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**How to Integrate Behavioral
Health Screening and
Treatment Programs in Home
Health Care**

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Conflict of Interest Disclosure

- **I DO NOT** have an actual or potential conflict of interest in relation to this educational activity or presentation.

Learning Objectives

- Describe how a behavioral health program can be implemented into a home care agency.
- Delineate the goals of a behavioral program within a home care agency.
- Describe the positive outcomes of incorporating behavioral health in a medical model.

The Case of the 70 Year Old Female

- 70-year old married woman with a past psychiatric history of Bipolar disorder but no history of mania referred to Montefiore Home Care Geriatric Psychiatry Program (MHC-GPP) for complicated medication regimen s/p recent psychiatric hospitalization.
- HPI:
 - She was treated with Lithium and Fluoxetine for years. But one year prior developed hand tremors (a known side effect of Lithium)
 - She saw a neurologist who tapered Lithium and subsequently underwent multiple medication changes.
 - She was eventually admitted to an outside psychiatric hospital for psychosis and depression.
 - Upon discharge, patient was still depressed, mildly psychotic and on multiple medications.
 - She also developed Parkinsonism likely due to medication and was treated with Carbidopa/Levodopa.

The Case of the 70-Year Old Female

- HPI (continued)
In the hospital she was diagnosed with a UTI during this hospitalization and treated with antibiotics.
And then discharged on
 - Quetiapine 100mg qhs
 - Haldol 2mg BID
 - Escitalopram 10mg daily
 - Bupropion 300mg daily
 - Mirtazapine 30mg qhs
 - Benztropine 0.5mg daily
 - Gabapentin 300mg TID
 - Carbidopa/Levodopa, Pramipexole and Lamotrigine were stopped during the hospitalization.

Thoughts?

- What are your main concerns?
- What can a home care agency offer this patient?
- What are potential gaps in service?

The Case of the 70-Year Old Female

- She was evaluated at the Montefiore Center for the Aging Brain: a multidisciplinary consultative clinic
 - Referred to Montefiore Home Care (MHC)
- She was seen by RN, PT, MSW and referred to the Montefiore Home Care- Geriatric Psychiatry Program (MHC-GPP).

Montefiore Home Care

- Established in 1947 as the nation's the first hospital-based home care agency
- Montefiore Home Care is a certified and licensed Home Care Agency, accredited by JCAHO
 - Provides Nursing, Rehabilitation, Social Work
 - Specialty programs: Behavioral Health, Wound Care, Joint Replacement, Heart Failure, Palliative Care
 - Serves Bronx and Westchester Counties of New York.

The Bronx

- Huge
 - 1.4 million residents
- Impoverished
 - 30% persons below poverty level
- Ethnically diverse
 - 53% speak language other than English at home
- Morbidity burden
 - Rated lowest in NY State for health outcomes
 - High rates of obesity, asthma, diabetes

Pioneer ACO Program

- Center for Medicare and Medicaid Services (CMS) initiative designed for organizations with experience managing populations
- Serves Medicare fee-for-service beneficiaries
- Start January 2012- last 3-5 years
- Quality scoring across multiple domains
- Potential shared savings with substantial financial risk and gain
- Montefiore Medical Center was selected to be the only Pioneer ACO in New York.

High Risk ACO Patients

- ❖ Highest-risk beneficiaries identified (1,906)
 - 9% of population = 55% of medical cost
 - 9% dual eligible
 - **55% mental health diagnosis**
 - Approximately 70% cared for by voluntary physicians

Montefiore Home Care

- 13,728 admissions annually
- Average Daily Census: 2,735
- Skilled Visits :
 - Nursing- 124, 347
 - Social Work- 8, 328
 - Rehabilitation Therapy: 43, 159

Unmet Behavioral Health Needs Lead to ...

