

## CME ARTICLE

# Mental Disorders in the Primary Care Sector: A Potential Role for Managed Care

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*This activity is designed for leaders and managers of managed care organizations and for primary care physicians involved in evaluating, treating, and caring for patients with mental disorders.*

### GOAL

To provide a better understanding of primary care patients' needs for mental health services and how managed care companies might best address these needs.

### OBJECTIVES

1. Describe problems in detection of mental disorders
2. Discuss the specific ways in which treatments can be improved for mental disorders under managed care systems

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### CONTINUING MEDICAL EDUCATION ACCREDITATION

The Long Island Jewish Medical Center, the Long Island campus for the Albert Einstein College of Medicine, designates this continuing medical education activity for 1 credit hour in Category 1 of the Physician's Recognition Award of the American Medical Association.

The Long Island Jewish Medical Center is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. This activity is cosponsored by the Johns Hopkins University School of Medicine.

This CME activity was planned and produced in accordance with the ACCME Essentials.

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The prevalence of mental disorders increases sequentially as one moves from the general community population to the outpatient primary care population to patients in a general hospital. Outcome studies show that there is significant under-recognition and undertreatment of mental disorders in the general medical sector.<sup>1</sup> Patients with mental disorders in all three sectors have higher utilization rates of general medical services and higher related medical costs compared with patients without mental disorders. Mental disorders also cost businesses money because of impaired performance, greater disability, and more sick days out of work. Aside from the direct and indirect economic costs, there is a high clinical toll in subjective suffering, reduced quality of life, and impaired functioning in spousal, parental, and social roles.

For many years the magnitude of disability and the economic impact associated with mental disorders were not fully appreciated, nor was it clear how patients with these problems sought help or how effectively our medical care systems treated them. As a result of more recent large epidemiologic and outcome studies, we have a better understanding of these issues and can determine how systems of managed care can address them more effectively.<sup>1</sup> As medicine has been transformed from a cottage industry to a corporate structure, it has gained economy of scale. Access to large data banks on clinical outcomes and costs can inform program planning in a way not previously possible. The broader public health perspective can now be more easily translated into efficient healthcare delivery.

These changes in structure and patterns of practice present significant opportunities for improving specific elements of healthcare delivery in the mental health sector. These elements are discussed below.

### **Improvement in Detection**

Patients with mental disorders are reluctant to seek treatment for their conditions. Of those patients who do seek help for their mental disorders, more will be seen by their primary care physicians than by mental health specialists.<sup>24</sup> Primary care physicians are optimally posi-

tioned to identify, triage, and initiate the treatment of mental disorders in their patients. Unfortunately, the rate of detection of mental disorders among outpatients and general hospital inpatients by primary care physicians and internists has been less than optimal. In this country and throughout the world, 25% to 50% of mental disorders in primary care outpatients are missed.<sup>5</sup> Among general hospital inpatients, research studies show that only 10% to 30% of those with documented mental disorders will receive a chart diagnosis on discharge.<sup>1</sup> Unless case finding is improved, a vast population of patients in the medical sector who require treatment will go undetected and untreated.

Detection of mental disorders can be improved by education, screening, and on-site psychiatric liaison. Education and training of primary care physicians have been shown to improve detection rates of mental disorders in the primary care setting.<sup>6</sup> Screening instruments such as the PRIME-MD, a patient-centered questionnaire, doubled the rate of recognition of mental disorders by primary care physicians and resulted in treatment referral in over 60% of patients whose mental disorders previously had been diagnosed but not treated.<sup>7</sup> A newer version of the PRIME-MD, the Patient Problem Questionnaire, is filled out by the patient. Thus, it requires less time from the physician and may offer the potential for a broader, more systematic application. It is still undergoing tests of validation.

Finally, screening by an on-site consultation-liaison psychiatrist trained in the interaction of medical and psychiatric disorders improved detection in inpatient settings by a reported 4- to 10-fold.<sup>8,9</sup> Screening in outpatient office practices also increased detection of mental disorders.<sup>7</sup>

### Improvement in Treatment

Education, screening, and the use of an on-site psychiatrist becomes more feasible and efficient as medical practice organizes into larger functional units that integrate systems approaches with individual healthcare delivery. However, improving detection of mental disorders is only the first step. Improvement also is needed in the treatment of patients with mental disorders after the disorders are detected. Outcome studies show that even when primary care physicians diagnose a mental disorder, the treatment they provide is substandard.<sup>1</sup> For example, depression, the most frequent and carefully studied psychiatric disorder in primary care, is poorly treated by primary care physicians compared with mental health professionals. After diagnosis, primary care physicians prescribe antidepressants only 20% of the time and often in subtherapeutic doses.<sup>10,11</sup> Poor initial instructions, too few

visits during the acute phase, and inadequate long-term monitoring more frequently lead to discontinuation of medication and poor treatment outcome with primary care physicians than with mental health professionals.

