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

David Brody, MD

Medical Director

Denver Health Managed Care Plans

Professor of Medicine

University of Colorado School of Medicine

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

Disorder	Prevalence in Primary Care
Bipolar Disorder	9.8% screen positive
Probable of alcohol abuse	4% - 7%
Eating Disorder	3.4% - 7%

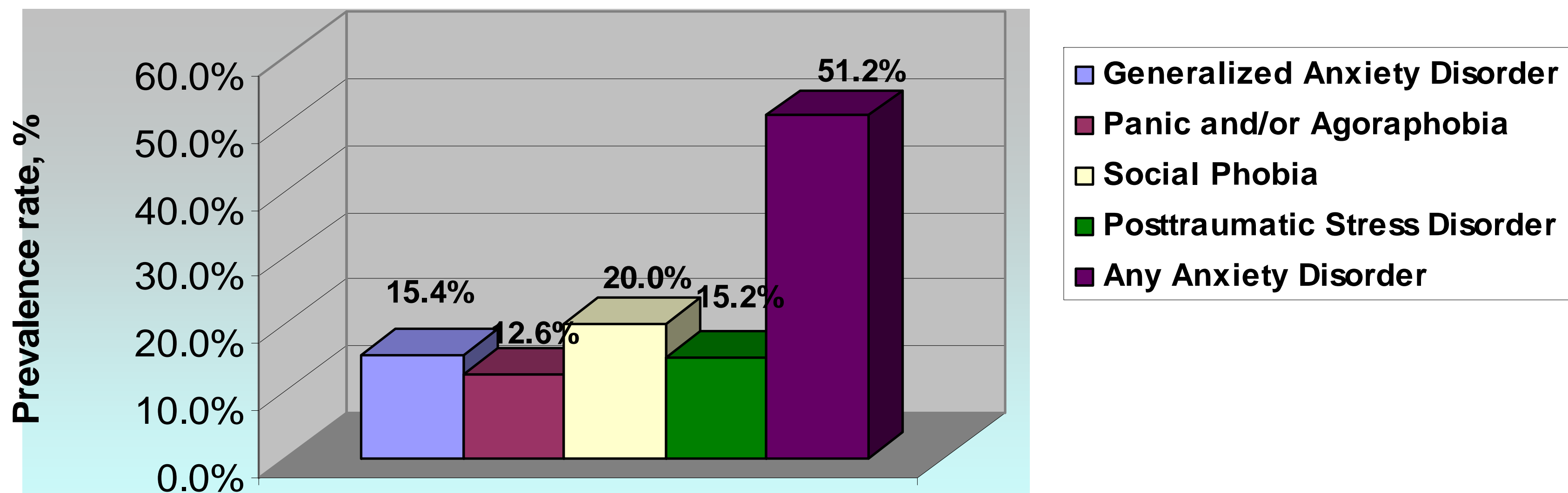
Psychiatric Comorbidity

- 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 diagnoses
- Among patients with a mental health diagnoses
  - 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

