Integrating Behavioral Health with Chronic Care to Improve Patient Outcomes

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STAR RATINGS

QUALITY OF PATIENT CARE STAR RATING METHODOLOGY

Process Measures:
1. Timely Initiation of Care
2. Drug Education on all Medications Provided to Patient/Caregiver
3. Influenza Immunization Received for Current Flu Season

Outcome measures:
4. Improvement in Ambulation
5. Improvement in Bed Transferring
6. Improvement in Bathing
7. Improvement in Pain Interfering With Activity
8. Improvement in Shortness of Breath
9. Acute Care Hospitalization

PATIENT SURVEY STAR RATINGS

When you first started getting home health care from this agency, did someone from the agency tell you what care and services you would get?

When you first started getting home health care from this agency, did someone from the agency talk with you about how to set up your home so you can move around safely?

In the last 2 months of care, how often did home health providers from this agency explain things in a way that was easy to understand?

In the last 2 months of care, how often did home health providers from this agency listen carefully to you?
CASE STUDIES

CASE STUDY 1 - COPD WITH ANXIETY

Mr. B is a 74 year male retired and recently discharged from the hospital. Prior to admission to hospital he had worsening SOB. He has fatigue and leg swelling. Diagnosed with heart failure 3 years ago. While hospitalized he said he didn’t know if he could go on anymore. His wife feels he is depressed but he doesn’t admit it. He is referred to home health upon DC and readmitted in 4 weeks due to what staff feel is non-adherence to diet and meds.

CASE STUDY 2 - DIABETIC WITH DEPRESSION

Mrs. G. is an 75 year old overweight female with type 2 diabetes (T2DM), hypertension, and dyslipidemia. Her blood sugars are high, She doesn’t smoke, and occasionally she drinks alcohol. She had just started a new exercise plan but fell and fractured her hip. She has also noted of late, that she is feeling depressed. She was referred to home health for therapy and nursing post-hospitalization.

Figure 26. Percentage of long-term care services users with a diagnosis of Alzheimer’s disease or other dementias, depression, and diabetes, by sector: United States, 2013 and 2014

NOTES: Denominators used to calculate percentages for adult day services centers, nursing homes, and residential care communities were the number of current participants enrolled in adult day services centers, the number of current residents in nursing homes, and the number of current residents in residential care communities in 2014, respectively. Denominators used to calculate percentages for home health agencies and hospices were the number of patients who received care from Medicare-certified home health agencies at any time in 2013 and the number of patients who received care from Medicare-certified hospices at any time in 2013, respectively. See Technical Notes for more information on the data sources used for each sector. Percentages are based on the unrounded numbers.

SOURCES: CDC/NCHS, National Study of Long-Term Care Providers and Table 4 in Appendix B.
HOME HEALTH STUDIES LOOKING AT BH

- Significant rates of comorbid depression have been identified in patients with conditions such as diabetes, heart failure, and fall risk (Acee, 2014; Mantyselka et al., 2011; Thomas et al., 2008; Byers et al., 2008).

- Depression increases HH patients’ risk for re-hospitalization, poorer quality of life, and suicidal ideation (Sheeran, Byers, & Bruce, 2010; Raue, Meyers, Rowe, Heo, & Bruce, 2006; Diefenbach, Tolin, & Gilliam, 2011).

- Patients in need of HH “suffer from physical and psychiatric illnesses at a much higher rate than non-homebound adults” (Qui, 2010). **RATE OF DEPRESSION IN HOMEBOUND IS 13.5-46% in HOME HEALTH**

- Depression is reported to be the second most prevalent psychiatric illness among HH patients (Qui et al., 2010).

- HH patients who are depressed, not effectively treated, and continue to meet criteria for depressive disorders have increased short-term risk of hospitalization (Sheeran, Byers, & Bruce, 2010).

- Symptoms of depression can also hinder and decrease patient engagement in treatment with physical and occupational therapies intended to improve functional status (Acee, 2014).

- Depression is significantly higher among elderly adults receiving home healthcare and leads to greater medical illness, functional impairment, and chronic pain. Targeting depression in home care has been found to decrease hospitalization rates (Pickett 2012).

