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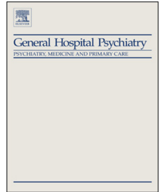

Psychiatry and Primary Care

Recent epidemiologic studies have found that most patients with mental illness are seen exclusively in primary care medicine. These patients often present with medically unexplained somatic symptoms and utilize at least twice as many health care visits as controls. There has been an exponential growth in studies in this interface between primary care and psychiatry in the last 10 years. This special section, edited by Jürgen Unutzer, M.D., will publish informative research articles that address primary care-psychiatric issues.

Diagnostic specificity and mental health service utilization among veterans with newly diagnosed anxiety disorders☆

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ABSTRACT

Objective: This study examined rates of specific anxiety diagnoses (posttraumatic stress disorder, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, social anxiety disorder, and specific phobia) and anxiety disorder not otherwise specified (anxiety NOS) in a national sample of Veterans and assessed their mental health service utilization.

Method: This study used administrative data extracted from Veteran Health Administration outpatient records to identify patients with a new anxiety diagnosis in fiscal year 2010 ($N = 292{,}244$). Logistic regression analyses examined associations among diagnostic specificity, diagnostic location, and mental health service utilization.

Results: Anxiety NOS was diagnosed in 38% of the sample. Patients in specialty mental health were less likely to receive an anxiety NOS diagnosis than patients in primary care (odds ratio [OR] = 0.36). Patients with a specific anxiety diagnosis were more likely to receive mental health services than those with anxiety NOS (OR = 1.65), as were patients diagnosed in specialty mental health compared with those diagnosed in primary care (OR = 16.29).

Conclusion: Veterans diagnosed with anxiety NOS are less likely to access mental health services than those with a specific anxiety diagnosis, suggesting the need for enhanced diagnostic and referral practices, particularly in primary care settings.

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Anxiety disorders are the most prevalent psychiatric disorders, with a 12 month prevalence rate of 18.1% in the general population [1]. This rate is nearly doubled in Veteran populations (33%) [2,3]. Anxiety disorders are associated with substantial functional impairment and high rates of comorbid psychiatric and medical disorders, and untreated anxiety can result in overutilization of medical services and increased healthcare costs [4–6].

Unfortunately, anxiety disorders often go unrecognized and untreated, particularly in primary care settings [7]. Only 50% of patients with mental health problems are detected by primary care providers, and even fewer are adequately treated or referred for specialty mental health services [5]. Although much work has been done to improve the detection and treatment of depression in primary care settings, far less attention has been given to anxiety disorders, despite their greater prevalence [8]. The under-recognition of anxiety disorders in primary care is likely a multifaceted problem, due in part to the complex overlap of anxiety symptoms with medical conditions, somatization, and lack of physician knowledge, time, and skill in diagnosing anxiety disorders [9].

This latter issue may also affect the specificity of anxiety diagnoses assigned by primary care physicians when they detect clinically significant anxiety. Providers who have less training in assessing and diagnosing mental health disorders or who face structural barriers, such as time and financial disincentives to conducting full psychiatric assessments [10], may use a nonspecific diagnosis such as Anxiety

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Disorder Not Otherwise Specified (anxiety NOS) if they are unsure whether a given patient meets diagnostic criteria for a specific anxiety disorder. The diagnosis of anxiety NOS refers to clinically significant symptoms of anxiety or phobic avoidance that do not meet criteria for any of the other *Diagnostic & Statistical Manual, Fourth Edition, Text Revision* anxiety disorders or when a clinician concludes that an anxiety disorder is present, but has not determined whether it is primary, due to a medical condition, or substance-induced [11]. The prevalence of anxiety NOS in the general population is unknown, as the diagnosis has not been estimated in epidemiological studies. However, anxiety NOS is the most commonly diagnosed anxiety disorder among active-duty service members [12] and primary care patients [13,14].

The high rate of diagnosis of anxiety NOS in primary care may reflect the true incidence of anxiety symptoms that are not classifiable using more specific anxiety disorder diagnoses, but anxiety NOS also is likely used frequently as a provisional diagnosis, with the expectation that the diagnosing physician or other provider will be able to classify the symptoms more accurately at a later date. In either case, a nonspecific diagnosis such as anxiety NOS may be a barrier to receiving mental health services. No specific treatment guidelines for anxiety NOS exist [15], and although general anxiety treatment approaches may be beneficial, the lack of specific treatment recommendations may make referral options for anxiety NOS less clear. Similarly, if anxiety NOS is being used as a provisional diagnosis, this may indicate that the provider does not yet have enough information to determine which mental health services would be beneficial, making it less likely that the provider will initiate referral.

