84

PHQ - 9 Symptom Checklist

1. Over the last two weeks have you been bothered by the following problems?


	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself, or that you are a failure ...	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading ...	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly ...	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead ...	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. ... how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				
Subtotals:		4	6	6
TOTAL:		16		






3rd Generation Depression System Change Interventions				
	IMPACT	RESPECT	PRISM	PROSPECT
Change	Depression Specialist	TCM	Integrated Mental health	Depression Specialist
Care Mgmt	On-site	Off-site	N/A	On-site
Patient Education	Yes	Yes	Variable	Yes
Psychiatric supervision	Face to face	Telephone	N/A	Face to face
Psychotherapy supervision	Telephone	N/A	N/A	Face to face
Rx algorithm	Yes	No	No	Yes

Implications for Applied Policy and Practice



Leon Eisenberg
 The NEW ENGLAND JOURNAL of MEDICINE
SOUNDING BOARD
TREATING DEPRESSION AND ANXIETY IN PRIMARY CARE.
Closing the gap between knowledge and practice

N Engl J Med 1992; 326:1080-1084, Apr 16, 1992
7th Annual Rosalyn Carter Symposium on Mental Health Policy, Atlanta, Nov 21, 1991

- Depression is common in primary care, with substantial morbidity
- Under recognized - not because of curriculum, but values of patients and physicians, inappropriate DSM nosology
- Target physicians in practice, involve patient, more follow-up consider special nurses, improve payment - reward time, assess quality


PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH

- Subcommittee on Mental Health and Aging: Recommendations on Policy
- Subcommittee on the Mental Health Interface with General Medicine
- Integrating Mental Health and General Health Care
- Implementing Evidence-based Medicine


PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH

- “The Federal Government should add evidence-based collaborative care services for psychiatric disorders to the list of covered services through the Medicare National Coverage Process”

