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MEDICAL PSYCHIATRY ALLIANCE
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The Centre for Seniors' Medical Psychiatry

Caring for Seniors with Coexisting Physical Illness and Depression/Anxiety Through Integrated Collaborative Care with Primary Care Providers

Canadian Collaborative Mental Health Care Conference
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Presenter Disclosure

- Presenters:
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  - Dr Judith Versloot PhD

- Relationships with commercial interest:
  - None

Learning Objectives

1. Illustrate the value of collaborative care models that involve partnerships between primary care and hospitals/specialists when caring for complex seniors with co-existing mental and physical health needs.

2. Outline the operations of a collaborative care model for seniors with chronic physical illness and depressed mood/anxiety with resulting functional impairment.

3. Describe how the collaborative care model builds capacity within primary care.

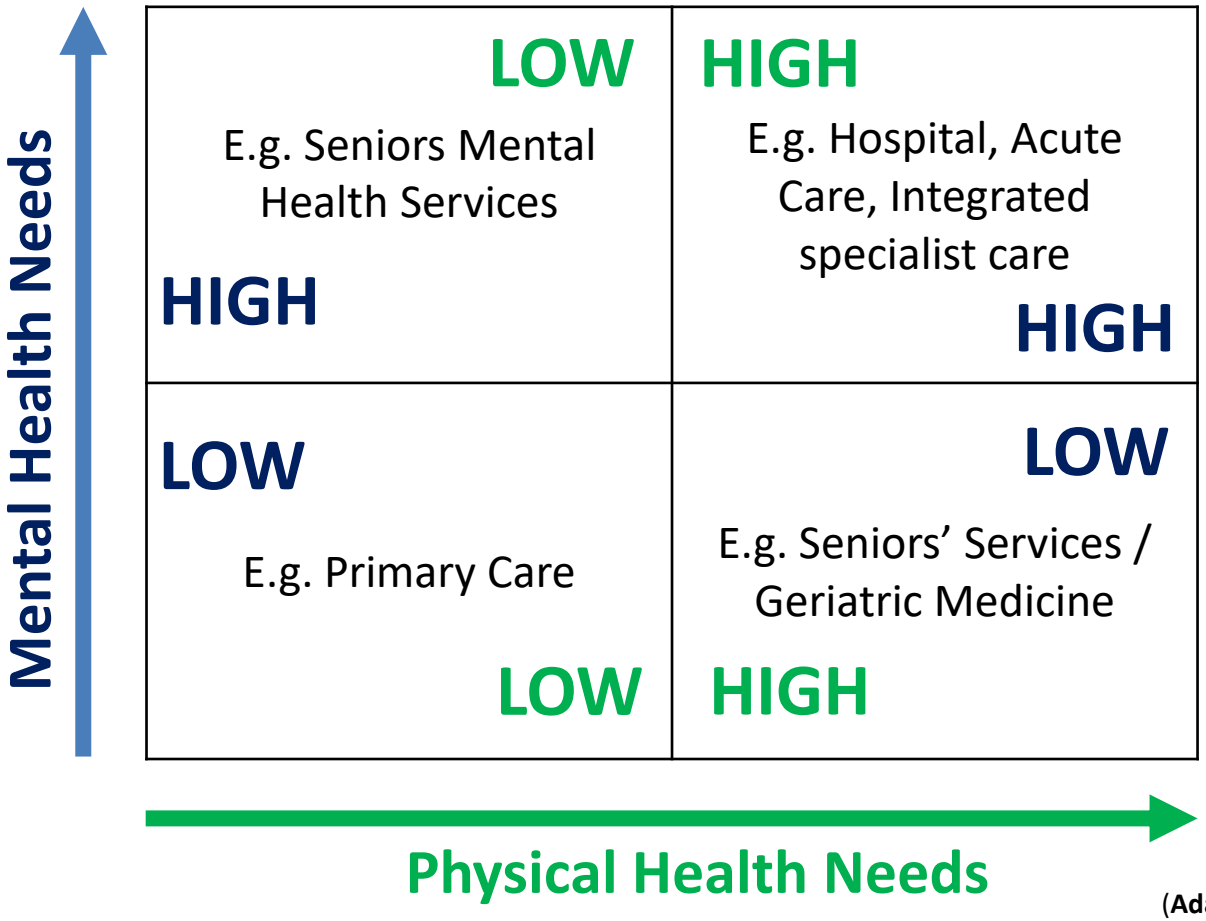
Medical Psychiatry Alliance (MPA)

