Behavioral Health

Why is Behavioral Health Important for FIDA Providers?

- FIDA covers a broad range of behavioral health (BH) services and supports
- Every FIDA provider may be in a position to be the first person to identify a particular participant’s need for BH services or supports
- All participating providers should be equipped with the skills, tools, and resources necessary to identify and respond effectively to BH needs

Prevalence of Behavioral Health Conditions

- 26% of all Medicare beneficiaries (more than 13 million) have some sort of mental health disorder including cognitive disorders.[1] 50% of duals 80 years and older have co-occurring physical and mental/cognitive conditions. [2]

- More than 50% of Dual/FIDA Participants have mental illness and/or cognitive impairments.[3]

- 56% of Medicare inpatient psychiatric patients are Dual Participants.[4]

- People with mental illness die younger than the general population, and have more co-occurring health conditions, such as hypertension, diabetes, heart disease, obesity, tobacco use and asthma. [4] Three out of five of Dual eligibles have multiple chronic physical conditions, and mental/cognitive issues.

- One in five adults with mental illness also have a co-occurring substance use disorder (SUD) [5]

http://www.medicareadvocacy.org/medicare-and-mental-health/
[1] The Social Security Administration, http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2011/ssi_asr11.pdf(Table 6, P. 25)
[2] https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8081.pdf
[3] The Kaiser Family Foundation, Medicare’s Role for Dual Eligible Beneficiaries, http://www.kff.org/medicare/upload/8138-02.pdf
[4] MedPAC, http://www.medpac.gov/transcripts/IPF%20presentation--October%202011--final.pdf
[5] http://www.integration.samhsa.gov/Integration_Infographic_8_5x30_final.pdf

Common Behavioral Health Conditions & Symptoms in the FIDA Population

- A September, 2014 study by the Centers for Medicare and Medicaid Services reports that of their sample, 41% of Duals enrolled in FFS Medicare-Medicaid are diagnosed with behavioral health conditions. [6]

- The most common mental health conditions in the FIDA population are:
  - Depressive Disorders
  - Anxiety Disorders

  Approximately 25% of home care recipients and 5% of older adults living independently in the community will score on the UAS-NY as high risk for Mood disorders; same percentage will score as medium risk.

  - Psychosis, including Schizophrenia spectrum disorders
  - Dementia or other neurocognitive spectrum disorders
  - *Substance Use*

  Approximately 10% of persons receiving home care, and 7% of older adults living independently in the community will trigger for Tobacco & Alcohol Use in the UAS-NY

Please click below for important information on the signs and symptoms of common mental health disorders (Appendix B)

Coordinated & Integrated Care Work Best

- For Participants with co-occurring Mental and/or Substance Use Disorders, integrated care - the coordination of mental health, substance use, primary care services, and long-term services and supports - produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs. [7]
  - Decreased inpatient and ER use
  - Improved mental and physical health
  - Improved engagement in care and health literacy
  - Improved quality of life
- The FIDA Person-Centered Service Plan (PCSP) should address cognitive deficits, psychiatric and behavioral disturbances, and substance misuse and abuse.
- FIDA participants may require reasonable accommodations, such as changes to scheduling, extra time needed for an appointment, flexibility around punctuality. This includes those individuals with mental illness and substance use disorders (SUDs).

[7] http://www.integration.samhsa.gov/Integration_Infographic_8_5x30_final.pdf

How Behavioral Health Needs are Identified

- ***By the FIDA Plan***
  - The UAS-NY Community Assessment screens, among other things, for depression, anxiety, alcohol and tobacco use, cognition, and other behavioral issues.
    - The UAS-NY will generate a Mental Health Supplement to further assess any triggered findings from the community assessment.
    - Pertinent findings should be discussed at the IDT meeting, and reflected in the PCSP with the participant's written consent.
- ***In Primary Care:***
  - Observation
  - Patient self-report (e.g. complaints of depressed mood, reporting physical symptoms of anxiety)
  - Use of free, valid, and reliable screening tools will improve your ability to quickly and reliably assess for some of the more common co-occurring mental health issues in your practice. They include:

How Behavioral Health Needs are Identified

- ***Please clink on the links below for additional resources that will assist you in identifying Behavioral Health needs***

- Depression: PHQ-2/PHQ-9 http://www.phqscreeners.com/overview.aspx?Screener=02_PHQ-9 (*see Appendix D for sample*)
- Anxiety: http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf
- Drug & Alcohol Use (General): http://www.integration.samhsa.gov/images/res/CAGEAID.pdf
- Alcohol Use (60+ Years Old): http://www.ssc.wisc.edu/wlsresearch/pilot/P01-R01_info/aging_mind/Aging_AppB5_MAST-G.pdf
- Mental Health Problems in Older Adults - http://www.cdc.gov/aging/pdf/mental_health.pdf
- Suicide Risk: http://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf
- *Additional screening tools and best practice information can be found at: http://www.integration.samhsa.gov/clinical-practice/screening-tools*

Mental Health Disorders/Symptoms: Depression

Symptoms of <u>Depression</u> include:

- A depressed mood
- Insomnia (an inability to sleep) or hypersomnia (excessive sleeping)
- Fatigue or loss of energy
- Appetite or weight changes
- Poor concentration
- Markedly diminished interest or pleasure in almost or all activities nearly every day
- Feelings of worthlessness or guilt
- Hopelessness
- Recurring thoughts of death or suicide (not just fearing death)
- A sense of restlessness or being slowed down

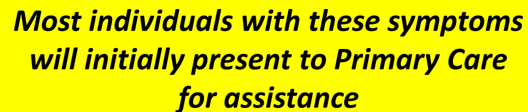
Many of these individuals will present to Primary Care complaining of the physical symptoms that limit their functioning (e.g. lack of motivation to complete projects, pulling away from friends or activities of interest)

<u>Late Onset Depression (50+)</u>

- ***Depression is not a normal part of aging***
- ***Depression in older adults complicates treatment of other illnesses and chronic diseases***
- ***80% of Depression cases in older adults are treatable***
- ***Risk factors for late-onset depression included widowhood, physical illness, impaired functional status, and heavy alcohol consumption [8]***

[8] http://www.cdc.gov/aging/pdf/mental_health.pdf

Mental Health Disorders/Symptoms: Anxiety & Panic



- Symptoms of Anxiety include:
  - Excessive worry about a number of events or activities
  - Restlessness, feeling on edge
  - Easy fatigue
  - Difficulty concentrating
  - Irritability
  - Muscle tension

- Symptoms of Panic include:
  - Palpitations, pounding hearts, accelerated pulse
  - Sweating
  - Trembling, shaking
  - Shortness of breath
  - Chest pain, discomfort
  - Nausea, abdominal distress
  - Dizziness, light headedness, faint
  - Fear of dying

Mental Health Disorders/Symptoms: Bipolar Disorder

Symptoms of Bipolar Disorder include:

Depressive Symptoms

- Sadness
- Hopelessness
- Suicidal thoughts/behavior
- Anxiety
- Guilt
- Sleep problems
- Low or Increased Appetite
- Low energy
- Loss of interest in activities that were once found enjoyable
- Problems concentrating
- Irritability
- Chronic pain with no cause
- Frequent absences/Poor performance at work or school

Manic Symptoms

For at least one week

- Abnormally and persistently elevated, expansive or irritable mood
- Increase in goal-directed activity
- Inflated self-esteem or grandiosity
- Decreased need for sleep
- Pressured speech; increased talkativeness
- Distractibility
- Racing thoughts
- Excessive involvement in activities that have a high potential for painful consequences (e.g. hypersexuality, shopping sprees, foolish business investments).

