
Improving the Health of Seniors with Mental Health Problems

BHL & PACE/PACENET Collaboration

David Oslin, M.D.

Where is Mental Health / Depression Care Delivered

- Depression: FY 2002: 64% of all outpatient depression visits for elderly occur in primary care (only 25% by psychiatrists) (Harmon et al., 2006)
- Nearly half of all antidepressants, sedatives, and hypnotics were prescribed by a primary care provider (20% of all antipsychotics) (cdc.gov/nchs/data/series/sr_13/sr13_157.pdf)

Quality of Care

- Depression is one of the five leading causes of disability worldwide and contributes to mortality
- Less than 50% of patients have an adequate treatment course for depression
- Suboptimal adherence to treatment
- Very low rates of counseling or therapy use in elders

Other Aging issues in Primary Care

- **Anxiety**
- **Loneliness/Loss**
- **Sleep problems**
- **Pain**
- **Cognitive decline**

BHL - PACE/PACENET

Phase 1 - completed

- Establish feasibility of phone based intervention in the aged
- Determine the severity and problems in older adults started on psychiatric meds
- Determine outcomes over course of treatment

Phase 2 - under way

- For those with significant symptoms, determine level of intervention that leads to the best outcomes
- For those with low symptoms
 - Establish the decision process to start meds
 - Consider discontinuation
- Develop an alternative to medication for those with low symptoms.
- Caregiver support program

BHL Program Goals

- **Deliver “on-time” “on-target” behavioral health assessment and counseling**
- **Provide an adjunct to the current care**
- **Improve access to mental health services**
- **Provide patient centered care**
- **Promote patient involvement in their care**

Care Management

- **Care Management is algorithm driven care delivered by a Behavioral Health Specialist as an adjunct to primary care.**
 - **Depression**
 - **Alcohol Dependence**
 - **Anxiety Disorders**
 - **Agitation**
 - **Pain**

Does care management work?

- **Better symptom and functional outcomes**
- **Greater adherence to treatment guidelines**
- **Reduced mortality**
- **Greater engagement in care**

Phase 1 - Feasibility

	Index Medication Type				
	Full Sample (n=1581)	Antidepressant (n=825 (52%))	Anxiolytic (n=478 (30%))	Antipsychotic (n=278 (18%))	<i>p-value</i>
Interviewed					
Patient Completed	439 (28%)	263 (32%)	143 (30%)	33 (12%)	<i>p<.001</i>
Cognitive Impaired	130 (8%)	58 (7%)	31 (7%)	41 (15%)	

Phase 1 - Severity

	Antidepressant (n=263 (60%))	Anxiolytic (n=143 (33%))	Antipsychotic (n=33 (8%))	<i>p-value</i>
Sociodemographic Characteristics				
Age (Mean, SD)	79 (7)	79 (7)	80 (7)	<i>p=0.67</i>
Gender				
Female	221 (84%)	121 (85%)	27 (82%)	<i>p=0.93</i>
Ethnicity				
White	245 (93%)	127 (89%)	31 (94%)	<i>p=0.28</i>
Financial Status (have at least "enough to get by")				
	237 (90%)	135 (94%)	31 (94%)	<i>p=0.29</i>
Married				
	76 (29%)	38 (27%)	4 (12%)	<i>p=0.12</i>
In Mental Health Care in Past 2 Years				
	29 (11%)	6 (4%)	13 (39%)	<i>p<.001</i>

Phase 1 - Severity

	Antidepressant (n=263 (60%))	Anxiolytic (n=143 (33%))	Antipsychotic (n=33 (8%))	<i>p-value</i>
Overall General Functioning (SF-12)				
Physical (Mean, SD)	43 (12)	40 (13)	41 (13)	<i>P=0.19</i>
Mental (Mean, SD)	49 (11)	52 (9)	47 (12)	<i>p=0.02</i>
Cognitive Function (Mean, SD)	5.5 (4.3)	5.1 (4.4)	7.0 (5.0)	<i>p=0.08</i>
Depression Severity				<i>p=0.03</i>
Low (0-4)	122 (46%)	82 (57%)	11 (33%)	
Mild (5-10)	97 (37%)	35 (25%)	16 (49%)	
Moderate (11-20)	35 (13%)	24 (17%)	4 (12%)	
High (21 or greater)	9 (3%)	2 (1%)	2 (6%)	
Suicidal Ideation				<i>p=0.02</i>
High	2 (0.8%)	1 (0.7%)	2 (6.1%)	

