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Using Telephonic Case Management & Psychiatric Integration In a Certified Home Care Agency

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Objectives

- Describe how Montefiore Medical Center (MMC) utilizes an interprofessional team to work across the health network to address the behavioral health needs of a high risk population

- Describe comprehensive and practical plans to provide mental health care to homebound patients and minimize unnecessary health care utilization using case examples

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The Setting

Montefiore Medical Center: Mission

Values: Humanity, innovation, teamwork, diversity, and equity

Vision: To be a premier academic medical center that transforms health and enriches lives

Mission: To heal, to teach, to discover, and to advance the health of the communities they serve

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Montefiore Medical Center Urban Safety Net & Integrated Health System

- 11 hospitals
  - 80% Medicare and/or Medicaid
- 2016 Utilization:
  - Discharges: 139,570
  - Births: 12,500
  - Ambulatory Visits: 4,757,650
  - Emergency Department Visits: 579,437
- 22 community based primary care clinics
  - 43,000 adults ≥65

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Montefiore's Care Management Organization (CMO)

- Established in 1996
- Wholly-owned subsidiary of Montefiore
- Performs **care management** delegated by health plans
- 15 years full risk managed care experience
  - 94,000 risk lives (2010)
  - 220,000 (2013)
- Over 1,900 physicians in the network

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Pioneer ACO Program

- Center for Medicare and Medicaid Services (CMS) initiative designed for organizations with experience managing populations
- Montefiore Medical Center was selected as the only Pioneer ACO in NYS beginning January 2012
- CMS assigned 23,000 Medicare Fee-for-service (FFS) beneficiaries
  - 18% aged < 65
  - 59% aged 65-84
  - 23% aged $\geq$ 85

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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

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Montefiore ACO Outcomes

- Montefiore ACO performance in 2014
  - 25% of patients 85 years or older
  - 3.6% in gross savings
    - $20 less per beneficiary/month
  - 86.2% quality score for integrated care

ACA, ACOs and Geriatric Mental Health

- 88% of ACOs are responsible for mental health/substance abuse in one or more contracts
  - Only 13% of ACOs report significant integration of mental health/substance abuse in primary care
  - Only 1 of 33 quality measures address mental health (depression)
    - Cognitive status is not included

Bartels et al. 2015

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NYS Medicaid

- Medical insurance for low income
  - Eligibility requirements and benefits are determined by each state
- NYS: the largest Medicaid Program in the Nation
  - Ranked 50th in outcomes
- In 2011 Governor Cuomo
  - Created the New York Medicaid Redesign Team (MRT) = New Medicaid 1115 waiver
    - Goals of the waiver
      - Lower health care costs
      - Improve patient outcomes
      - Reduce health disparities
      - Align with the Triple Aim of the ACA

NYS Dept of Health . A Plan to transform the Empire State's Medicaid program-Multi Year Action Plan

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Managed Long Term Care

- A Managed Long Term Care Plan is a Medicaid benefit that provides services and support to people with a chronic health problem or disability
- The Plan provides personal care services and other long term care benefits to help the individual live safely at home or in a nursing home
- The member must have stable housing (any housing in which services can be delivered)
- There are four different types of Managed Long Term Care Plans in New York State (MLTC, MAP, PACE, FIDA)

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Montefiore Diamond Care® Covered Services

Covered Capitated Benefits

Care Management (includes): • Home Delivered or Congregate Meals • Social Day Care • Social and Environmental Supports	Audiology / Hearing Aids, Respiratory Therapy, Nutrition and Private Duty Nursing
Nursing Home Care (Residential Health Care Facility)	Consumer Directed Personal Assistance Services
Home Care • Nursing • Home Health Aide • Physical Therapy (PT), Occupational Therapy (OT), and Speech Pathology (SP) • Medical Social Services	PT, OT, SP or other therapies provided in a setting other than a home. Limited to 20 visits of each therapy type per calendar year *Community First Choice Option (CFCO) services will become effective 7/1/17 (i.e. vehicle modifications, assistive technology, social transportation)
Adult Day Health Care	**Fee-For-Service Benefits**
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	• Inpatient & Outpatient Hospital Services • Physician Services • Laboratory and Radiology Services • Chronic Renal Dialysis • Mental Health Services • Alcohol and Substance Abuse Services • Prescription and Non-Prescription Drugs
Personal Care	
Personal Emergency Response System	
Non-Emergent Transportation	
Podiatry, Dentistry and Optometry (eyeglasses)	

Source: https://www.health.ny.gov/health_care/managed_care/mltc/coverservices.htm

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Unmet Needs and Impact on Health Outcomes and Utilization

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

DiMatteo et al 2000, Anderson et al 2001, Koenig et al 1998

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Unmet Behavioral Health Needs Lead to…

- Hospital Costs: Depression and anxiety increases re-hospitalization
  - Unplanned 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

