Managing Mental Health Problems in the Primary Care Setting is a Team Sport

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Opportunities for Improvement

- Opportunities for improvement:
  1. Psychiatric assessment
  2. Adherence to antidepressant medications
  3. Medication adjustment based on depression outcomes
  4. Provision of evidence based psychotherapy
Topics for Today’s Discussion

1. What is the evidence supporting the need to address these problems
2. How can care be organized to address these problems
3. How cost effective are these options
4. What approaches are being implemented at Denver Health
Problem: Psychiatric Assessment
While we may look for depression other psychiatric disorders are also common and are usually not detected.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence in Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar Disorder</td>
<td>9.8% screen positive</td>
</tr>
<tr>
<td>Probable of alcohol abuse</td>
<td>4% - 7%</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>3.4% - 7%</td>
</tr>
</tbody>
</table>
Psychiatric Comorbidity

- 19.5% of Primary care patients have at least 1 anxiety disorder
  - 8.6% PTSD
  - 7.6% GAD
  - 6.8% Panic Disorder
  - 6.2% Social Anxiety Disorder

Each Disorder is associated with substantial impairment in functional and quality of life status

Kroenke K et al, Ann. Of Internal Med. 2007
Primary Care patients frequently have more than 1 mental health disorder

Hirschfeld R., Primary care companion J. of Psychiatry, 2001
Co-occurrence of Mental Disorders in Primary Care

- 26% - 29% of primary care patients meet full criteria for a mental health diagnosis.
- Among patients with a mental health diagnosis:
  - 56% have more than 1 disorder
  - 29% had 3 or more disorders
- 65% of patients with a mood disorder had 1 or more other mental disorders

Spitzer R., et al., JAMA 1994
<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Observed Adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP detection of depression</td>
<td>79%</td>
</tr>
<tr>
<td>Follow-up for patients newly started in antidepressant therapy</td>
<td>80%</td>
</tr>
<tr>
<td>PCP assessment of symptoms and depression history</td>
<td>34%</td>
</tr>
<tr>
<td>PCP suicide assessment</td>
<td>24%</td>
</tr>
<tr>
<td>PCP alcohol assessment</td>
<td>23%</td>
</tr>
</tbody>
</table>

Potential inappropriate use of antidepressants in primary care

- 159 Primary care patients
- 31% in Non-clinical range
- 20% Substance Abuse or Bipolar
- Only 43% appropriate for SSRI or anxiolytic
Problem: Adherence to Antidepressant Medications

- Observed Adherence to Indicators of Quality of Depression Care

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Observed Adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of Initial Treatment</td>
<td>46%</td>
</tr>
</tbody>
</table>

*At Denver Health >50% of patients stop taking antidepressant medications within 3 months*

Problem: Medication Adjustment based on Depression Outcomes

- Observed Adherence to Indicators of Quality of Depression Care

| Treatment adjustment for non responsive patients | 36% |

Problem: Provision of Evidence based Psychotherapy

Observed Adherence to Indicators of Quality of Depression Care

<table>
<thead>
<tr>
<th>Quality indicator</th>
<th>Observed Adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP referral to mental health specialist for suicidal ideation</td>
<td>36%</td>
</tr>
<tr>
<td>PCP referral to mental health specialist for patients still depressed at 6 months</td>
<td>30%</td>
</tr>
</tbody>
</table>

Hepner K et al Ann of Internal Med 2007
What type of mental health treatment do primary care patients want?

- **Counseling 62%**
  - Listen to me describe stress
  - Help me understand stress
  - Offer advice on how to deal with stress
  - Reassure me that I will improve
  - Discuss impact on health

- **Medication 23%**
  - To relax or feel happier

- **Referral 11%**
  - To mental health specialist

Team Based Strategies to Improve Mental Health Care in Primary Care

- Practice Reorganization Strategies
- Behavioral Health Integration Strategies
  - Consultative Care
  - Collaborative Care
  - Concurrent Care
- Co-location of mental and physical health providers
- Telephone Interventions
Practice Reorganization Strategies

- Physician and nurse training
- Systematic approach to assessment, treatment planning, and outcomes monitoring developed through QI process
- Involves expanded role of ancillary staff, tools, and clinical guidelines or algorithms
- Results in improved outcomes
- Costly to implement and difficult to sustain
Behavioral Health Integration Models: Consultative Care

