Assessment in Integrated Care

J. Patrick Mooney, Ph.D.

Purpose of assessment in integrated care:

Assessment provides feedback to promote individual and group learning and change.

- Physicians
- Mental health professionals
- Patients
- Organizations
- Interactive Systems

Why should physicians assess their patients' mental health status?

- 11 to 36% of primary care patients have a mental disorder;
- Only 1/3 of them receive minimal care.
- < 10% of patients diagnosed with major depression ever receive beneficial therapy. (American Academy of Physicians, 2001).

- In first world countries, Major Depression has the greatest disease impact on populations—"Disability Adjusted Life Years" or lost healthy years— due to its early onset and growing impact with age.

  (World Health Organization, "The Global Burden of Disease: 2004 Update" (2008)).

- 85% of depressed see a medical provider; fewer than half are diagnosed.

(Young AS, Klap R, Sherbourne CD, et al. The quality of care for depressive and anxiety disorders in the United States. Arch of Gen Psychiatry 2001; 58 (1): 55-61.)

Why should physicians assess their patients' mental health status?

- Half of all lifetime cases of mental illness begin by age 14.
- Approximately 14-20% of children are affected every year.

(National Institute of Mental Health, 2009).

- Yet, only one in four children and adolescents get treatment. This neglect increases mortality and produces decades of disability and unfulfilled lives.

(Center for American Progress, 2010).

- Early intervention can delay the first psychotic break and even prevent psychosis in the pre-illness stage of adolescents at high risk for schizophrenia. (AHRQ Health Care Innovations Exchange (2010).

- Yet, typically, three years elapse between first symptoms and intervention.
- 7 ½ years elapse for young people with mood disorders.

(Center for American Progress, 2010).

Why should physicians assess their patients' mental health status ?

- Patients with mental disorders use medical services more often and have higher related medical costs than those without mental disorders.

- Patients with diabetes and comorbid depression have health care costs that are 4.5 times higher than those without comorbid depression.

(Diabetes Care. (2002) Mar; 25 (3): 464-470).

- Failure to treat both physical and mental health conditions results in poorer health outcomes and higher health costs.

(Center for American Progress, 2010).

Why should physicians assess their patients' mental health status?

In 2008, the total economic costs of mental illness were estimated at $317 billion— $1,000 per year for every American—excluding costs associated with comorbid conditions, incarceration, homelessness, and early mortality.

(Thomas R. Insel, "Assessing the Economic Costs of Serious Mental Illness", Am J Psychiatry 165 (2008): 663-665).

So if assessing is so important, why isn't it done?

Barriers to assessing mental health problems in primary care?

- Primary Care visits typically last an average of **13 minutes**.
- "The detection and management of mental health problems must compete with other priorities such as treating an acute physical illness, monitoring a chronic illness, or providing preventive health services".

  (Center for American Progress(2010).
- The Affordable Care Act has just added 8 million people to the health care system and increased primary care demands.
- 80% of patients with depression initially present with physical symptoms.

  (American Academy of Family Physicians, "Mental Health Care by Family Physicians" (2001).

Barriers to assessing mental health problems in primary care?

"It is very difficult to implement any routine screening, though we do them, currently post-partum depression and SBIRT questionnaires for ethanol use, but compliance is spotty and the burden of what we are being asked to routinely survey is increasing by the month, unfortunately…

So more and more we end up treating what patients bring to our attention as we try to ensure that a myriad of other metrics—Pap's, mammograms, vaccinations, colonoscopy, etc. (including at least 6-8 in all diabetics)—are met in the midst of whatever list of concerns are brought in by the patient."

(Personal communication with Salem physician)

Assessment goal: Determine need

- Identify patients needing MH care.
- Initiate service delivery protocols.
- Trigger referrals to MH practitioner.

Triple Aim goals:

- *Improve patient experience/outcomes,*
- *Improve population health,*
- *Decrease costs*

Assessment Goal: Measure progress

Physicians and WOMHA members should use common assessment tools in order to:

- Speak the same language by identifying pertinent symptoms.
- Provide feedback to support physicians' Patient Centered Medical Home (PCMH) function—Collaborative services.
- Identify what's working to improve patient health.
- WOMHA assessment process becomes an organizational "Brand".

Assessment Goal: Measure patient satisfaction

- Measure the quality of the therapeutic relationship and therapeutic alliance—most important factor in therapy success.

- Provides therapist feedback to keep therapy on track.

***Triple Aim goal**: Enhance patient experience.*

Features of assessment utility in primary care:

- Brief & Patient Friendly
- Reliable
- Valid
- Inexpensive
- Assists in both diagnosis and in the measurement of progress
- Incentives to use

Common measures used in primary care:

- **Patient Health Questionnaire (PHQ), includes**:
- PHQ 15 (Somatization)
- PHQ 9 (Depression)
- GAD 7 (Anxiety)
- Above 3 components together are also known as PHQ-SADS (Somatization, Anxiety, Depression)

Robert Spitzer, MD

Lead developer of the PHQ measures and father of modern mental disorders' classification

Development of the PHQ measures

- Originally developed as a questionnaire and structured interview assessment technique in the early 1990s (**Prime MD**).
- Prime MD required patients to fill out a 27-item paper and pencil screening followed by physician follow-up interview.
- Prime MD took 5-6 minutes of physician's time if no mental disorder present and 11-12 minutes if there was a diagnosis.
- The Patient Health Questionnaire (PHQ) operationalized PRIME MD so patients could self-administer (Spitzer, et al from 1999-2010).