Marcantonio et al 1997, Mudge er al 2011, Onge et al 2014

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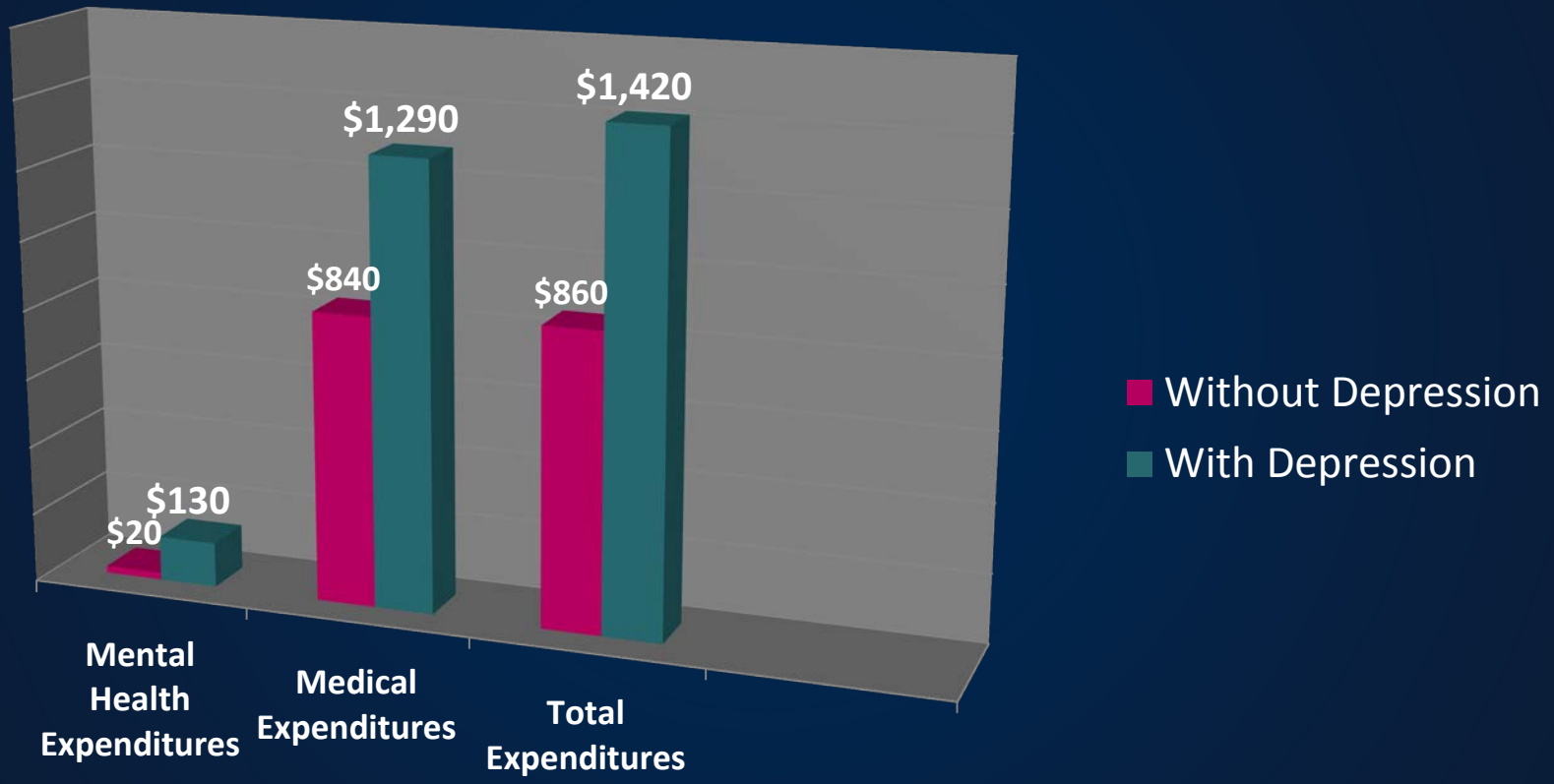
Impact of Depression on Health Care Expenditures



Melek, S. and Norris, D. *Chronic Conditions and Comorbid Psychological Disorders,* February 2008

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Cognition and Health Outcomes

- Cognitive impairment is associated with poor outcomes
  - Health care utilization:
    - Home health needs
    - Hospitalizations (within 1 yr: 75 to 85% vs 50%) and (Mean LOS: 20 to 30 d vs 10d)
    - Nursing facilities (within 1 yr: 50% vs 14%) and (Mean LOS: 95 to 135d vs. 48d)
  - 30 day readmission:
    - If discharged home, increased readmission
    - Heart failure; 27% vs 13%
  - 6 months mortality : HR 1.6 (95% CI: 1.3-2.1) community long term care patients

Callahan et al 2010, Agarwal et al 2016, Tropea e al 2016, Fried et al 1998

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Cognition and Health Outcomes

- Early identification and intervention of cognitive disorders improves health outcomes
  - 30 day readmission:
    - Heart Failure: decreased readmission with caregiver education (14%)
  - Overall cost
    - Intervention with early identification, cognitive enhancers and caregiver education
    - $10,000 state savings per diagnosed patient

