

“CO-MORBIDITY/INTEGRATION OF BEHAVIORAL HEALTH AND PRIMARY CARE”

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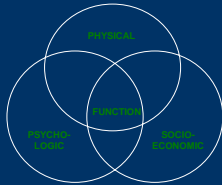
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Slide 1

AGING

- Is not a disease
- Occurs at different rates
 - Among individuals
 - Within individuals
- Increases susceptibility to many conditions
- Does not generally cause symptoms

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IMPROVING AND MAINTAINING FUNCTIONAL ABILITIES



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PAYING ATTENTION TO MEDICAL CONDITIONS

- Undiagnosed, potentially treatable conditions are common
- Treatable conditions should not be undertreated for fear of side effects

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CHARACTERISTICS OF GERIATRIC MEDICAL CONDITIONS

- Generally chronic with acute illnesses superimposed
- Often multiple and coexisting
- Commonly present atypically

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COMMON COGNITIVE AND AFFECTIVE DISORDERS

- Dementia
- Behavioral disturbances (associated with dementia)
- Delirium
- Dysphoria
- Depression
- Bereavement

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IATROGENIC ILLNESSES

- Adverse drug reactions/interactions
- Complications of hospitalization
 - Delirium
 - Falls
 - Immobility
 - Impaired functional status
- Complications of unnecessary diagnostic and therapeutic procedures

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GOALS OF CARE IN GERIATRICS

- Care vs. cure
- Improvement or maintenance of function and quality of life
- Prevention
- Comfort for terminally ill

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GERIATRIC CARE

- Is commonly multidisciplinary
- Frequently focuses on family care givers

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ASSESSMENT OF THE ELDERLY PATIENT

- Medical
- Cognitive
- Affective
- Functional
 - Physical
 - Social
- Economic
- Social support/care giver
- Environmental
- Quality of well-being

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PRINCIPLES OF GERIATRIC ASSESSMENT

- | | |
|-------------------|---|
| Goal | Promote wellness, independence |
| Focus | Function, performance (gait, balance, transfers) |
| Scope | Physical, cognitive, psychologic, social domains |
| Approach | Multidisciplinary |
| Efficiency | Ability to perform rapid screens to identify target areas |
| Success | Maintaining or improving quality of life |

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GOAL OF COMPREHENSIVE GERIATRIC ASSESSMENT

To determine a patient's

- medical status
- functional capabilities
- psychosocial status

in order to develop an overall plan for treatment and long-term follow-up

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TOOLS TO ASSESS FUNCTIONAL STATUS

Activities of Daily Living (ADLs)

Bathing, dressing, transferring, toileting, grooming, feeding, mobility

Instrumental Activities of Daily Living (IADLs)

Using telephone, preparing meals, managing finances, taking medications, doing laundry, doing housework, shopping, managing own transportation

"Get Up and Go" test

Qualitative, timed, assesses gait, balance, and transfers

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WHY SCREEN FOR COGNITIVE LOSS?

- Prevalence of Alzheimer's disease:
 - 10% of those aged 65+
 - nearly 50% of those aged 85+
- Most people with dementia do not complain of memory loss
- Cognitively impaired older persons are at ↑ risk for accidents, delirium, medical nonadherence, and disability

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COGNITIVE ASSESSMENT: PERFORMANCE MEASURES

- Recall 3 items
- Folstein's Mini-Mental State Examination (MMSE)
 - widely used
 - tests orientation, registration, recall, attention, calculation, language, visuospatial skills
- Tests of executive control
 - clock-drawing test
 - listing 4-legged animals test

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ASSESS PSYCHOLOGICAL STATUS

Although prevalence of major depression among older adults is low (1%-2%), "subclinical" depression is common

- Ask "Do you often feel sad or depressed?"
- If "Yes," do further evaluation, e.g., Geriatric Depression Scale
- Watch for signs of anxiety, bereavement

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SOCIAL ASSESSMENT SHOULD INCLUDE:

- Availability of a personal support system
- Caregiver burden
- Economic well-being
- Elder mistreatment (*If concerned, consider referral to visiting nurse to assess home safety, level of personal risk*)
- Advance directives

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EPIDEMIOLOGY AMONG OLDER ADULTS

Minor depression is common

- 15% of older persons
- Causes ↑ use of health services, excess disability, poor health outcomes, including ↑ mortality

Major depression is not common

- 1%-2% of community dwellers
- Elders less likely to recognize or endorse depressed mood

Bipolar disorder rates ↓ with age

- However, bipolar disorder remains a common diagnosis among elderly psychiatric patients
- Accounts for 3%-10% of psychiatric hospital admissions for older adults

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DIAGNOSIS IN OLDER PATIENTS IS DIFFICULT BECAUSE THEY . . .

