Chronic Illness and Emotional Distress- It takes a Village

William Gunn, PhD
Director of Primary Care Behavioral Health
NH Dartmouth Family Medicine Residency
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Learning Objectives – Part 1

- Identify the vulnerability of specific populations to depression and anxiety particularly in chronic medical conditions and in substance use/abuse
- Discuss creative ways to provide a resource to patients and families
- To apply these learnings to your settings
Chronic Medical Conditions

- Diabetes
- Coronary Artery Disease
- Hypertension
- Asthma
- COPD
- Chronic Pain
- Back Problems
- Migraines
- Functional GI Syndromes
Chronic Disease is Common & affect over 50% of the U.S. Population

<table>
<thead>
<tr>
<th>Examples</th>
<th>Descriptors</th>
<th>Patient Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>Are characterized by being noncontagious in origin</td>
<td>Patient adherence and self-reliance is expected</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Have a long latency period and period of illness and disability</td>
<td>Patient self-management is usually key in maintenance and successful outcomes</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>Not Curable</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>Are a major cause of morbidity and mortality</td>
<td>Unintended behaviors, lifestyle, and social factors can interfere with successful self-management</td>
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<tr>
<td>Kidney Disease</td>
<td>Significant Psychosocial Component</td>
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Depression Bucket – DSM-V

- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)
- Premenstrual Dysphoric Disorder
- Depressive Disorder due to another Medical Condition
- Depressive Disorder NOS
Depression and chronic diseases

- Lifetime prevalence of depression ranges from 2-15% worldwide
- Depression is associated with significant disability and lower health status scores
- Co-morbidity of depression with chronic physical disease and substance use/abuse is well recognized
Chronic Obstructive Pulmonary Disease

Depression in COPD patients associated with:
- poorer survival
- longer hospitalization stay
- persistent smoking
- increased symptom burden
- poorer physical and social functioning
Anxiety Syndromes

- Panic Disorder with or without agoraphobia
- Social Phobia
- Simple Phobias
- PTSD
- Obsessive Compulsive Disorders
- Generalized Anxiety Disorder
- Anxiety Disorder NOS

Worry, fears, tension, physiological arousal, restlessness, irritability, concentration problems
Anxiety and Chronic Illness

- Rates of anxiety disorders 2-5 times as likely with IBS
- Two times increase in anxiety with children and adults who have asthma. Leads to poor asthma control, increased functional impairment, decreased quality of life, cost and utilization
Multiple Unexplained Symptoms

- Irritable Bowel Syndrome
- Chronic Fatigue Syndrome
- Fibromyalgia
- Chronic Pain Syndromes
Substance Use Disorders

- Alcohol use, abuse and dependence
- Drug use, abuse and dependence
- Smoking
- Prescription Drug Abuse
Prevalence of Behavioral Health Problems in Primary Care

<table>
<thead>
<tr>
<th>Problem</th>
<th>PHQ-3000</th>
<th>Marrilac 500</th>
<th>Concord 500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depression</td>
<td>10%</td>
<td>24%</td>
<td>17%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>6%</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>7%</td>
<td>21%</td>
<td>10%</td>
</tr>
<tr>
<td>Somatic</td>
<td>7%</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td>Sub-Threshold</td>
<td>28%</td>
<td>52%</td>
<td>45%</td>
</tr>
</tbody>
</table>
Katon, 2007

- Research evidence suggests that there are bidirectional effects between depression/anxiety and severity of medical illness.

Adherence issues, increased medical complications, polypharmacy, costs,

Comorbidity should trigger cointerventions!
Interaction Between Mental Disorders & Chronic Medical Disease

Risk Factors
- Childhood Adversity
  - Loss
  - Abuse & Neglect
- Heredity
- Stress
  - Adverse life events
- SES
  - Poverty

Chronic Medical Disorders

Adverse Health Behaviors
- Obesity
- Sedentary Lifestyle
- Smoking
- Self care
- Symptom Burden

Mental Disorders
Disease AND Illness

- **Disease** – the biological process which is understood at the cellular and organ system level

- **Illness** – the psychological and social process understood at the individual and family level
Types of Illness Stories – Arthur Frank (1998)

- Restitution stories – getting sick and hope of restoration to health
- Chaos stories – “it is intolerable”, social consequences
- Quest stories – “cranky but grateful”
Key Attitudes and Skills

- Provide educational information about illness and coping strategies
- Listen to stories and themes, resisted attempts to change the story too quickly
- Negotiate as much as possible
Key Attitudes and Skills

- Reinforce strengths in adapting, coping, and hoping – look for function
- Help to reinforce connection with support systems
- Ask about meaning and belief systems
And with Families

- Meet “family” who are involved in care – help caregivers
- Identify other developmental tasks
- Encourage open discussion of the illness and their response to it
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Learning Objectives – Part II

