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Technology-assisted process speeds diagnosis, treatment

Hand-held devices ease burden of behavioral health assessment

By now, most providers have at least gotten the message that they need to be on the lookout for depression, anxiety, and other behavioral disorders that can present with physical symptoms -- and even interfere with treatment for traditional medical problems. However, while many health organizations have begun to screen for behavioral problems in some patients, the time constraints faced by PCPs often make it difficult for them to analyze these screens so that appropriate treatment or referrals can be made.

Why is this such a big problem? There is ample evidence to suggest that well over half of all visits to PCP offices are related to psycho-social problems. Further, many of these individuals will keep utilizing health care services as long as their problems persist. In the absence of effective treatment, these individuals will be less productive at work, they will experience a poor quality of life, and they will unnecessarily drive up health care costs as they continually seek relief.

"It is a pervasive problem that not only affects the patients, but the health care of the patients as well," stresses **Rick Harris**, PsyD, a clinical psychologist and president of Collaborative Health-Care, Inc. (CHI), based in Denver, CO. For example, Harris suggests that 40% of all oncology patients experience psycho-social distress, and 95% of patients with irritable bowel syndrome have a diagnosable psychological problem. Further, it is well-documented that individuals suffering from chronic diseases, such as diabetes or CVD, often experience depression and other behavioral problems that have a deleterious impact on their self-care regimens.

What physicians most need to solve this problem, stresses Harris, is an efficient way to assess and diagnose patients who are suffering from emotional distress -- a method that *does not* require

extra staff or time-consuming analyses. Working with partners, Harris believes he can now deliver such a solution in a way that will not only help physicians take better care of their patients, but also make a positive impact on their bottom line as well.

New tools needed for PCPs

Any providers or health care organizations seriously interested in addressing these issues must accept the fact that treating behavioral problems is their responsibility. It is well-documented that the vast majority of people with behavioral health issues seek assistance from primary health care providers. Further, in cases where these individuals receive referrals to a mental health professional, they often never act on that referral, either because they feel there is a stigma associated with seeing a mental health professional, it is too costly, or it is inconvenient. As a result, PCPs are treating the vast majority of these people -- and they can do so effectively in most cases, stresses Harris, with a correct diagnosis and treatment plan.

The biggest obstacle to this task for most providers is finding the time and the staff to deliver and analyze an adequate screen for behavioral problems. For example, in many cases, patients actually fill out lengthy questionnaires, but these forms never get analyzed.

Clearly, to accommodate a typical primary care office, shorter surveys or screens are needed, along with quicker results.

Array of screens meet specific needs

To meet this need, CHI offers a series of brief assessment tools that rely on patient reporting to detect signs of underlying behavioral health issues. For example, the Quick PsychoDiagnostics Panel,

or QPD, developed by **Jonathan Shedler, PhD**, in 1997, detects 10 disorders including major depression, generalized anxiety disorder, substance abuse, bipolar disorder, bulimia, dysthymic disorder, panic disorder, obsessive compulsive disorder, somatization, and suicide risk.

The QPD works by asking patients about the presence of psychiatric symptoms that are consistent with the diagnostic criteria specified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. "It takes about six to ten minutes for the patient to complete the instrument," notes Harris. "It was developed with primary care patients in mind, and it does give some tentative diagnoses for the physician to take a look at."

For providers who need a quicker screen, CHI offers the Quick-Screen 20 (QS-20), another assessment developed by Shedler that contains just 20 items. Additionally, there are several other screens that primary care physicians or specialists may want to use for specific reasons. For example,

oncologists may be interested in using the Fatigue Severity Scale or the Shedler Pain Survey. Other practitioners may be more interested in information gleaned from the Functional Assessment of Chronic Illness Therapy (FACIT) screen.

