Body System: Geriatrics

Session Topic: Geriatric Grief Reaction

Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
• Knowledge and practice gaps with regard to providing counseling for geriatric patients to help them appropriately deal with grief reactions. • Choosing appropriate differential diagnosis • Screening for disease conditions • Effective treatment for identified conditions.	1. Distinguish among bereavement, grief, depression, and anxiety. 2. Utilize the appropriate depression and anxiety screening tools. 3. Implement the new psychiatric collaborative care management process with the appropriate billing requirements.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

ACGME Core Competencies Addressed (select all that apply)

	Medical Knowledge	X	Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism	X	Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management

- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
  - Visit http://www.aafp.org/journals for additional resources
  - Visit http://familydoctor.org for patient education and resources
- Provide recommendations to help distinguish among bereavement, grief, depression, and anxiety.
- Provide recommendations for utilizing the appropriate depression and anxiety screening tools.
- Provide recommendations for implementing the new psychiatric collaborative care management process with the appropriate billing requirements.

*Note – the scope of this topic is to include depression, anxiety & grief reactions

Needs Assessment

Psychological distress is common in geriatric patients, particularly among terminally ill persons, and can be a source of great suffering.[1] Grief is an adaptive, universal, and highly personalized response to the multiple losses that occur at the end of life. It is often a challenge for physicians to distinguish between normal and adaptive reactions to loss for patients living with terminal illness and the disabling diagnosis of major depression. In approximately 10% of cases, grief becomes prolonged and can result in a major depressive disorder.[2]

Depression is a common disease affecting approximately 18% of the primary care population, and currently underdiagnosed in older adults.[3-5] Major depressive disorder is listed as the primary diagnosis for 8 million ambulatory visits to physician offices, hospital outpatient clinics, and emergency departments, as well as 395,000 inpatient visits. The cost to employers for work days lost due to depression is as great as, or greater than that generated by heart disease, diabetes, or back problems.[6] Depression screening is not new for family physicians. However, recent recommendations from the US Preventive Services Task Force (USPSTF) expand the criteria to include depression screening for the general adult population.[6] Screenings should be a component of systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.[5]

Anxiety disorders are the most common mental illness in the U.S., affecting 40 million adults age 18 and older, or 18% of the U.S. population; with only 36.9% receiving treatment.[7,8] Physicians made a diagnosis of mental disorders during 47 million ambulatory office visits, and ordered stress management health education services during 25 million ambulatory office visits 2010.[9] Over 33% of family physicians offer psychiatric services in their practice.[10] Prevalence of each anxiety disorder varies by gender and age.

The collaborative care model has been recently studied and results indicate it may be an effective plan for treating adults with depression and/or anxiety. The model incorporates a multi-professional approach, structured management plan, scheduled patient follow-ups, and enhanced inter-professional communication. The collaborative care model allows for better outcomes

through more accurate referrals, and appropriation of resources for patients to improve treatment adherence and overall quality of life.[11]

Approximately 1 in 5 adults in the U.S.—43.8 million, or 18.5%—experiences mental illness in a given year. Approximately 1 in 25 adults in the U.S.—9.8 million, or 4.0%—experiences a serious mental illness in a given year that substantially interferes with or limits one or more major life activities. Approximately 1 in 5 youth aged 13–18 (21.4%) experiences a severe mental disorder at some point during their life. For children aged 8–15, the estimate is 13%.[12]

Primary care physicians deliver half of all mental health services (92 percent among the elderly).[13]

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment survey indicate that family physicians have statistically significant and meaningful knowledge and practice gaps with regard to providing counseling for geriatric patients to help them appropriately deal with grief reactions (e.g. depression and anxiety).[14]

Practice Gaps

CME outcomes data from the 2016 AAFP Geriatric Medicine: *Depression, Anxiety and Phobias* session, suggest that family physicians have knowledge and practice gaps with regards to appropriate and effective use of validated screening tools for depression, suicide, and anxiety (e.g. PHQ-9, SSRI, 5-item GDS); helping elderly patients more effectively manage their medications; and helping elderly patients more effectively manage their reactions to grief and other stressful situations.[15]

Standard treatment options for anxiety disorders include therapy, medication, and complementary and alternative treatments.[8] However, American Academy of Family Physicians (AAFP) CME Needs Assessment Survey data suggests that family physicians have statistically significant and meaningful knowledge gaps to utilize psychotropic medications, crisis counseling, stress management strategies generally to manage psychiatric disorders; and have significant gaps to manage patients with anxiety specifically.[16] Family physicians should be familiar with DSM IV criteria, the relevant changes in the DSM V criteria, first line therapies for anxiety disorder, and be able to coordinate care with a psychiatrist when conditions warrant referral.