Current State: System Challenges

Seniors with co-existing mental and physical health concerns encounter challenges with accessing care, including:

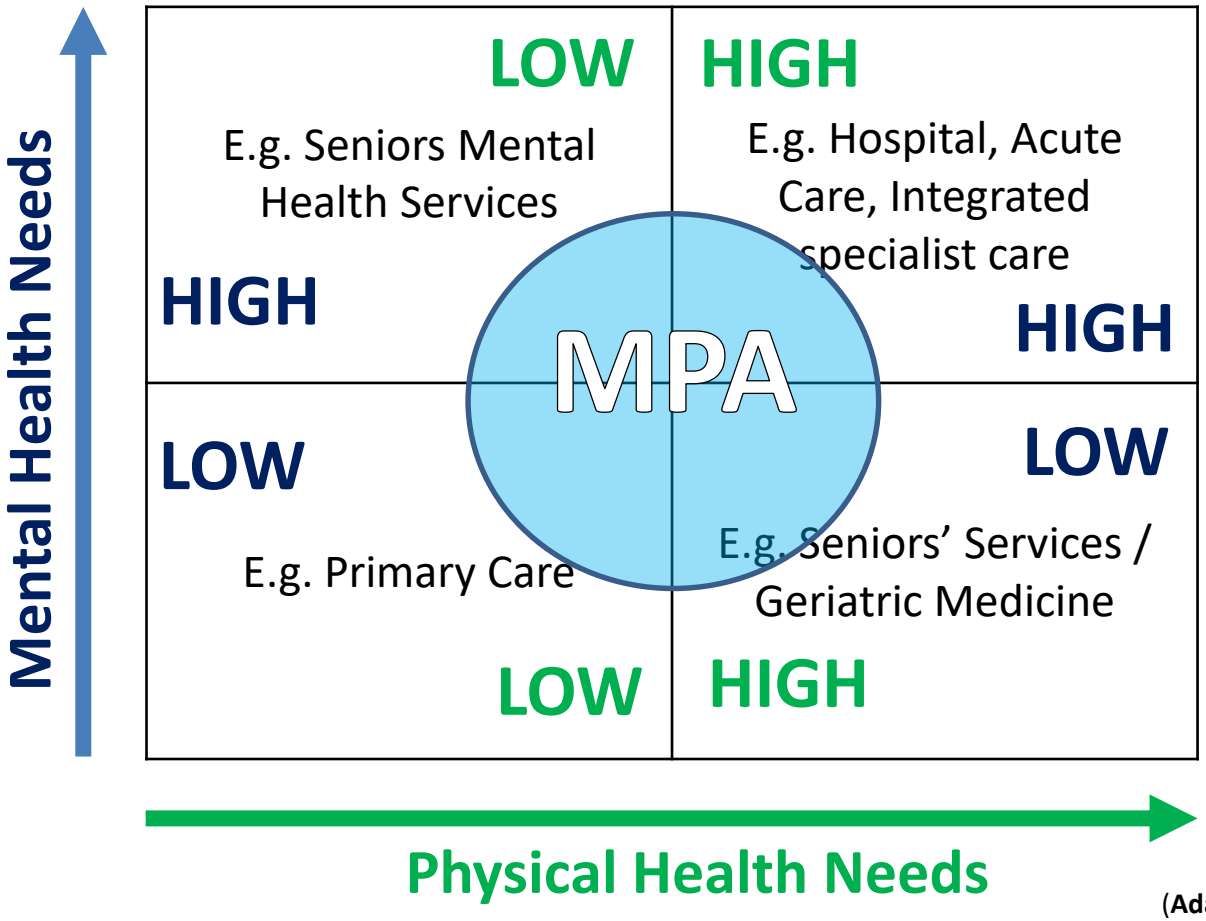
- Siloes of unintegrated specialized geriatric mental health and medical care services
- Limited availability of specialized geriatric mental health and medical care
- Lack of support for patients/caregivers to navigate health care system
- Disjointed communication across patient journey
- Stigmatization within all levels of mental health care
- Limited provider knowledge/ capacity to manage patients with co-occurring physical and mental health conditions