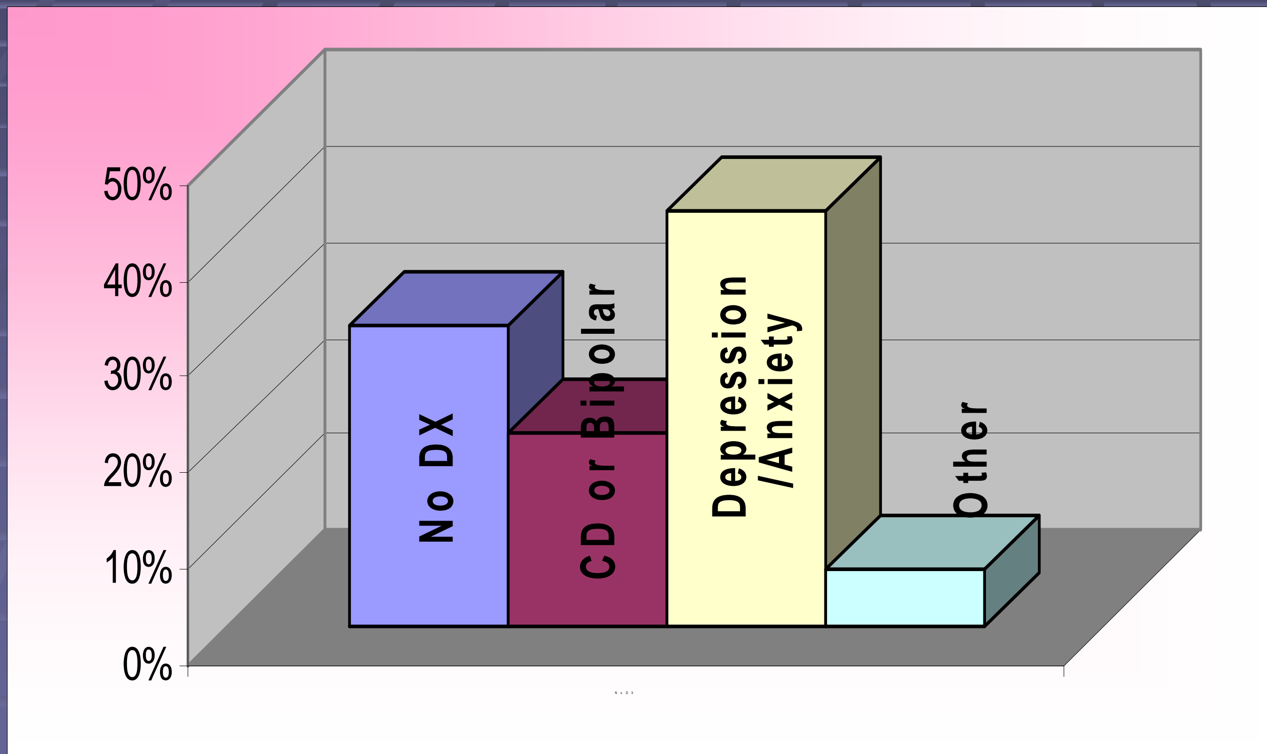
Spitzer R., et al. , JAMA 1994

Observed adherence to indicators of quality of depression care

Quality indicator	Observed Adherence
PCP detection of depression	79%
Follow-up for patients newly started in antidepressant therapy	80%
PCP assessment of symptoms and depression history	**34%**
PCP suicide assessment	**24%**
PCP alcohol assessment	**23%**

Hepner K. et al Ann. of General Int. Med. 2007

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**

Quality Indicator	Observed Adherence
Completion of Initial Treatment	46%

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

Hepner K. et al Ann. of General Int. Med. 2007

Problem: Medication Adjustment based on Depression Outcomes

- **Observed Adherence to Indicators of Quality of Depression Care**

Treatment adjustment for non responsive patients	36%

Hepner K. et al Ann. of General Int. Med. 2007

Problem: Provision of Evidence based Psychotherapy

Observed Adherence to Indicators of Quality of Depression Care

Quality indicator	Observed Adherence
PCP referral to mental health specialist for suicidal ideation	36%
PCP referral to mental health specialist for patients still depressed at 6 months	30%

