Managing Depressive Disorders in Homebound Patients

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HCCIntelligence™ Webinar and Virtual Office Hours

December 18, 2019

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Housekeeping

- The first 30 minutes of today's HCCIntelligence™ Webinar will consist of a slide presentation and all participants will be muted during this time.
- The following 30 minutes will be HCCIntelligence™ Virtual Office Hours, and all participants will be able to submit questions via the question box.
- To submit a question, click on the arrow next to Questions, type in your question, press send.
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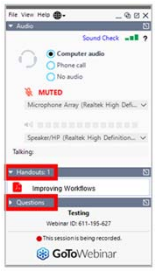

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Introductions

James Ellison, MD, MPH

The Swank Foundation Endowed Chair in Memory Care and Geriatrics,
Swank Memory Care Center

Dr. Ellison is The Swank Foundation Endowed Chair in Memory Care and Geriatrics at Christiana Care Health System. He is a recognized clinician, researcher and educator in geriatric and adult psychiatry with special expertise in geriatric mood and anxiety disorders, and neurocognitive disorders. Dr. Ellison joined Christiana Care from McLean Hospital in Belmont, Massachusetts, where he had served as director of the Geriatric Psychiatry Program, the Memory Disorders Clinic, and the Partners HealthCare Fellowship in Geriatric Psychiatry.

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Objectives

1. Describe the varied presentations and assessment approach for different types of depressive disorders in complex, frail, elderly patients in the home setting.
2. Explore effective strategies for the treatment of depression in homebound patients.
3. Provide timely guidance to caregivers of homebound patients with depressive disorders.

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Prevalence of Depressive Syndromes in Later Life

	Clinically Significant Depressive Symptoms[1]	Major Depressive Disorder[1]
Community	8-15% 9.7-26.1% for 75+[3] 6.1% for men, 9.6% for women in age 60+ (2013-6)[3]	1-3% 4.4-10.6% for 75+[2]
Primary Care		6-9%[3]
Long Term Care	30-50%	6-25%
Bipolar Disorder		0.1-0.4%[4]

[1]Ellison JM, Gottlieb G: Recognition and management of late life mood disorders. In: Sirven JI, Malamut BL (eds): Clinical Neurology of the Older Adult, 2nd Edition. Philadelphia, Lippincott Williams & Wilkins, 2008; [2]Luppa et al. J Aff Dis 2012;136:212-221;
[3]National Health and Nutrition Survey 2013-2016
[4]Unutzer et al. Milbank Q 1999;77:225-6

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Some Risk Factors for LLD

Demographics
- Older age
- Female
- Lower income

Health
- New/chronic medical illness
- Vascular disease
- Psychiatric illness history
- Cognitive impairment
- Sleep disturbance
- Pain
- Functional limitations

Coping/Social Support
- Recent negative life events
- Lack of social support
  - Small social network
  - Unmarried
  - Bereaved
- Loneliness

Habits
- Alcohol problem
- Smoking
- Low exercise level

Vink et al. Journal of Affective Disorders 2008;106:29–44.

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Adverse Outcomes of Untreated LLD[1-6]

- **Increased use of non-mental health services**
  - Twice as many doctor appointments
  - Twice as likely to received 5 or more medication
- **Reduced adherence to medical treatment**
  - Functional decline/Increased disability
- **Increased medical morbidity/mortality**
  - CVA/MI/Dementia
- **Increased risk for suicide**

And yet – more than ½ of depressed elders go untreated.[7]

[1]Beekman et al. Psychol Med 1997;27:1397-409; [2]Bruce and Leaf. Am J Public Health. 1989;79:727-30; [3]Romanelli et al. J Am Geriatr Soc 2002;50:817-22; [4]Alexopoulos GS. *Lancet* 2005; 365): 1961–70; [5]Katon et al. Arch Gen Psychiatry 2003;60:897-903; [6]Hall and Reynolds. Maturitas 2014;79:147-52; [7]Barry et al. J Affect Dis 2012;138:789-96.

