What Does Behavioral Health Have To Do With Outcomes

WHY INTEGRATING BEHAVIORAL HEALTH WITH CHRONIC CARE MANAGEMENT CAN IMPROVE STAR RATINGS

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STAR RATINGS

QUALITY OF PATIENT CARE STAR RATINGS 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 current daily medications include extended-release metformin 2000 mg daily, atorvastatin 10 mg daily, lisinopril 20 mg daily, extended-release metoprolol 50 mg daily, and aspirin 81 mg daily but 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.

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; Mantysekla 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)

- 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 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 (Loxton 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
- Stable COPD prevalence of anxiety ranges between 10% and 19%
- Severe COPD prevalence of anxiety from 50 to 75%
- Anxiety in COPD patients is often associated with clinical depression
- Recently recovered from an acute exacerbation of COPD, the prevalence of depression is high and ranges between 19.4% and 50%.
DEPRESSION IN THE ELDERLY IS PERFECT STORM

WHAT HAPPENS AS WE AGE?

SO MANY LOSSES-JOB, 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

*Pennsylvania’s Medicare Home Health Users are typically much sicker than the general Medicare population

Top 10 ICD-9 Diagnoses for Home Health Episodes, Pennsylvania

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<tr>
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<tbody>
<tr>
<td>Other and unspecified aftercare</td>
<td>12,564</td>
<td>7.20%</td>
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<tr>
<td>Other orthopedic aftercare</td>
<td>22,069</td>
<td>5.51%</td>
</tr>
<tr>
<td>Heart failure</td>
<td>16,804</td>
<td>7.25%</td>
</tr>
<tr>
<td>Care involving use of rehabilitation procedures</td>
<td>14,438</td>
<td>6.21%</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>10,833</td>
<td>4.60%</td>
</tr>
<tr>
<td>Chronic ulcer of skin</td>
<td>10,236</td>
<td>4.43%</td>
</tr>
<tr>
<td>Chronic bronchitis</td>
<td>6,947</td>
<td>2.99%</td>
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<tr>
<td>Late effects of cerebrovascular disease</td>
<td>6,168</td>
<td>2.65%</td>
</tr>
<tr>
<td>Symptoms involving nervous and musculoskeletal systems</td>
<td>6,040</td>
<td>2.60%</td>
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<tr>
<td>Cardiac dysrhythmias</td>
<td>4,728</td>
<td>2.03%</td>
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Medicare FFS Readmissions Among Post-Acute Care Users, Pennsylvania

30-Day Readmission Rates for Top 20 Most Common MS-DRGs Discharged from Hospital to Selected Post-Acute Care Providers, by Setting, 2014

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>% of Home Health Users Readmitted Within 30 Days</th>
<th>% of SNF Users Readmitted Within 30 Days</th>
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<tbody>
<tr>
<td>Major joint replacement of knee, open w/ implant</td>
<td>4.60%</td>
<td>6.60%</td>
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<td>Septicemia of a native heart valve w/ no endocarditis</td>
<td>15.12%</td>
<td>28.12%</td>
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<tr>
<td>Heart failure &amp; shock w/ no cardiac arrest</td>
<td>34.99%</td>
<td>52.99%</td>
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<td>Heart failure &amp; shock w/ cardiac arrest</td>
<td>11.74%</td>
<td>41.74%</td>
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<tr>
<td>Hip &amp; femur procedures except major joint w/ no cardiac arrest</td>
<td>24.99%</td>
<td>38.99%</td>
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<td>18.12%</td>
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Medicare Beneficiaries in Pennsylvania who use Home Health

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<tr>
<th>Category</th>
<th>Total Number</th>
<th>Percentage with 3+ Chronic Conditions</th>
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<td>Medicare Beneficiaries in Pennsylvania who use Home Health</td>
<td>146,015</td>
<td>89.0% (66.8 have 5+)</td>
</tr>
<tr>
<td>All Medicare Beneficiaries in Pennsylvania</td>
<td>2,350,558</td>
<td>21.0%</td>
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C&V
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.

Reference: https://www.psychu.org/lessons-early-adopter-aco/
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

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 to self-manage their illness.

Model of care that was developed for seniors

Has criteria for services that must be met

PIECESS Model

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.

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-MEDICARE

1- PRIMARY PSYCHIATRIC DISORDER  
• Major Depression  
• Anxiety Disorders  
• 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

Type of Program
Population served
Payers

BEHAVIORAL HEALTH OPTIONS

Integrate BH teaching

What does your Intermediary require?

BH PROGRAM

BEYOND DIAGNOSIS- WHY DO PATIENTS NEED BEHAVIORAL HEALTH?

- 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
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 treatment modalities at discharge.

Cost of home care was 10% of cost of hospital stay.

OTHER BH HOME HEALTH STUDIES

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.

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 Vanderhorst, Carson, Midla, 1998

WHAT WOULD IMPROVED SELF CARE IMPROVE IN STAR RATINGS?

- 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

EVIDENCE REVEALS THAT PSYCHOTHERAPEUTIC INTERVENTIONS AND PSYCHOPHARMACOLOGY TREATMENT IS EFFECTIVE IN MANAGING DEPRESSION IN CHF.

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

60% of patients were stabilized in the home setting following a BH hospitalization or in lieu of hospitalization and decrease in ER Use Vanderhorst, Carson, Midla, 1998)

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

WHAT WOULD IMPROVED SELF CARE IMPROVE IN STAR RATINGS?

Acute Care Hospitalization Rates
How Would These Results Effect Star Ratings?-Telephone Follow-up?

If can 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 to 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)

Patient Satisfaction

What Can We Do?

1-Screen for Depression, Anxiety, Impaired Cognitive Function (Beyond the Oasis)
   ◦ Look for triggers

2-Communicate Findings to MDs or NPs

3-Teach Staff / Assessors How to Talk to Patient’s About BH Symptoms
   ◦ How to “Normalize”

4-Determine an Agency Strategy

5-Development Depression, Anxiety, Dementia Care Management
   ◦ Teach how to use evidenced based tools

6-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
• 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).

SUMMARY

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

❖ TREATING BH ASPECT IMPROVES FUNCTION AND QUALITY OF LIFE AND OUTCOMES

❖ WE ARE ALREADY MANAGING PATIENTS WITH BH DX-WHY NOT ADDRESS IT?
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