Context within Existing Services



(Adapted from Bartels, 2004)

Context within Existing Services

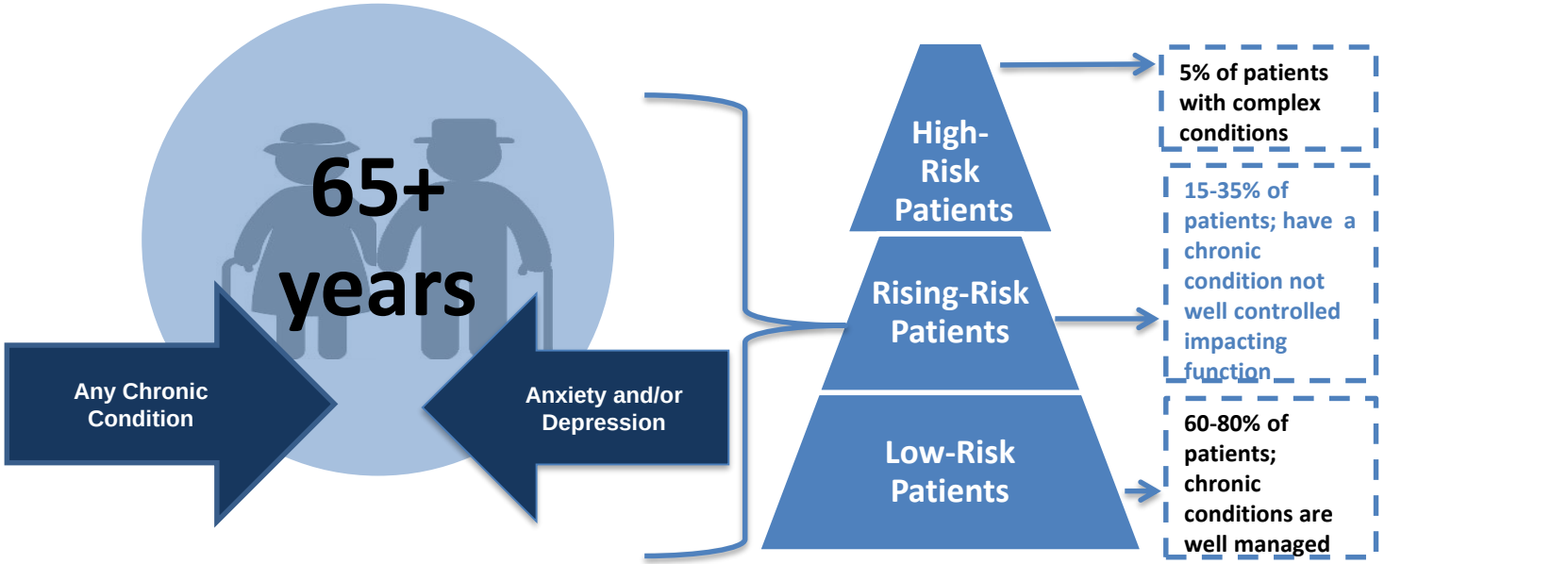


(Adapted from Bartels, 2004)

Objectives

- Improve health outcomes of frail seniors with chronic physical illness and depressed mood and/or anxiety.
- Use the limited specialist resources more efficiently by applying a collaborative care model anchored in primary care.
- Build capacity of primary care providers to manage patients with medical psychiatry concerns