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DSM 5 MDD = DMS14TR Minus Bereavement Exclusion

- **Depressed mood** OR **loss of interest/pleasure**, plus
- At least 4 other SIGECAPS
- Present at least during the same 2 week period
- Distress or functional impairment
- Medical/Substance/Psychiatric exclusions
- There has not been a manic/hypomanic episode
- NO BEREAVEMENT EXCLUSION (differs from DSMIVTR: Depression resembles but differs from "responses to a significant loss")

SIG E CAPS
Sleep
Interest
Guilt/worthlessness
Energy
Concentration
Appetite/weight
Psychomotor
Suicidal

MDD = "Major Depressive Disorder"
American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

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DSM 5 CMDD+DD = Persistent Depressive Disorder (Dysthymia)" 300.4

Consolidates 2 DSM IV disorders: Chronic Major Depressive Disorder and Dysthymic Disorder

- Depressed mood more days than not, for at least 2 years
- Two or more symptoms: appetite, sleep, energy, self-esteem, concentration, hopelessness
- No remission more than 2 months at a time in 2 year period
- Major Depressive Disorder criteria may also be met
- Symptoms not explained by manic, hypomanic, cyclothymic, other psychiatric, substance, medical
- Significant distress (social, occupational, other)

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

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What is Special About LLD?

Etiologies

- Recurrence of early onset mood disorder
- Psychosocial stressors of late life
- Physiologic effects of aging/illness
  - Disease sx can mimic depressive sx
  - Vascular depression hypothesis[1]
  - Inflammation hypothesis[2]

Elders seek help in Primary Care

- Higher medical burden (illnesses, symptoms)
- Fewer than half of cases are recognized[3]
- Disguised/Limited symptoms

[1]Alexopoulos et al. Dialogues Clin Neurosci 1999;1:68-80 [2]Maes et al. Metab Brain Dis 2009;24:27-53; [3]Mitchell et al. Psychother Psychosom 2010;79:285-94.

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Special Symptomatic Presentations of LLD

Beneath the "Major Depression" threshold

"Depression without sadness"[1]

Somatic (sometimes cognitive) focus

Depression with psychotic features

Depression with cognitive impairment [2,3]

[1]Gallo and Rabins. Am Fam Physician 1999;60:820-6
[2]Butters et al. Am J Psychiatry 2000;157:1949-54
[3]Saez-Fonseca et al. J Affect Disord 2007;101:123-9

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Vascular Depression: Neuropsychological Correlations[1]

Presence of moderate to severe white matter hyperintensities in depressed patients has been linked with decreased agitation/guilt, increased psychomotor retardation and disability, and:

- Poorer Executive Functioning
- Slower response to citalopram treatment[2]
- Greater relapse risk

[1]Kelly Jr and Alexopoulos. In Ellison et al (eds). Mood Disorders in Later Life. Informa Healthcare 2008
[2]Manning et al. Am J Geriatr Psychiatry. 2015 May; 23(5):440-5.

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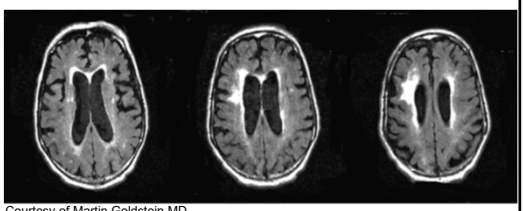
MRI Illustration



Courtesy of Martin Goldstein MD

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Depression with Psychotic Features

- **Psychotic symptoms (delusions or hallucinations) with major depression**
- **More prevalent among older vs younger depressives**
- **Associated with:**
  - Later onset
  - Hypochondriacal and nihilistic delusions
  - Poorer response to monotherapy/maintenance
  - Higher recurrence rate
  - Higher suicide risk

Gournellis et al. Int J Geriatr Psychiatry 2001;16:1085-91;
Flint and Rifat Am J Psychiatr. 1998;155:178-83.

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Depression in Alzheimer's Dementia: Provisional Diagnostic Criteria

3 or more of following in 2 week period

- Depressed mood
- Decreased positive affect/pleasure in usual activities/contacts
- Social isolation or withdrawal
- Disruption in appetite
- Disruption in sleep
- Psychomotor changes
- Irritability
- Fatigue/loss of energy
- Worthlessness, hopelessness, guilt
- Thoughts of death, SI or behavior

- Meets criteria for DAT
- Distress or disruption
- Not delirium, drug, medication, or better accounted for by other conditions

Olin et al. Am J Geriatr Psychiatry 2002;10:125-8

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"Masked Depression" Associated with Dementia

Likelihood that depression is present is increased in the presence of:

- Delusions[1]
- Verbal/physical aggressive behaviors[2]
- Suicidal or self-destructive behaviors
- Disruptive vocalizations[3]
- Weight loss[4]

[1]Bassiony et al. Int J Geriatr Psychiatry. 2002;17:549-56
[2]Menon et al. Int J Geriatr Psychiatry 2001;16:139-46
[3]Dwyer and Byrne Int Psychogeriatr. 2000;12:463-71
[4]Morley and Kraenzle J Am Geriatr So 1994;42:583-5.