Not surprisingly, many patients treated by primary care physicians (50-80%) will not have recovered over the course of 1 year.<sup>12,13</sup> When depression persists, so do all the related problems: poor quality of life; impaired family, career, and social functioning; increased disability; and greater utilization of medical resources and costs. Education and clinical training of primary care physicians may enhance treatment efficacy to some degree, but are unlikely to be sufficient by themselves.<sup>7</sup>

### On-Site Integrated Care

Studies show that on-site psychiatric care integrated with general medical care has distinct advantages with respect to clinical outcomes.<sup>7</sup> In the general hospital, an integrated approach (on-site integration of consultation-liaison psychiatry with medical care) has been shown to improve clinical symptoms, reduce length of stay, reduce inpatients costs, and reduce postdischarge outpatient utilization and costs.<sup>14</sup> By contrast, consultation provided by a psychiatrist that is not integrated with the care provided by the treatment team failed to show any change in outcomes.<sup>15</sup>

Similar findings emerged in outpatient primary care studies. The best clinical outcomes were achieved in a more fully integrated model where, in addition to case detection and formulation of an initial treatment plan, the psychiatrist played a continuing therapeutic and supervisory role, including ongoing collaboration with primary care physicians and direct patient contact and intervention where indicated.<sup>6,16</sup> When patients with major depression were treated collaboratively (ie, an on-site psychiatrist and the primary care physician both saw the patient and communicated about treatment), significantly better clinical outcomes were achieved.<sup>12</sup>

The advantages shown for on-site psychiatric involvement and collaboration with the medical team in treating depression have important implications for the deployment of psychiatry in primary care. Even in uncomplicated cases of depression, primary care physicians using the newer selective serotonin reuptake inhibitors may need close psychiatric collaboration to achieve optimum results. However, depression, like other psychiatric disorders, usually does not occur in a "pure" state; more likely, other comorbid psychiatric disorders will complicate treatment and require expertise. Two thirds of patients in

primary care with major depression will have at least one other psychiatric disorder.<sup>17</sup> It has been shown that 50% to 60% of psychiatric disorders are complicated by at least one other psychiatric diagnosis, and 25% of patients have two or more additional coexisting psychiatric disorders.<sup>18,19</sup>

Patients with a psychiatric disorder that is combined with another Axis I or Axis II psychiatric disorder will function worse, experience more stress, and have poorer general health.<sup>13,17,20</sup> Patients with comorbid psychiatric disorders are more likely to have a difficult, complicated treatment course and a poorer prognosis with worse outcome.

To further bedevil the primary care physicians, psychiatric patients may have coexisting medical disorders and a panoply of drugs to treat them; these also may complicate diagnosis and treatment. In addition, the first psychotropic drug tried may not work or may have side effects that require trials of different medications sequentially or in combination. Finally, a consensus is emerging that combined psychotherapeutic and psychopharmacologic treatment is most effective in treating depression and other disorders.<sup>21</sup> That may be especially true for patients with multiple problems. Thus, management of a significant majority of patients with mental disorders in the care of primary care physicians will require the close collaboration and direct involvement of a psychiatric specialist. In response to these imperatives, psychiatry training programs have incorporated training in primary care settings for their residents and consultation-liaison fellows.<sup>22</sup>

### Specialized Treatment for Somatization Disorder

The psychiatric disorders of patients with somatization disorder (ie, those whose emotional disorders are expressed in physical symptoms) are more likely to be missed.<sup>23</sup> They are high utilizers of medical services. A healthcare utilization and economic perspective can be used to identify this group of patients with mental disorders. These patients typically have been resistant to psychiatric treatment and use an excessive proportion of medical services. They may be most effectively treated in specialized programs that can be located on- or off-site.

Studies of psychiatric disorders in medical outpatients document an increased use of medical resources.<sup>1</sup> Patients with depression have twice the medical costs and make seven times more medical visits than those who are nondepressed.<sup>1</sup> The majority of patients with panic disorder will consult 10 or more physicians with complaints of chest pain, palpitations, dizziness, and other symptoms before that diagnosis is made.<sup>24</sup> They will visit emergency rooms 10 times

more frequently than patients without panic attacks. Patients with somatization disorder generate nine times the healthcare costs of the rest of the population.<sup>25</sup>