The goal of the current study was to determine the rates of specific and nonspecific anxiety diagnoses in a national sample of Veterans receiving care at VA medical centers and examine patterns of mental health service utilization in the year following diagnosis. The VA is the largest healthcare system in the United States, and the availability of VA national databases allows an examination of diagnostic and mental health service utilization patterns in a sizeable sample of patients. We hypothesized that anxiety NOS would be a common diagnosis, particularly in primary care settings where providers tend to have less time and expertise in diagnosing psychiatric disorders relative to specialty mental health settings. To determine whether patient factors are related to diagnostic specificity, we examined the role of patient demographic and clinical characteristics in predicting the diagnosis of specific vs. nonspecific anxiety disorders. We expected anxiety NOS to be used primarily as a placeholder, and therefore expected that most patients initially diagnosed with anxiety NOS would receive a diagnosis of a more specific anxiety disorder within the following 12 months. Finally, because diagnostic specificity may facilitate treatment use, we predicted that patients with specific anxiety diagnoses would be more likely to receive mental health services in the 12 months following diagnosis than patients diagnosed with anxiety NOS.

1. Methods

This retrospective database cohort study used patient data from the Veterans Health Administration (VHA) National Patient Care Database (NPCD) outpatient encounter files for Veterans receiving care during the fiscal year 2010 (October 1, 2009, to September 30, 2010). The NPCD contains encrypted patient identifiers that are associated with broad patient and service characteristics and are available for health services research. The accuracy and validity of the NPCD data are monitored by the VHA Veteran Information Resource Center [16].

1.1. Patient population

This study focused on patients who received a new anxiety diagnosis in VHA outpatient facilities during the specified year. Patients were categorized using the *International Classification of Diseases, Ninth Edition, Clinical Modification*. Anxiety disorder NOS was identified by the *ICD-9* codes 300.00 and 300.09, while specific anxiety diagnoses included posttraumatic stress disorder (PTSD; 309.81), generalized anxiety disorder (GAD; 300.02), panic disorder (PD; 300.01 and 300.21), obsessive-compulsive disorder (OCD; 300.3), social anxiety disorder (SAD; 300.23), and specific phobia (SP; 300.29).

Restricting the sample to patients with new diagnoses reduced the likelihood of contamination from patients who previously received a nonspecific anxiety diagnosis that was subsequently clarified and provided greater assurance that patients would likely benefit from mental health services. A new diagnosis was defined as one occurring after a 6-month period without a related diagnosis before the index date (the date of first diagnosis during the study period). No patients received both a new anxiety NOS diagnosis and a specific anxiety diagnosis on their index date. However, several patients received multiple new-onset specific anxiety diagnoses on their index date and were therefore classified into more than one specific anxiety diagnostic category (e.g., a patient with a new PTSD diagnosis and a new GAD diagnosis would be classified into both categories for descriptive purposes). We excluded patients with 60 or more inpatient hospital days in the 180days following the index date to limit the sample to patients with adequate opportunities to use outpatient mental health services. Thus, the final sample included 292,244 patients with a new anxiety diagnosis (180,646 diagnosed with a specific anxiety disorder and 111,598 diagnosed with anxiety NOS).

1.2. Diagnostic care settings

Within the VHA, specific identifiers known as stop codes are used to indicate the primary work group responsible for each patient encounter. We used VA clinic stop codes to identify diagnostic patterns across the following care settings: primary care, specialty mental health, integrated primary care mental health (PC-MHI), and “other” specialty settings. Primary care visits included stop codes 301, 322, 323, 348 and 350; and PC-MHI included stop codes 531, 534, 539, 571 and 572. Specialty mental health care was defined by VA clinic stop codes 500–599, excluding the above-mentioned PC-MHI stop codes. Finally, anxiety diagnoses associated with any other VA clinic stop codes were categorized as “other” specialty settings, and most frequently included laboratory and emergency care services.

1.3. Mental health service utilization

Patient use of mental health services was assessed during the 12 months following each patient’s index date. The full spectrum of mental health Current Procedural Terminology (CPT) codes (90801–90911, 96100–96155) were used to assess mental health service use.

Psychotherapy use was classified using the following CPT codes for fiscal year 2010: 90804, 90806, 90808, 90810, 90812, 90814, 90845, 90846, 90847, 90849, 90853, 90857, 90875, 90876, 96152, 96153, 96154, 96155). Psychiatric medication visits (90862) and psychotherapy with medication-management visits (90805, 90807, 90809, 90811, 90813, 90815) were also examined. Descriptive statistics related to mental health service visits were calculated for the 12 months following each patient’s index date.

1.4. Patient characteristics

We examined patient sociodemographic characteristics, including age, gender, marital status, income (estimated using the average adjusted gross income for each patient zip code, based on 2008 Internal Revenue Service data), and distance in miles to the nearest VA facility (calculated using patient zip code). Patient race was not

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