Mental Health and Co-Occurring Conditions

A Patient’s Perspective

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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:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>69%</td>
</tr>
<tr>
<td>Alzheimer's Disease and Related Disorders or Senile Dementia</td>
<td>52%</td>
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<tr>
<td>Hyperlipidemia</td>
<td>31%</td>
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<tr>
<td>Diabetes</td>
<td>29%</td>
</tr>
<tr>
<td>RA/OA (Rheumatoid Arthritis/Osteoarthritis)</td>
<td>26%</td>
</tr>
<tr>
<td>Acquired Hypothyroidism</td>
<td>23%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>21%</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>20%</td>
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<tr>
<td>Ischemic Heart Disease</td>
<td>18%</td>
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</table>
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
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
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