CREATING REGIONAL PARTNERSHIPS TO IMPROVE CARE TRANSITIONS

Care Transitions Programs: Creating a Behavioral Health Intervention

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Aligning Forces for Quality

When an elderly patient or a patient with a serious or complex illness is discharged from the hospital, that person is particularly vulnerable. As patients move from one care setting to another, problems such as lack of follow-up care and miscommunication among clinicians often occur and can put patients at risk for serious complications and hospital readmission. Some patients have additional problems such as depression, social isolation, or a lack of housing or transportation that may increase their risk of hospital readmission. Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days, at a cost of more than $26 billion every year.[1]

Several Aligning Forces for Quality (AF4Q) Alliances have implemented or are partnering in care transitions programs using care transitions coaches to ensure patient care that is coordinated across care settings. This brief highlights the successes of care transitions coalitions that have developed interventions for patients with behavioral health problems such as depression and substance use disorders.

Patients with comorbid physical and behavioral health conditions are at greater risk of being readmitted to the hospital and tend to have worse health outcomes. Care transitions coaches can identify mental health problems that the hospital staff and other health care providers may have overlooked using behavioral health screening tools.

Here's how two care transitions coalitions have screened patients enrolled in a 30-day care transitions program for mental health and substance abuse problems and connected patients with behavioral health services.*

CASE STUDY

Southeast Michigan Community-Based Care Transitions Coalition

While preparing to start the Southeast Michigan Community-Based Care Transitions Coalition in 2012, the Area Agency on Aging 1-B subcontracted with Oakland Family Services in Pontiac, MI, to develop procedures for screening patients for behavioral health problems. The Area Agency on Aging 1-B is a partner in the Greater Detroit Health Council, which leads the AF4Q initiative in Detroit. Micheline Sommers, LMSW, director of Older Adult Specialty Services at Oakland Family Services, helped hire, train, and supervise a behavioral health coach who worked for the care transitions program. The coach was a Licensed Master Social Worker with a certificate in geriatrics. When she joined the care transitions team, she received training in Dr. Eric Coleman's Care Transition Intervention® and on how to look for symptoms of depression, anxiety, and substance abuse in patients.

At the four local hospitals that were partners in the Southeast Michigan Community-Based Care Transitions Coalition, "liaison" care transitions coaches enrolled eligible patients. The liaison coaches notified the behavioral health coach when they identified patients they thought could benefit from receiving a mental health assessment. After these patients were discharged from the hospital, the behavioral health coach would visit them at home and administer an evidence-based screening tool called the Patient Health Questionnaire-2 (PHQ-2). The assessment includes two simple questions *(see "Screening Patients for Depression," Box 1)*: "Over the past two weeks, how often have you been bothered by any of the following problems: Little interest or pleasure in doing things? Feeling down, depressed, or hopeless?" If the patient got a score of "1" or more on either question (meaning that they had been experiencing that problem for several days), then the behavioral health coach would conduct an additional 15-question assessment called the Geriatric Depression Scale. This helped the coach determine the patient's level of depression and whether they should be referred to the emergency room, a physician, or for counseling.

SCREENING PATIENTS FOR DEPRESSION

The Patient Health Quesionnaire-2 (PHQ-2) is a brief, initial screening test for depression. It consists of the following two questions:

Over the past two weeks, how often have you been bothered by any of the following problems?

1. **Little interest or pleasure in doing things.**
   0 = Not at all
   1 = Several days
   2 = More than half the days
   3 = Nearly every day
2. **Feeling down, depressed, or hopeless.**
   0 = Not at all
   1 = Several days
   2 = More than half the days
   3 = Nearly every day

Scoring:
A PHQ-2 score ranges from 0 to 6. The scoring guidelines say that patients with a score of 3 points or more should be further evaluated with other diagnostic tools or an interview to determine whether they meet criteria for a depressive disorder.

But the Southeast Michigan Community-Based Care Transitions Coalition's behavioral health coach further evaluated patients if they had a score of 1 or more points.

Source: Kroenke, K., R. L. Spitzer, and J. B. Williams. 2003. "The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. *Med Care* 41:1284-1292.

To download a PDF of the PHQ-2, go to: *http://www.med-iq.com/files/noncme/material/pdfs/LI042%20IG%20tools.pdf.*

The behavioral health coach often referred patients with depression to Oakland Family Services, which could develop a treatment plan, provide counseling in the home, or make referrals to other behavioral health resources. If the patient lived in Macomb County, the coach referred them to a similar agency called Macomb Family Services that could connect the patient with behavioral health resources in that area. Both Oakland Family Services and Macomb Family Services also offer

substance abuse treatment services and had funds to assist with covering the costs if the patient didn't have insurance coverage for that.

Sommers thinks that ideally all the patients enrolled in a care transitions program should receive a behavioral health assessment. She also notes that it's important to educate hospital staff about identifying behavioral health issues. "They are focused on the physical health of the patient and don't always understand how depression or anxiety can affect the disease process or how it impacts readmissions," she said.

In the offices where the case managers at the local hospitals complete their documentation, Sommers and her team posted cards they created *(see the "Raising Awareness of Behavioral Health Issues," Box 2)* with facts like "25 percent of people with cancer experience depression" and "a history of anxiety increases risk of stroke in women by 31 percent." They also distributed the cards to the care transitions coaches and representatives of the organizations that participated in the Southeast Michigan Community-Based Care Transitions Coalition, including the skilled nursing facilities and home health care agencies.

