Targets for Telephone-Based Behavioral Health Interventions

Gary J. Kennedy, MD

A growing body of evidence supports the efficacy and cost effectiveness of psychotherapy and disease management for mental illness provided over the telephone. However, telephone behavioral health care is not reimbursable under present Center for Medicare and Medicaid Services standards. Nonetheless, elements of telephone-based behavioral health care are being incorporated into Veterans Administration health programs and by a limited number of major insurers. A review of the evidence suggests this trend will continue.

ARE TELEPHONE-BASED INTERVENTIONS NEEDED?

Cohen and colleagues recently wrote:

In the face of increasingly constrained resources, there is a realistic way of achieving better health results: conduct careful analysis to identify evidence-based opportunities for more efficient delivery of health care—whether prevention or treatment—and then restructure the system to create incentives that encourage the appropriate delivery of efficient interventions.

What follows argues that telephone screening and interventions for common behavioral health problems may be both effective and efficient.

There is considerable evidence indicating that screening and interventions for both depression and at-risk or unhealthy drinking are effective by telephone. In addition, a variety of interventions for dementia caregivers conducted by “dementia managers” via telephone lead to better outcomes for both dementia patients and caregivers. Nonetheless, telephone screening and interventions for behavioral health are best characterized as emerging, rather than established, evidenced-based practices.

DEPRESSION

In studies of depression care, uniformly superior outcomes result from the integration of mental health specialists into primary care sites. Nonetheless, the integration of mental health specialists is not considered economically viable, leaving the primary care practices ill-prepared to reduce the disability of depression. In contrast to an “integrated model” where mental health specialists are co-located with primary care physicians (PCPs), a collaborative disease management model utilizing behavioral health managers supervised by psychiatrists has demonstrated benefits. Large-scale, multisite studies have shown greater rates of response and remission as well as reduced levels of suicidality and costs associated with the disease management for depression.

Even when routine care is enhanced by improved access to specialist consultation, the collaborative disease management model proves superior. The critical element that distinguishes disease management from routine care is a third party (eg, a master's level social worker, psychologist, or nurse) who collaborates with the primary care provider, patient, and family to achieve superior outcomes.

Telephone management of depression by behavioral health managers not
located in the primary care sites also appears to be an effective alternative to integrated care. Studies of depression care incorporating telephone psychotherapy as part of the disease management package show benefits as well. However, the economic benefits of behavioral health management are uncertain. In contrast, disease management in managed care practices controls costs by reducing hospital admissions related to diabetes and congestive heart failure without shifting the expense from the hospital to the primary care provider or sacrificing patient satisfaction.

Perhaps the most fully developed telephone disease management (TDM) is described by Oslin and colleagues and Zanjani and colleagues. TDM was originally developed for Veterans Administration outpatient programs to reduce depression and at-risk drinking as a Behavioral Health Laboratory (BHL). TDM has been adopted by AETNA and Blue Cross/Blue Shield of South Carolina to reduce costs among primary care populations by offering a more aggressive care plan to patients prescribed to antidepressants. Although cost offset data have not been made available, the explicit expectation is that the carriers’ investment in depression care will reduce the volume of claims for primary care and hospital services (DW Oslin, MD, personal communication, March 2008).

The BHL is a screening and assessment service designed to help manage the behavioral health needs of patients seen in primary care. The Core Assessment of the BHL is a briefly scripted interview that provides PCPs with an assessment of patients’ substance abuse and behavioral health symptoms. In addition, the BHL both offers structured treatment response and outcomes assessments and serves as a base for the disease management approach to specific mental illnesses. The BHL is capable of focused decision support, including triage to specialty behavioral health or substance abuse care. For older adults, the BHL quantifies the level of impairment and comorbid psychiatric disorders such as depression, at-risk drinking, and anxiety. The University of Pennsylvania and Philadelphia Veterans Affairs Medical Center are the development and founding sites of the BHL. The BHL has been recognized as a “Best Practice” for identification and early intervention in behavioral health problems of primary care patients within the Department of Veterans Affairs.

In the BHL, the telephone interaction is “facilitation” rather than psychotherapy. Facilitated care by telephone limits scope, but it does not necessarily limit the number of interactions with the patient. These interactions between patient and the behavioral health manager include solving problems with barriers such as reluctance to either initiate prescribed antidepressant therapy or communicate difficulties with side effects to the PCP; providing positive reinforcement and praise once barriers are overcome; monitoring progress, assessing response to treatment, and countering premature discontinuation of medication; purposefully scheduling physical activity and pleasant events for behavioral activation; and teaching self-management techniques. Periodic case reviews with a supervising psychiatrist and reports to the PCP are used to both coordinate care and facilitate referrals when psychotherapy or direct psychiatric consultations are indicated.

The BHL uses the Patient Health Questionnaire (PHQ) for screening (2 items), initiating treatment (9 items), and assessing outcome as non-response, response, or remission. At each juncture, the PHQ score is used to indicate the need for assessment, treatment or referral, or adequacy of antidepressant therapy. The BHL is fully manualsed with sections specific for implementation, documentation, assessment, interventions, and oversight. The structured assessments and scripted interventions for depression, anxiety, and at-risk drinking are fully adapted to telephone administration.