Population

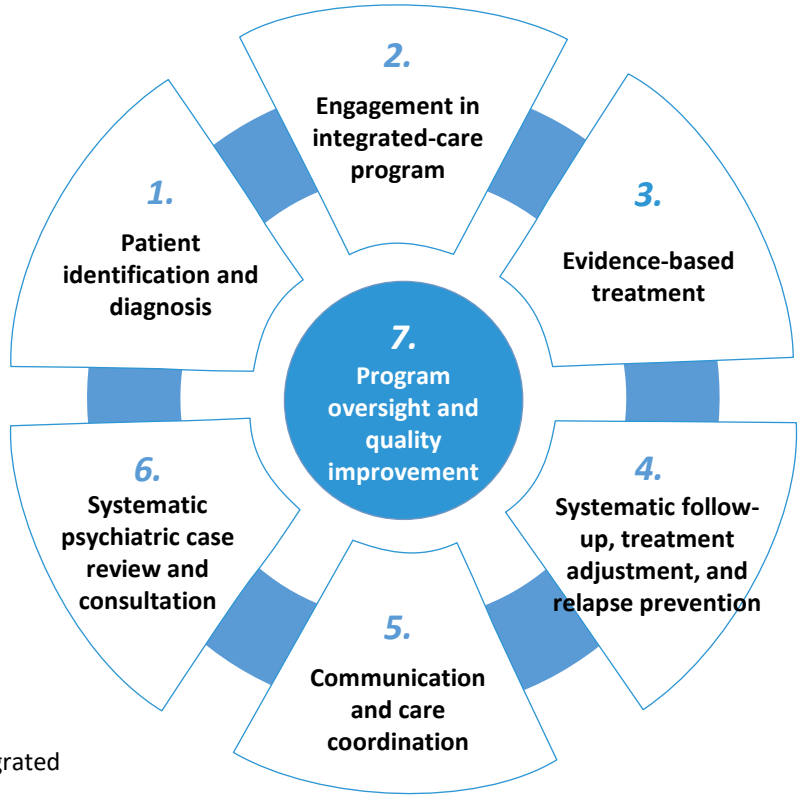


Elements of Collaborative Care

Principles

1. Patient-Centered Care
2. Population-Based Care
3. Measurement-Based Treatment to Target
4. Evidence-Based Care
5. Accountable Care

Tasks



Source: Adapted from the AIMS Centre (Advanced Integrated Mental Health Solutions, University of Washington)

Program Description

- Collaborative care model integrating Geriatric Medicine and Geriatric Psychiatry in an outpatient setting
- Primary care providers remain the most responsible practitioner
- Designed to facilitate collaboration, communication, and navigate health system resources
- Referrals are currently received from three sources

Program Components

A. Integrated Therapeutic Care Management with Psychotherapy (ENGAGE)
B. Systematic Case Reviews
C. Integrated Care Plan
D. Education and Capacity Building

A. Integrated Therapeutic Care Management

Care Managers/ allied health providers with dual training in mental and physical care will work with primary care providers and provide intervention for up to 16 weeks including:

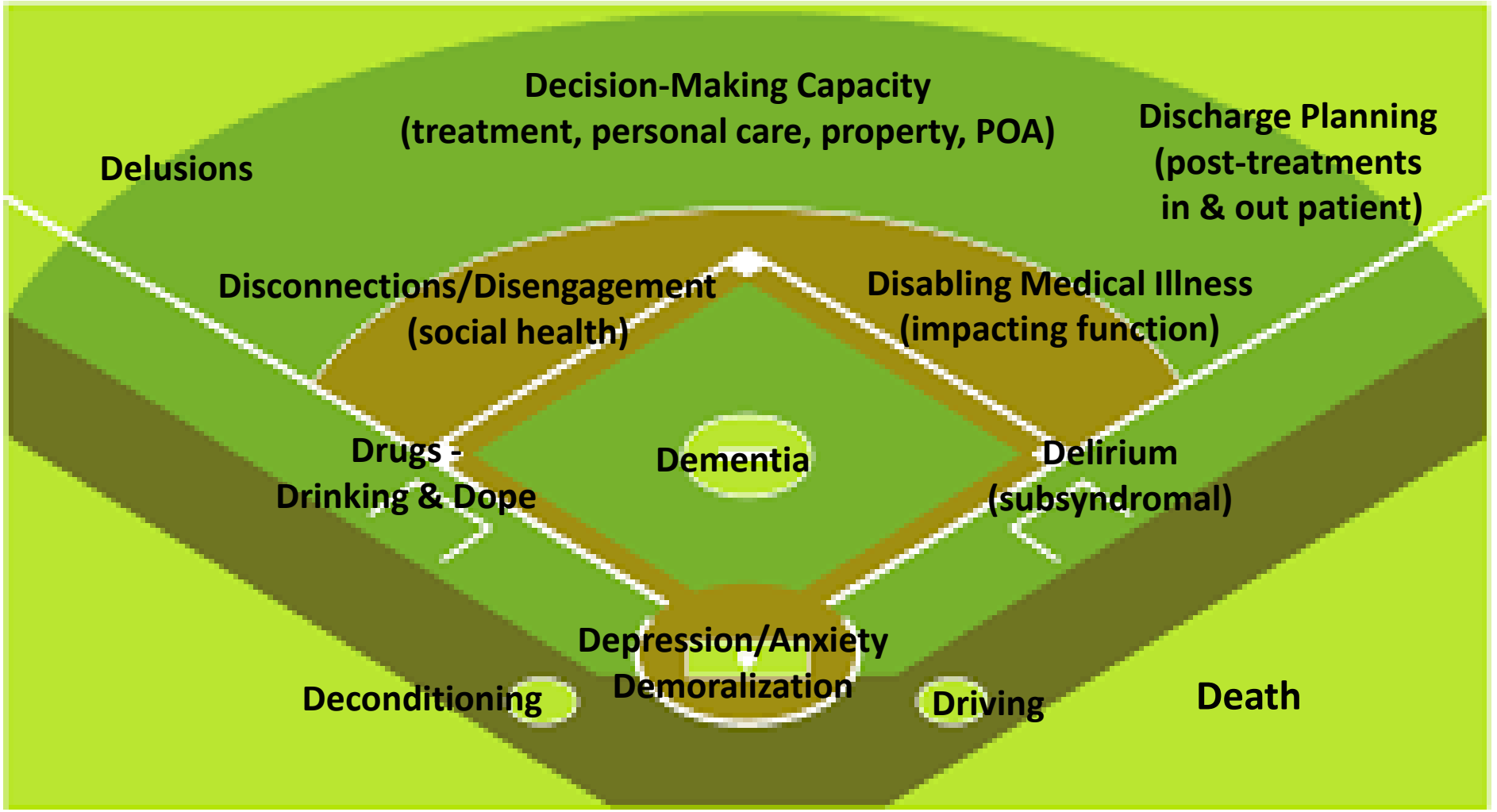
- Comprehensive assessment
- System navigation
- Modified problem solving and behavioural psychotherapy (ENGAGE)
- Use of symptom rating scales (Anxiety, depression, and function scales)
- Monitoring through Treat-to-target outcomes

Care Managers/ allied health providers will be supported with clinical supervision from the MPA Geriatrician and Geriatric Psychiatrist.

B. Systematic Case Review (SCR)

- Weekly structured patient case presentations
- Participants include a geriatrician, geriatric psychiatrist, primary care representative, and other allied health providers
- Primary care providers are encouraged to participate in the SCR of their patient by telephone
- Goals and treat to target outcomes are reviewed
- Recommendations made during the SCR- Care Managers/ allied health providers will work with the patient, caregivers, and primary care to implement these recommendations
- Primary care providers will remain MRP and consultations with geriatrician and / or geriatric psychiatrist are available as determined by team

12Ds of Geriatric Psychiatry



C. Integrated Care Plan

- Co-development of a single plan of care incorporating patient goals to be developed and shared with the patient, primary care team, and other involved health care providers.

D. Education and Capacity Building

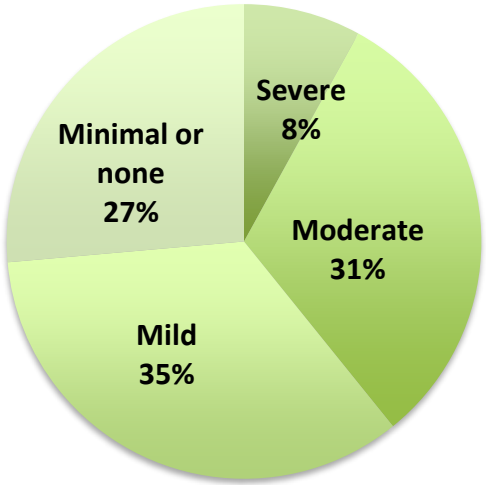
- Education and support for patients with co-occurring mental and physical health conditions and health care providers in the management of geriatric medical psychiatry conditions. This will be achieved through various modes of communication and educational opportunities.
  - PCP involvement in SCRs
  - PCP recognition of co-occurring mental and physical illness in the geriatric population.

