Coming to The Heart of Integrated Care
An Integrated Primary-Care Approach to Heart Disease

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Psychiatry in The Mountains: Bridging Psychiatry and Primary Care

No Financial Conflicts to Disclose

Objectives

- Discuss current evidence on heart disease and psychiatric co-morbidities
- Address behavioral issues in heart disease
- Examine the intersection of clinical medicine and behavioral health—explore models for integrative care in chronic disease
Question for Consideration

• What behaviors and psychiatric conditions would concern you, in the care of a patient with active heart disease?
• Write down a list of these behaviors and conditions.

2-Person Discussion

• Turn to your neighbor to discuss your lists.
• Add conditions to your list, as appropriate.
Summary of the Effect of Psychiatric Concerns on CHD

• Depression, anxiety, anger, acute stress, and cocaine abuse all cause more cardiac events, and increase mortality.
• Treatment for these conditions will definitely help the conditions themselves.
• It is less clear that treatment for depression/anxiety/anger/stress reduces the increased CHD risk.

Depression

• Depression is very common:
  – Most surveys find a prevalence about 15% in the CHD population, with range as high as 30%
  – Counting minor depression, prevalence can exceed 40%
  – But in patients hospitalized for MI, CABG, of HF, the diagnosis is difficult—many “cases” resolve after discharge—perhaps counting minor depression inflates prevalence numbers
  – Women have higher rates of depression than men
  – Post-MI patients have depression rate 20%

Over All Depression in Adults

• In 2013, 6.7% of adults aged 18 or older (15.7 million people) had at least one MDE in the past year. The percentage of adults who had a past year MDE remained stable between 2005 (6.6%) and 2013 (6.7%).
• Among adults aged 18 or older, the percentage having past year MDE in 2013 was lowest for those aged 50 or older (5.1%), followed by those aged 18 to 25 (6.0%), and highest for those aged 26 to 49 (7.5%).

References 1, 2, 4, 6, 6'
Other Risk Factors for Depression

- Some prevalence studies have shown rates as high as 27% in men and 35% in women
- Women have more cognitive-affective and somatic symptoms than men when hospitalized for CHD; feelings of "constraint" also worsens risk
- Poor education—less than H.S. degree—also increases CHD risk: 73% in men and 48% in women

References 1, 4, and 5

Depression Is a Trigger for CHD

- Depressed people without CHD, compared with controls, have HR for CHD 1.6 to 1.93 (2nd study followed over 6 years)
- In the INTERHEART case-control study, with over 11,000 subjects, the population-attributable risk of depression + perceived stress was 32.5%; equal to smoking, and more than diabetes and hypertension
- Heart and Soul study of stable CHD, positive PHQ for depression gave HR 1.5/AR 3.3% for annualized cardiovascular events

References 1, 2

Depression Associated with Increased Mortality

- Multiple studies established an association between depression and increased CHD mortality:
  - All-cause mortality HR's in leading studies: 1.80, 1.76, 1.31, 1.4, 2.0, and 1.63; with diabetes, 2.50
  - All-cause mortality increases with severity of the depression, per the Cardiovascular Health Study
  - Cardiovascular mortality HR's: 1.52 and 1.75; 2.43 with concurrent diabetes

References 1, 2, 12, 17, 18
Depression Worsens Other Outcomes

• In the literature review for the Australian guidelines for depression and CHD, depression was also associated with:
  – Delayed return to work
  – Poorer exercise tolerance (predicts 5-yr decline)
  – Poorer adherence to the treatment plan
  – Worsened disability and more dependence
  – Poorer quality of life
  – Increased cognitive decline

References 1 and 8

Anxiety and Stress

• Anxiety + depression = HR 3.10 for all-cause mortality
• Acute stress + depression = increased ischemia in patients with stable CHD
• Anxiety is an independent risk factor for MI, with hazard ratio 1.43 per standard deviation above the mean.
• Acute and chronic stress are independent risk factors in development of a 1st cardiac event

References 2, 16, 18, and 19

Anger

• The ARIC trial of ~ 13,000 subjects with normal blood pressure and high trait anger showed HR 2.7 for acute MI or cardiac mortality
• Acute anger within 2 hours of MI symptom onset noted in 2.4% of MI’s in 1 study; a meta-analysis of 4 observational trials showed HR of 5 for acute cardiac events within 2 hours of an outburst of anger