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

Brody, D et al J. of General Internal Med 1997

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

Smith GR. et al , New England J. of General Internal Med 1986

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

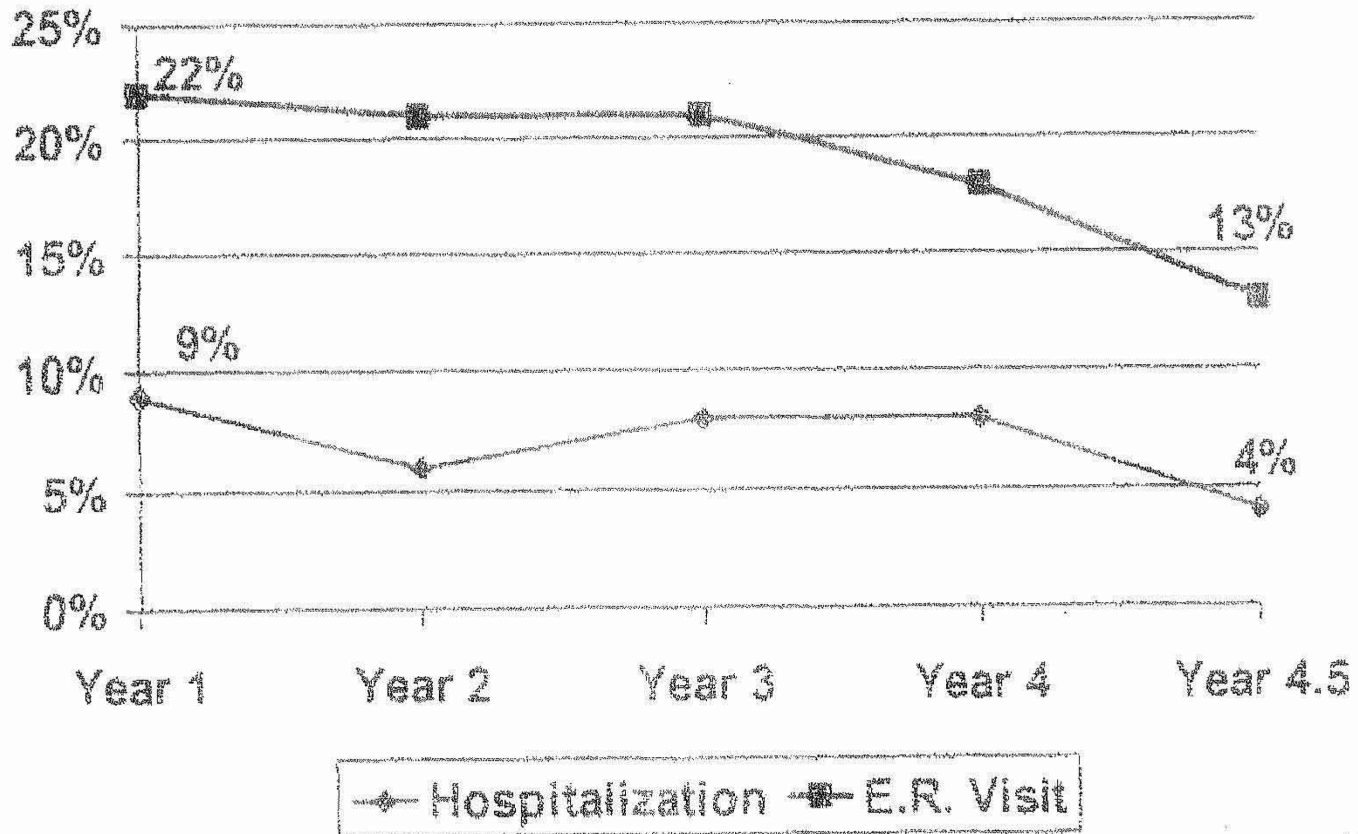
Co-location of PCPs and MHS: Hamilton Ontario Canada