Preliminary Results

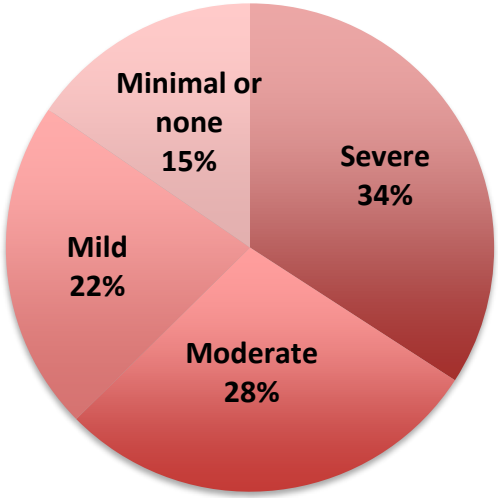
Demographics
n=127 (Jan 2017- April 2018)

- **Age**: mean 77.9 ± 7.3
  range 65-96 (26% ≥85 years)
- **Gender**: female 69% (n=88), male 31% (n=39)
- **Most Common Physical Conditions:** Heart Disease, Stroke, Chronic Pain

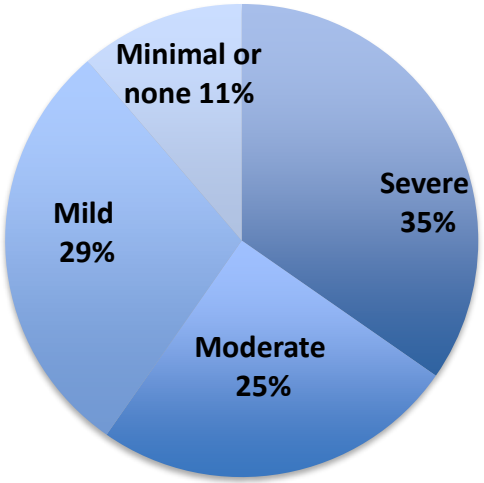
Function (WHO-DAS)



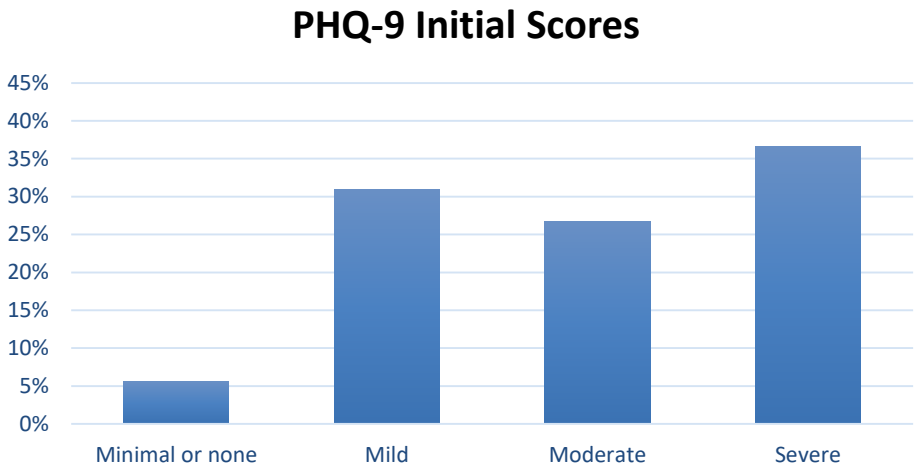
Anxiety (GAD-7)

