Mental Illness and Mental Health Care Receipt among Seriously Ill Veterans

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• Nothing to disclose

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Poll Question:
Which of the following best describes your role in the CDA program? (Check all that apply)

A. Current CDA awardee
B. Past CDA awardee
C. CDA Mentor
D. Other CDA program involvement
E. Not affiliated with CDA program
Case – Mr. Jones

Image from http://www.agingcarefl.org/
Case from Am Assoc for Geriatric Psychiatry  2003. The Clinical View: Geriatric Psychiatry in LTC, 2(1)
Psychological Distress among Seriously Ill Older Adults

- Depression
- Generalized Anxiety Disorder
- Adjustment Disorder
- PTSD

Symptoms → Diagnosis

- Preparatory Grief
- Spiritual Distress
- Concerns about Preparing for the End of Life
Psychological and Spiritual Distress
Symptoms Overlap near End of Life

Depression symptoms

PTSD symptoms

Guilt/Shame

Unresolved Grief

Fear

Anxiety

Spiritual distress symptoms
Distress Related to Practical and Social Concerns

Factors Very Important to Seriously Ill Patients (%)

- Name a decision maker
- Have financial affairs in order
- Say goodbye to important people
- Resolve unfinished business w/loved ones
- Spend time with close friends
- Family prepared for death
- Funeral arrangements planned
- Presence of family
- Treatment preferences in writing

Steinhauser et al. 2000 JAMA 284(19): 2476-2482
Depression and Anxiety Complicate Management of Serious Physical Illnesses

↑ Physical symptoms
↑ Risk of hospital readmission
↑ Hospital length of stay
↓ Quality of life
↓ Pain control
Keeping up with Demand for Mental Health Providers in VHA?

Executive Order -- Improving Access to Mental Health Services for Veterans, Service Members, and Military Families

https://www.whitehouse.gov/the-press-office/2012/08/31/executive-order-improving-access-mental-health-services-veterans-service

https://www.govtrack.us/congress/bills/113/hr3230/text/enr
Strategies to Improve Mental Health Management among Seriously Ill Veterans

• Target specialty mental health care to patients most likely to benefit from it

• Alternative means for providing mental health care
  – Palliative Care
  – Spiritual Care
Palliative Care Includes Focus on Psychological Symptoms

Preferred Practice #15:

“Manage anxiety, depression, delirium, behavioral disturbances, and other common psychological symptoms in a timely, safe, and effective manner to a level acceptable to the patient and family”

Impact of Palliative Care on Depression and Anxiety Symptoms

Percent of Patients Exhibiting Mood Symptoms

<table>
<thead>
<tr>
<th></th>
<th>Standard Care</th>
<th>Early Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>HADS-D (Depression)</td>
<td>38%</td>
<td>16%</td>
</tr>
<tr>
<td>PHQ-9 (Depression)</td>
<td>17%</td>
<td>4%</td>
</tr>
<tr>
<td>HADS-A (Anxiety)</td>
<td>30%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Temel et al. 2010. NEJM 363: 733-742
Chaplains’ Role in Addressing Distress

• Chaplain care associated with improved quality of life

• Less stigma associated with chaplains than mental health professionals

• VA Mental Health and Chaplaincy Collaborative
Research to Identify Ways to Improve Management of Distress among Seriously Ill Veterans

• Characterize unmet needs for distress management
• Characterize variations in care
• Develop decision support tool to identify veterans most likely to benefit from specialty mental health care
• Improve evidence base for management of overlapping symptoms of psychological and spiritual distress
Characterizing Psychological Distress Management in VISN 3

- Was psychological distress assessed and addressed?
- Was mental health care provided to distressed patients?
- Were potentially inappropriate medications used to manage distress?
Methods

• Electronic medical record review (n=287)

• Veterans with an inpatient PC consultation request in a VISN 3 acute care facility in FY2009-2010

• Diagnosis of advanced cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), or HIV/AIDS
Variables

• Psychological needs assessment:
  • Condensed Memorial Symptom Assessment Scale

• Receipt of mental health care prior to discharge:
  • Emotional/psychological support
  • Psychotherapy
  • Health and behavior interventions
  • Counseling
  • Support groups
Patient Characteristics