Validation and utility studies:

- N=3000 adult patients from Family Practice and Internal Medicine.
- Administered the PHQ to 3000 patients by 62 Primary Care Physicians.
- 585 of the 3000 PHQ patients also had an interview with a mental health professional within 48 hours.

Validation and utility studies:

- **Findings:** 28% of PHQ and 29% of interviewees had PHQ dx.
- Good agreement between PHQ and Interview (85% accuracy).
- Patients with PHQ diagnosis had: more functional impairment, disability days, and health care utilization.
- Results were similar to PRIME MD, but took < 3 minutes (avg).
- 80% of physicians reported routine use of PHQ would be useful; only 32% of newly PHQ diagnosed received interventions.

(Spitzer, RL, Kroenke, K, Wiliams, JBW. Validation and Utility of a Self-report Version of PRIME-MD: The PHQ Primary Care Study. 1999; 282 (18): 1737-1744.)

PHQ 15 Somatization

- Screens for 15 somatic symptoms accounting for:
  > 90% of physical symptoms reported in primary care.
- 10.3% women and 8.1% men had moderate to high scores.
  Scores are higher in lower SES levels.
- Higher scores correlated with decreased quality of life, and increased depression, disability days, and health care utilization.
- Diagnose Somatoform Disorder (ICD-9) if 3 or more of (a-m) bothered “a lot” <u>without adequate biological explanation</u>.
- Severity Cutoffs: 5= Low, 10= Medium, 15= Severe.

PHQ 9 Depression

- DSM-IV's depression criteria operationalized. 4 pt. frequency scale—in "last 2 weeks." N=6000 adult patients in 8 primary care and 7 OB-GYN clinics.
- As PHQ 9 scores went up: a) decreased functioning, b) increased symptom-related difficulty, c) more sick days, d) increased health care utilization, e) more likely to receive depression diagnosis from mental health professional.
- Dx Major Depression: if rate "more than ½ the days" on items #1 or #2 plus five or more of items 1-9 = "more than ½ the days".
- Severity Cutoffs: 5=Mild, 10=Moderate, 15=Moderately Severe, 20=Severe.

Kroenke K, Spitzer RL, Williams J B (2001) The PHQ: Validity of a brief depression severity measure. J of General Internal Medicine. 16 (9): 606-613.

GAD 7: Anxiety

- 7-item scale of general anxiety symptoms
- 4 pt. frequency scale—in "last 2 weeks"
- N= 2740 adult patients in 15 U.S. primary care clinics

- Higher scores correlated with a) greater functional impairment, b) disability days, c) MH clinician dx of PTSD, GAD, Panic Disorder and Social Anxiety Disorder.

- Severity Cutoffs: 5=Mild, 10=Moderate, 15=Severe.
- Score of 10 or more should prompt further evaluation of specific dx.

Spitzer RL, Kroenke K, Williams JB, Lowe, B (2006) A brief measure for assessing anxiety disorder: the GAD-7. Arch. of Intern Med. May 22; 166 (10): 1092-7.

Kroenke K, Spitzer RL, Williams JB, Monahan PO, Lowe B (2007) Anxiety Disorders in primary care: prevalence, impairment, comorbidity, and detection. Ann Intern Med. Mar 6; 146 (5): 317-25.

Problems with the PHQ Measures

- Severity cutoff scores based on ease of remembering.
- PHQ study found that 1/3 of primary care patients with MDD were severely depressed and only 10% mildly depressed—Unlikely.
- About twice as many patients diagnosed “severe” on **PHQ9** than **Hospital Anxiety and Depression Scale (HADS)**.
- Four times as many scored in mild range on the **Hamilton Depression Rating Scale (HAMD)** than the **PHQ 9**.
- **Beck Depression Inventory** also classified patients as more severe.

Above from: Zimmerman M. Symptom severity and Guideline-Based Treatment Recommendations for Depressed Patients: Implications of DSM-5’s Potential Recommendation of the PHQ-9 as the Measure of Choice for Depression Severity. Psychotherapy and Psychosomatics, 2012; 81 (6): 329-332.)

Implications of using the PHQ Measures

PHQ may promote an increased use of medication and a decreased use of psychotherapy.

The American Psychiatry Association (APA) guidelines for the treatment of depression recommend:

- Use psychotherapy or medication for mild or moderate depression.
- Use medication (with or without psychotherapy) for severe depression.

American Psychiatric Association: Practice Guideline for the Treatment of Patients with Major Depressive Disorder, ed 3, Washington, APA (2010)

Assessment to improve service delivery:

- Patient access to care.
- Meets physicians' needs.
- Reliable use of Carepath's documentation—3rd party need for self-auditing.
- Cost-benefits of integration.