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Treatment of obsessive compulsive disorder in a nationwide survey of office-based physician practice

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Abstract

Objective—To examine the treatment of obsessive compulsive disorder (OCD) in office-based physician practices.

Methods—Data from the 2003–2010 National Ambulatory Medical Care Survey, a nationally representative survey of visits to office-based physicians in the United States, were used to examine treatment of adult outpatient visits with a diagnosis of OCD.

Results—Most visits with a diagnosis of OCD (N=316) had been seen previously by the same physician (96%), usually a psychiatrist (86%), 6 times (56%) within the previous year. Most visits included psychotropic medications (84%), most commonly a serotonin reuptake inhibitor (69%) and less commonly included any psychotherapy (39%).

Conclusions—OCD is predominantly treated by psychiatrists using SRI medications, despite the prevalence of OCD and SRI prescribing practices in primary care. Given the potential shift in OCD treatment practice patterns after health care reform, future research on the treatment of OCD in primary care are warranted.

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Introduction

Obsessive-compulsive disorder (OCD) is associated with a profoundly diminished quality of life, social isolation¹, and a substantial economic burden on society.² Evidence-based guidelines for the treatment of OCD identify two types of efficacious treatments: serotonin reuptake inhibitors (SRIs, i.e. clomipramine and the selective serotonin reuptake inhibitors), and cognitive-behavioral therapy (CBT) consisting of exposure and response prevention.³ Research in specialty settings has shown that individuals with OCD often do not receive evidence-based care⁴, with lower rates of treatment with exposure and response prevention (range: 7.5%–18%) than SRI medications (range: 39%–77%). To broadly examine how OCD is treated in community practice, we analyzed the 2003–2010 National Ambulatory Medical Care Survey (NAMCS),⁵ focusing on the treatment provided to adults diagnosed with OCD in office-based physician practices in the United States.

Method

This study was conducted between July 2012 and August 2013, and Institutional Review Board approval was obtained. The NAMCS is conducted annually by the National Center for Health Statistics.⁵ It samples a nationally representative group of visits to non-federally employed office-based physicians who are primarily engaged in direct patient care. The annual NAMCS physician target sample includes all physicians maintained by the American Medical Association and American Osteopathic Association representing an array of medical specialties (i.e. primary and specialty care). Visits to other health and mental health care providers are not included in the survey. The NAMCS uses a multistage probability sample design involving primary sampling units (a county, a group of adjacent counties, or a standard metropolitan statistical area), physician practices within primary sampling units, and patient visits within physician practices. During one week, attending physicians or office staff, complete a 1-page form that queries demographic, clinical, and treatment characteristics about selected patient visits. Each visit is weighted by sampling probability, adjustment for nonresponse, physician specialty, and geographic location to obtain nationally representative estimates. Following National Center for Health Statistics recommendations, we combined data from contiguous survey years 2003 to 2010 to establish a larger base on which to derive more stable estimates. Survey response rates across survey years varied from 58.3% to 66.9% (median=61.6%).

Diagnoses (recorded in three data fields as “primary” and the last two fields as, “other”) were made by the treating physicians according to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). We limited the sample to outpatient visits in which either a primary diagnosis of OCD (ICD-9-CM: 300.3) was assigned or OCD was assigned as a secondary or tertiary diagnosis and the other diagnoses were an anxiety disorder other than PTSD, a mood disorder other than bipolar disorder, an adjustment disorder, or a general medical disorder. Visits with a comorbid primary diagnosis of a mood disorder and other anxiety disorders were included in our sample because these commonly co-occur with OCD⁶ and have first-line treatments similar to OCD (i.e., antidepressants or CBT). Visits with comorbid primary diagnoses of schizophrenia, bipolar

disorder and other psychotic disorders were excluded because they have different first-line treatments than OCD.

Data were collected on patient age, sex, race, and ethnicity. Visits were also classified according to whether the physician had seen the patient before. Data regarding sources of payment for the visit were collapsed into 4 non-mutually exclusive categories: public insurance, private insurance, self payment, and a residual category other including no charge, uncompensated care, workers' compensation, and unknown payment source. Specialty of physicians was classified as psychiatry, primary care (general, family and internal medicine), or other specialty.