- **MHS role**
  - Establish diagnoses
  - Plan treatment
  - Educate patient and PCP about how to carry out treatment
  - Respond to problems

- **PCP Care**
  - Identify mental health problem
  - Provide ongoing care

- **Methods of Communication**
  - email
  - phone
  - in person
Consultative Care - Example

- **Population**: patients with Somatoform Disorder
- **Intervention**: 1-2 consultation visits with a psychiatrist who provided management recommendations and guidelines vs. usual care
- **Results**: 53% reduction in average quarterly health care charges but no significant change in functional status or patient satisfaction

Behavioral Health Integration Models: Collaborative Care

- Patients receive mental health care from both MHS and PCPs in PC setting
  - Psychologists: 4 to 6 visits for cognitive behavioral skills and medication adherence, counseling, and outcomes monitoring
  - Psychiatrists: review outcomes and recommend medication changes
- PCPs:
  - Identify mental health problems
  - Review consultation notes
  - Prescribe medications and continue to follow patients

- Results in greater improvement in depression symptoms than usual care but difficult to maintain

Katon et al, J. of Arch of Psychiatry 1996
Behavioral Health Integration Models: Concurrent Care

- Patients seen in primary care setting by both PCP and MHS
  - PCP identifies mental health problem and refers patient to MHS
  - PCP reinforces need for continued care by MHS
  - MHS manages mental health problems
  - MHS helps PCP select tools and develop a system to identify and refer patients with mental health disorders
- Results in greater improvement in depression symptoms than usual care
Co-location of PCPs and MHS: Hamilton Ontario Canada

- MHS (therapists and psychiatrists) see patients in primary care practices at specified intervals ranging from several times per week to once every 3 weeks.
- All express great satisfaction with this program.
- PCPs indicated that program increased skills and comfort with handling mental health.
- Probably results in an increased number of patients receiving mental health care.
- Problems identified included finding space for MHS and scheduling difficulties.

Farrar S et al of Fam Psychiatry 2001
Outcomes

Utilization of ER and Inpatient Services by Marillac’s Integrated Care Patients

- Hospitalization
- E.R. Visit
Telephone Case Management

- Practice based or centralized intervention
- Series of telephone contacts by nurses or psychologists to provide:
  - emotional support
  - cognitive behavioral counseling
  - monitoring of adherence and outcomes
- Frequency of contacts 3 to 16 times
- Results in improved outcomes
Improvement in Mean Hopkins Symptom Checklist (HSCL) Depression Scale Scores by Treatment Assignment

Components of successful interventions

- Systematic approach to the recognition and assessment of depression
- Evidence based decision support
- Use of pamphlets and staff to promote patient education and activation
- Ongoing monitoring and feedback regarding patient adherence and outcomes
- Involvement of mental health specialists
## Cost - effectiveness analyses

<table>
<thead>
<tr>
<th>Type of intervention</th>
<th>Incremental costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice reorganization</td>
<td>$9,478 - $30,663 per additional depression free day</td>
</tr>
<tr>
<td>Collaborative care*</td>
<td>$35 per additional depression free days</td>
</tr>
<tr>
<td>Telephone case management</td>
<td>$23 per additional depression free days</td>
</tr>
<tr>
<td>Telephone Case Management + CBT</td>
<td>$9 per additional depression free day</td>
</tr>
</tbody>
</table>

* for treatment resistant patients

Simon GE et al. Arch of Gen Psych 2009
Denver Health Strategies

- Co-location of Physical and Behavioral Health Providers
- Telephonic Depression Intervention (TDI)
Co-Location of physical and behavioral health providers

- Role of behavioral health clinicians (BHCs)
  - Assessment
  - Triage and referral
  - Case management/community liaison
  - Outcomes and medication adherence monitoring
  - Short term psychotherapy
  - Substance abuse counseling
  - Crisis intervention
Co-location of physical and behavioral health providers

- Role of psychiatrist
  - Psychiatric evaluation
  - Medication review and recommendations
  - Consultation by phone or in person
  - PCP education
Co-location of physical and behavioral health providers

Process

- BHC assigned to each clinic
- PCPs refer patients to BHC
- BHC seek patients in clinic and works with patients over the phone
- BHC sees scheduled as well as non-scheduled patients
- BHC runs wellness, stress management +/- or depression groups in clinic
- PCPs meet with BHC and possibly psychiatrist weekly to update management recommendations
- Psychiatrist is available by phone to provide management recommendation to PCPs
- Psychiatrist is available to see PCP referrals in consultation clinic
Telephonic Depression Intervention (TDI) Goals