Reference 2
Limited Benefit from Pharmacologic Therapy

- Antidepressants help depression, and anxiety treatment helps anxiety, but neither clearly helps reduce the increased cardiac risk
- SSRI’s do not benefit the increased ischemia associated with acute stress in stable CHD
- Adding omega-3 FA’s to sertraline does not benefit cardiac outcomes
- Tricyclics not recommended due to adverse effects

References 1, 10, 11, and 16

Some Benefit from Non-Pharmacologic Therapy

- Exercise helps depression as much as sertraline. Cardiac rehab reduces depression, and improves cardiac markers
- Music helps anxiety/lowers BP and pulse
- Community interventions slightly benefit elderly adults with depression and CHD
- Most benefit from CBT; some benefit from relaxation therapy and general education
- 2 Cochrane reviews of psychologic interventions in CHD showed benefit on depr/anxiety, but not CHD benefit—a?some with treating Type A behavior

References 3, 6, 7, 11, 13, 14, and 15

Guidelines: National Heart Foundation of Australia

- Screen all newly-diagnosed CHD patients for depression at the 1st and 2nd appointments, and after 2 to 3 months.
- Consider CBT, collaborative care, exercise, and antidepressants (excluding TCA’s).
- Offer treatment, but patient should be aware that better CHD outcomes may not be attainable, even with treatment of the depression.
Review & Discuss Case 1

Integration Defined

Integration is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve the services in relation to access, quality, user satisfaction and efficiency.

Levels of Integration

Full Integration

“We’re all in this together”
Integration vs. Co-Location

**Integrated Care**
- Embedded member of primary care team
- Patient contact via hand off
- Verbal communication predominate
- Brief, aperiodic interventions
- Flexible schedule
- Generalist orientation
- Behavior medicine scope

**Co-Located Mental Health**
- Ancillary service provider
- Patient contact via referral
- Written communication predominate
- Regular schedule of sessions
- Fixed schedule
- Specialty orientation
- Psychiatric disorders scope

The Behavioral Health Consultant in Primary Care Characteristics, Skills and Orientation to Practice

**Characteristics**
- Flexible, high energy level
- Team Player
- Interest in health and fitness

**Skills**
- Finely honed clinical assessment skills
- Behavioral medicine knowledge base
- Cognitive behavioral intervention skills

**Orientation to Practice**
- Action-oriented, directive, focus on patient functioning
- Emphasis on prevention and building resiliency
- Utilizes clinical protocols and pathways
- Invested in educating patients, health literacy

Integration in Context

**Full Integration**
- Supports cultural competency among staff
- Shared/coordinated responsibility of care
- To the patient it feels like primary care.
- Charting in one chart/one format
- Creates seamless spectrum of care

Integration in Context
**Integrated Care in Action**

**Active movements** + **Passive movements** = **Medical Home**

- **Medical**
- **Family**
- **Community**
- **Behavioral**

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**Integration in Practice…**

- Emphasize functional goals over symptom elimination and cure.
- Focus on the small positives – motivational interviewing & stages of change.
- Realize that problems and their solutions are culturally influenced.
- Act as a consultant, not a therapist.
- Work with the patient to own the need for change.
- Recognize that preventing or slowing decline is a legitimate goal.

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**Clinical Outcome and Service Quality**

**Benefits of Integration**

- Improvement in depression remission rates: from 42% to 71% (Katon et. al., 1996)
- Improved self management skills for patients with chronic conditions (Kent & Gordon, 1998)
- Better clinical outcome than by treatment in either sector alone (McGruder et. al., 1986)
- Improved consumer and provider satisfaction (Robinson et. al., 2000)
- High level of patient adherence and retention in treatment (Mynors-Wallis et. al., 2000)
Review & Discuss Case 2

The Need for Inter-professional Education and Competencies

• Integrated behavioral healthcare cannot move forward without a healthcare workforce that is trained in and embraces inter-professional collaboration
• Our current healthcare system operates predominantly in professional silos
• Education of healthcare professionals is also done in silos - few students have an opportunity to work together and are not prepared to function as part of a team in an integrated approach to care
References