Visits that included psychotropic medications were classified into 6 medication groups: serotonin reuptake inhibitors (SRIs), other antidepressants, benzodiazepines, antipsychotics, mood stabilizers, and stimulants. Psychotherapy visits included psychotherapy, mental health counseling or social problem counseling. Visit duration was recorded in minutes and included only time spent in face-to-face contact with the patient. A study comparing NAMCS ratings with direct observation found high specificity; however, NAMCS ratings moderately overestimated the time spent with patients.⁷ To account for this tendency in recording visit duration, we analyzed only those psychotherapy visits that were 45 minutes or longer.⁷

Statistical Methods

Sample means, standard errors and 95% confidence intervals were calculated for characteristics of persons in treatment for OCD. We used the STATA statistical software package (Version 12.0) to accommodate the complex sampling design and weights from NAMCS. Sample means and 95% confidence intervals are reported averaged over the study time period. Logistic regression analyses were used to determine predictors of treatment with SRIs or any psychotherapy (lasting >45 minutes) of an unspecified type.

Results

Between 2003 and 2010, 316 patient visits with a diagnosis of OCD were sampled in the NAMCS, representing approximately 728,644 annual office visits (619,871 [psychiatrist], 79,990 [primary care physician], 28,783 [other physician specialty]). Table 1 shows visit characteristics. Most of the visits (66%) were for primary OCD; thirty percent were for a primary diagnosis of a mood, adjustment or anxiety disorder, and four percent were for a general medical diagnosis. Most visits were by patients who had been previously seen by the same physician, six or more times within the previous 12 months. Psychotropic medications were prescribed in most visits, primarily SRIs, followed by benzodiazepines, antipsychotics, stimulants, and mood stabilizers. Fewer than half of the visits included psychotherapy (lasting >45 minutes) of an unspecified type.

In a sensitivity analysis, we examined whether receipt of psychotherapy or SRI medications varied by age, gender, race/ethnicity, payment type, and physician specialty (psychiatrist vs. other specialty). Persons who self-pay for treatment had higher odds of receiving psychotherapy, compared to persons with private insurance (OR=2.84, p=.0.01, [95% CI:

1.28–6.27]). Persons seeing a psychiatrist had higher odds of receiving psychotherapy, compared to other physician specialties (OR=113.23, $p=0.00$, [CI: 13.22–970.00]). Persons age 36–50 had higher odds of receiving psychotherapy than persons age 18–35 (OR=2.19, $p=0.02$, [CI: 1.13–4.27]). No differences were found in receipt of psychotherapy by gender or race/ethnicity. No differences were found in receipt of SRI medications by age, gender, race/ethnicity, payment or physician type.

Discussion

This is the first national study examining OCD treatment in office-based medical practice. Despite findings of similar prevalence of OCD among non-Hispanic blacks and whites among major US epidemiological studies,^{8–9} we found a large imbalance in the ethnic and racial distribution of OCD visits (91% non-Hispanic white, 1% non-Hispanic black, 3% Hispanic, and 4% other non-Hispanic) which has also been reported in OCD treatment and clinical trials.¹⁰ More research to identify barriers to outpatient treatment for racial/ethnic minorities with OCD (e.g. lack of knowledge about OCD, mistrust of providers, and lack of proximity to specialized treatment centers)¹¹ and strategies for combating these treatment disparities.

Consistent with previous studies in more specialized settings⁴, individuals with OCD who receive office-based medical treatment are more commonly treated by physicians with medications than psychotherapy. We found that those who self-pay for treatment or saw a psychiatrist had higher odds of receiving psychotherapy, suggesting that financial barriers¹¹ and physician specialty play a role. Given the training psychiatrists receive in psychotherapy, we are not surprised to find that medical specialty was associated with the treatment received. We also found that patients with OCD are relatively high-intensity users of mental health services and that OCD is largely treated by psychiatrists in office-based medical practice even though studies estimate a 12-month prevalence of OCD between 1.9–2.2% in primary care settings,¹² and SRIs are a first-line treatment for OCD that are commonly prescribed in primary care.¹³

This study has several limitations related to the source of the data. First, the sample is restricted to office-based visits and does not include visits to non-physician mental health care professionals, who likely account for a substantial proportion of psychotherapy for OCD. Second, NAMCS data are cross-sectional and data on previous treatments, treatment response and specific type of evidence-based psychotherapy (CBT) were not collected, common to large administrative data sets.¹⁴ Third, the NAMCS records visits rather than individual patients which may affect clinical interpretation of visit distributions if the number of visits per treatment episode varies across patient characteristics. Fourth, incomplete response of eligible physicians to the surveys opens the potential for selection effects which may bias the reported estimates. Last, diagnoses in the NAMCS are based on independent judgment of the clinician and are not subject to expert validation.