Using their data banks, managed care organizations can identify the top 10% high utilizers of general medical resources. These patients account for 40% of all hospital days and over 50% of all specialty visits.<sup>26</sup> Half of these patients have been found to be psychologically distressed.<sup>26</sup> They suffer from psychiatric disorders such as depression, anxiety, and somatoform disorder, which contribute to their excessive use of medical services. Managed care organizations can use their data banks to provide structured, goal-oriented, time-limited treatment programs of proven efficacy. Patients with somatization disorder identified by their primary care physicians often can be effectively treated with minimal on-site intervention, resulting in clinical improvement and decreased medical utilization with cost savings.<sup>25,27</sup> Patients gathered from various geographically disparate practices can be treated on-site through established treatment protocols or off-site through centralized, specialized group programs. Managed care programs by virtue of their organization and size provide the necessary scale for concentrating appropriate numbers of patients for such programs.

### Summary

A number of forces are now converging that enhance the likelihood for success of a more effective integrated approach to address mental disorders in primary care practice. First, in the last decade or so, epidemiologic and outcome studies have documented the prevalence of mental disorders in the medical sector and the personal and economic toll these exact, thus defining the scope of the problem. Second, primary care physicians called on to detect and treat or refer these disorders need close collaborative on-site assistance from their psychiatric colleagues to carry out these responsibilities most effectively. Third, the economy of scale provided by larger organizations devoted to healthcare delivery makes screening programs more feasible. These organizations can use data banks to identify patients, and they can give feedback about practice patterns that can be incorporated into systemwide education and training about detection and treatment of mental disorders. Fourth, psychiatrists now are being trained in clinical primary care settings that prepare them to work effectively with their primary care colleagues. Finally, the reduction of general medical costs that may result from treating the mental disorders in primary care patients may elicit more support from managed care organizations to develop integrated approaches.

The size and organization of managed care programs present opportunities to enhance the treatment of medical patients with mental disorders through (1) improvement of detection and treatment in on-site programs that integrate psychiatric and medical care, and (2) development of specialized on- or off-site programs for patients with somatization disorder who are high utilizers of medical services.

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**CME QUESTIONS: TEST #049809**

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**Instructions**

After reading the article, "Mental Disorders in the Primary Care Sector: A Potential Role for Managed Care," select the best answer to each of the following questions. In order to receive 1 CME credit, at least 7 of the 10 answers must be correct. Estimated time for this activity is 1 hour. CME credits are distributed on a yearly basis.

1. What percentage of primary care medical outpatients will have their mental disorders missed by the primary care practitioner?

- a) 20-25%
- b) 25-50%
- c) 50-60%
- d) 60-75%

2. When primary care practitioners diagnose depression, what percentage of the time will they prescribe anti-depressants?

- a) 20%
- b) 30%
- c) 50%
- d) 75%

3. What percentage of patients with depression treated by primary care practitioners will have recovered over the course of the year?

- a) 10-20%
- b) 50-80%
- c) 90%
- d) 20-50%

4. Primary care patients with a psychiatric disorder are likely to have more than one psychiatric disorder what percentage of the time?

- a) 10-20%
- b) 20-40%
- c) 60-80%
- d) 50-60%

5. Patients who have more than one psychiatric disorder are likely to have a worse outcome and a worse prognosis.

- a) true
- b) false

6. The top 10% of high utilizers of general medical services account for what percentage of all hospital days?

- a) 40%
- b) 50%
- c) 20%
- d) 10%

7. The top 10% of high utilizers of general medical services account for what percentage of all specialty visits?

- a) 10%
- b) 50%
- c) 20%
- d) 40%

(CME QUESTIONS CONTINUED ON FOLLOWING PAGE)

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*On the whole, how do you rate the information presented in the article?*

\_\_\_\_\_ excellent    \_\_\_\_\_ good    \_\_\_\_\_ fair    \_\_\_\_\_ poor

*Is the information presented useful in your practice?*

\_\_\_\_\_ yes    \_\_\_\_\_ no

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\_\_\_\_\_ yes    \_\_\_\_\_ no

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\_\_\_\_\_ yes    \_\_\_\_\_ no

If so, which?

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\_\_\_\_\_ yes    \_\_\_\_\_ no

*Is there subject matter you would like included in the future?*

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\_\_\_\_\_ yes    \_\_\_\_\_ no

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Program Evaluation

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(continued from previous page)

**8. What percentage of the top 10% of high utilizers of general medical services have emotional disorders?**

- a) 70%
- b) 30%
- c) 50%
- d) 40%

**9. The most effective treatment with the best outcome for patients with depression in primary care does not involve combined collaborative treatment between the primary care physician and psychiatrist.**

- a) true
- b) false

**10. Treatment of patients with somatization disorder has been shown to result in clinical improvement and decreased medical utilization with cost savings.**

- a) true
- b) false