Weimer et al. 2009, Agarwal et al. 2016

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Primary Care and Cognitive Disorders

- Recognition:
  - Severe dementia 90% of the time
  - Moderate dementia 50% of the time
  - Mild dementia 10% of the time
- Documentation:
  - Severe dementia 80% of the time
  - Moderate dementia 29% of the time
  - Mild dementia 21% of the time
- Contributing factors
  - Provider: Younger PCPs outperform Older PCPs
  - Patient/Caregiver: lack of education, relying on PCPs, cultural concerns
  - System: lack of time, low reimbursement in dementia care
- Behavioral integration models have focused on depression but ignored cognition

Valcour et al 2000, Bradford et al 2009

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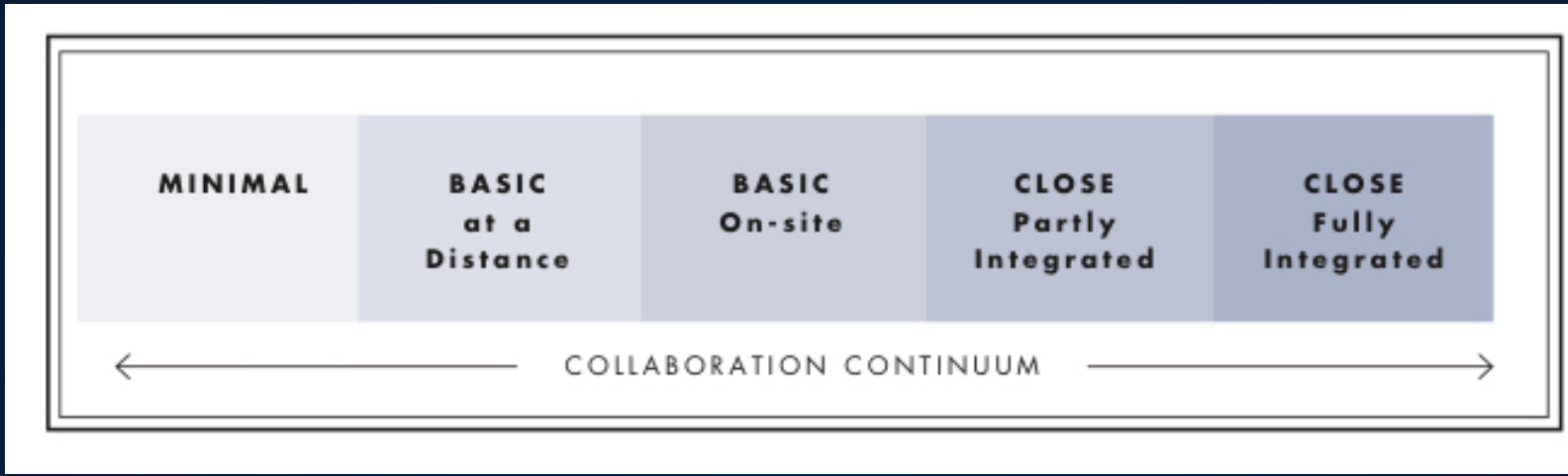
A Model of Integration

Integrating Psychiatry



- Strategies:
  - Collaborative model: IMPACT multisite trial
    - Validated in the elderly
    - 50% decrease in thoughts of suicide
  - Colocation: Small scale model in Home Care and Inpatient settings
    - Most cost effective in capitated or cost sharing systems

Unutzer et al 2002, Weiss et al.2013

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Montefiore Home Care (MHC)

- Established in 1947 as the nation's the first hospital-based home care agency
  - "Hospital without walls"
- Montefiore Home Care is a certified and licensed Home Care Agency, accredited by JCAHO
  - Provides Nursing, Rehabilitation, Social Work, Wound Care, Infusion, Telehealth, Palliative Care; Behavioral health
  - Serves Bronx and Westchester Counties of New York
- First hospital based social work department in 1905

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Montefiore Home Care

- Annual admissions: 13,728
- Bronx and Westchester
- Average daily census: 2,735
- Skilled Visits:
  - Nursing: 124,347
  - Social Work: 8,328
  - Rehabilitation Therapy: 43,159

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Homebound Adults

- Psychiatric disorder: 40.5%
  - 40% of those receive certified home health agency (CHHA) services
- Dementia: 29%
  - atleast 17% of homebound adults have undiagnosed cognitive impairment
- Depression: 13 to 15%
- Substance abuse: 10%

Qui et al 2010

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Model for Geriatric Psychiatry in Home Care

- Identify and treat the homebound elderly with depression
- Model program to integrate psychiatry into Home Care
  - In 2004 United Jewish Appeal-Federation of New York City supported the creation of Montefiore Home Care Geriatric Psychiatry Program (MHC-GPP)
  - Montefiore Home Care (MHC) and Dept. of Psychiatry at Montefiore Medical Center (MMC)

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Model for Geriatric Psychiatry in Home Care

- New York Cornell Westchester (Martha Bruce, PhD, Patrick Raue, PhD) provided the training for clinical staff on recognizing symptoms of depression
- After grant ended, MMC has sustained program for past 10 years
- Educational program for geriatric psychiatry fellows, psychiatry residents and medical students
- Other home care specialized initiatives have utilized the MHC-GPP model

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Training Program

- PHQ2 and PHQ-9
  - assessment instrument was promoted as a means of both screening and evaluating
  - 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	☐ 0	☐ 1	☐ 2	☐ 3	☐ na
b. Feeling down, depressed, or hopeless?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 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.