LEADING HOME CARE DIAGNOSES & OVERLAP WITH BH DIAGNOSES

**CHF/CARDIOVASCULAR**
- Prevalence rates of depression in congestive heart failure patients range from **24%-42%**.
- Rates of Anxiety **20-25%** in cardiovascular disease
- Prevalence of anxiety **70-80%** in pts who have experienced a cardiac event

**WOUNDS**
- Persons living in the community with chronic wounds had more mental health problems than those without wounds, and they are less able to cope with stressful events (Upton et al., 2013).
- Those with Depression two-fold increased risk of developing a diabetic foot ulcer

**DIABETES**
- Depressive disorders are higher among adults with diabetes than in the general population with the incidence of major depression in patients with diabetes estimated to be **11% to 31%** (Markowitz et al., 2011).
- Depression affects **20% to 40%** of individuals with diabetes and is accompanied by an increased risk of myocardial infarction (Home Health NOW)

**COPD**
- Prevalence of anxiety ranges between **10% and 19%** in Stable COPD
- Prevalence of anxiety from **50 to 75%** in severe COPD
- Anxiety in COPD patients is often associated with clinical depression
- In Pts who recently recovered from an acute exacerbation of COPD, the prevalence of depression is high and ranges between **19.4 to 50%**.
DEPRESSION IN THE ELDERLY IS A PERFECT STORM

WHAT HAPPENS AS WE AGE?
SO MANY LOSSES-JOB, SPOUSES, CAREER, LEVEL OF FUNCTION(DRIVING)
DECREASED LEVELS OF SOCIAL INTERACTION
MEMORY LOSS
MEDICAL ISSUES
SYMPTOMS OFTEN LOOK LIKE MEDICAL DIAGNOSES
PAIN

RISK FACTORS FOR DEPRESSION IN ELDERLY
- Being single, divorced, or widowed
- Social isolation
- Lacking a strong support system
- Experiencing numerous stressful life events
- Recent loss of a significant person in their life
- Previous history of depression
- Family history of depression
- Chronic disease or pain
- Alcohol abuse
- Medications-B/P, steroids, arthritis meds

Top 10 MS-DRG Codes for Home Health Episodes, New York

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Major joint replacement or reattachment of lower extremity w/o mcc</td>
<td>9,091</td>
<td>7.03%</td>
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<tr>
<td>Septicemia or severe sepsis w/o mv 96+ hours w mcc</td>
<td>3,413</td>
<td>2.64%</td>
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<tr>
<td>Heart failure &amp; shock w cc</td>
<td>3,302</td>
<td>2.55%</td>
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<tr>
<td>Cellulitis w/o mcc</td>
<td>2,448</td>
<td>1.89%</td>
</tr>
<tr>
<td>Kidney &amp; urinary tract infections w/o mcc</td>
<td>2,393</td>
<td>1.85%</td>
</tr>
<tr>
<td>Heart failure &amp; shock w mcc</td>
<td>2,311</td>
<td>1.79%</td>
</tr>
<tr>
<td>Simple pneumonia &amp; pleurisy w cc</td>
<td>2,133</td>
<td>1.65%</td>
</tr>
<tr>
<td>Syncope &amp; collapse</td>
<td>2,060</td>
<td>1.59%</td>
</tr>
<tr>
<td>Hip &amp; femur procedures except major joint w cc</td>
<td>1,975</td>
<td>1.53%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease w mcc</td>
<td>1,906</td>
<td>1.47%</td>
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*NEW YORK  Medicare Home Health Users are typically much sicker than the general Medicare population

aahqi.org
Top Ten conditions that cause 30-day readmissions for Medicare, Medicaid patients and Private Insurers

**MEDICARE**
- Congestive heart failure
- Septicemia
- Pneumonia
- COPD
- Cardiac dysrhythmias
- UTIs
- Renal Failure
- Acute myocardial infarction
- Complication of device; implant or graft
- Cerebrovascular accident

**MEDICAID**
- Mood Disorders
- Schizophrenia
- Diabetes
- Complications of pregnancy
- Alcohol disorders
- Early or threatened labor
- Septicemia
- COPD
- Substance abuse disorders

**PRIVATE INSURERS**
- Maintenance chemotherapy; radiotherapy
- Mood disorders
- Complications of surgical procedures or medical care
- Complication of device; implant or graft
- Septicemia
- Diabetes mellitus with complications
- Secondary malignancies
Lack of treatment for Anxiety and Depression with Chronic Illnesses

- Poor quality of life
- Premature death
- Medical costs are higher
- Increased hospitalizations
- Prolonged lengths of stay
- Increased Primary Care Visits

IDENTIFY HIGH UNTILIZERS:
Have in Common
- Mental health dx
- CHF, COPD, Diabetes
- ER visits
- 3+ hospital admits

*DEPRESSION screening most important quality measure
*Pts with anxiety have highest ER services use.