Device delivers instant results, analysis

The key time-saving advantage offered by these screens stems from the fact that they can be taken on a hand-held device developed by Denver, CO-based Point-of-View Survey Systems. The device can be simply given to a patient in the waiting room or an exam room. He can then complete the screen without any assistance. When the patient has completed the screen, the hand-held device can then immediately be picked up by a medical assistant and placed in a base or port, where an instant analysis of the results is generated for the physician to review right away. (See **Figure 1**.) "It is like an instant lab report, and what we have found is that it removes resistance; it gets

Figure 1: Collaborative HealthCare

Shedler Pain Survey



Name: _____
 ID: 123456
 Date: 9/12/2002 3:08:33 PM

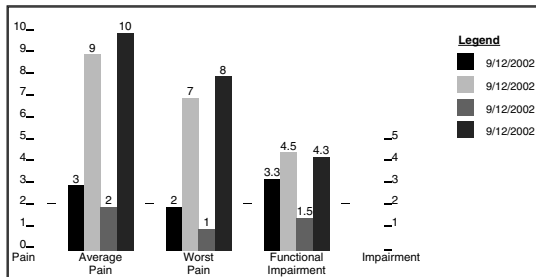
Gender: Male
 Age: 22

Results

Previous two weeks:

Average pain: 10 (0=no pain 10=the worst pain I could ever imagine)
 Worst pain: 8

Functional impairment: 4.33 (1=none 2=moderate 3=significant 4=severe)
 Psychological distress: positive



Patient reports significant functional impairment in the following areas due to

- sleep
- work
- normal household chores
- social activities
- relationships
- self care

Disposition:

The results of this assessment were reviewed and discussed with the patient: The following recommendation was made:

- No follow-up indicated at this time
 - Further evaluation
 - Referral to mental health provider
 - Other: _____
- Physician Signature: _____ Date: _____

Source: Collaborative Healthcare, Inc., Denver, CO.

Shedler QS-20 (Quick Screen-20)

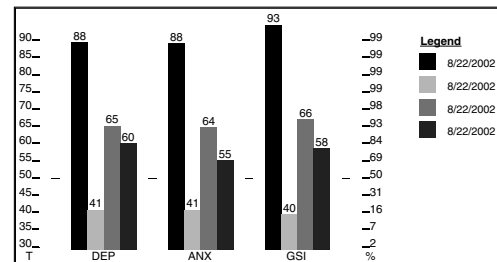


Name: _____
 ID: 123456
 Date: 8/22/2002 2:54:12 PM

Sex: Female
 Age: 45

Results

Negative for psychological distress.



Depression items answered True:

- I find little or no interest or pleasure in my daily activities.
- I have trouble falling asleep or staying asleep.
- I just can't seem to get myself "going".
- I feel tired or fatigued most of the time.

Anxiety items answered True:

- I often worry about things I should not have done or said.
- I sometimes get so anxious that I tremble or shake.
- I often feel dizzy or lightheaded for no good reason.

Disposition:

The results of this assessment were reviewed and discussed with the patient: The following recommendation was made:

- No follow-up indicated at this time
 - Further evaluation
 - Referral to mental health provider
 - Other: _____
- Physician Signature: _____ Date: _____

through all the barriers," stresses Harris.

In addition to helping physicians make quicker and more accurate diagnoses, the technology and quick assessments can also combine to provide the means for more effective monitoring of therapy, according to Harris. If a patient is placed on a specific dosage of a medication for depression, and then is asked to come back for follow-up in three weeks, for example, the assessment can be taken again and compared with the first assessment for any change. "There is a graph, so the physician can tell that the patient is doing well on the medication and that he is less depressed, or that he is not responding and may need an increased dose," adds Harris. "So now what you have is outcome measurements. It is evidence-based medicine."

CHI's offerings are relatively new, but providers have begun to integrate the survey tools and the handheld device into their practice. For example, **Jeff Greiff, MD**, a PCP in Plantation, FL, began using the handheld device when he received a grant to conduct research on depression in cancer patients. "We needed an easy-to-administer test," notes Greiff, explaining that he uses the device to administer the Brief Symptom Inventory, or BSI-18, to his cancer patients. This brief survey tool, developed by **Leonard Derogatis, PhD**, in 1999, summarizes patient responses into three scales: depres-

sion, anxiety and somatization. It takes four minutes to complete, and it provides comparisons to norm groups from a general adult population and adult cancer patients.