<table>
<thead>
<tr>
<th>% with Condition</th>
<th>Advanced Cancer</th>
<th>COPD</th>
<th>CHF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>56.8</td>
<td>33.5</td>
<td>19.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable</th>
<th>M(SD) or N(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>74 (11)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>151 (53%)</td>
</tr>
<tr>
<td>African American</td>
<td>110 (38%)</td>
</tr>
<tr>
<td>Other or Missing</td>
<td>26 (9%)</td>
</tr>
<tr>
<td>Hispanic ethnicity</td>
<td>28 (10%)</td>
</tr>
<tr>
<td>Length of stay (days)</td>
<td>20 (19)</td>
</tr>
<tr>
<td>Died during index hospitalization</td>
<td>72 (25%)</td>
</tr>
</tbody>
</table>
Percent with History of Mental Illness Noted in Medical Record in Year Prior to Hospitalization

(N = 287 veterans in VISN 3; FY 2009-2010)

- Depression: 15%
- Anxiety: 14%
- Alcohol dependence/abuse: 13%
- Adjustment disorder/reaction: 11%
- Drug dependence/abuse: 9%
- Schizophrenia / schizoaffective: 6%
Psychological Distress Assessment in Palliative Care Consult

220 patients were cognitively and physically able to complete the psychological symptom assessment

- 91% were assessed
- 44% reported some sadness, worry, and/or nervousness
- 14% had at least one of these symptoms frequently or almost constantly
Psychotherapy and Emotional Support Provided to Patients Post-Palliative Care Consultation

In adjusted analyses, psychological distress documented during the consultation did not predict mental health care receipt after the consult.
Unmet Need for Mental Health Care

Hospitalized Patients Reporting Nervousness, Worry, or Sadness at Palliative Care (PC) Consult

- 62% No In-Hospital Mental Health Care after PC consult
- 38% In-Hospital Mental Health Care after PC Consult

Factors Associated with Mental Health Care after PC Consult

<table>
<thead>
<tr>
<th>Variable</th>
<th>Adjusted Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of substance abuse</td>
<td>2.64 (1.08-6.50)</td>
</tr>
<tr>
<td>Psychotropics earlier in hospitalization</td>
<td>2.72 (1.26-5.87)</td>
</tr>
<tr>
<td>Depression/anxiety earlier in hospitalization</td>
<td>0.43 (0.20-0.92)</td>
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<tr>
<td>Died during hospitalization</td>
<td>0.41 (0.17-0.99)</td>
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- 49% of veterans who died reported psychological distress during the PC consult
- Mean time between PC consult and death was 13.2 days (SD=15.0)
Characterizing Psychological Distress Management Nationally

• How many hospitalized seriously ill veterans have comorbid mental illnesses?

• Are there geographic variations in treatment of comorbid mental illnesses?

• Are there relationships among mental illness, mental health treatment, and risk of ICU admission?


Methods

• Secondary analysis of data from 2006-2011 Medical SAS Inpatient and Outpatient files, DSS NDE Pharmacy and Treatment Specialty files, and Vital Status File for seriously ill veterans admitted to a VHA acute care facility in FY2011 (n=22,230)

• Included: advanced cancer, CHF, COPD, HIV/AIDS

• Excluded: delirium, dementia, admission to psychiatric wards, <48 hour length of stay, admission for regular chemotherapy
## Characteristics of Sample and Hospital Stays

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD) or N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>68 (11)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>16,143 (72.6%)</td>
</tr>
<tr>
<td>Black</td>
<td>4,032 (18.2%)</td>
</tr>
<tr>
<td>Other</td>
<td>2,035 (9.2%)</td>
</tr>
<tr>
<td><strong>Serious physical illness(es)</strong></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>10,343 (46.5%)</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>371 (1.7%)</td>
</tr>
<tr>
<td>COPD</td>
<td>7,754 (34.9%)</td>
</tr>
<tr>
<td>CHF</td>
<td>5,827 (26.2%)</td>
</tr>
<tr>
<td><strong>Length of stay (days)</strong></td>
<td>8 (10)</td>
</tr>
<tr>
<td><strong>Total direct hospitalization costs</strong></td>
<td>$14,096 ($20,165)</td>
</tr>
<tr>
<td></td>
<td>(Median $8,317; IQR $4,952-$15,606)</td>
</tr>
<tr>
<td><strong>ICU admission</strong></td>
<td>3,839 (17.3%)</td>
</tr>
<tr>
<td><strong>Palliative care or hospice care</strong></td>
<td>5,297 (23.8%)</td>
</tr>
<tr>
<td><strong>Died during hospitalization</strong></td>
<td>1,219 (5.5%)</td>
</tr>
</tbody>
</table>
One-Quarter of Veterans had a Mental Illness Diagnosis at Index Hospitalization