**AT-RISK DRINKING**

Hospitalizations related to alcohol among older adults are nearly as frequent as those related to heart attack. At-risk alcohol use among older adults increases both medical complexity and costs to patients as well as their families and communities. However, existing services are not prepared to meet the needs of the projected 2-fold increase in alcohol and substance-abusing older adults in the next 15 years. Using a nationally representative sample of 12,413 people from the Current Medicare Beneficiary Survey, Merrick and colleagues found unhealthy drinking patterns in 16% of men and 4% of women. Unhealthy drinking was defined either by >30 drinks in any month or >4 drinks in any single day during the last year. As operationalized by Merrick and colleagues in their Medicare Beneficiary Survey, respondents were considered to be at-risk or unhealthy if they either consumed as much as one drink daily for 30 days in any month during the last year or exceeded four drinks in any given day during the last year. This level of intake is slightly above what was recommended for screening in the Substance Abuse and Mental Health Services Administration’s Treatment Improvement Protocol for substance abuse among people ≥65 years of age; however, the level of intake is well below a score of ≥3 on the Short Michigan Alcohol Screening Test-Geriatric Version employed by Oslin and colleagues’ Telephone Disease Management study of ambulatory care Veterans Administration patients.
Numerous studies suggest that at-risk or unhealthy drinking can be reliably detected through telephone interviews and that interventions conducted by telephone can reduce the number of “risky drinking” days among people not seeking treatment for problem drinking. These data are further supported by the literature on brief interventions among primary care patients that reduce risky/harmful drinking without requiring lengthy or multiple counseling sessions to be effective. Approaching select patients during “teachable moment” following admission to the emergency department or discharge from hospital may heighten the probability of an alliance for change.

DementiA careGiver BurDen

It is widely acknowledged that primary care settings are poorly designed and under-resourced to provide comprehensive care for dementia patients and their family caregivers. Even when routine primary care is augmented with improved access to dementia specialists, patients and families fare better from a collaborative care, disease management model similar to that used for chronic illnesses such as congestive heart failure or diabetes. In addition, disease management services provided to dementia care givers allow for cost savings. Given the increasing number of people with dementia, the need to find more efficient models of care is pressing. Estimates of the prevalence of memory problems or confusion in the National Health Interview representative survey of older community residents 65–85 years of age range from 7% to 20%, respectively. However these data are based on self-report or proxy respondents. In the Aging, Demographics, and Memory Study, in-home comprehensive assessments with diagnoses determined by expert consensus found dementia among 13.9% people ≥71 years of age.

Deficits in the cognitive domains of memory and executive function threaten the older adults' capacity to adhere to medical therapy, avoid institutionalization, and survive in the community. However, screening for memory impairment to detect dementia in primary care settings remains controversial due to the confounding influence of physical illness, education, race and language on the screening test’s reliability. Moreover, evidence-based practices combining patient and caregiver interventions from mild cognitive impairment to end-of-life dementia care exceed the resources of most primary care practices. The critical period to screen for cognitive impairment may be immediately after hospital discharge when unrecognized persistent delirium or dementia places the patient at heightened risk for re-admission.

Brief screening measures for memory impairment and executive dysfunction have been validated for telephone administration by the Einstein Aging Study. More recent data suggest these measures, when used as part of a two-step screening procedure may represent an advance over the more commonly used Mini-Mental Status Examination in both distinguishing Alzheimer’s from vascular dementia and reducing the test’s sensitivity to education and race. Two separate studies listed in SAMHSA's National Registry of Evidence-based Programs and Practices reduced depression among dementia caregivers of various racial and ethnic backgrounds. In addition, the Resources for Enhancing Alzheimer's Caregiver Health II improved caregiver quality of life. The New York University Caregiver Intervention demonstrated superior health and perceived social support for caregivers as well as substantial delay in nursing home admissions for spouses with dementia. Although face-to-face counseling and peer support groups formed the bulk of the intervention, contact by telephone was included as well.

In contrast, two studies conducted in primary care sites used a disease management model with the care manager integrated into the primary care site or modified to include care mangers recruited from community based agencies. In the latter, caregiver interventions were conducted mainly by social workers via telephone following an in-home assessment. Outcomes for both patients and caregivers in the intervention groups were generally superior to enhanced routine care. Four of the studies cited suggest that some, if not all, of the caregiver intervention may be conducted by telephone. The potential of caregiver interventions to reduce costs and the detection of cognitive impairment to delay re-hospitalization warrant consideration.

Cultural considerations and issues with access

Rather than presume that the communications between the patient and primary care provider are adequate, the Behavioral Health Manager can follow up by telephone to ensure that self-management and treatment adherence are optimized. Limited health literacy can be overcome with additional information regarding etiology, diagnosis, and treatment. Telephone-based depression care programs offer hope of reducing disparities in both access to and receipt of antidepressant treatment. Finally, although telephone interventions are limited to people without substantial hearing impairment, the capacity to provide behavioral health services by telephone is a marked advantage for individuals whose physical disability or geographic distance poses as barriers to more frequent office visits.
CONCLUSION
Depression, at-risk drinking, and caregiver burden are prevalent, and each is the subject of an emerging evidence-based practice incorporating interventions administered by telephone. Although the effectiveness and economic value of the interventions are yet to be established, their accessibility offers the hope of reducing behavioral health disparities among ethnic, minority, and physically disabled groups. If behavioral health interventions delivered by telephone reduce the costs of primary care or the risk of hospitalization, the Center for Medicare and Medicaid Services may be compelled to approve reimbursement. PP

REFERENCES