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Assessment

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PHQ-2

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Psychometric Properties[1]

Major Depressive Disorder (7% prevalence)				Any Depressive Disorder (18% prevalence)			
PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)	PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)
1	97.6	59.2	15.4	1	90.6	65.4	36.9
2	92.7	73.7	21.1	2	82.1	80.4	48.3
3	**82.9**	**90.0**	**38.4**	**3**	**62.3**	**95.4**	**75.0**
4	73.2	93.3	45.5	4	50.9	97.9	81.2
5	53.7	96.8	56.4	5	31.1	98.7	84.6
6	26.8	99.4	78.6	6	12.3	99.8	92.9

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Assessment: GDS 15

1. Are you basically satisfied with your life?
2. Have you dropped many of your activities and interests?
3. Do you feel that your life is empty?
4. Do you often get bored?
5. Are you in good spirits most of the time?
6. Are you afraid that something bad is going to happen to you?
7. Do you feel happy most of the time?
8. Do you often feel helpless?
9. Do you prefer to stay at home, rather than going out and doing new things?
10. Do you feel you have more problems with memory than most?
11. Do you think it is wonderful to be alive now?
12. Do you feel pretty worthless the way you are now?
13. Do you feel full of energy?
14. Do you feel that your situation is hopeless?
15. Do you think that most people are better off than you are?

GDS is in the Public Domain, can be freely reproduced and used.
Score 1 point for each "Yes" on 2, 3, 4, 6, 8, 9, 10, 12, 14, 15
or "No" on 1, 5, 7, 11, 13.
A score of 6 or higher suggests need for
definitive diagnostic evaluation. (http://www.stanford.edu/~yesavage/GDS.html)

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Psychometrics of GDS

Appears to be most widely used screen
In public domain, multiple translations
4 versions range from 4 to 30 questions
GDS15 with cut-off of 5/6:

- Sensitivity overall 84.3%
- Specificity 73.8%
- Figures are lower in in outpatient and nursing home settings

Ottawa (ON): Canadian Agency for Drugs and Technologies in Health; 2015 Sep 8. Diagnosing, Screening, and Monitoring Depression in the Elderly: A Review of Guidelines [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK321381/ accessed 12/31/18

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Cornell Scale for Depression in Dementia

Scoring System
A = unable to evaluate 0 = absent 1 = mild or intermittent 2 = severe

Ratings should be based on symptoms and signs occurring during the week prior to interview.
No score should be given in symptoms result from physical disability or illness.

A. Mood-Related Signs

1. Anxiety: anxious expression, ruminations, worrying	a 0 1 2
2. Sadness: sad expression, sad voice, tearfulness	a 0 1 2
3. Lack of reactivity to pleasant events	a 0 1 2
4. Irritability: easily annoyed, short-tempered	a 0 1 2

B. Behavioral Disturbance

5. Agitation: restlessness, handwringing, hairpulling	a 0 1 2
6. Retardation: slow movement, slow speech, slow reactions	a 0 1 2
7. Multiple physical complaints (score 0 if GI symptoms only)	a 0 1 2
8. Loss of interest: less involved in usual activities (score only if change occurred acutely, i.e. in less than 1 month)	a 0 1 2

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Alexopoulos et al. Biol Psych 1988;23:271-284.

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Cornell Scale for Depression in Dementia

C. Physical Signs

9. Appetite loss: eating less than usual	a 0 1 2
10. Weight loss (score 2 if greater than 5 lb. in 1 month)	a 0 1 2
11. Lack of energy: fatigues easily, unable to sustain activities (score only if change occurred acutely, i.e., in less than 1 month)	a 0 1 2

D. Cyclic Functions

12. Diurnal variation of mood: symptoms worse in the morning	a 0 1 2
13. Difficulty falling asleep: later than usual for this individual	a 0 1 2
14. Multiple awakenings during sleep	a 0 1 2
15. Early morning awakening: earlier than usual for this individual	a 0 1 2

E. Ideational Disturbance

16. Suicide: feels life is not worth living, has suicidal wishes, or makes suicide attempt	a 0 1 2
17. Poor self esteem: self-blame, self-depreciation, feelings of failure	a 0 1 2
18. Pessimism: anticipation of the worst	a 0 1 2
19. Mood congruent delusions: delusions of poverty, illness, or loss	a 0 1 2

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Alexopoulos et al. Biol Psych 1988;23:271-284.