Mental Health Disorders/Symptoms: Psychosis

Psychosis

- Psychosis can present as a symptom in any of the aforementioned disorders (e.g. depression, bipolar disorder, substance use, unresolved medical conditions, etc.).
- It may also occur as a feature of delirium or other manifestations of an underlying medical condition.
- Symptoms of psychosis may include:
  - Impaired reality testing
    - Perceptual disturbances (e.g. auditory hallucinations)
    - Delusions (fixed, false beliefs)
  - Disorganized thought process
  - Disorganized speech
  - Disorganized behaviors
- Psychosis is a cardinal symptom of Schizophrenia
  - Diagnosis of Schizophrenia requires at least six (6) months of symptoms
  - Additional symptoms of Schizophrenia may include.
    - Abnormal motor behavior
    - Impairments in self-care
    - Impaired social and/or occupational functioning
    - Negative symptoms = an absence of something that should be there (e.g. facial expressions, variation in voice, descriptive speech)
- Psychosis should **always** be evaluated for underlying cause and appropriate treatment.

Mental Health Disorders/Symptoms: Dementia

- Dementia, is a progressive neurocognitive disorder. The most common form is Alzheimer's Disease. Symptoms include:
  - Memory impairment
  - Difficulty with recognition of familiar people/places/things
  - Restlessness
  - Aggression
  - Sleep disturbances
  - Wandering

Symptoms occur in about 50% (or higher) of individuals with dementia.

Approximately 85% of individuals receiving home care will score on the UAS-NY to monitor for or reduce risk of cognitive loss.

- Research has shown that elderly patients are especially at risk for the development of dementia. The identification of symptoms in the elderly may be obscured by the presence of multiple medical illnesses and medications. In order to prevent/minimize negative behaviors, we need to understand the communication of the person with dementia and it is helpful to look for and record any patterns of behavior. A nonpharmacological approach should be the first step in treating the psychotic symptom.
- Elderly patients presenting with psychotic symptoms require social, behavioral, and environmental interventions that are necessary for their safety and reorientation. However, some patients may need pharmacologic intervention in order to manage the behavioral disturbance that often results from the psychotic symptoms. This article reviews psychopharmacologic treatment strategies for managing psychotic symptoms in elderly patients.

Mental Health Disorders/Symptoms: Dementia

- ***Please see the links below for additional information***

- http://www.crisisprevention.com/Blog/June-2011/Treating-Psychotic-Symptoms-in-Persons-With-Dement
- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC181181/

Mental Health Disorders/Symptoms: Substance Use Disorders (SUDs)

- Substance Use Disorder (SUD) is when an individual continues using a substance despite significant substance-related problems. These include cognitive, behavioral, and physiological symptoms:
  - An underlying change in brain circuits may persist beyond detoxification
  - Behavioral effects include repeated relapses and intense cravings
  - Disorder severity ranges from intoxication → use → abuse → dependence

- The criteria for these disorders follow a pattern of behaviors, leading to clinically significant impairment within a specified time course. Criteria are grouped as follows:
  - Impaired control: Desire, but inability to cut down; time spent obtaining, using & recovering, craving
  - Social impairment: Not filling major role obligations in deference to use
  - Risky use: Not solely the usage itself, but the individual's lack of abstaining from using the substance, despite the physical difficulty it is causing

- Pharmacological criteria (not required for diagnosis of SUD):
  - Tolerance: needing more to achieve same effect. Increased ability to tolerate negative effects (e.g. respiratory depression, sedation)
  - Withdrawal: symptoms that result when blood or tissue concentrations of a substance decline after prolonged, heavy use. The individual is more likely to use the substance to relieve the symptoms.

- Routine Screening for potential drug and alcohol use is a best practice. If evidence of an SUD exists, a Brief Intervention, and Referral to Treatment is indicated.