- Noncompliance: noncompliance with plan of care
 - 3x more likely
- Morbidity: Increases morbidity from chronic medical illnesses
 - DM twice as likely to have depression
 - 36% of hospitalized older adults with HF have MDD

Unmet Behavioral Health Needs Lead to...

- Hospital Costs: Depression and anxiety increases re-hospitalization.
 - Unplanned hospital 30 day readmission 3x as likely in elderly with history of depression.
 - 6 months readmission 3x as likely in older adults with depressive symptoms.
- Mortality: Major Depression associated with increased mortality
 - 43% increase of risk of all cause death
 - 2.6x risk of CVD death

Geriatric Depression

**Dr. Gary Kennedy, Chief of Geriatric Psychiatry
Montefiore Medical Center, Albert Einstein:**

- *Major public health problem*
- *Many health practitioners don't ask the simple questions that screen for depression*
- *Seniors themselves often ignore-even hide-their debilitating mental conditions.*
- *Older adults are more sensitive to the mental illness stigma than any other group. They tend to think of mental health treatment as leading to mental hospitals or nursing homes*

Embedding Psychiatry into Home Care

- < 3% of adults see a mental health professional
- 2/3 of PCPs had trouble accessing mental health services
- Older adults are less likely to receive follow up mental health care
- Major Depression:
 - 13.5% of elderly home health care
 - 6.5% of older primary care patients

Model for Geriatric Psychiatry in Home Care

- Identify and treat the homebound elderly with depression
- Model program to integrate psychiatry into Home Care
 - 2004: Home Care established collaboration with Dept. of Psychiatry at Montefiore.
 - New York Cornell Westchester provided the training for clinical staff on recognizing symptoms of depression.
 - Educational program for geriatric psychiatry fellows, residents and medical students

Montefiore Home Care-Geriatric Psychiatry Program (MHC-GPP)

- Goals :
 - Establish a program to provide care to population that underutilizes mental health services
- Outcome measures:
 - Reached men and minorities who underutilize mental health treatment
 - Timeliness of evaluations from time of referral to date of evaluation
 - Provide access to psychiatric treatment
 - Minimize unnecessary hospitalizations

Training Program

- PHQ2 and PHQ-9
 - assessment instrument was promoted as a means of both screening and evaluating
 - They have both been validated in primary care populations. Sensitivity > 80%
- Training utilized the Outcome and Assessment Information Set (OASIS)
 - CMS instrument required of home health agencies for reimbursement
 - This allowed depression screening and treatment to be captured in the reimbursement for Home Care

Screening Tool- PHQ-2

- M1730 Depression Screening

(M1730) Depression Screening:
 Has the patient been screened for depression, using a standardized depression screening tool?

0 - No

1 - Yes, patient was screened using the PHQ-2© scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?")

PHQ-2© Pfizer	Not at all 0 – 1 day	Several days 2 – 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A Unable to respond
a. Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b. Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na

2 - Yes, with a different standardized assessment - and the patient meets criteria for further evaluation for depression.

3 - Yes, patient was screened with a different standardized assessment - and the patient does not meet criteria for further evaluation for depression.

Why the PHQ2 for Depression Screening?

- 2- symptom Screen
- Cardinal or gateway symptoms of depression
- - “depressed mood”
- - “diminished interest or pleasure in most activities”

Model: Embedded Home Care Geriatric Psychiatrist

RN and SW identify patients with depression, anxiety or other mental health issues

SW contacts PMD for approval for psychiatric evaluation

Geriatric psychiatrist evaluates patients in their homes and provides consultative services and treatment

Geriatric psychiatrist works jointly with RN, SW, and PMD to manage patients

Reasons for Referrals to MHC-GPP

- Cognitive Disorders with or without behavioral problems
- Depression
- Anxiety
- Psychosis
- Hoarding
- Substance Abuse
- Capacity evaluation

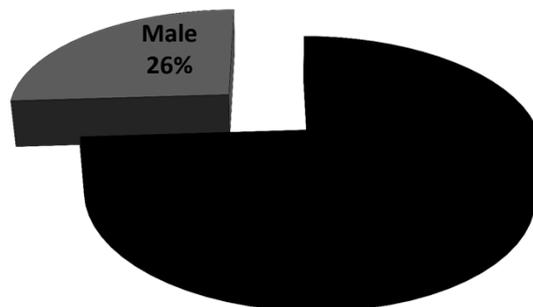
Gender

- Men are less likely than women to seek help from a mental health professional for mental health concerns.