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2. Assessing Effect of Medical Burden

- Medications, Alcohol, Drugs
- Endocrinopathy
- Malignancy
- Infection
- Metabolic disorders
- Nutritional deficiencies
- Sleep disorders
- Vascular disease
- Neurological disorders

Depressive episode should be treated while managing the comorbid medical condition

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Assessing Laboratory Results

Hematology
- CBC with indices/differential
- ESR

Chemistry
- Lytes, BUN, Creatinine
- Liver function tests
- Thyroid function tests
- Fasting glucose level
- Folate, B12[1]

Urine
- Urinalysis
- Culture and sensitivity

Additional tests, e.g.
- Electrocardiogram
- Chest X-Ray
- Neuroimaging (?)

[1]Petridou et al. Aging Ment Health 2015 Jun 8:1-9 epub

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Treatment Approach

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Non-Pharmacological Treatments

Non-pharmacological strategies, alone or with antidepressants, are effective in treating Late Life Depression and should be strongly considered when planning treatment.

Reynolds CF 3rd, Dew MA, Martire LM, *et al.* Treating depression to remission in older adults: a controlled evaluation of combined escitalopram with interpersonal psychotherapy versus escitalopram with depression care management. Int J Geriatr Psychiatry 2010; 26:1134–1141.

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1. Psychotherapy

Several are evidence-based treatments for Late Life Depression

RCTs support[1]

- Cognitive Behavioral Therapy (CBT)
- Interpersonal Therapy (IPT)
- Problem Solving Therapy (PST)
- ENGAGE

[1]See Antognini and Liptzin in Ellison et al. Mood Disorders in Later Life. Informa 2008

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2. Physical Activity

- **Greater midlife physical activity is associated with lower depressive symptomatology in later life[1]**
- **Physical inactivity in older adults is associated with both depression and cognitive deficits[2]**
- **Higher and faster remission in LLD linked with exercise augmentation of sertraline (24 wk of PAE).[3]**

[1]Chang et al. J Gerontol A Biol Sci Med Sci 2015 Nov 2.pii: glv 196 (epub)
[2]Paulo et al. J Aging Phys Act 2015 (epub)
[3]Belvederi Murri et al. Br J Psychiatry 2015;207:235-42.

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Pharmacologic Treatment Antidepressant Efficacy

All FDA-indicated antidepressants treat LLD[1]
Response rate (50% symptom decrease)[2]

- 50 – 65% in trials with ITT analyses
- 25 – 30% respond to placebo
- Number Needed to Treat (NNT): 2.5 to 5

Remission (≥90% symptom decrease)[2]

- Typically 30 – 40% with medication vs 15% for placebo
- NNT: 4 to 7

ITT: Intention to Treat
NNT: Number Needed to Treat

[1]See Ellison et al. Mood Disorders in Later Life. Informa Health Care 2008
[2]Shanmugham et al. Psychiatr Clin North Am. 2005;28:821-35.

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Antidepressant Side Effects: SRIs

- **Discontinuation is less common with SSRI treatment (17%) than with TCA treatment (24%)**
- **Significant side effects with SSRs:**
  - Sedation
  - Weight Gain
  - GI Symptoms
  - Hyponatremia
  - Risk for bruising
  - Risk for GI bleeding
  - Sexual dysfunction
  - Falls?

