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, or 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%

References 1, 2, 4, 6, 6’
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 26 to 49 (7.6%), then by those aged 18 to 25 (8.7%).
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—?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 1\textsuperscript{st} and 2\textsuperscript{nd} 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
“Integrated Care 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

<table>
<thead>
<tr>
<th>Integrated Care</th>
<th>Co-Located Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Embedded member of primary care team</td>
<td>• Ancillary service provider</td>
</tr>
<tr>
<td>• Patient contact via hand off</td>
<td>• Patient contact via referral</td>
</tr>
<tr>
<td>• Verbal communication predominate</td>
<td>• Written communication predominate</td>
</tr>
<tr>
<td>• Brief, aperiodic interventions</td>
<td>• Regular schedule of sessions</td>
</tr>
<tr>
<td>• Flexible schedule</td>
<td>• Fixed schedule</td>
</tr>
<tr>
<td>• Generalist orientation</td>
<td>• Specialty orientation</td>
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<tr>
<td>• Behavior medicine scope</td>
<td>• Psychiatric disorders scope</td>
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Characteristics

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

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

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
Integrated Care in Action

Active movements + Passive movements = Medical Home

Family  Medical  Community

Behavioral
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.
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., 1988)
- Improved consumer and provider satisfaction (Robinson et. al., 2000)
- High level of patient adherence and retention in treatment (Mynors-Wallace et. al., 2000)
Review & Discuss Case 2
Integrated behavioral healthcare cannot move forward without a healthcare workforce that is trained in and embraces interprofessional 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.
THIS TEAM IS AWESOME!

THEY RUN A GREAT PREVENT OFFENSE...

THEY PASS OVER UNNECESSARY PROCEDURES...

...DO END RUNS AROUND BUREAUCRATS... SLASH THROUGH COSTS...

HOLD IT! EXACTLY WHO ARE YOU TALKING ABOUT?

DOCTORS, NURSES, PHYSICIAN ASSISTANTS, DENTISTS... THEY'RE ALL ON MY PRIMARY CARE TEAM!


Selected References


Thank You