Phase 1 – Severity – Other issues

	Antidepressant (n=263 (60%))	Anxiolytic (n=143 (33%))	Antipsychotic (n=33 (8%))	Test, p-value
Drank Alcohol in Past 3 Months	50 (19%)	22 (15%)	6 (18%)	$p=0.14$
Generalized Anxiety Disorder &/or Panic Disorder	16 (6%)	9 (6%)	4 (12%)	$p=0.41$
Psychosis &/or Mania	4 (2%)	2 (1%)	4 (12%)	$p<.001$
Overall Sleep Quality**				$p=0.99$
Very good	52 (21%)	28 (20%)	7 (23%)	
Fairly good	143 (58%)	81 (57%)	16 (53%)	
Fairly-very bad	53 (21%)	32 (23%)	7 (23%)	
Daily or weekly episodes of pain (yes)**	130 (52%)	86 (61%)	14 (47%)	$p=0.17$
Irritability (Mean, SD)**	1.6(1.9)	1.2 (1.6)	2.1(2.3)	$p=0.02$

Phase 1 – Severity – Overall

	Antidepressant	Anxiolytic	Antipsychotic	Test, <i>p</i> -value
Low Overall Symptomatology	118 (45%)	80 (56%)	10 (30%)	<i>p</i> =0.01

Phase 1 – Reasons for Meds

Self-Reported Reason	Antidepressant (n=240)	Anxiolytic (n=139)	Antipsychotic (n=21)
Anxiety (Stress, Tension, Worry, Nervousness)	50 (21%)	74 (53%)	3 (14%)
Depression (Low Mood, Lack of Interest)	69 (29%)	6 (4%)	3 (14%)
Stressful Life Event, Adjustment, Grief	28 (12%)	19 (14%)	1 (5%)
Sleep Difficulties	15 (6%)	28 (20%)	
Pain	14 (6%)	1 (1%)	
Physical/Somatic Condition	10 (4%)	5 (4%)	
Irritability (Agitation, Anger)	1 (1%)		1 (5%)
Cognitive/Memory Difficulties	3 (1%)		
Upsetting thoughts, visions, voices	1 (1%)		1 (5%)
Miscellaneous	2 (1%)	1 (1%)	1 (5%)
Reason Unknown (e.g., "don't know")	47 (20%)	5 (4%)	11 (52%)