Conclusions

In broad terms, treatment of OCD in office-based medical practice is mainly comprised of SRI treatment by psychiatrists. Despite the prevalence of OCD in primary care and primary care physician SRIs prescribing practices, OCD treatment by non-psychiatrists remains uncommon. Findings from this study represent an assessment of the treatment of OCD prior to health care reform under the Affordable Care Act (ACA). It is likely that practice patterns will change under the ACA given estimates that by 2019 the ACA would extend health insurance to nearly 4 million previously uninsured individuals with severe mental disorders. Given this potential shift in care of more mental health care to primary care physicians and nurse practitioners¹⁵, efforts to better understand the recognition and treatment of OCD in primary care are warranted.

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Table 1

Characteristics of office-based visits for OCD, 2003–2010 (n=316)

	Unweighted cell count	Percent	95% CI
Age			
18 – 35	102	33.4	26.5 – 40.3
36 – 50	98	34.7	27.7 – 41.6
51 – 64	98	27.5	21.3 – 33.8
65+	18	4.4	2.1 – 6.7
Sex			
Female	168	51.6	44.2 – 59.0
Male	148	48.4	41.0 – 55.8
Race/Ethnicity			
White, non-Hispanic	292	91.3	87.1 – 95.4
Black, non-Hispanic	5	1.4	0.0–2.9
Hispanic	10	3.3	1.0–5.6
Other, non-Hispanic	9	4.0	1.0–7.0
Payment Source			
Private insurance	151	52.1	44.3 – 59.8
Public insurance ¹	57	18.0	12.0 – 24.0
Self pay	95	26.4	19.4– 33.5
Other ²	13	3.5	0.6 – 6.4
Visit Status			
Previously Seen	305	95.9	93.0 – 98.9
Not Previously Seen	11	4.1	1.1 – 7.0
Number of Visits in past 12 months			
0	16	6.5	2.9 – 10.0
1–2	41	16.3	10.4 – 22.2
3–5	63	21.6	15.5 – 27.6
6+	196	55.7	47.8 – 63.6
Major Reason for Visit			
New/acute	21	6.9	2.7 – 11.1
Chronic, routine	230	71.8	64.6 – 78.9
Chronic, flare up	49	15.0	9.8 – 20.2
Other	16	6.3	3.1 – 9.5
Physician specialty			
Psychiatry	284	85.9	79.9 – 91.9
Primary care	21	11.0	5.5 – 16.4
Other ³	11	3.1	0.2–6.0
Treatment			
Any Psychotherapy ⁴	151	39.1	29.7 – 48.4
Any Psychotropic Medication	259	83.5	78.3 – 88.7
SRI or Psychotherapy	269	84.2	8.7– 89.8

	Unweighted cell count	Percent	95% CI
SRI ¹	208	68.9	62.8 – 75.0
Benzodiazepines	89	29.0	23.2 – 34.7
Antipsychotics	49	12.9	8.5 – 17.3
Mood Stabilizers	13	3.0	0.5 – 5.5
Stimulants	19	6.7	3.2 – 10.2
Other ⁵	62	19.2	14.1 – 24.2

a Data are from the 2003–2010 National Ambulatory Medical Care Survey. Percentages are based on weighted and survey corrected sampling. CI denotes the 95% confidence interval.

¹ Medicare, Medicaid, and other government insurance

² Other includes no charge, uncompensated care, workers' compensation, and unknown payment

³ Other physician specialty includes general surgery, cardiovascular diseases, neurology, and a residual category of all other specialties.

⁴ Psychotherapy visits were limited to 45 minutes or longer;

⁵ Other included tricyclics and tetracyclics, and other antidepressants