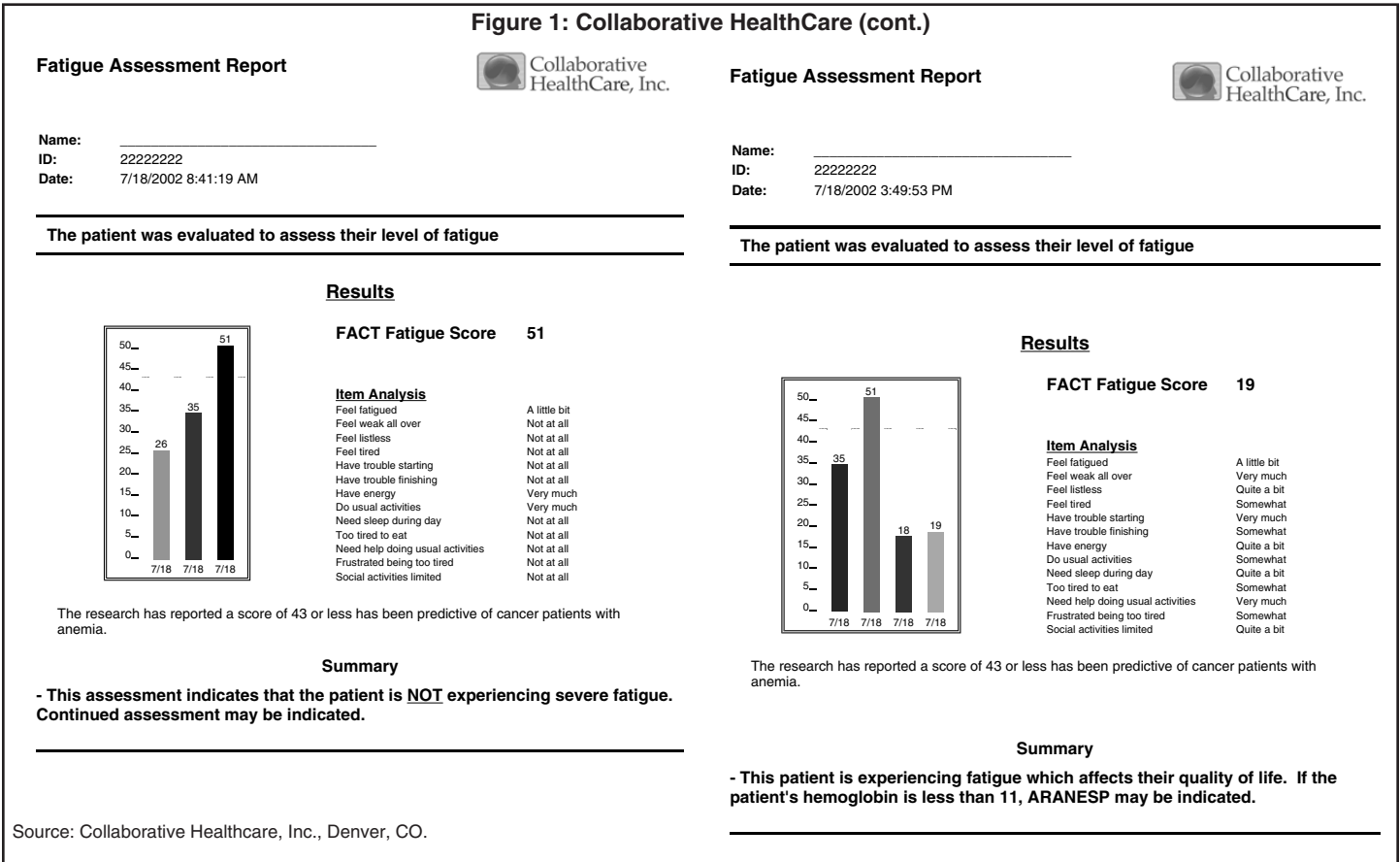
"What happens with cancer patients is that their oncologist does a great job treating their cancer, but no one except their PCP pays any attention to their mental status," stresses Greiff. "In the study we are doing, we are trying to prove that [cancer patients] do better when they are treated for depression. Their outcomes are better. I think a good mental attitude really helps."