OASIS: Cognition

Cognitive Functioning

- **(M1700)**
- 0. Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
- 3. Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

Confused

- **(M1710):**
  - 0. Never
  - 1. In new or complex situations only
  - 2. On awakening or at night only
  - 3. During the day and evening, but not constantly
  - 4. Constantly
  - 5. Patient nonresponsive

Cognitive, behavioral, and psychiatric symptoms

- **(M1740):**
- 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- 2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- 3. Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 4. Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- 5. Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- 6. Delusional, hallucinations, or paranoid behavior
- 7. None of the above behaviors demonstrated

Model: Embedded Home Care Geriatric Psychiatrist

RN screens for depression and other psychosocial concerns and refers to SW

SW completes PHQ9 and full psychosocial assessment. SW contacts PCP and MLTC for approval for psychiatric evaluation. Referrals are discussed in weekly meeting

Geriatric psychiatrist evaluates patients in the home and provides treatment

Geriatric psychiatrist works jointly with RN, SW, PCP and MLTC case manager to develop comprehensive treatment plans in agreement with patient identified goals

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Montefiore Home Care: Social Work

- SW visits made on 2015
  - Over 8000 SW home visits
  - 1800 SW visits for MLTC patients- managed by Montefiore
    - Present census- over 1000 patients shared by MHC and CMO/ MLTC
- Of the 178 patients referred to MHC-GPP
  - 12% are ACO patients
  - 39% of them were MLTC patients – case managed by Montefiore
  - 75% of patients Montefiore is involved in financial risk arrangement with insurer

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MHC-GPP: Psychiatrist Role

- 0.4 FTE
- Educational component: geri psych fellows, psych residents, students
- Weekly meeting with social work team
- Psychiatric evaluations completed in the home
  - Limited follow up
  - Over 80% will be managed by PCP
  - Utilize the EHR and ACO/CMO network to maximize collaboration
- All evaluations included a cognitive assessment (ie. MOCA or MMSE or Picture MIS)

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Reasons for Referrals to MHC-GPP

- Depression
- Dementia with behavioral disturbance
- Capacity evaluation
- Anxiety
- Psychosis
- Hoarding
- Substance Abuse

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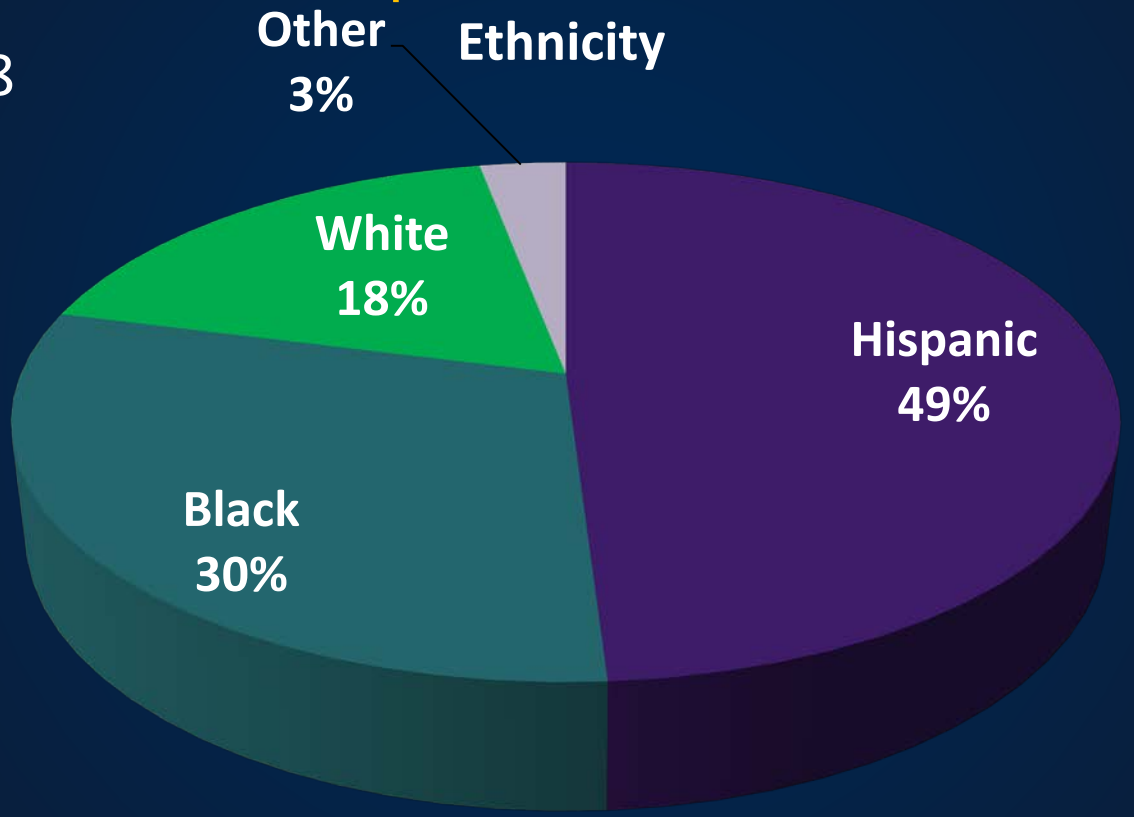
Ethnicity

