Depression Treatment Disparities Among Older Minority Home Healthcare Patients

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Objective: *Determine the racial/ethnic effect on depression treatment among home healthcare patients.* **Design:** *Cross-sectional analyses of administrative data.* **Setting:** *A large home healthcare agency in Bronx, NY.* **Participants:** *Patients 65 years and older admitted to homecare in 2010 (N = 3,744).* **Measurements:** *Patient Health Questionnaire (PHQ)-2 depression screen. Other data, such as diagnosis, medications, and demographics, were collected from the patient electronic medical record.* **Results:** *6.52% of the sample had a depression diagnosis, 11.11% screened positive for depression (+PHQ-2), and 13.39% were prescribed antidepressants. The odds of receiving an antidepressant among those who screened positive for depression were 0.42 (95% confidence interval [CI]: 0.22–0.79) for African Americans and 0.49 (95% CI: 0.26–0.93) for Hispanics compared with Caucasians.* **Conclusions:** *These findings suggest that disparities continue to exist in depression treatment for older minority home healthcare patients compared with older Caucasians.* (Am J Geriatr Psychiatry 2014; 22:519–522)

Key Words: Geriatric depression, race/ethnicity, home healthcare

Late-life depression treatment, particularly in those with chronic medical comorbidity or disability, has advanced in recent years.[1] Home healthcare (HH) is an area of growing interest for depression care, especially with the recent Medicare mandate to assess and document depressive symptoms for all HH patients. These changes began January 2010, resulting in most agencies incorporating the Patient Health Questionnaire (PHQ)-2, a depression screening measure widely used in primary care,[2] into their routine nursing assessment. Results of national survey data have shown lower antidepressant prescription rates in older minorities, specifically African American home healthcare patients, compared with Caucasians,[3] but these data were collected prior to changes in Medicare regulations. Therefore, any change in depression treatment based on the effects of widespread use of the PHQ-2 in home healthcare have not yet been reported. This study examines the racial and ethnic effect on treatment for HH patients with positive depression screens. We hypothesize that disparities in depression treatment will continue to occur in older HH patients.

METHODS

The data collected for these analyses were extracted from the electronic medical records of a large, urban HH agency in the Bronx, NY, from January 1, 2010, to December 31, 2010. HH patients aged 65 and older, admitted to the certified home healthcare agency, and having a valid depression screen were included in the sample (N = 3,744). Racial and ethnic groups were identified from a single variable in the medical record, providing no distinction between race and ethnicity. Only Caucasians, Hispanics, and African Americans were included in these analyses, with other groups (Native Americans, Asians, Pacific Islanders) excluded due to small sample sizes (>4%

Received January 2, 2013; revised January 25, 2013; accepted January 28, 2013. From the Department of Psychiatry (YRP, RLG, KNB, MLB), Weill Cornell Medical College, New York, NY; and the Department of Psychiatry and Behavioral Sciences (YRP), Albert Einstein College of Medicine, New York, NY. Presented at the American Association for Geriatric Psychiatry Annual Meeting, Washington, DC, March 2012. Send correspondence and reprint requests to Yolonda R. Pickett, M.D., M.S., 21 Bloomingdale Rd., White Plains, NY 10605. e-mail: yop2003@med.cornell.edu
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http://dx.doi.org/10.1016/j.jagp.2013.01.078

of sample). Approval for this study was obtained by the institutional review boards of the Montefiore Medical Center and the Weill Cornell Medical College.

PHQ-2 scores were obtained from the first start-of-care nursing assessment in the calendar year. A cutoff of 2 points instead of the traditional cutoff of 3 points was used here because a cutoff of 2 was found to have greater sensitivity and negative predictive value, therefore reducing the number of false negative findings.[4] Antidepressants were identified from medication records at the start-of-care and reviewed by the physician investigator (YRP) for accuracy. Sex, age, and Activities of Daily Living (ADL) impairments were also collected from medical records. Depression diagnoses were determined from patient ICD-9 codes and represented all forms of unipolar depression disorders (major depression, dysthymia, minor depression, subthreshold depression, or adjustment disorder with depressed mood) that may require treatment. Medicaid eligibility was obtained from patient insurance information and used as a proxy for socioeconomic status because income was not recorded. The Chronic Disease Score (CDS),[5] a measure of medical comorbidity, was calculated using an algorithm adapted by R. Greenberg based on 2010 American Hospital Formulary Service medication codes.

Descriptive statistics of associations between race and the other covariates were reported as analysis of variance for continuous variables and χ^2 for categorical variables. χ^2 tests were repeated for antidepressant use by race, stratifying by positive or negative PHQ-2 screen. Multiple logistic regression was used to determine odds ratios for antidepressant use by race overall, and then stratified by positive or negative PHQ-2 screen while controlling for age, sex, and other covariates (Medicaid eligibility, living arrangement, CDS, and depression diagnosis) statistically significant at p less than 0.10 on bivariate analyses. The statistical program used to conduct these analyses was STATA Statistical Software Release 10 (Statacorp, College Station, TX).

RESULTS

The racial composition of this sample was 29.27% (1,096/3,744) Caucasian, 37.90% (1,419/3,744) African American, and 32.82% (1,229/3,744) Hispanic. The overall rate of documented depression diagnosis in the sample was 6.52% (244/3,744), with 11.11% (416/3,744) of the sample reporting depressive symptoms by PHQ-2 less than or equal to 2. There were 13.39% (497/3,711) of the total sample with an antidepressant prescription and 33 patients with missing medication data.

Caucasians were generally older than African Americans or Hispanics [Caucasians (C) = 81.04 years (SD = 8.78); African Americans (AA) = 78.05 years (7.97); Hispanics (H) = 76.81 years (7.80); F = 81.79, df = 2; $p < 0.01$], and had a higher rate of depression diagnosis [C = 8.30% (91/1,096); AA = 4.72% (67/1,419); H = 7.00% (86/1,229); $\chi^2 = 13.71$, df = 2; $p < 0.01$]. African Americans were more often female than Caucasians and Hispanics [AA = 71.39% (1,013/1,419); C = 58.58% (642/1,096); H = 63.27% (777/1,228); $\chi^2 = 46.92$, df = 2; $p < 0.01$] and had lower rates of positive PHQ-2 screens [AA = 9.37% (133/1,419); C = 13.50% (148/1,096); H = 10.98% (135/1,229); $\chi^2 = 10.71$, df = 2; $p < 0.01$]. A greater proportion of Hispanics received Medicaid compared with Caucasians and African Americans [H = 56.71% (697/1,229); C = 15.60% (171/1,096); AA = 25.09% (356/1,419); $\chi^2 = 505.02$, df = 2; $p < 0.01$], and were more likely to have chronic disease [Mean CDS: H = 6.29 (3.16); C = 5.54 (2.94); AA = 6.00 (2.97); F = 17.86, df = 2; $p < 0.01$]. There were no statistically significant differences in ADL impairments.

In Table 1, the rate of antidepressant prescriptions as indicated from medication records was reported overall, and then stratified by PHQ-2 scoring. Caucasians consistently had the highest rates of antidepressant use among the racial/ethnic groups and African Americans consistently had the lowest. The unadjusted likelihood of an African American patient receiving an antidepressant prescription was about a third of that for Caucasians among those with negative depression screens, and more than half for those with positive screens. Hispanics had consistently greater odds of receiving an antidepressant compared with African Americans regardless of PHQ-2 score, but less than Caucasians. The racial differences became more apparent when adjusting for patient demographic and clinical factors. Among all patients with antidepressants, the proportion of those with a negative depression screen was consistent

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