N=178

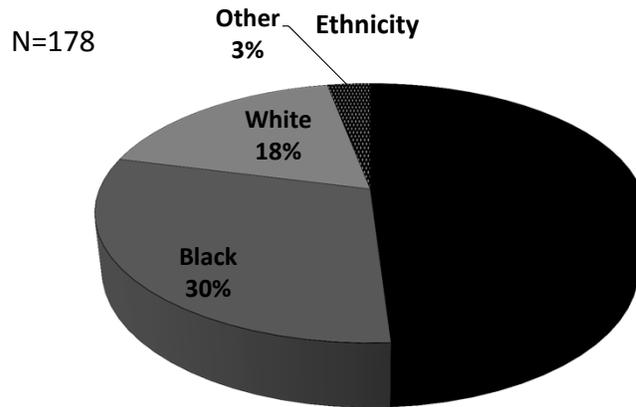
35% over 80 years old

Gender



Ethnicity

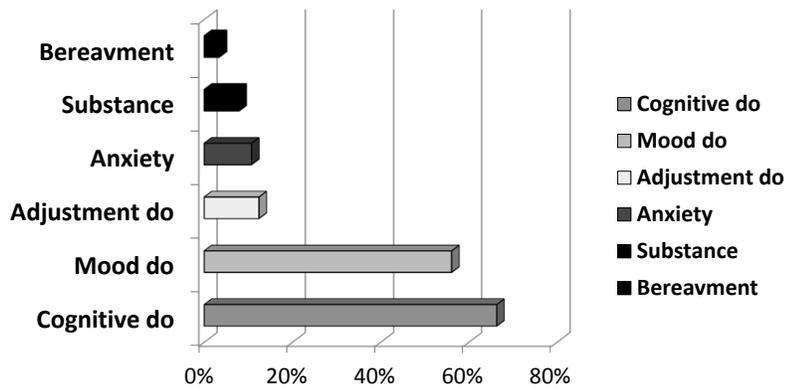
- Hispanics and African Americans are less likely to find antidepressants acceptable.



Diagnoses

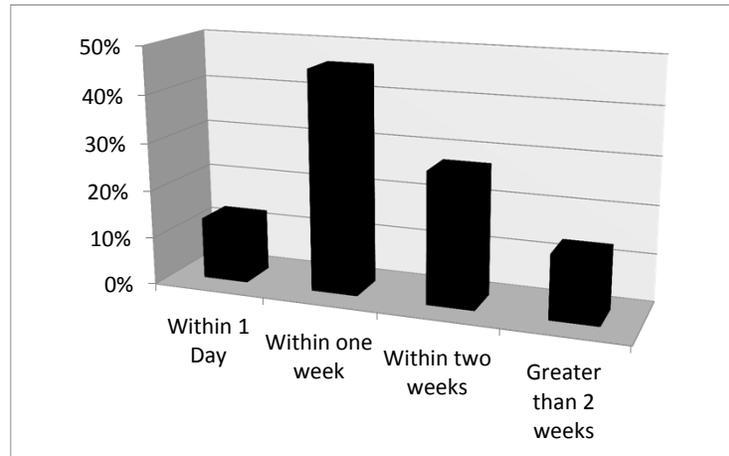
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Diagnoses



Timeliness of Evaluation Visits

N=178



Treatment Options

- **Medications**
 - Depression/Anxiety: Selective Serotonin Reuptake Inhibitors (SSRI's) are most commonly prescribed or Serotonin Norepinephrine Reuptake Inhibitors and other drug classes.
 - Dementia with Psychosis/Behavioral Disturbance: Antipsychotics-atypical or typical.
- **Psychological Interventions**
 - Counseling provided by home care social workers
 - Out patient mental health providers for continued care
- **Adult Day Program/ Senior Centers**
 - Pts with Medicaid are eligible for day programs.
 - Minimizes agitation, improves depression, improves sleep.