1. Perform more complete and accurate mental health assessment to identify:
   a. Patients who do not meet criteria for MDD (and antidepressants)
   b. Patients with undetected psychiatric comorbidity who might benefit from an alternate treatment

2. Improve adherence to antidepressant medications

3. Facilitate medication adjustment based on depression outcomes

4. Provide a brief evidence based psychotherapy

5. Improve depression outcomes
TDI Program: Methods

- **Primary Care patients who receive a new prescription for SSRI**
- **Patients identified by PCP referral or pharmacy data**

**Intervention**

- Up to 6 scripted telephone calls conducted by health psychology interns and PhD graduate students
- Patients receive self help materials and summaries of each call
- Providers receive treatment planning feedback
<table>
<thead>
<tr>
<th>Phone Calls</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 5</th>
<th>Week 7</th>
<th>Week 9</th>
<th>Week 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic assessment</td>
<td>Full</td>
<td>PHQ9</td>
<td>PHQ9</td>
<td>PHQ9</td>
<td>PHQ9</td>
<td>PHQ9</td>
</tr>
<tr>
<td>Medication adherence</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Behavioral activation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing self care plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patients receive copy of depression coping plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providers receive reports</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
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</table>
Initial Antidepressant Medication Management Report

As part of the Mental Health Work Group Depression Intervention Pilot Project I performed a diagnostic assessment of your patient ____________, medical record # ____________. The results of this evaluation are as follows:

PHQ9 score ______

No depression
Mild depression
Moderate depression
Moderately severe depression
Severe depression

Identified psychiatric comorbidity

Bipolar
Post Traumatic Stress Disorder
Panic Disorder
Psychosis
Substance Abuse

We would appreciate it if you would consider the following management recommendations which are based on protocols developed by the Mental Health Work Group in collaboration with the Department of Psychiatry.

Depression Treatment: ____________________________
Treatment of Psychiatric Comorbidity ____________________________
Followup ____________________________

We plan to repeat the PHQ9 at the following intervals:

6 weeks
3 months
6 months

We will provide additional feedback after each assessment. Please feel free to contact me at (e-mail) ________ or (pager/phone#) ____________ if you have any questions about this assessment or report.
### TDI PROGRAM: DATA

- Depression severity at initial assessment

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal (PHQ9 &lt; 5)</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>Mild (PHQ9 5-9)</td>
<td>7</td>
<td>18%</td>
</tr>
<tr>
<td>Moderate (PHQ9 10-14)</td>
<td>11</td>
<td>29%</td>
</tr>
<tr>
<td>Moderately severe (PHQ9 15-19)</td>
<td>13</td>
<td>34%</td>
</tr>
<tr>
<td>Severe (PHQ9 ≥ 20)</td>
<td>5</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>38</td>
<td></td>
</tr>
</tbody>
</table>
**TDI PROGRAM: DATA**

- **Prevalence of Psychiatric Comorbidity**

<table>
<thead>
<tr>
<th>Comorbidity</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic Disorder</td>
<td>6</td>
<td>16%</td>
</tr>
<tr>
<td>PTSD</td>
<td>5</td>
<td>13%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>No comorbidity</td>
<td>25</td>
<td>66%</td>
</tr>
</tbody>
</table>
Outcomes for members who have received ≥ 3 calls (n=13)

<table>
<thead>
<tr>
<th>Sx status</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No improvement</td>
<td>5</td>
<td>38%</td>
</tr>
<tr>
<td>Improved</td>
<td>4</td>
<td>31%</td>
</tr>
<tr>
<td>Resolved</td>
<td>4</td>
<td>31%</td>
</tr>
</tbody>
</table>
FUTURE PLANS

- Conduct RCT to compare TDI vs. usual care with funding from Robert Wood Johnson Foundation
- Modify and evaluate scripts for the following populations:
  - Chronic pain and other medical problems
  - Adolescents
  - Latinos
- Modify and evaluate scripts for the following psychiatric disorders:
  - Bipolar
  - Perinatal depression
  - Depression and comorbid anxiety disorders
  - Depression and comorbid substance abuse
FUTURE PLANS-continued

- Statewide Depression Support Line
  - Patients can self refer or be referred by PCP
  - Services available by phone or online
  - Services tailored to specific patient populations and psychiatric disorders