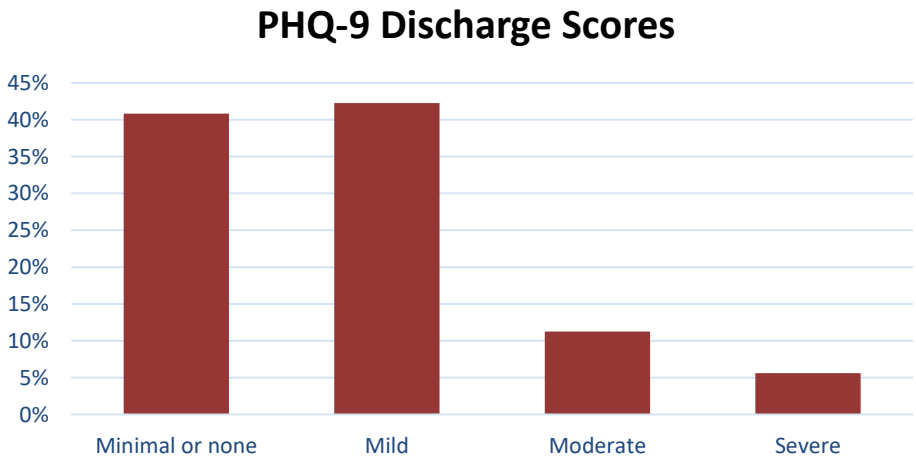


Depression (PHQ-9)



Clinical Outcomes
Depression



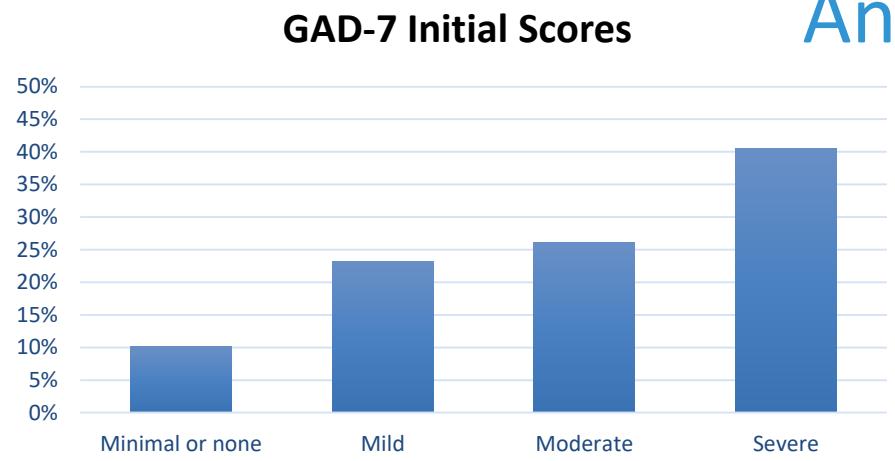


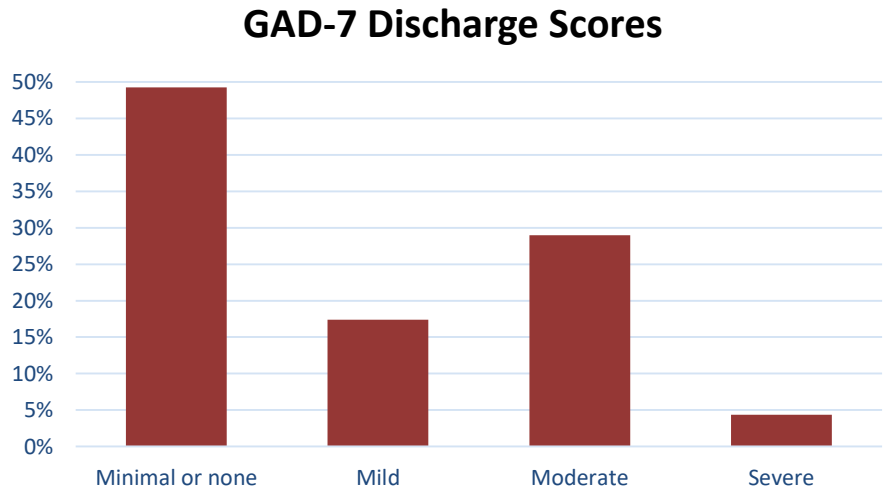
Depression (PHQ-9)

Of the patients who started the program with moderate or severe depression:

- 78% improved more than 30%
- 27% were asymptomatic at discharge (minimal or no depression)