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



Korenblatt et al 2015, Berkman et al 2004, Cooper et al 2003

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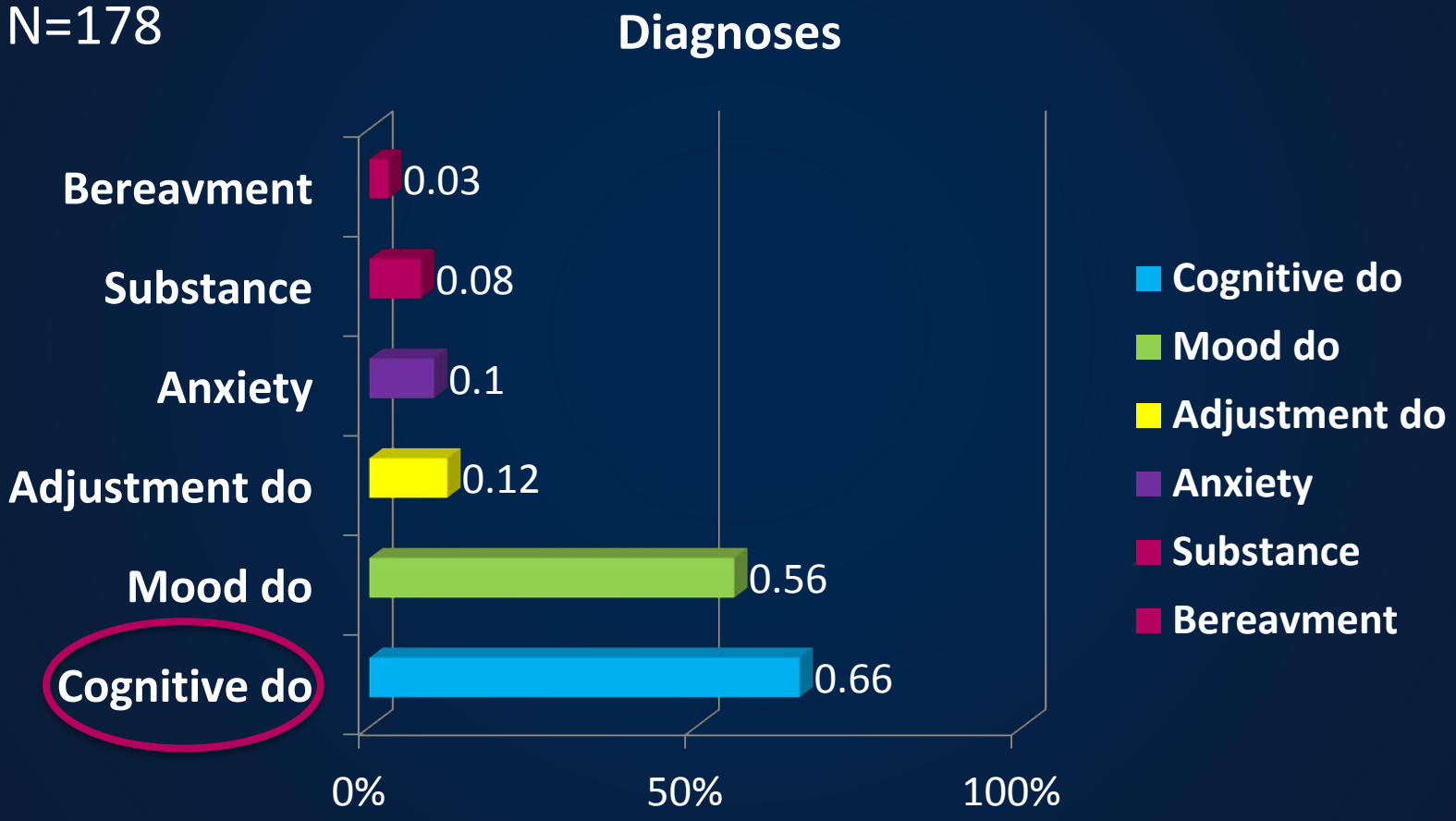
MHC-GPP: Psychiatric Diagnoses