Depression in older adults often goes underdiagnosed and undertreated with associated negative consequences such as functional decline, increased morbidity and mortality and higher healthcare costs. Primary care physicians often must detect, manage and prevent these conditions without assistance from other professionals trained to treat these specific disorders.[11] Diagnosing depression can be difficult as nonspecific co-morbid symptoms may overlap with a wide range of other psychiatric and medical illnesses, and cognitive decline; may display an atypical presentation in older adults; and some may view depression as a normal part of aging.[6,17] These patients may be undertreated due to multiple comorbidities, concerns about adverse events and drug interactions, and lack of confidence in safety and efficacy of pharmacologic and non-pharmacological treatments in the elderly depressed patient.[17] Additionally, primary care

physicians have struggled in the past to receive payment for providing mental health services in their office.[6]

Screening alone does not improve clinical outcomes. Family physicians must provide appropriate follow-up for diagnosis and treatment, including initiating medical therapy and making referrals to behavior health resources when indicated. Evidence-based screening tools have been developed and validated for primary care physicians to appropriately identify and diagnose depression. This is significant as older persons, particularly those who have recently lost a loved one, have a suicide rate 1.5 times that of the general population.[18] Key recommendations for practice exist, as well as standardized screening tools, and new pharmacologic options for the treatment of depression.[3,4,19-21]

The USPSTF guidance on depression screening is a grade B recommendation. This means that this service is now covered under the Affordable Care Act (ACA) by both the Center for Medicare and Medicaid Services (CMS) and private payers. Additionally, an increasing number of physician quality programs, including the CMS physician quality reporting system (PQRS) use depression screening as a quality indicator. In 2015, the PQRS program expanded the depression quality metric to include treatment and remission.[6]

While screening is now covered, payment for managing patients with depression in primary care is less straightforward. Improper or incomplete documentation can lead to payment denials. Common mistakes include failing to record the amount of time spent providing the service, not documenting in the office note the service provided, and failing to sign the documentation. Family physicians require continuing medical education on screening, diagnosis and management of depression in order to gain knowledge of the most up-to-date evidence-based recommendations, review the evidence of novel therapies and management plans, and gain understanding of the necessary documentation and coding needed to ensure proper payment for services provided.[6]

Time is one of the major obstacles to providing counseling in primary care.[22] Adults with behavioral health (BH) disorder often (67% of adults with BH) do not receive adequate treatment.[23] Clinical guidelines will often recommend behavioral counseling; however, many practices are not structured to offer these services effectively.[22,24-26]

Physicians may improve their care of patients experiencing a crisis by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[22,27-30]

- Patients who are experiencing a crisis should be assessed for suicidal and homicidal ideations.
- Patients who are suicidal and have comorbid psychiatric or medical problems, a history of violent or near-lethal suicide attempts, a poor response to outpatient treatment, or limited family or social support should be considered for inpatient hospital admission.
- Physicians must warn and protect intended victims of a patient.
- Physicians should help patients experiencing a crisis to stabilize acute distress, to explore options, to make a specific plan, and to commit to the plan.

- Selective serotonin reuptake inhibitors and other antidepressants are reasonable clinical interventions for patients with acute stress disorder or post-traumatic stress disorder.
- Primary care counseling leads to short-term benefits for psychiatric symptoms.
- Because there is no significant difference in performance among the different depression screening instruments, the most practical tool for the clinical setting should be used.
- Adults and adolescents 12 to 18 years of age should be screened for depression in clinical practices that have systems to ensure effective diagnosis, treatment, and follow-up.
- There is insufficient evidence to balance the benefits and harms of screening children seven to 11 years of age for depression.
- There is insufficient evidence to recommend for or against screening for suicide risk in the general population.
- The PHQ-2 is accurate for depression screening in adolescents, adults, and older adults.
- The PHQ-9 is a valid, quick screening instrument for depression that also can be used as a follow-up to a positive PHQ-2 result and to monitor treatment response.
- Depression screening in older adults can be accomplished with multiple instruments, including the PHQ-2, PHQ-9, and various Geriatric Depression Scales.
- Rapid screening for substance misuse or substance use disorders can be performed in the primary care setting with a validated single-question screening tool.
- Emergency contraception should be offered to all sexual assault survivors who are of childbearing potential and have a negative pregnancy test.
- All sexual assault survivors should be treated for the prevention of sexually transmitted infections.
- Physicians should discuss IPV and family violence with their patients in a routine, nonjudgmental manner.[31]

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Managing grief and depression at the end of life[1]
- Common Questions About the Pharmacologic Management of Depression in Adults[4]
- Collaborative care for depression and anxiety[11]
- Integrating a Behavioral Health Specialist Into Your Practice[13]
- The Geriatric Assessment[32]
- New Codes, New Payment Opportunities for 2017[33]
- Realistic Approaches to Counseling in the Office Setting[22]

- Managing Behavioral Health Issues in Primary Care: Six Five-Minute Tools[25]
- Screening Your Adult Patients for Depression[6]
- FamilyDoctor.org. Depression in Older Adults (patient education)[34]

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