Mental Health and Co-Occurring Conditions

A Patient's Perspective

Joyce Racanelli, LCSW
Director of Ambulatory Care Services
Northwell Health

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We are Northwell Health House Calls

Northwell Health

- One of the nation's largest health care systems located in NYC, Long Island and Westchester
- New York's largest private employer with over 62,000 employees
- Includes 22 hospitals, over 550 ambulatory and physician offices, post-acute services, population health management, emergency medical services
- Service area of over 8 million people in one of the most demographically diverse places in the country

Advanced Illness Management–House Calls Program

- Delivers HBPC to over 1200 debilitated, homebound older adults in Queens, Nassau and Suffolk counties
- Interdisciplinary, value-driven model
  - 14 Providers, 5 Social Work Care Managers, 4 RN Care Managers
- Program goals include decreasing disease burden, improving symptoms, reducing caregiver stress, decreasing unwanted care, and providing full support for those aging at home

Who We Serve

- House Calls patients have multiple chronic medical, mental health and behavioral conditions, including a high prevalence of dementia
    - A third of our patients with dementia have some sort of behavioral disturbance
    - Mental or behavioral health condition, 35.83%
        - Depression, 25%
        - Anxiety, 15%
        - Bipolar Disorder, 1%
        - Schizophrenia and Other Psychotic Disorders, 1%

Co-Occurring Conditions:	Chronic Conditions
Hypertension	69%
Alzheimer's Disease and Related Disorders or Senile Dementia	52%
Hyperlipidemia	31%
Diabetes	29%
RA/OA (Rheumatoid Arthritis/ Osteoarthritis)	26%
Acquired Hypothyroidism	23%
Heart Failure	21%
Atrial Fibrillation	20%
Ischemic Heart Disease	18%

Who We Serve: Case 1

A 58 year old female patient with severe and persistent mental illness with an extensive h/o psychiatric hospitalizations when she joined the program in 2014.

- **Living Situation:** lived with mother, also a House Calls patient
- **Homebound due to**: psychiatric illness and comorbidities
- **Psychiatric Diagnosis:** schizoaffective disorder
- **Comorbidities:** hypertension, hypothyroid, obesity, CKD
- **Functional Status:** relied on aide for assistance with ADLs and IADLs
- **Caregiver Support:** out of town family support
- **Advance Care Status:** family member was Power of Attorney and Health Care Proxy for both patient and mother
- **Primary Concerns**: management of psychiatric illness and planning for living situation when her mother's condition deteriorated
- **Services/Interventions:** supervised medication compliance 2x's weekly and home visits from psychiatry through the Assertive Community Treatment (ACT) Team, the House Calls team provided primary care; social work counseling and care management bi-weekly; Community Paramedicine

Who We Serve: Case 2

A 65 year old female patient pain management needs when she joined the program in 2014.

- **Living Situation:** at home with husband
- **Homebound due to**: pain and debility from fibromyalgia
- **Behavioral Health Condition:** anxiety disorder, depression, insomnia
- **Comorbidities:** chronic pain syndrome, fibromyalgia, mild cognitive impairment
- **Functional Status:** independent, some assistance dressing
- **Caregiver Support:** HHA 8 hours x 5 days – Spouse with caregiver fatigue
- **Advance Care Status:** Do Not Resuscitate, Health Care Proxy
- **Primary Concerns:** pain control/medication management
- **Services/Interventions:** intermittent psychiatric medication management, ongoing House Calls primary care; social work supportive counseling and care management, pain management; Community Paramedicine

Who We Serve: Case 3

A 74 year old female with who joined the program in 2015. She had been enrolled due to COPD exacerbation and recent discharge from hospice program.

- **Living Situation:** at home with husband
- **Homebound due to**: debilitating disease process
- **Psychiatric Diagnosis:** bipolar disorder
- **Comorbidities:** CKD, COPD, hypothyroidism, dementia with behavioral disturbances
- **Functional Status:** patient needs some assistance with all ADL's and IADLs
- **Caregiver Support:** formal HHA 8 hours x 5 days. Spouse supportive but fatigued
- **Advance Care Status:** Do Not Resuscitate and Health Care Proxy
- **Primary Concerns:** managing the patient as her physical condition declines; historically her behavioral disturbances increased with psychiatric hospitalizations needed.
- **Services/Interventions:** increased visit frequency by provider and social work care manager; community psychiatric visits until patient became homebound; community paramedicine; caregiver supportive counseling

House Calls Provider Survey Results

- **Informal survey :** managing patient's behavioral and mental health needs
- **What percentage of your current patient panel do you feel could use additional behavioral health support? 42% (average)**
- **Comments/Suggestions:**

- "High incidence of depression, anxiety, mood disorders, undiagnosed mental health disorders, borderline personality disorders and substance dependency"
- "We need psychiatric assistance from [professionals]. It's extremely common in geriatric homebound patient population and very difficult to manage with no training in psychiatric illness"
- "Home based psychotherapy: cost is a factor as any home care psychiatric costs more than most can afford"
- "Having a psychiatrist paid by Medicare join our team 1-2x/month; current psychiatrists are charging $500-$1000 to visit patients once"
- "Many family members can use behavioral health support"
- "Would love to have option for video conferencing for psych support"

Recommendations

- Recognize and implement plans that achieve the highest quality of care, within a patient centered model for patients having mental health needs along with co-occurring conditions while addressing payment and cost.
- Continue building on existing HBPC models by integrating psychiatric support to homebound patients and assist providers through consultation and medication management.
- Continue to train behavioral health professionals to be utilized as care managers and counselors to allow for billing opportunities similar to CoCM. (Collaborative Care Model)
- Support technology infrastructure to bring behavioral health services to patients through telemedicine or Project ECHO-like structure.
- Develop advance training programs for home health aids to allow for administration of medications in order to support patient adherence to medication regimens prescribed.
- Recognize and build relationships with informal and formal caregivers as a source of support for the patient and the medical team.

Thank You