40 primary care groups and 53 organizations and served 14,000 Medicare beneficiaries
This is an opportunity to differentiate your agency, improve outcomes and address the recent CMS proposed changes

- In June 2017, CMS announced in the Proposed Measure Specifications and Standardized Data Elements for CY 2018 HH QRP Proposed Rule that there would be expanded cognitive function and mental status assessment tools added to the assessment.
- This will assist in more effective person-centered care planning. The proposed Measure Specifications and Standardized Data Elements for CY 2018 HH QRP Proposed Rule adds several new standardized patient data assessment elements that relate to cognitive and behavioral health functionality.
- Cognitive impairments, depression and behavioral issues all may have a huge impact on a patient’s ability to recover from their illness.
- Having staff who can better understand the needs of their patients by establishing a baseline for their cognitive and mental status will assist an agency to identify the appropriate supports and plan of care for their patient’s needs.

WHAT IS BEHAVIORAL HEALTH HOME CARE?

The Behavioral Health Home Care Program assists patients and families who are broken and wounded by mental illness to move towards wholeness

Provided under a Medicare model and other payers

Holistic model of care provided by a Medicare/Certified Agency that can provide care to patients with primary behavioral health issues or those with medical and behavioral health issues. Focus is on assessment, psychoeducation and teaching patients and their caregivers how to manage their illness.

Model of care that was developed for seniors, adults

Has criteria for services that must be met
The ROAD TO WHOLENESS brings together the PIECESS of an individual broken and wounded by Mental Illness

- Physical
- Interpersonal
- Emotional
- Communicative
- Education
- Social
- Spiritual

The Behavioral Health Home Care Program assists patients and families who are broken and wounded by mental illness to move towards wholeness.

**Goals**

A. Transition patients from the more acute levels of care to the home and community
B. Prevent expensive in-patient utilization
C. Improve functional ability
D. Decrease symptoms
E. Improve knowledge base about medications, illness, coping, staying well, accessing community services
F. Improve medication compliance
G. Improve quality of patient’s life through a committed therapeutic relationship that facilitates positive change in the patient
H. Improve family life through supportive interventions and education.
BH ADMISSION CRITERIA

1- PRIMARY PSYCHIATRIC DISORDER
   • Major Depression
   • Anxiety Disorders
   • Dementia with Behavioral Disturbances
   • Schizophrenia
   • Bipolar Disorder

2- Psychiatrically homebound

3- Skills of a psychiatric nurse required

4- Patient must be under the care of a physician

5- Establish reasonable goals

MODELS OF CARE TO MARKET

Type of Program
Population served
Payers

BEHAVIORAL HEALTH OPTIONS

BH PROGRAM
Integrate BH teaching

What does your Intermediary require?
BEYOND DIAGNOSIS- WHY DO PATIENTS NEED BEHAVIORAL HEALTH CARE?

- Decrease maladaptive behaviors (unhealthy diet, missing doctor appointments, unsanitary living conditions)
- Minimize tendency toward noncompliance, lack of follow through with treatment
- Reduce hospitalization and ER USE
- BH needs are neglected
- Provide caregiver support and education
- Quality of life

KEY FINDINGS

“Psychiatric Home Care: Clinically Valid and Cost-Effective” (Vanderhorst, Carson, Midla, 1998)

83% of patients were 100% medication compliant through education, monitoring and administration

60% of patients were stabilized in the home setting following a BH hospitalization or in lieu of hospitalization.

Overall patients were stabilized within 43 days with an average of 10 nursing visits

Only 10% of patients used emergency services while on services where all had used it frequently prior to home care in past 6 months.

76% compliance rate to other BH/Other treatment modalities at discharge.

Cost of home care was 10% of cost of hospital stay.
Integrating Depression Care Management into Medicare Home Health Reduces Risk of 30 and 60 Day Hospitalization: The Depression Care for Patients at Home Cluster Randomized Trial (Bruce, M et al.)

Being admitted to the hospital directly from home health was 35% lower within 30 days of starting home health care and 28% lower within 60 days for patients who received management of depression during regular home health visits. Clinical functions include weekly symptom assessment, medication management, care coordination, patient education, and goal setting.

Implementation and Evaluation of a Depression Care Model for Homebound Elderly by Madden-Baer et al.

If an evidence-based depression care management (DCM) protocol can be implemented in a financially, operationally, and clinically feasible manner at the Visiting Nurse Service of New York.

RESULTS-using specialty mental health nurses led to accurate screening and improved access to depression care, reducing patients’ symptoms of depression. Improved depression scores-GDS decreased by 3 points from SOC to DC.
OTHER BH HOME HEALTH STUDIES

Clinical Effectiveness of Integrating Depression Care Management Into Medicare Home Health The Depression CAREPATH Randomized Trial By BRUCE ET AL.

Requires nurses to manage depression at routine home visits across 6 agencies by weekly symptom assessment, medication management, care coordination, education, and goals. Study demonstrated effectiveness (P = .02), with lower HAM-D scores at 3 months (14.1 vs 16.1, P = .04), at 6 months (12.0 vs 14.7, P = .02), and at 12 months (11.8 vs 15.7, P = .005). Benefit seems to be limited to patients with moderate to severe depression.

