Moderator: Our next presenter is Doctor Terri Barrera. Oh, you’re there already, I’m sorry. She’s an investigator in behavioral health implementation programs that center on innovation, effectiveness at the Michael Debakey VA medical center, assistant professor in department of psychiatry and behavioral sciences. Her research interests include improving diagnosis in practices. Her presentation today is diagnostic error among Veterans with anxiety and trauma related disorders.

Terri Barrera: Thank you. Alright, I’ll just start with a brief overview about anxiety and primary care. Of course, anxiety is one of the most prevalent psychiatric disorders. In the general population, the estimates, lifetime prevalence estimates are around 28 percent and of course, it’s associated with lots of negative outcomes including functional impairment, poor quality of life and high rates of comorbid disorders. We do know that patients with anxiety are most likely to present in the primary care setting but unfortunately, many of them do not get treatment. About 50 percent of patients with anxiety go untreated in primary care and even fewer receive evidence-based interventions, either pharmacotherapy or psychotherapy.

 That was just in the general public. In the VA, we looked at data from fiscal year 2015 and found that around 500,000 Veterans carried a diagnosis of one of the anxiety disorders in the medical record, and this number here, the unspecified anxiety diagnosis, was really striking to me that the majority of patients had this unspecified anxiety diagnosis versus one of the more specific anxiety diagnoses such as generalized anxiety disorder, panic disorder, social anxiety disorder, obsessive compulsive disorder or agoraphobia. We’ll come back to this idea of the high rates of this diagnosis. As Rebecca talked about earlier, the VA mandates that Veterans with anxiety and PTSD should have access to evidence-based interventions for these disorders, whether it be psychotherapy or pharmacotherapy, and the VA’s invested substantial resources in trying to make this come to life, so hiring more mental health providers, embedding mental health providers in the primary care setting, but we all have questions about whether Veterans are receiving these evidence-based interventions.

 One of the things that we thought about, we looked at a cohort—some of my colleagues in the room here and I looked at a cohort of patients who were newly diagnosed with anxiety disorders to see whether or not they received any mental health services. And this isn’t even talking about evidence-based mental health services, but just whether they had one visit, whether it would be a medication management visit or a psychotherapy visit. We looked at some bench data, 292 thousand Veterans who were newly diagnosed with an anxiety disorder and up by 2010 and the rates of diagnoses that are presented here and some patients had multiple specific anxiety disorders, but the patients who had an unspecified anxiety disorder did not have another specific anxiety disorder. Of course, PTSD was the most frequent diagnosis, but then unspecified anxiety was pretty close to that, followed by GAD, panic, OCD, and social anxiety. What was striking to me about this was that patients with any of the specific disorders were likely to get services, at least one mental health visit, whereas patients who were diagnosed with unspecified anxiety were much less likely to get even one visit after this diagnosis.

 To summarize these finding, again, high rates of unspecified anxiety, about 38 percent diagnosed with that and it was more likely to be diagnosed in primary care versus specialty mental health, which made some sense to me and in some ways, it’s good, even, that patients are getting recognized as having anxiety in primary care. I mean, that’s another important step in the process. But, there is that differential rate of receiving services between the specified disorders and the non-specified disorders. Another thing we thought about, diagnosis is an evolving process that can occur over time. And so, maybe these patients who were diagnosed with an unspecified anxiety disorder initially, because remember, this was a group of patients who were newly diagnosed, so maybe these patients were recognized as having some form of anxiety but they required more time to really figure out what specific diagnosis they might meet criteria for. Unfortunately, this didn’t turn out to be the case very often, only 13 percent of patients who were initially diagnosed with the unspecified anxiety disorder went on to receive a specific anxiety diagnosis in the year following. Just to say a little bit more about unspecified anxiety. it’s the most common anxiety diagnosis in primary care and PCMHI settings. It’s actually 74 or 75 percent of anxiety diagnoses in our VA PCMHI clinics are unspecified anxiety disorder. Now, this is true not just in VA. This is not a VA only problem. This is also true in the general public, as well. It’s meant to be diagnosed, when a patient exhibits clinically significant anxiety symptoms that don’t meet criteria for one of the specific disorders. There’s a lack of treatment guidelines for unspecified anxiety. We have treatment guidelines for every other anxiety disorder and PTSD and this is true, again, within VA and outside of VA. There isn’t a treatment guideline for unspecified anxiety and the evidence-based treatments, even though SSRIs are generally our first line for all the anxiety disorders and PTSD, there is some difference in prescribing between the anxiety disorders and even though CBT is our general gold standard for all the specific anxiety disorders, it is differentially tailored to the patients presenting problems. It is important to have a better sense of the anxiety presentation.

 The high rates of anxiety disorders and the VA, we don’t know whether or not this unspecified—the rate of unspecified anxiety diagnosis—is that an accurate rate of representation of that diagnosis, because in the general—the epidemiological studies in the general public, anxiety disorder not otherwise specified or unspecified anxiety was not included, so we don’t have prevalence estimates of this disorder. We decided to look at a cohort of patients that we had enrolled in a trial of CBT for generalized anxiety disorder and so we had SCID diagnosis on these patients so we could look at the gold standard research diagnosis and then compare that to what was in the medical record. It was 61 older Veterans who were in primary care and were screened for inclusion in this RCT and they were diagnosed with an unspecified anxiety disorder in the electronic health record. Then again, we looked at the SCID diagnosis to see whether or not this was an accurate diagnosis.