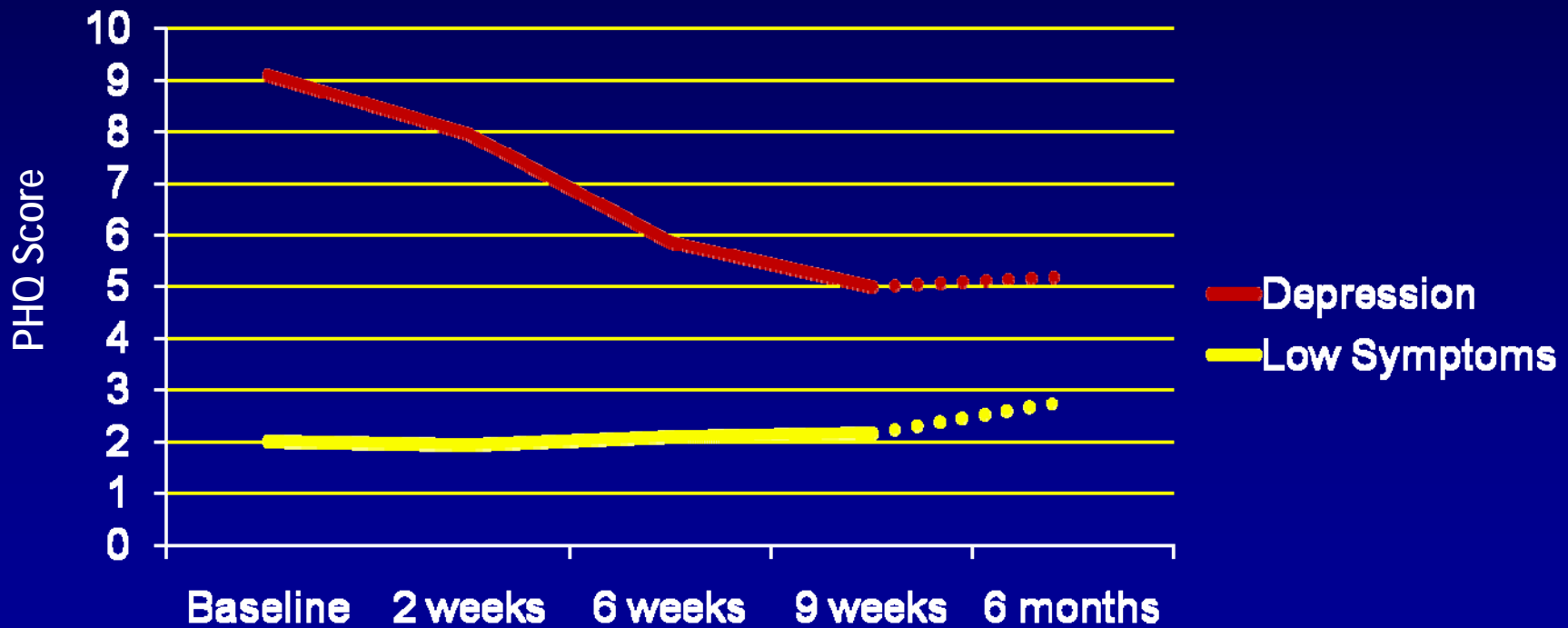
Phase 1 – Identified Needs

Endorsed Need	All Core Interviewees (n=417)
<i>Help with home needs (assistive devices, ramps, grab bars, etc.)</i>	99 (24%)
<i>Help with mood or health (identifying a therapist, physician, support group)</i>	41 (10%)
<i>Advice, support, or information about financial/legal matters</i>	78 (18%)
<i>Information about housing, transportation, home health care, etc.</i>	59 (14%)
<i>Information/guidance about medications</i>	42 (10%)
<i>Help/advice about how to manage free time</i>	32 (7%)
<i>Information/education about health, memory, mood, or other areas</i>	43 (10%)
<i>Other</i>	12 (3%)
<i>No need(s) reported</i>	215 (52%)