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Antidepressant Drug/ Drug Interactions

- **Age exacerbates potential for adverse effects and interactions**
  - Hepatic inactivation of drugs ↓
  - Renal elimination of drugs ↓
  - Anticholinergic vulnerability ↑
- **Average adult > 65 years old is on 5 prescribed medications**
- **Many interactions are possible**
  - Pharmacodynamic
  - Pharmacokinetic

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Antidepressant Cost

- **Adherence can depend upon affordability**
- **Limitations of Medicare Part D**
- **Range of generically available antidepressants**
- **Avoid first line use of brand name drugs:**
  - Trintellix (vortioxetine)
  - Fetzima (levomilnacipran)
  - Viibryd (vilazodone)
  - Emsam (transdermal selegiline)

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SSRs – Still 1st Choice in LLD

Several well-tested, generic, well-tolerated, with limited drug interactions, appropriate elimination half-lives:

- **Sertraline**
- Citalopram (Note FDA dosage warning)
- **Escitalopram**

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Ellison et al., in Ellison et al (eds), Mood Disorders in Later Life, Informa HealthCare 2008.

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SNRIs

SNRIs share potential adverse effects of:

- Hypertension
- Anxiety
- Insomnia
- Share with SSRIs the potential for discontinuation symptoms

Duloxetine – analgesic effects are a bonus

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Other Antidepressants to Consider

Bupropion

- Less sedation and sexual side effects
- Less help with anxiety/psychosis
- Special contraindications

Mirtazapine

- More anxiolytic, less sexual side effects, less nausea
- More weight gain and sedation
- Could exacerbate REM sleep behavior in PD[1]
- Associated with small/significant risk for neutropenia, agranulocytosis; minimal interaction with warfarin

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[1]Onofrj M, Luciano AL, Thomas A, Iacono D, D'Andreamatteo G. Mirtazapine induces REM sleep behavior disorder (RBD) in parkinsonism. Neurology 2003;60:113–5.

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On The Horizon: Ketamine*?

Limited data in elderly

- Early open trial with 4 subjects reported limited benefit and severe dissociative adverse effects in 3 nonresponders.[1]
- Pilot RTC showed subq ketamine up to 0.5 mg/kg to midazolam in 16 older TRD adults superior to midazolam, with only 50% remitting 7 or more days.[2]
- Case report – remission induced after 4 infusions.[3]
- Case series – poor maintenance of remission in the older adults treated.[4]

***ketamine is still investigational or off label in the treatment of depression**

[1]Szymkowicz et al. J Clin Psychopharmacol 2014;34:285-6
[2]George et al. AJGP 2017;25:1199-1209
[3]Srivastava et al. Indian J Psychiatry 2015;57:328-9.
[4]Bryant et al. J Clin Psychopharmacol 209;39:158-61.

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Electroconvulsive Therapy

Underused modality, especially suitable with:

- Antidepressant intolerance or non-response
- Prior positive response to ECT
- Delusions
- Catatonia
- Mania
- Emergency

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37 Flint and Rifat. Int J Geriatr Psychiatry 1998;13:23-8; Manly et al. Electroconvulsive therapy in old-old patients. Am J Geriatr Psychiatry. 2000 Summer;8(3):232-6.

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ECT Efficacy

Greater in older adults[1]

- RUL: for ≥60 yr old, 70.4% remission vs 46% in <60
- BT: for ≥60 yr old, 75% remission vs 58.3% in <60

Better than meds in recent comparison:*

- 3.1 +/- 1.1 wk to ECT remission vs 4.0 +/- 1 wk with meds[2]
- Remission rate: 63.8% at 6 wk vs 33.3% at 12 wk in med group[2]

Cognitive effects: stable or improved in recent study[3], mixed findings in earlier studies attributed to technique and/or underlying disease.[4]

[1]Sanghani et al. Am J Geriatr Psychiatry 2014;22:S114
[2]Spanns et al. Br J Psychiatry 2015;206:67-71
[3]Verwijk et al. Int Psychogeriatr 2014;26:315-24
[4]Galvez et al. Curr Psychiatry Rep 2015;17:59-74
*This study contrasted results from two possibly noncomparable RCTs

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Additional Neurotherapies[1]

Repetitive Transcranial Magnetic Stimulation[2]

- 20-50% response rate open label, older adults
- Poorer response associated with cortical atrophy
- Better response with higher intensity stimulation?