HOW WOULD THESE RESULTS EFFECT STAR RATINGS?

IF WE CAN DECREASE DEPRESSION AND DEPRESSIVE SYMPTOMS RESULT IS IMPROVED SELF CARE (Markowitz et al., 2011)

IF WE INCREASE COMPLIANCE WITH TREATMENT THE RESULT IS IMPROVED MED MANAGEMENT, ADLS AND DECREASE HOSPITALIZATION AND IMPROVED QUALITY OF LIFE

HOW WOULD OTHER STAR RATING ITEMS IMPROVE WITH INCREASED COMPLIANCE AND DECREASED DEPRESSION? IF PATIENT IS LESS DEPRESSED, LESS ANXIOUS

- How often home health patients got better at walking or moving around.
- How often home health patients got better at getting in and out of bed
- How often home health patients had less pain when moving around.
- How often home health patients got better at bathing.
HOW WOULD THESE RESULTS EFFECT STAR RATINGS?

IF WE CAN DECREASE HOSPITALIZATIONS- RESEARCH SHOWS THE FOLLOWING:

EVIDENCE REVEALS THAT PSYCHOTHERAPEUTIC INTERVENTIONS AND PSYCHOPHARMACOLOGY TREATMENT ARE EFFECTIVE IN MANAGING DEPRESSION IN CHF. HOME HEALTH CARE CAN SUPPORT THIS.

Multifaceted collaborative home care intervention for depression resulted in lower hospitalization rates (23.5%) (Flagerty et al., 1998)

Follow-up-Telephone-Calls - Decrease Hospitalizations-Days of week and hours

HOW WOULD AN IMPROVEMENT IN SELF CARE IMPROVE STAR RATINGS?

Acute Care Hospitalization Rates would decrease, quality of care would increase and overall patient outcomes would increase

HOW WOULD THESE RESULTS EFFECT STAR RATINGS?-TELEPHONE FOLLOW-UP?

CAN WE INCREASE PATIENT SATISFACTION AND LEVEL OF INTERACTION?

Of the seven studies analyzed, five showed evidence of some benefit from telephone follow-up. (Furuya, 2013)

As for treatment results, 93% of the patients in the TFU group as compared to 84% in the control group reported improvement in their symptoms. A non-significant trend towards fewer readmission was observed in the TFU group (26% vs. 35% P=0.062). TFU can improve medical treatment by increasing satisfaction and compliance. (European Journal of Internal Medicine, 2009)

VBP studies show HH agencies that implemented pre-week-end calls to high risk pts increased customer satisfaction ratings.

Patient Satisfaction Improves, Decreases ER and Hospital Use
WHAT CAN WE DO?

1-LEARN TO SCREEN FOR DEPRESSION, ANXIETY, IMPAIRED COGNITIVE FUNCTION (BEYOND THE OASIS), THOUGHT DISORDERS
   ◦ LOOK FOR TRIGGERS

2-TEACH STAFF / ASSESSORS HOW TO TALK TO PATIENT’S ABOUT BH SYMPTOMS
   ◦ HOW TO “NORMALIZE”

3-DETERMINE AN AGENCY STRATEGY

4-DEVELOPMENT DEPRESSION, ANXIETY, THOUGHT DISORDER, DEMENTIA CARE MANAGEMENT
   ◦ TEACH STAFF EVIDENCED BASED TOOLS

5-DEVELOP DOCUMENTATION GUIDELINES
   ◦ How frequently to reassess

- Assessment and individualized treatment planning with evidenced based tools
- Medication management, including Clozaril monitoring; administration of decanoate medications
- Psycho-education about medications, the illness, coping strategies (Self-Management)
- Supportive counseling around the illness
- Behavioral Management
- Case Management
- OT-Identify and Engage in activities that are appropriate/safety
- Telephone support – 24-hour on-call (Behavior Issues).
Depression increases the overall burden of illness in patients with chronic medical illness. It decreases activity, prognosis and adherence to treatment. There is an overlap between medical and depressive symptoms-fatigue, appetite, somatic symptoms, etc.

SUMMARY

- DEPRESSION AND ANXIETY ARE PART OF CHRONIC ILLNESSES AND EFFECT COMPLIANCE AND FUNCTIONAL LEVELS

- TREATING THE BH ASPECT IMPROVES FUNCTION AND QUALITY OF LIFE AND OUTCOMES

- WE ARE ALREADY MANAGING PATIENTS WITH BH DX-WHY NOT ADDRESS?
www.cvseniorcare.com

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