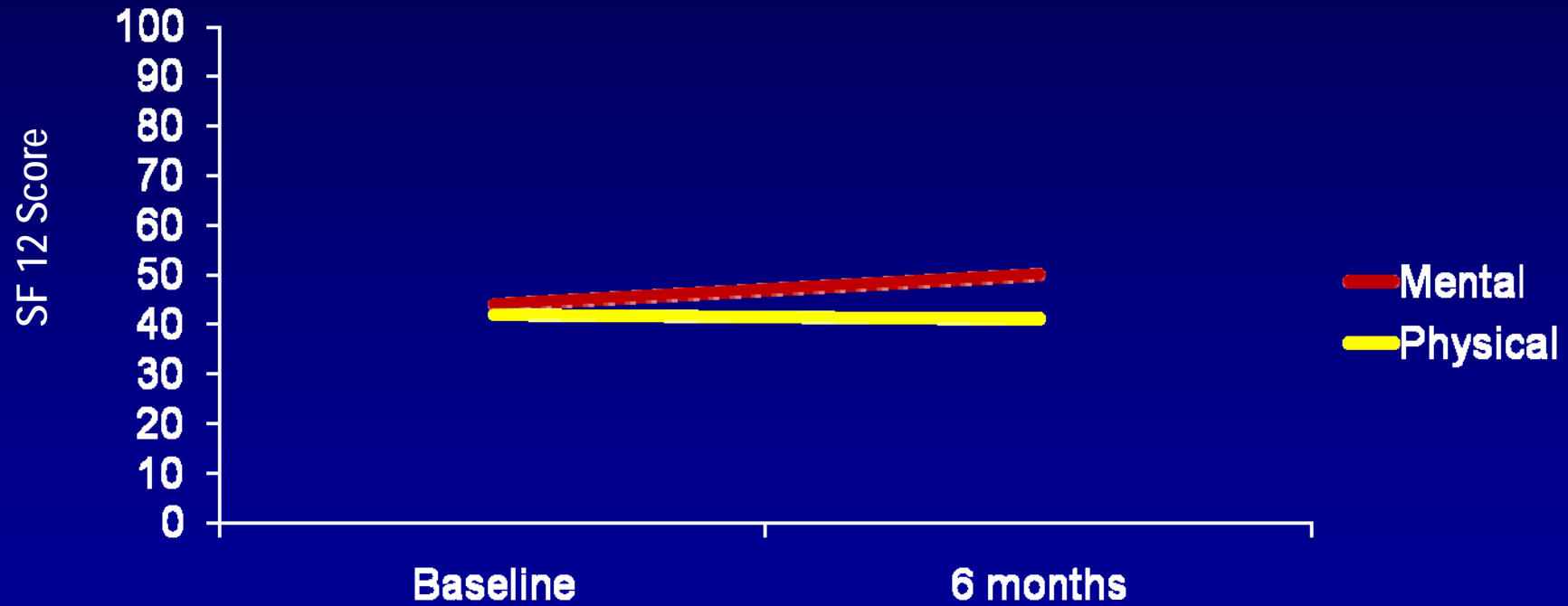
Phase 1 - Needs

	Need Endorsed	
	No	Yes
<i>Overall Symptomatology</i>		
Low (n=197)	126 (64%)	71 (36%)
High (n=220)	89 (41%)	131 (60%)