"Many patients with chronic illnesses suffer from depression and anxiety, so we all have to get more comfortable with asking patients questions about their mental health and about whether they are misusing their prescriptions or drinking alcohol with their prescriptions," Sommers said.

CASE STUDY
The Merrimack Valley Collaborative

Since the Merrimack Valley (Massachusetts) Collaborative's care transitions program began in 2012, the lead coaches have screened every patient they enroll using a mental/behavioral health risk assessment tool. Elder Services of the Merrimack Valley (not a member of an AF4Q Alliance) leads the Merrimack Valley Collaborative and developed this tool. It includes questions about mental and behavioral health factors that put patients at risk for re-hospitalization, such as a history of alcohol or substance abuse, suicide attempts, and admission to a psychiatric hospital within the past two years.

The lead coaches administer the mental/behavioral health screening and a health risk assessment before the patient leaves the hospital. In 2014, they started inputting the patient's answers to the questions on a tablet device using an app called Care at Hand. The scheduling team automatically receives a notification that is based on the patient's mental health risk score. If the patient is scored as "high" risk, the scheduling team gets a notification

RAISING AWARENESS OF BEHAVIORAL HEALTH ISSUES

The Southeast Michigan Community-Based Care Transitions Coalition's behavioral health team printed the following facts on cards that they posted in the offices of care managers at local hospitals. Their goal was to help draw the attention of the care managers to identifying behavioral health issues in patients.

- 25 percent of persons with cancer experience depression.
- Heart disease and anxiety increase the risk of heart attack in women by 59 percent.
- The presence of depression after recovery from a heart attack increased the risk of death (mortality) by 17 percent.
- 27 percent of stroke survivors experience depression.
- 25 percent of diabetics experience depression.
- Heart attack survivors experience the highest rate of depression—40 percent to 65 percent.
- 15 percent of patients with cardiovascular disease experience major depression.
- 20 percent of patients who have undergone coronary artery bypass graft (CABG) surgery experience major depression.
- A history of anxiety increases risk of stroke in women by 31 percent.

Depression has been proven to be such a risk factor in cardiac disease that the American Heart Association (AHA) has recommended that all cardiac patients be screened for depression using simple screening questions.

telling them to assign the patient to a transitions coach who specializes in mental health. If the patient is scored as "medium" risk, he or she gets a notification to have a behavioral health manager call to ask some additional questions and determine whether the patient should be assigned to a coach specializing in mental health or to a traditional coach.

The role of the mental health coaches is to connect patients with mental health services in the community. Elder Services of the Merrimack Valley (ESMV) has developed a larger network of local behavioral health resources since the care transitions program began, and the coaches can now help patients see a therapist or counselor more quickly. Another new development is that the coaches can refer patients to therapists within ESMV who have Medicare provider numbers.

Starting in 2014, United Healthcare contracted with ESMV to provide care transitions services for patients in Massachusetts. ESMV's care transitions coaches are using the mental/behavioral health risk assessment tool with United Healthcare patients but refer those who need mental health services only to resources within United Healthcare.

HOW YOU CAN DEVELOP AN INTERVENTION FOR PATIENTS WITH UNMET BEHAVIORAL HEALTH NEEDS:

1. Select one or more mental/behavioral health screening tools.
2. Train specific coaches to administer the screening tools and work with patients with behavioral health problems.
3. Develop a network of local behavioral health resources (including substance abuse resources) that you can refer patients to or partner with agencies that can provide these referrals.
4. Find ways to help patients access behavioral health resources—for example, arranging for therapy to be provided in the home.
5. Educate the staff of the organizations that are partners in your care transitions program about identifying behavioral health problems in patients so they can tell the coaches when they notice that a patient could benefit from a screening.

*This “peer-to-peer” meeting about care transitions was held on August 21, 2014, in Detroit. Aligning Forces for Quality organized and funded the meeting, with a goal of sharing strategies and tools for sustainability planning, staffing, physician engagement, and serving patient subsets. Attendees and subsequent interviewees were involved in the Center for Medicare & Medicaid Services (CMS) Community-Based Care Transitions Program. Attendees included Lisa Mason from the Greater Detroit Area Health Council; Caitlin Gerlach from MPRO; Tina Abbate Marzolf and Barbara Lavery from Area Agency on Aging 1-B; Sandy Kiesel from Go Lean, Inc.; Micheline Sommers from Oakland Family Services; Carrie Hays McElroy and Cathy Ponder from St. Mary Mercy Livonia Hospital; Dave Wilson and Jason Maciejewski from The Senior Alliance/Area Agency on Aging 1-C; Barbara Bremer and Denise Robertson from St. John Providence Health System; Susan Miller and Sara Gleicher from Adult Well-Being Services; Cathy Davis, Trent DeVreugd, and Cathy Lauridsen from the Kansas City Quality Improvement Consortium; Lori O’Connor from Elder Services of the Merrimack Valley; Melissa Pessefall from Akron Canton Area Agency on Aging; Dee Moore from Brewster Place Topeka Kansas; Megan MacDavey from the P2 Collaborative of Western New York; Sharon Mathe from Healthy Community Alliance; Jerry Bartone from Community Concern of WNY; Deanna Ruff from the York County Area Agency on Aging; Amy Shuttlesworth, Winnie Reineberg, and Mandi Waltemyer from WellSpan Health.

REFERENCES

[1]*The Revolving Door: A Report on U.S. Hospital Readmissions*. 2013. Princeton, NJ: The Robert Wood Johnson Foundation.

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