N=178



Korenblatt et al 2015

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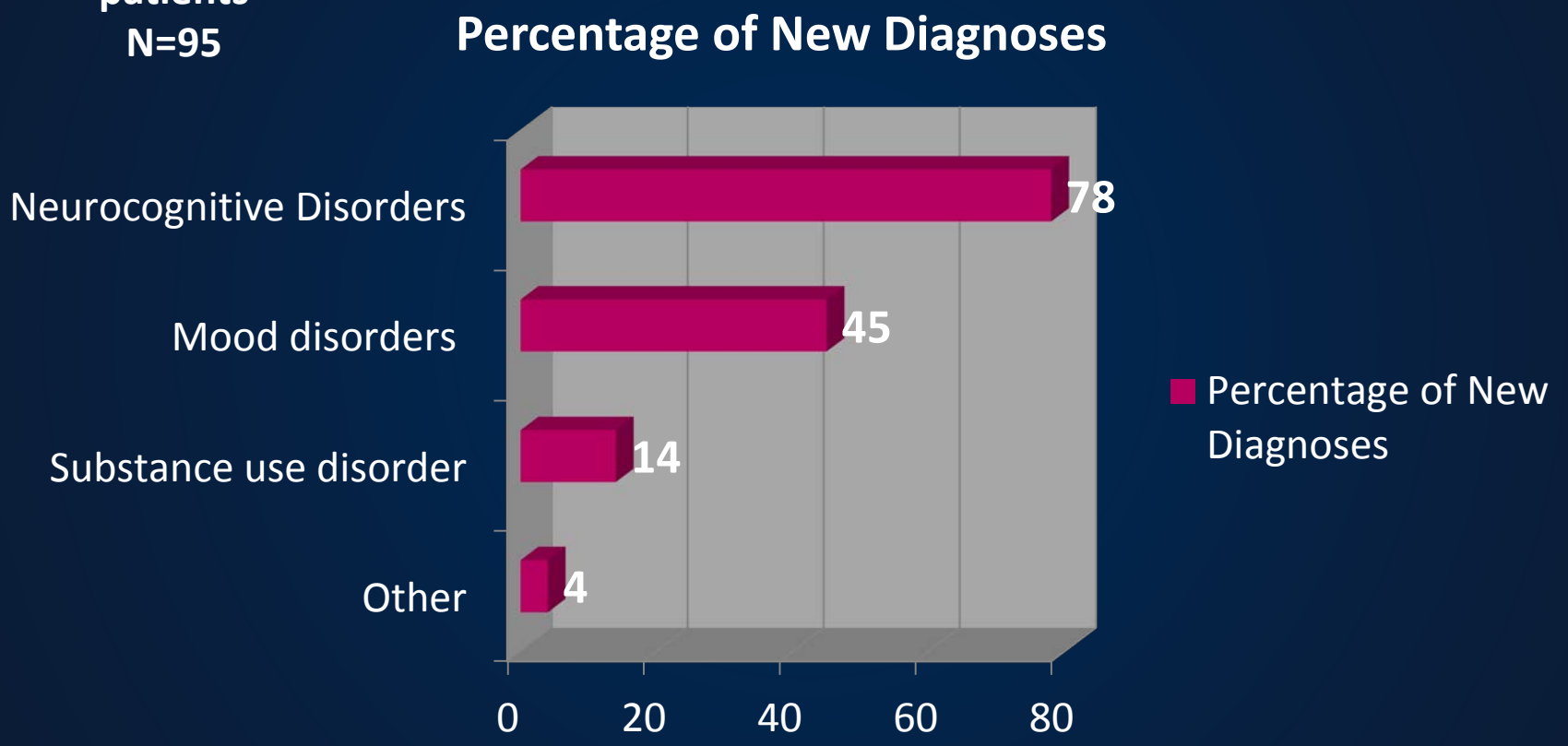
MHC-GPP Chart Review