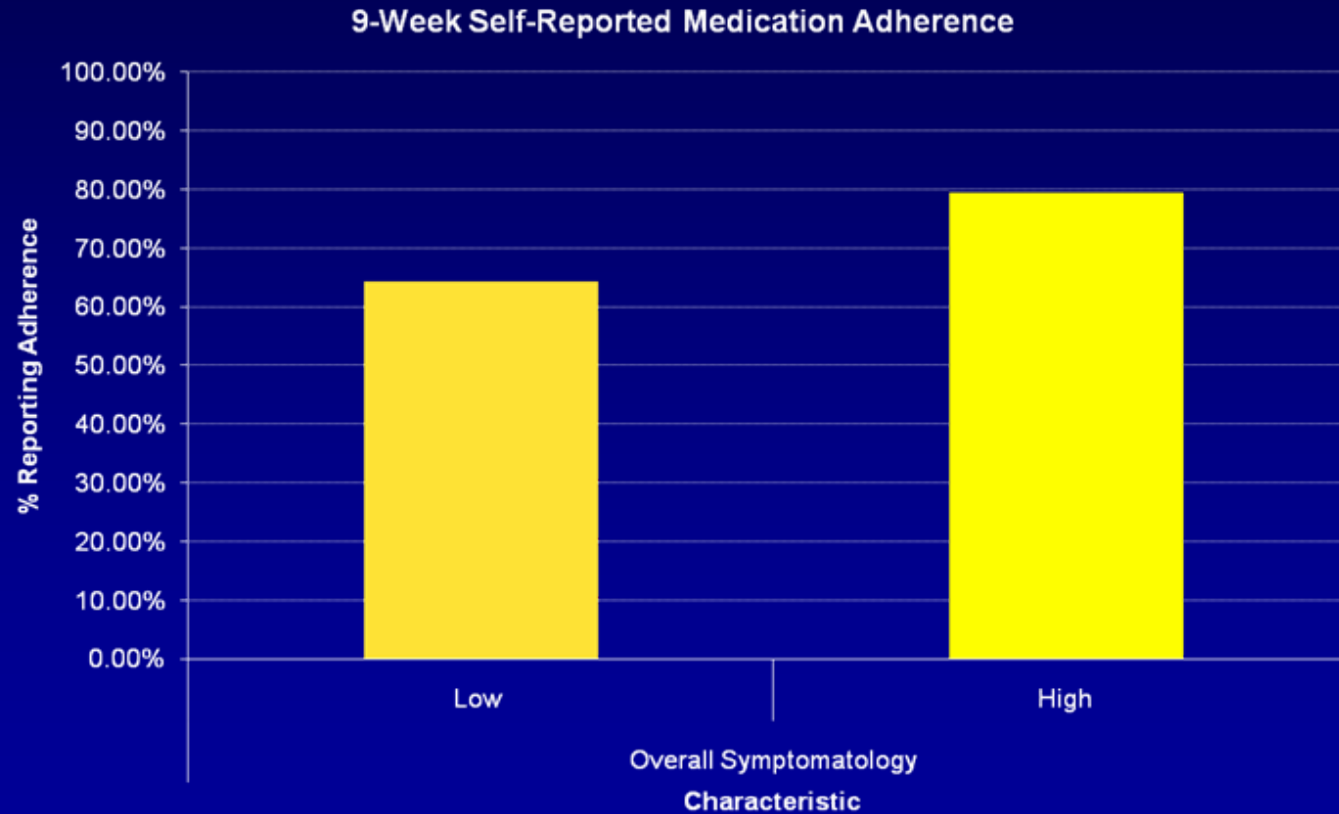
Depression Outcomes



Depression Outcomes



Medication Adherence



BHL - PACE/PACENET

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- Determine outcomes over time of treatment

Phase 2 - under way

- For those with significant symptoms, determine level of intervention that leads to the best outcomes
- For those with low symptoms
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- Caregiver support program

Phase II – Level of intervention

- **Symptomatic patients are randomized to two levels of treatment**
 - **Simple monitoring**
 - **Care management**
- **Progress to date:**
 - **145 interviews completed**
 - **81 patients with high symptoms (56%)**
 - **41 randomly assigned to monitoring only**
 - **28 randomly assigned to care management**
 - **12 refused randomization**
 - **52 patients with low symptoms**
 - **10 Failed BOMC- cognitively impaired**
 - **2 patient required referral to specialty care**

Phase II – Low symptom patients

- **Two Goals**
 - **Determine reasons for prescribing – in depth review with patient**
 - **Consider appropriate discontinuation of meds after persistence of low symptoms – strict criteria for low symptoms**
- **Progress to date**
 - **52 patients with low symptoms (36 %)**
 - 27 randomized to monitoring alone
 - 23 randomized to monitoring with possible discontinuation
 - 2 Refused randomization

Phase II – Promoting Non-Pharmacological Interventions

- **Pilot program to offer assessment and counseling to patients prior to a prescription**
 - **Work with PACE/PACENET Medication Educator to “market for assessment services”**
 - **Goal is to measure uptake and utility**

Phase II – Caregiver Support

- **Goal: develop a psychoeducation program to assist caregivers of patients with significant dementia**
 - **Program involves**
 - 2-3 calls with general education about dementia and problem solving techniques
 - Up to 6 calls regarding specific challenges such as safety, behavior management, improving communication, etc.
 - Assistance with referral to community resources and general patient management
- **Progress to date**
 - **57 Caregiver interviews**
 - 13 - did not have significant dementia by caregiver report
 - 8 - refused the randomized program
 - 22 - were randomized to receive a summary report sent to clinician only.
 - 14 - were randomized to our interventional program in addition to a summary report sent to the clinician.

Conclusions

- **BHL is a flexible, evidence based program**
 - **Fills gaps in the system**
 - **Focused on a broad array of behavioral health problems**
 - **Improves symptoms and satisfaction of patients**
 - **Provides valid information and documentation**
 - **Acceptable to patients**
 - **Valued by provider**
 - **Can function at low cost across diverse settings**
 - **Valuable as a tool for improving system performance**

Staffing

- **Director – David Oslin, MD**
- **Medical Director – Joel Streim, MD**
- **Trainer / Senior Manager – Suzanne DiFilippo, RN**
- **Coordinator – Amy Benson**
- **BHS staff**
 - **Bia Lewis, LCSW**
 - **Deb Rooney, RN**
 - **Karen Libber, LCSW**
- **Health Techs – Dan Tanh, Gulnaz Khan, Kate O’Neill Menezes**
- **Health Scientist – Shahrzad Mavandadi, PhD**
- **Psychiatry Resident - Donovan Maust, MD**