 Turns out that only two percent of cases met criteria for unspecified anxiety disorder according to the SCID in our research study. 75 percent of them met diagnostic criteria for one of the specific anxiety disorders, PTSD and GAD being the most common follow by social anxiety and panic disorder. The remainder either met diagnostic criteria for a mood disorder, but not an anxiety disorder or they just didn’t meet criteria for any of the psychiatric disorders that we assess for on the SCID. Again, this rate of diagnostic error, 98 percent of the time this was a diagnostic error. Patients were better conceptualized as meeting criteria for a specific anxiety disorder or a depressive disorder in most cases. I think there are a lot of reasons that this might be the case, so just some things that come to mind, especially when we’re thinking about primary care as the setting, patient presentation, it can be very complex and of course our Veterans are very complex and so there can be some overlap with anxiety and medical conditions, some somatization of symptoms, but I think there are also a lot of provider and system level barriers. Not all providers are skilled or knowledgeable in differentiating among the many various anxiety disorders, it takes a lot of time to do that well, and I think in primary care and PCMHI in particular, there’re time and financial disincentives for doing full structure diagnostic interviews so it’s just not always possible. And, this, I think, is specific to the VA, but I think that there’s a pressure to not diagnose PTSD in primary care because that starts the clock on some of our performance measures.

 It seems really basic, but accurate diagnosis is so foundational and key to delivering evidence-based healthcare. It provides patients with an explanation of their symptoms, which is really important for a lot of our patients. I think this idea of facilitating communication between providers and we think about how many providers one Veteran meets with, and to be able to have this common language and this common understanding of the patient’s problem without the patient having to tell their story over and over and over again to each new provider they meet, but to have that common language already in the electronic health record to at least give the next provider some starting point with which they’re coming from. And it also provides the healthcare system with an accurate prevalence of these conditions. Currently, VA has not rolled out an evidence-based psychotherapy for any of the anxiety disorders other than PTSD and so, in planning which EVPs they might roll out, it’s important to know which disorders are the most common, which ones should we really be focusing our resources on delivering evidence-based health care.

 And finally, I love this quote from the institute of medicine. They did a report on improving diagnosis in healthcare, and they say that improving the diagnostic process is not only possible, but it also represents a moral, professional and public health imperative.

 To summarize, specified anxiety disorder is the most common anxiety related diagnosis in the VA, but is often a diagnostic error and accurate and timely anxiety diagnosis really facilitates access to appropriate evidence-based treatments, and improving the anxiety diagnostic process is really a critical step in VA’s mission to provide patient-centered quality healthcare. Some future work, like I said, psychiatric diagnosis is not easy. It’s a complex and evolving process and so I think we need to do a little bit more work to really understand where the breakdowns are happening and which patient level, system level, provider level factors are influencing this process before we can determine which specific points in the process would be ideal for intervention. I think that’s it. Questions?

[Applause]

Ranak Trivedi: Ranak Trivedi from Palo Alto. Great study, really eye-opening, also. I had two questions. One is, of the people who had the unspecified anxiety, do you know how many of them were carrying another—especially depression and is there any suggestion or speculation that maybe they initially present with anxiety but then they were getting good treatment for depression and that somebody just forgot to take off the unspecified anxiety diagnosis? And the other is, what is the problems of adjustment disorder with anxiety if that’s documented?

Terri Barrera: Okay, the first question about the morbid depression. This sample of patients, I only presented on the anxiety patients, but in this sample, we also—we pulled a cohort of patients who were newly diagnosed with either an anxiety, depression or PTSD diagnosis and so, there was some comorbidity with depression, but these were patients who didn’t have any of those three categories of diagnoses before this initial cohort. They might have had both diagnoses at the same time, but it wasn’t long standing. And again, I think the rates of receiving treatment for that unspecified anxiety group are just so much lower than all the other disorders, even with the comorbid depression still a concern and then I don’t have data on the adjustment disorder.

Unidentified Male: Questions?

Justin Benser: Hi, Justin Benser. I wonder if you’ve thought at all about why these diagnoses aren’t followed up? It seems to me that the problem isn’t that primary care is diagnosing uncertainty in the anxiety. It’s that they aren’t referring to PCMHI, they aren’t sending—especially mental health, it just stops right there.

Terri Barrera: Yeah, great question. I wish I knew the answer. I think—I thought the same thing, actually. Again, great that they’re being recognized as having anxiety in primary care, let’s just get them to PCMHI and then PCMHI can nail down that diagnosis. But again, 74 percent of diagnoses—of anxiety diagnoses in PCMHI are unspecified anxiety. Something is still not working in that setting, as well. And PCMHI, they have to do rapid assessment. They do these 30-minute assessments and I think it can be difficult for them to do a full diagnostic evaluation in that time, but that’s certainly something we’re looking at and trying to figure out, like you said, where in the process do we really intervene to make that work.

Vanessa Panaite: Hi, I’m Vanessa Panaite and I’m a clinical psychologist. I wonder if you looked at severity of symptoms because sometimes people tend to assign a diagnosis like this when severity is low and are uncertain about kind of chronicity or whether certain symptoms are due to anxiety or other problems, like you mentioned, somatization.

Terri Barrera: Right. No, that’s a great question and that’s something we did consider, but remember, in order to be diagnosed with anxiety, an unspecified anxiety disorder, they have to have clinically impairing symptoms. The symptoms should be severe enough to warrant a diagnosis at all, but I do think that in practice sometimes that is the case that it’s diagnosed when they have lower symptoms. But again, then when we looked at the diagnosis according the SCID, actually 75 percent, 74 percent of them met criteria for a specific anxiety disorder suggesting that many of them do have clinically significant symptoms that would warrant treatment.

[Applause]

[End of Audio]