- 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

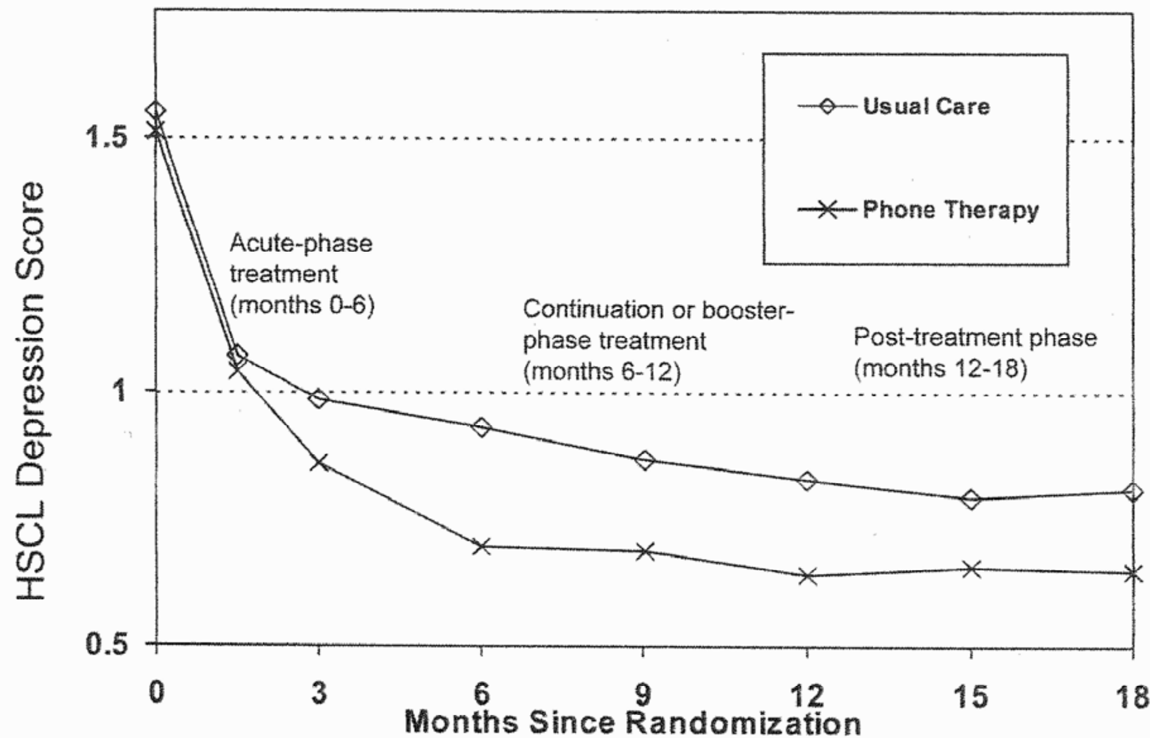
Utilization of ER and Inpatient Services
by Marillac's Integrated Care Patients



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



Ludman EJ et al J of Con and Clin Psychol 2007

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

Type of intervention	Incremental costs
Practice reorganization	$9,478 - $30,663 per additional depression free day
Collaborative care*	$35 per additional depression free days
Telephone case management	$23 per additional depression free days
Telephone Case Management + CBT	$9 per additional depression free day

*** 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

Phone Calls	Week 2	Week 3	Week 5	Week 7	Week 9	Week 11
Diagnostic assessment	Full	PHQ9	PHQ9	PHQ9	PHQ9	PHQ9
Medication adherence	√	√	√	√	√	√
Behavioral activation		√	√	√	√	√
Developing self care plan					√	√
Patients receive copy of depression coping plan		√	√	√	√	√
Providers receive reports	√	√		√		√

Provider Report

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

Symptoms	#	%
Minimal (PHQ9 <5)	2	5%
Mild (PHQ9 5-9)	7	18%
Moderate (PHQ9 10-14)	11	29%
Moderately severe (PHQ9 15-19)	13	34%
Severe (PHQ9 $\geq$ 20)	5	13%
	38	

TDI PROGRAM: DATA

- Prevalence of Psychiatric Comorbidity

Comorbidity	#	%
Panic Disorder	6	16%
PTSD	5	13%
Substance Abuse	3	8%
Bipolar	3	8%
No comorbidity	25	66%

TDI PROGRAM

- Outcomes for members who have received $\geq$ 3 calls (n=13)

Sx status	#	%
No improvement	5	38%
Improved	4	31%
Resolved	4	31%

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