- Identify systemic factors than can enhance the effectiveness of working with patients and families with chronic illness
- Integrated (collaborative) care in primary care can be very effective
- Apply learnings to your settings
The Chronic Care Model

Community
- Resources and Policies
- Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Improved Outcomes
- Informed, Activated Patient
- Prepared, Proactive Practice Team
- Productive Interactions

(Developed by The MacColl Institute, AGP/AMH Journals and Health)
Comprehensive Whole Person Care

There is a neck............
René Descartes
Challenges in Primary Care Management

- Detection
  - Up to 50% of psychiatric and SA conditions undiagnosed
  - PCP’s do better with more severe conditions
  - Elderly more likely to be missed
  - Minorities more likely to be missed
  - Somatization processes particularly difficult
  - Stress consultation visits particularly helpful
Challenges in Primary Care Management

- Treatment
  - Overuse of medications (Katon, 1995)
  - Not adequate dosing of medications
  - Non-adherence a major issue (60% at four weeks)
  - Time to address issues more completely
  - Lack of adequate patient education materials
  - Inadequate co-management programs
Challenges in Primary Care Management

- Follow-up
  - Difficulties with timely return visits to monitor response and side-effects (less than 30% seen within a month)
  - High patient drop out rates
  - Difficulties managing overserviced/underserved patients
  - Difficulties in weaning patients off medicines
Medical Home: Relationship Centered Care

- Increased rate of recognition with those having a chronic medical condition vs those without a defined condition
- Results of study showed trust and continuity of care may explain difference
- Takes a willingness to talk “both sides of the street”, the mind/body connection
Questions – Areas in Which to Focus?

- Some new approaches:
  - Improving care in the primary care acute setting reducing unnecessary ER visits
  - Group visits to reduce rehospitalizations
Two major Models

- **Behavioral Health Consultant**
  - Enhance work of primary care team
  - Screenings and Brief Interventions

- **Collaborative Care**
  - Identification and monitoring of high risk groups
  - Stepped care
  - Psychiatric consultation
BHC Model

- Colocation and Conjoint Treatment Plans
- PCP enhanced approaches
- Licensed Mental Health Therapists provide a wide range of brief interventions
Impact Treatment Model – For Depression in Older Persons (Bartels, et.al)

- Collaborative Care Model includes:
  - Care manager: Depression Clinical Specialist
  - Patient education, symptom and side effect tracking, PST-PC
  - Consultation/weekly supervision meeting with PCP and Psychiatrist
  - Stepped model using medication and PST-PC

OF NOTE: The presence of multiple chronic medical illnesses did not affect the response rate to treatment
Implementation and role of care manager

- Care management focuses on high-cost and high-volume conditions...and involves proactively coordinating with patients to ensure that they are following doctors’ orders, taking medications, improving their health habits, and adhering to best practices.

www.microsoft.com/office/showcase/caremanagement
Care Manager - Navigators

- **Who?** Associate or Bachelor level paraprofessional with good communication skills

- **Role?** Acts as coordinator between patient, PCP, specialist especially for persons who have difficulty with compliance and/or complex needs
Care Manager - Navigators

- **What?** Tracking, information/referral, follow up with patients before, during and after PCP visit.

- **How?** Face to face visits while patient waits to see provider, phone calls, letters.
How can this work in a busy Primary Care /Family Practice?

- Challenge - how to keep visits to 10 to 15 minutes per patient and still screen for depression, anxiety, and stress
- Identify high risk patients
- Identify high utilizers of services with complex medical conditions.
How can this work in a busy Primary Care /Family Practice?

- Integration of disease management programs to include both medical and psychosocial/SA
- Utilize an EMR with decision support
- Utilize on site, integrated behavioral health specialist
- Utilization of a care manager/navigator
- Group Medical Visits
- Self Care Management
- Pharmacological interventions
Two minute PCP interventions – Strossal (2000)

- Identify something to do that will boost confidence
- Identify 1-2 pleasurable activities to do this week
- Identify an obstacle to taking medicine and a specific solution
- Teach a relaxation or mindfulness skill
- Teach a mood monitoring strategy
Effect of Depression/Anxiety on Self Management

Difficulty in following recommendations for diet and exercise:

- Medication adherence
- Functional impairment
- Health costs
Group Medical Appointments

- 90 minute group of eight to 10 patients with an interdisciplinary team

- Focus is education, discussing strategies for self-management, and creating support networks.
Barriers to Integrating Care

- Financial Issues – Behavioral Health often carved out of medical plans
- Workforce Issues
- Practice and culture transformation issues
Summary Points

- Mental and emotional health is part of overall health
- The “movement” towards medical home must include incorporation of psychosocial and behavioral components
- Separate disease management strategies can work at cross purposes and must be integrated
Questions – It takes a Village!
Chronic Illness and Emotional Distress

- How are you managing your patients in this population in your practice?

- Do you feel you are meeting your desired outcome measures effectively and in a timely fashion?
Summary

It Takes a Village………….