VNS – limited data in elderly

***Transcranial Direct Current Stimulation**

***Magnetic Seizure Therapy**

***Deep Brain Stimulation**

***these neurotherapies are used investigationally or off label in treatment of depression**

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39 [1]Alexopoulos GS, Kelly Jr RE. Research advances in geriatric depression. World Psychiatry. 2009; 8(3): 140–149
[2]Galvez et al. Curr Psychiatry Rep 2015;17:59-74

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Treatment of Depression in Dementia

- **Multiple antidepressants studied, including**
  - Citalopram[1]
  - Sertraline[2,5]
  - Clomipramine[3]
  - Moclobemide[4]
  - Mirtazapine[5]
- **Large controlled trial (DIADS) failed to show superiority of sertraline over placebo**
- **Side effect assessment - more difficult in dementia**
- **Clinical approach – try, but discontinue if ineffective**

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40 [1]Nyth et al. Acta Psychiatr Scand 1992;86:138-45; [2]Lyketsos et al. Am J Psychiatry. 2000;157:1686-9; [3]Petracca et al. J Neuropsychiatry Clin Neurosci.1996;8:270-5; [4]Roth et al. Br J Psychiatry 1996;168:149-57; [5]Banerjee et al. Health Technology Assessment 2013;17(7):1-166.

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Treatment Resistant Depression and the "ABCD" Review

Adequacy of prior treatment

- Duration of treatment
- Dosage of medication

Behavioral/Environmental factors

- Personality disorder
- Psychosocial stressors

Compliance/Adherence

- Patient education
- Treatment intolerance

Diagnosis

- Missed medical diagnosis or adverse medication effect
- Missed psychiatric

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DSM 5: Persistent Complex Bereavement Disorder

- Death of close relationship
- For more days than not, clinically significant, persistent for at least 12 months (6 for bereaved children):
  - At least 1 of following:
    - Yearning/longing
    - Sorrow/emotional pain
    - Preoccupation with deceased
    - Preoccupation with circumstances of the death
  - And at least 6 symptoms from a group describing reactive distress and social/identity disruption
- Significant functional impairment/distress
- Out of proportion to cultural/religious/age-appropriate norms

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42 Summarized from American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA. American Psychiatric Association. 2013.

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Complicated Grief: Risk Factors

Pre-loss factors:
- Prior personal or family psychiatric illness
- Female sex
- Cognitive decline

Loss-related factors:
- Type of loss (e.g. spouse/child, stigma)
- Suddenness
- Immediate response

Post-loss factors:
- Negative coping strategies (e.g. avoidance, alcohol)
- Lack of social support
- Negative consequences

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43 Bui et al. Bereavement, grief, and depression: clinical update and implications. Psychiatric Times 2017;34:31-3.

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Spotlight on Substance Use

Benzodiazepines:
- Chronic use (daily>3 months): 12% of elderly [1]
- 9.5% of users are dependent[1]

Alcohol (>7 drinks/wk is considered excessive)
- 25% of elderly are daily drinkers
- 10% of elderly alcohol users "binge drink"[2]

Other drugs of concern: analgesics, hypnotics Illicit and nonmedical prescription drug use much greater among 50-64 year olds.[1]

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44 [1]Wu and Blazer 2010 (in press) J Aging and Health
[2]Culberson 2006;Geriatrics 61:23-27.

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Spotlight on Pain

- **Pain often accompanies MDD[1]**
  - Chronic painful physical conditions are increased fourfold in MDD patients.
  - Headache, neck and back, abdominal, and musculoskeletal pain are common.
- **Chronic painful physical conditions are an independent risk factor for MDD and poor treatment response.[1]**
  - Pain affects other depressive symptoms adversely (exacerbates sleep, energy, anxiety symptoms).
  - MDD+pain is associated with worse outcome to SSRI treatment proportional to pain severity.
- **The presence of pain is associated with increased help-seeking[2]**

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45 [1]Brannan et al. J Psychiatr Research 2005;39:43-53; [2]Bonnewyn et al. J Aff Dis 2009;117:193-6.

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Next Step in Treatment Resistant Depression

Optimize

Switch

Augment/Co-prescribe

ECT

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Importance of Maintenance

Even with maintenance, there is a high recurrence rate

Maintenance pharmacotherapy reduces recurrence risk
- Nortriptyline + IPT[1]
- Citalopram[2]
- Paroxetine[3]

Slower initial responders may do better with combined therapy in maintenance[4]

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47 [1]Reynolds et al. JAMA 1999;281:39-45
[2]Klysner et al. Br J Psychiatry 2002 Jul;181:29-35.
[3]Reynolds et al. N Engl J Med. 2006;354:1130-8
[4]Dew et al. J Affect Disord 2001;65:155-66.