Subset of MHC patients N=95



Nguyen et al 2015

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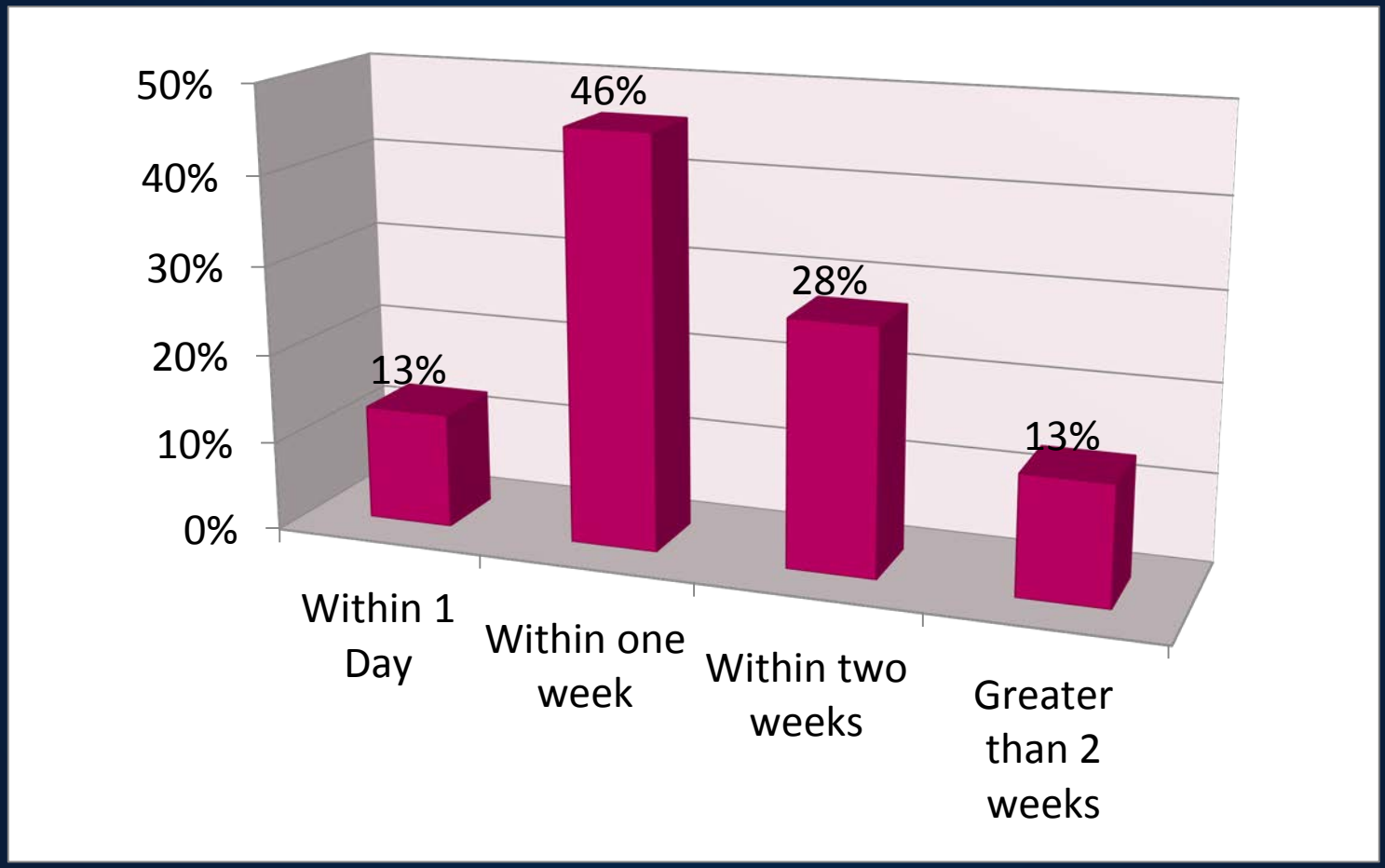
MHC-GPP: Timeliness

N=178



Montefiore Home Care Risk Score for Readmission

- MHC Risk Score:
  - calculated by giving 1 point for each risk factor for 30 days readmission

MHC Risk Score	Average Score
N=178	7

- MHC Risk Score of 7 is associated with a 30 day readmission rate of 22%

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Risk Factors for Readmission	
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)

Korenblatt et al 2015

Risk Factors for Readmission

Social Risk Factors	% (N)
Support Network Issues	57.5% (100)
Low Socio Economic	60.9% (106)

Korenblatt et al 2015

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Hospital Admissions in High Risk Population

- While expected hospitalization for MHC-GPP population would have been 22% or higher, we found:
  - 16% admitted within 30 days of social work and psychiatric evaluations
  - 9% admitted within 60 days of social work and psychiatric evaluations

Korenblatt et al 2015

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MHC-GPP: Treatment Recommendations

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

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A Clinical Case Presentation

Case of Ms. N: Background

- ID: 70 years old widowed woman managed by Montefiore Home Care (MHC), Managed Long Term Care Program (MLTC) and MMC Medical House Calls

- Past Medical History:
  - Morbid obesity, hypertension , insulin dependent DM2, CKD3, Heart Failure, h/o post-polypectomy LGIB, B/L LE edema due to venous insufficiency

- Functional Assessment:
  - At baseline patient has stable dyspnea , sleeps in a geriatric recliner

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Case of Ms. N: Background

- Psychiatric History:
  - No past psychiatric until 5 to 7 years ago
  - Was living with her sister and granddaughter but left because patient developed a belief that her granddaughter was “evil”
  - Subsequently she moved into a basement apt alone with dtr next door
  - About 2 years prior to presentation began reporting landlord was breaking into her home and spying on her
  - Stopped leaving the house to go to medical appointments

Case of Ms. N: SW role

- -Home Care SW
  - Referred for visiting RN service in 2011
  - Patient had refused referrals for mental health treatment stating “I am not crazy”
  - Patient did recognize need for PCA services
    - SW determined patient was Medicaid eligible and help her apply for benefits
    - SW referred patient to Managed Long Term program

Case of Ms. N: SW role

- Patient very upset about her housing situation;
  - wanted to move; was in arrears for rent
- Allowed SW to help her explore housing options
- SW developed a relationship with patient regarding housing concerns
  - Landlord was a “Bedouin; Rasta man” who monitors her 24/7 and has placed cameras in the floor boards
  - She believed this was because he opened up an electricity account in her name and wanted patient to list him as a dependent on her taxes