Program 'quantifies and qualifies' illness

In carrying out the research -- which is still ongoing -- the hand-held survey approach worked so well that Greiff began using it with his other patients too. He now uses the handheld device to administer the QPD to patients he suspects are suffering from somatic complaints.

A typical example of this is when a patient comes in complaining of a number of different problems such as aches and pains, shortness of breath, and sometimes even chest pain. Greiff does a work-up to make sure the patient isn't experiencing heart disease or some other internal disease process, but when those issues are ruled out, his suspicions increase that the patient is suffering

Figure 1: Collaborative HealthCare (cont.)



Source: Collaborative Healthcare, Inc., Denver, CO.

from depression or a related behavioral issue.

"What we have found is that instead of us sitting around and asking questions for an hour, the patients can just sit with the [device]; they get all the appropriate questions, and then the program quantifies and qualifies their illness," explains Greiff.

Written reports boost patient compliance

Further, Greiff explains that the report generated by the device often serves as an effective tool for patient education. Typically he gives the report, which lists all of a patient's symptoms, back to the patient, and asks him if it accurately sums up how he feels. In most cases, Greiff emphasizes that even those patients who have insisted they are not depressed or anxious will acknowledge that the report provides an accurate description.

"They don't know how to [express how they feel], but when you give them this test and you show them what they have indicated, they get the idea. It makes it easier to treat them, and get them to be compliant, too, because they are seeing what their problem is," says Greiff. "We also use the test to see how well they are doing on therapy. We repeat it on down the line and see if they are getting better or not."

While Greiff feels very comfortable treating depression and anxiety, he will refer patients to a specialist when an assessment suggests a more severe or complex disorder such as schizophrenia. Further, he points out that the QPD does indicate when a person is suicidal, and in that instance the person would be hospitalized.

Good alternative for primary care

Greiff says he has always been particularly attuned to behavioral issues in his patients. However, prior to using the hand-held devices with CHI's assessments, he used paper-based assessment tools and asked patients a lot of questions. The process took more time, and he suggests it was not as effective.

What did work quite well was having a psychologist in the office available for instant referrals. But that arrangement did not last long because the model did not produce enough income for the psychologist. Given the economics involved, Greiff believes that the CHI assessment process is a good alternative for primary care. "I think every physician in the country should have

one of these -- at least every PCP," he says.

While PCPs are taking an interest in CHI's assessment process, it has thus far gotten the biggest response from the field of oncology. For example, a pharmaceutical company recently contracted with CHI to assess fatigue in cancer patients, using its Fatigue Severity Scale -- a tool designed to differentiate clinical depression from fatigue.

The purpose of this effort is to help physicians identify cancer patients who are experiencing fatigue, because drugs are now available to treat cancer-related anemia, the number one cause of fatigue in cancer patients. "Cancer patients are notorious for denial," stresses Harris. "They don't tell their physicians what is bothering them. This is an opportunity to identify fatigue so that the physicians can take a look at what is going on medically with the hemoglobin level and treat patients, when appropriate."

More than 70% of all cancer patients will experience fatigue at some point during their treatment or their disease, according to Harris. In fact, he notes, it is the number one complaint of cancer patients, even over nausea and vomiting. While the effort to identify patients experiencing fatigue may drive up pharmaceutical costs, Harris suggests those costs should be more than offset by reduced utilization. And quality of life should definitely be improved for patients who receive effective treatment.

Cost equation works

CHI bills for its assessments and the hand-held device either with a monthly fee or a per-assessment charge. Harris contends that physicians working under fee-for-service can increase their revenues by billing for the extra services. However, Greiff contends that the extra effort and paperwork involved in obtaining these higher reimbursements may not be worth the trouble.

Both men agree, however, that the cost-equation works well under managed care for those willing to look at the big picture. Stresses Harris, "We know for a fact that the highest utilizers of medical services are people who have emotional difficulties, so if you identify them early, in the long run you save money."

Editorial note: For more information about Digital Diagnostics, please visit their web site at DigitalDiagnostics.com or call them at (800) 559-9886. ❖