Clinical Outcomes
Anxiety



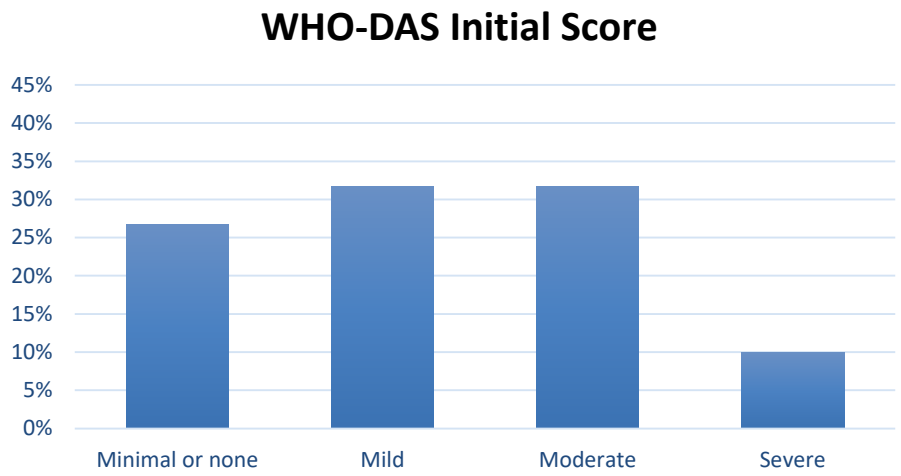


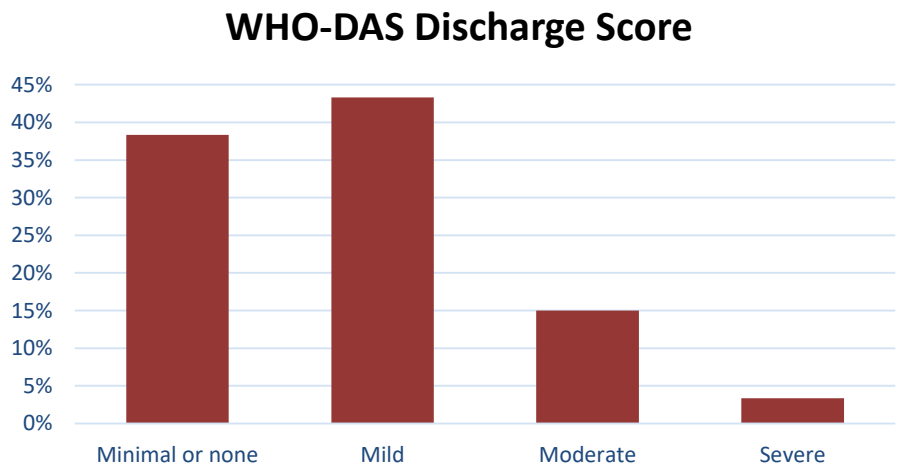
Anxiety (GAD-7)

Of the patients who started the program with moderate or severe anxiety:

- 63% improved more than 30%
- 30% were asymptomatic at discharge (minimal or no anxiety)

Clinical Outcome
Function





Function (WHO-DAS)

Of the patients who started the program with moderate or more severe disability:

- 48% improved more than 30%
- 12% displayed minimal or no disability at discharge

Capacity Building Outcomes

- 100% PCP's managing patients with support of the collaborative care model, without need for specialist consults
- Of the recommendations made during the systematic case reviews 78% of recommendations for PCP's were implemented
- Length of stay of all patients is around 15 weeks
  - Patients categorized as 'Low risk' have a length of stay around 9.5 weeks

Family & Patient Quote:

"Thank you for coming into our lives and getting support and help for my mom… She displays less anxiety, complains less of muscle aches, has more stamina… We both appreciate the time you took to listen and care for my mom. I know my mom feels she was heard when she spent time with you."

"I find this program was very very helpful to me. (My care manager) meant a great deal to me, she was very helpful, caring and supportive… She has taught me a lot."

Generating System Change – Work to Date

Imbed learnings from MPA into internal THP services:

1. Implemented systematic screening in the Seniors Rehab Day Hospital and trained RN with ENGAGE psychotherapy
2. Implemented PHQ2 in Senior Services telephone triage
3. Learnings from Systematic Case Reviews helped drive practice changes for the Nurse Practitioner in Senior Services to promote more independent practice
4. Seniors Mental Health training staff in Cognitive Behavioural Therapy as a form of structured psychotherapy instead of the usual supportive care

Questions…

Thank you

This work is supported in part by the Medical Psychiatry Alliance, a collaborative health partnership of the University of Toronto, the Centre for Addiction and Mental Health, the Hospital for Sick Children, Trillium Health Partners, the Ontario Ministry of Health and Long-Term Care and an anonymous donor