Case of Ms. N: Social Work

- Patient goal of care:
  - to remain in community and daughter supports this wish.
- Monthly SW visits and as needed
- Provided support and education to daughter
- Collaborated with MLTC by monitoring mental status in the home
- Able to keep patient and family engaged
- Provided education about alternative housing options such as assisted living
- Developed a plan in keeping with patient and daughter's values while maintaining safety

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Case of Ms. N: Telephonic Case Management

- Referred from MHC to MLTC
- Initial concerns:
  - Reluctant to speak with care manager due to persecutory delusions
  - Difficult to assess patient and build a relationship
  - Utilized PCA to engage patient on the phone
  - Patient would whisper or garble her speech on the phone
  - She would often dismiss the PCA because she was distrustful.
  - Daughter was also defensive, normalized her mother's delusions
  - Inadequately treated CHF, DM

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Case of Ms. N: Telephonic Case Management

- Intervention:
  - Care manager allied with patient, family and PCA
    - Empathized with daughter's frustrations and concerns
    - Eventually daughter confided that patient was verbally abusive to her
  - Developed relationship with patient by not challenging delusions rather empathing
  - Addressed concrete issues allowed trust to build
  - Over ~1 yr, care manager worked with patient to accept MMC Medical House Calls for primary care
  - She eventually accepted psychiatric assessment despite repeated refusals in the past.

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Case of Ms. N: Psychiatry

- First visit: Joint visit with MHC SW
  - For delusions about landlord and noncompliance with medical care
- Mental Status Exam:
  - Cluttered apartment, Soiled night dress, PCA. Ambulates slowly with walker. Noted to have dyspnea while walking and lower extremity edema
  - Whispered at times so that “the landlord would not hear”
  - Mood “stressed” Affect Full range
  - No SI, no HI towards neighbor

Case of Ms. N: Psychiatry

- Mental Status Exam (cont'd)
  - Persecutory delusions about landlord
  - AH: hearing wiring placed by landlord, VH: lights in the apartment
  - MOCA 21/30 (impaired clock, abstraction and missed 3 recall)
- MRI Brain four years prior to presentation
  - Scattered white matter disease, possible cerebral micro hemorrhages
  - Unable to repeat neuroimaging due patient refusal
- Diagnosis:
  - Delusional Disorder, Mild Neurocognitive Disorder (possibly due to cerebrovascular disease or untreated DM)
  - Despite delusions had capacity to make health care decisions and refuse medical hospitalization at that time

Case of Ms. N: Psychiatry

- Treatment Course:
  - Started with MMC Medical House Calls
  - Agreeable to Risperidone 0.5mg BID
    - Seen one month later, felt sedated and Risperidone was decreased to 0.5mg at bedtime
    - Patient later refused psychiatric follow up and stopped Risperidone because landlord called her “crazy”
    - Daughter enmeshed in delusion as well

Challenges in Medical and Psychiatric Management

- Quickly became paranoid about House Calls PCP
  - Worsening of LE edema complicated by ulcers and recurrent cellulitis requiring increased RN visits
  - Fluctuating course of her uncontrolled insulin dependent diabetes
  - Heart Failure exacerbation
  - Patient refused hospital care despite multiple efforts by PCP, MHC and MLTC care manager including HCP in decision making

Challenges in Medical and Psychiatric Management

- Capacity to make decisions remains questionable as her decision making fluctuates
  - Example: reason for not going to hospital
    - “I can be managed as an outpatient (true)”
    - “Last time I went to the hospital the RN gave me a placebo (delusion)”
    - “If I go to the hospital I will be placed in a nursing home (probably true)”

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Honoring the Final Wish

- Patient goal of care: to remain in community and daughter supports this wish
  - Delusions improved after moving in with daughter
  - MLTC care manager continued frequent telephonic communication and support
  - MHC continued to provided RN and SW services
  - New House Calls PCP with good rapport
  - Joint visits with House Calls PCP and Psychiatrist

- Patient was able to die at home with care and support in place

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Final Thoughts and Discussion

- Telephonic case management is a successful means for engaging chronically ill homebound older adults with mental/cognitive disorders and their caregivers

- Social work is a powerful component of a home care agency as most homebound elders with cognitive impairment and/or psychiatric symptoms have significant psychosocial needs

- Models of integrating psychiatry such as colocation and collaborative care provide timely in-home psychiatric evaluation and treatment

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Final Thoughts and Discussion

- Health systems which facilitate collaboration between case management, social work, psychiatry and primary care allow for comprehensive, patient centered care can achieve:
  - Triple Aim
    - Improving the quality of care: safety, effectiveness, patient centeredness, timeliness efficiency and equity
    - Improving health by addressing under recognized and undertreated mental and cognitive disorders
    - Reducing unnecessary health care expenditures

NYS Dept of Health . A Plan to transform the Empire State's Medicaid program-Multi Year Action Plan

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