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Epidemiology of Suicide in Later Life

In older adults, one of 4 suicide attempts is fatal.[1]

Increased risk with[2]:
- Older, white, male
- Widower, living alone, isolated, loss of social support, financial stress
- Pain, Perceived poor health
- Greater functional impairment
- Acute stressful event, bereavement
- Access to lethal means
- DEPRESSION!

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48 [1]Crosby et al. Suicide Life Threat Behav 1999;29: 131-140
[2]Blazer and Friedman. Am Fam Physician 1979;20:91-6; also see Conwell et al. Completed suicide at age 50 and over. J Am Geriatr Soc 1990;38: 640-644; Conwell et al. Completed suicide among older patients in primary care practices: a controlled study. J Am Geriatr Soc 2000;48: 23-29.2000

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Illness Risk Factors

Major depression[1]:

- Among depressed elderly seen in primary care during 12 months prior to suicide attempt, fewer than 1/10 received appropriate depression dx before attempt.

Medical illnesses[2]:

- Cancer, neurological diseases and cardiovascular diseases are the most frequently reported disorders associated with suicide.
- The relative risk for suicide is 1.5 to 4 times higher if an individual has one of these illnesses.

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[1]Suominen et al. Int J Geriatr Psychiatry 2004;19:35-40
[2]Juurlink et al. Arch Intern Med 2004;164:1179-1184.

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Depression and Medical Illness

- Medical burden in the elderly is great, and illnesses complicate the diagnosis of depression because of overlapping symptoms.
- Many illnesses are linked with increased depression risk: e.g. Coronary Artery Disease (15-23%), Diabetes Mellitus (17-25%), ESRD with dialysis (25%), Cancer (25%)
- Disease mechanisms can be synergistic; treatment requires attention to adverse effects / interactions.
- In general, the medical disorder and depression are both treated.

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see Harnett and Pies, in Ellison et al (eds). Mood Disorders in Later Life. Informa Health Care 2008.

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Detecting and Treating LLD More Effectively

Primary Care settings are optimal site for detecting and initiating treatment of late life depression.

Several model programs have demonstrated efficacy:

- IMPACT
- PROSPECT
- PRISM-E
- TIDES

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Conclusions

Depression: Not a normal part of aging
Age affects LLD:

- Risk
- Etiology
- Presentation
- Assessment
- Treatment
- Prognosis

Remember to look for LLD and to treat actively!

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HCCIntelligence™ Virtual Office Hours: Ask the Experts

An open forum for questions and answers

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Introductions

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CEO, Home Centered Care Institute
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Questions

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HCCIntelligence™ Resource Center

Free Technical Assistance:

Hotline
Call 630.283.9222 or email Help@HCCInstitute.org 9:00 am–5:00 pm (CST) Monday through Friday

Webinars
Every third Wednesday of the month, HCCI hosts a webinar on topics relevant to HBPC.

Virtual Office Hours
Immediately following the monthly webinar, HCCI hosts Virtual Office Hours where experts address questions on any HBPC topic.

Tools & Tip Sheets
Downloadable tools, tip sheets, sample forms and how-to guides on a variety of HBPC topics.

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HCCI Upcoming Events

HCCI & NNPEN Joint Conference
February 7-8, 2020 in Phoenix, AZ

HCCI Essential Elements of Home-Based Primary Care™ Workshop
March 26-27, 2020 in Schaumburg, IL

HCCI Advanced Applications of Home-Based Primary Care™ Workshop
April 23-24 in Schaumburg, IL

HCCIntelligence™ – Webinars
Every third Wednesday of the month, HCCI hosts a free webinar on a clinical or practice management topic relevant to home-based primary care (HBPC). Visit www.HCCInstitute.org for more details.

- **Self-Care: Avoiding Burnout and Maximizing You and Your Team**
  Wednesday, January 15th, 4 pm – 5 pm CST

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HCCI Consulting Services

Relationship focused. Results driven.

HCCI is pleased to offer affordable consulting services that assist organizations in enhancing the patient experience, improve health outcomes, and reduce costs.

Our consultants include:

- **Providers** with extensive experience in HBPC.
- **Practice managers** skilled in running house call programs and recognized with national certifications in coding and medical auditing.
- **Other professionals** with expertise in strategic planning, marketing, education and training, and quality.

To connect with HCCI, call 630.283.9222 or email help@HCCInstitute.org.

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