- More often report somatic symptoms
- Less often report depressed mood, guilt
- May present with “masked” depression (hidden by preoccupation with physical concerns and complicated by overlap of physical and emotional symptoms)

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DIAGNOSTIC CHALLENGES IN MEDICAL SETTINGS

- Symptoms of geriatric medical and depressive illnesses often overlap, e.g.,
 - fatigue
 - disturbed sleep
 - diminished appetite
- Seriously ill or disabled persons may focus on thoughts of death, worthlessness
- Side effects of drugs for other illnesses may be confused with depressive symptoms

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INCIDENCE OF DELIRIUM AMONG ELDERLY PATIENTS IS HIGH

- 1/3 of older patients presenting to the ER
- 1/3 of inpatients aged 70+ on general medical units, half of whom are delirious on admission

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MORBIDITY ASSOCIATED WITH DELIRIUM

- A 10-fold risk of death in hospital
- A 3- to 5-fold ↑ risk of nosocomial complications, prolonged stay, postacute nursing-home placement
- Poor functional recovery and ↑ risk of death up to 2 years following discharge
- Persistence of delirium → poor long-term outcomes

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DIAGNOSING DELIRIUM

Under-recognition is a major problem

- nurses recognize and document < 50%
- physicians recognize and document only 20%

DSM-IV criteria precise but difficult to apply

Confusion Assessment Method (CAM)

- clinically more useful
- >95% sensitivity and specificity

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CONFUSION ASSESSMENT METHOD

Requires features 1 and 2 and either 3 or 4:

1. Acute change in mental status and fluctuating course
2. Inattention
3. Disorganized thinking
4. Altered level of consciousness

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PREDISPOSING FACTORS

Advanced age
Dementia
Functional impairment in ADLs
Medical comorbidity
History of alcohol abuse
Male sex
Sensory impairment (↓vision, ↓hearing)

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PRECIPITATING FACTORS

- Acute cardiac events
- Acute pulmonary events
- Bed rest
- Drug withdrawal (sedatives, alcohol)
- Fecal impaction
- Fluid or electrolyte disturbances
- Indwelling devices
- Infections (esp. respiratory, urinary)
- Medications
- Restraints
- Severe anemia
- Uncontrolled pain
- Urinary retention

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INCIDENCE & RISKS FOR POSTOPERATIVE DELIRIUM

- Occurs in 10%-15% after elective noncardiac surgery
- May exceed 50% after emergent hip-fracture repair
- Increased risk with preoperative risk factors
 - age, cognitive impairment, physical functional impairment, hx of alcohol abuse, abnormal serum chemistries, intrathoracic and aortic aneurysm surgery
 - 1 or 2 factors = 10% risk of delirium
 - 3 or more factors = 50% risk of delirium

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MANAGEMENT: GENERAL PRINCIPLES

- Requires interdisciplinary effort by MDs, nurses, family, others
- Multifactorial approach is most successful because multiple factors contribute to delirium
- Failure to diagnose and manage delirium → costly, life-threatening complications, loss of function

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MANAGEMENT: DRUGS TO REDUCE OR ELIMINATE

Almost any medication if time course is appropriate

Alcohol	Barbiturates
Antibiotics	Benzodiazepines
Anticholinergics	Chloral hydrate
Anticonvulsants	H ₂ -blocking agents
Antidepressants	Lithium
Antihistamines	Opioid analgesics (esp. meperidine)
Antiparkinsonian agents	
Antipsychotics	

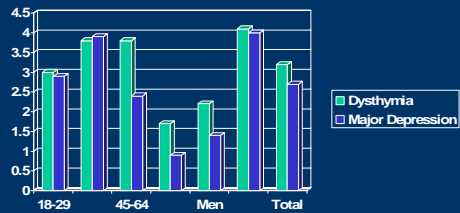
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LIFE EXPECTANCY

In 1900, life expectancy at birth was 49 years.
In 1997, life expectancy at birth was 79 years for women and 74 years for men.
People who survive to age 65 can expect to live an average of nearly 18 more years.
Life expectancy of persons who survive to age 85 is 7 years for women and 6 for men.

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PREVALENCE OF MOOD DISORDERS BY AGE, GENDER (ECA)



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PREVALENCE OF MOOD DISORDERS IN PARTICULAR MEDICAL ILLNESSES

- Renal Failure 6.5-20%
- Diabetes Mellitus 10-20%
- Cerebral Vascular Disease 20-50%
- Hyperthyroidism 10-20%
- AIDS/HIV 20-35%
- Emphysema 20-40%
- Coronary Artery Disease 30-60%

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DIFFERENTIAL DIAGNOSIS

Medical illness can look like depression

- Thyroid disease
- Conditions that promote apathy

Dementia has overlapping symptoms

- Impaired concentration
- Lack of motivation, loss of interest, apathy
- Psychomotor retardation
- Disrupted sleep

Bereavement is different because

- Most disturbing symptoms resolve in 2 months
- Not associated with marked functional impairment

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MEDICATIONS ASSOCIATED WITH DEPRESSION

Cardiovascular Drugs

- Alphamethyldopa
- Reserpine
- Propranolol
- Guanethidine
- Clonidine
- Thiazide diuretics
- Digitalis

Anticancer Agents

- Cycloserine

Hormones

- Oral Contraceptives
- ACTH (corticotrophin)
- Glucocorticoids
- Anabolic steroids

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Slide 34

GOALS OF CARE IN GERIATRICS

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Assessment
Slide 35

Small Changes in Function Can Make Big Differences in the Quality of Life for Patients

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