(n = 22,230 seriously ill veterans nationwide; FY 2011)

- Depression: 10.4%
- Alcohol abuse/dependence: 5.2%
- PTSD: 4.7%
- Other anxiety: 3.2%
- Drug abuse/dependence: 2.5%
- Schizophrenia spectrum disorder: 2.4%
- Bipolar disorder: 1.6%
- Other psychosis; delusion: 1.3%
- Adjustment disorder: 0.9%
- Other: 0.7%
Percent of Patients with a Mental Illness Diagnosis Present at Index Hospitalization

- COPD
- HIV/AIDS
- Cancer
- CHF

- Depression
- Anxiety
- Alcohol use disorder
- Drug use disorder
Prevalence and Incidence of Depression and Anxiety During and Before Hospitalization

<table>
<thead>
<tr>
<th></th>
<th>Depression</th>
<th>Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index hospitalization</td>
<td>0.6</td>
<td>5.1</td>
</tr>
<tr>
<td>1 year before hospitalization</td>
<td>1.6</td>
<td>2.2</td>
</tr>
<tr>
<td>5 years to 1 year before hospitalization</td>
<td>10.4</td>
<td>15.8</td>
</tr>
</tbody>
</table>
Receipt of Any Mental Health Care among Patients with Incident Depression or Anxiety

<table>
<thead>
<tr>
<th></th>
<th>Psychotropic Medication</th>
<th>Psychotherapy</th>
<th>Either</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Index hospitalization</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression (n=482)</td>
<td>187 (38.8%)</td>
<td>31 (6.4%)</td>
<td>200 (41.5%)</td>
</tr>
<tr>
<td>Anxiety (n=125)</td>
<td>40 (32.0%)</td>
<td>2 (1.6%)</td>
<td>42 (33.6%)</td>
</tr>
<tr>
<td><strong>Year before hospitalization</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression (n=1249)</td>
<td>563 (45.1%)</td>
<td>477 (38.2%)</td>
<td>772 (61.8%)</td>
</tr>
<tr>
<td>Anxiety (n=360)</td>
<td>172 (47.8%)</td>
<td>138 (38.3%)</td>
<td>231 (64.2%)</td>
</tr>
</tbody>
</table>
Wide Geographic Variation in Prescription of Antidepressants to Hospitalized Patients with Depression

Veterans Integrated Service Network (VISN)
• Many veterans hospitalized with advanced physical illnesses have comorbid mental illnesses

• Many may benefit from additional depression and anxiety treatment

• How do we identify who is most likely to benefit from specialty mental health care?
Identification of Patients Most Likely to Benefit from Specialty Mental Health Care

- Depression/Anxiety (PTSD)
- Patient physical health
- Sociodemographics
- Site of care

Flowchart:
- Depression/Anxiety (PTSD) → ICU Admission
  - ICU Admission → Costs of Care
  - ICU Admission → Palliative Care → Mental Health Care
Preliminary Results

• Diagnosed depression before hospitalization associated with a small but statistically significant increase in risk of ICU admission during hospitalization (18% vs. 17%)

• Relationship no longer significant in logistic regression model adjusting for patient illness, sociodemographic characteristics, and site of care
Future Directions:
Improving Evidence Base for Management of Psychological and Spiritual Distress

“Shame, guilt, anger, and issues of forgiveness”
[Chaplain 1]

“We also deal with some of the.. existential pain as well as physical pain management at end of life and help with the psychological factors of that.” [Psychologist 3]
Summary

• Many veterans hospitalized with advanced physical illnesses have comorbid mental illnesses

• Many may benefit from additional depression and anxiety treatment

• For individuals near death, hospitalization may be the only opportunity to address psychological distress

• Palliative care providers and chaplains play a role in addressing distress among seriously ill older patients
“Ideally, health care harmonizes with social, psychological, and spiritual support as the end of life approaches” (IOM 2014)

“All clinicians should be able to identify distress and direct its initial and basic management” (IOM 2014)
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