Treatment

N=178

Treatment Recommendation	Percentage
Pharm Intervention	61.2%
Psychotherapy	16.3%
Long Term Psychiatric Care	14.6%

92% of patients were agreeable to a pharmacological intervention.

Montefiore Home Care Risk Score for Readmission

- MHC Risk Score:
 - calculated by giving 1 point for each risk factor.
- Only factors with prevalence over 10% were included in table.

MHC Risk Score	Average Score
N=178	7

- MHC Risk Score of 7 is associated with a 30 day re-hospitalization rate of 22%.

MHC Risk Score and Patient risk factors for Hospitalization	
Medical Comorbidities	
Three or More Diagnoses	81.6% (142)
CHF	14.4% (25)
Diabetes	46.0% (80)
Obesity	13.2% (23)
Medical Related Factors other than disease process	
Confusion	13.2% (23)
DC From Hosp	16.1% (28)
Polypharmacy (5 or more meds)	75.9% (132)
History of Falls	14.4% (25)
High risk of Falls	68.4% (119)
Med Management Issues	67.2% (117)
Multiple Hospitalizations	31.0% (54)
Social Risk Factors	
Support Network Issues	57.5% (100)
Low Socio Economic	60.9% (106)

Hospital Admissions in High Risk Population

- While expected hospitalization would have been 22% or higher we found:
 - 16% admitted within 30 days of home care psychiatric evaluation
 - 9% readmitted within 60 days of home care psychiatric evaluation

The Case of the 70-Year Old Female

- Diagnosis:
 - Bipolar Affective Disorder with psychotic features, most recently depressed
 - At least some of the cognitive changes, likely due to polypharmacy
- Treatment goal: taper meds as much as possible to minimize side effects but treat depressive and psychotic symptoms.
 - Discontinued Benztropine 0,5mg
 - One week later decreased Wellbutrin SR to 200mg daily.

The Case of the 70-Year Old Female

- Per follow up phone call: experienced some improved “sharpness” and memory.
- RN: provided medication monitoring and education on medical side effects and assessed compliance.
- MSW: provided counseling to patient and husband, referral to outpatient mental health and provided information of community resources.
- PT: provide exercises for strengthening lower extremities and improving safety with transfers and ambulation.

The Case of the 70-Year Old Female

- Follow up visit 2 weeks later
 - More engaged. Was shopping independently and cooking
 - She was adherent with medication regimen.
 - Taking daily walks with husband
 - MOCA 20/30, improved from 12/30 (abnormal clock, abnormal trails, poor attention, 2/5 delayed recall, decreased phonemic fluency)
 - Continued to follow up until patient was transitioned to outpatient mental health clinic.

Affordable Care Act: Triple Aim

- Better care for individuals
 - Demonstrated the benefits of a colocation model of mental health integration in order to:
 - Identify high risk patients
 - Provide timely evaluation
 - Provide psychiatric treatment
 - **Increase access to mental health care**

Affordable Care Act: Triple Aim

- Better health for populations:
 - engage hard to reach populations (ie men and minorities)
 - Collaborate with primary care, hospital and community agencies
- Reduced expenditures
 - Minimize unnecessary hospitalizations

Adapting the Model

- Partnering with a hospital based psychiatry department or mental health providers
 - Training site for learners
- Forging relationship with community agencies
- Aligning with recent CMS payment and policy updates
 - Bundle payments
 - Pay for performance
 - Shared cost models

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