Mental Health Disorders/Symptoms: Substance Use Disorders (SUDs)

- ***For more information on SBIRT and screening for SUD, please click on the links below.***
  - Guide to Substance Abuse for Primary Care Clinicians: http://www.ncbi.nlm.nih.gov/books/NBK64827/pdf/TOC.pdf
  - SBIRT: http://www.integration.samhsa.gov/clinical-practice/SBIRT
  - Substance Abuse Among Older Adults: http://www.ncbi.nlm.nih.gov/books/NBK64419/pdf/TOC.pdf

Assisting FIDA Participants in Obtaining Behavioral Health Services

- Routinely using valid and reliable screening tools using (such as the Patient Health Questionnaire (PHQ-2 and PHQ-9) for depression) will help you identify who should be referred for further evaluation and treatment. *(See sample screening questions by clicking here – Appendix A)*

- Support effective care coordination by documenting and communicating necessary information to IDT members to integrate services and transition Participants' care between health care settings and health care providers.
  - Identify any current behavioral health services received by the Participant to ensure continuity of care
    - To support continuity of care, FIDA participants can keep their current behavioral health providers for up to two years for current episode of care.
  - Obtaining the FIDA participant's consent *before* you communicate any identified MH/SUD issues to the IDT will (a) improve their engagement in the recovery process, and (b) ensure their privacy rights are protected as consistent with HIPAA and 42 CFR Part 2 ***(see Appendix C for description of relevant privacy laws)***

- Support Participant's treatment plan as part of the Person-Centered Service Plan (PSCP) to ensure that both medical and non-medical health needs are met

Click below for a complete listing of behavioral health care benefits and Community Resources available under FIDA (Appendix D)

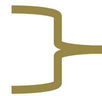
Appendix A: Preventive Health Questionnaire - PHQ-2/PHQ-9 Screening Questions

Over the last 2 weeks, how often have you been bothered by any of the following:

Not at all (0) **Several days (1)** **More than half the days (2)** **Nearly every day (3)**

1. Little interest or pleasure in doing things?……

2. Feeling down, depressed, or hopeless?………



These two questions comprise the PHQ-2. If a participant screens positive on one or both questions, continue to the PHQ-9

3. Trouble falling or staying asleep, or sleeping too much? …….

4. Feeling tired or having little energy?.........

5. Poor appetite or overeating?............

6. Feeling bad about yourself - that you are a failure or have let yourself or your family down?…………

7. Trouble concentrating on things, such as reading the newspaper or watching television?

8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual? …………

9. Thoughts that you would be better off dead or of hurting yourself in some way? …….

Appendix B: Behavioral Health Covered Services

Medicare/Medicaid physical, behavioral healthcare and long-term supports & services

Integration of BH and enhancements to care/case management

Fully Integrated Duals Advantage (FIDA) Services

Including the following services:

- AIDS Adult Day Health Care
- Assertive Community Treatment (ACT)
- Assisted Living Program
- Assistive Technology
- Case Management for Seriously Mentally Ill
- Community Transitional Services
- Comprehensive Medicaid Case Management
- Consumer Directed Personal Assistance Services
- Continuing Day Treatment
- Day Treatment
- Family-Based Treatment
- Health and Wellness Education
- Home and Community Support
- Home Visits by Medical Personnel
- Independent Living Skills and Training
- Intensive Psychiatric Rehabilitation Treatment
- Medicaid Pharmacy Benefits -per State Law
- Moving Assistance
- OMH Licensed CRs
- Partial Hospitalizations
- Personalized Recovery Oriented Services
- Positive Behavioral Interventions and Support
- Social Day Care Transportation
- Structured Day Program
- Substance Abuse Program
- Telehealth
- Wellness Counseling

Appendix C: Confidentiality of Alcohol and Drug Abuse Patient Records

- In December, 2000, the Department of Health and Human Services (HHS) issued the "Standards for Privacy of Individually Identifiable Health Information" final rule (Privacy Rule), pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, Subparts A and E.[1] Substance abuse treatment programs that are subject to HIPAA must comply with the Privacy Rule.[2 3]

- 42 CRF Part 2 protects all information about any person who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program.

- To be considered a Part 2 provider, providers must be both "federally-assisted" and meet the definition of a program under 42 CFR § 2.11. Physicians who prescribe controlled substances to treat substance use disorders are DEA-licensed and thus meet the test for federal assistance [42 CFR § 2.12(b)(2)]. This guidance also applies to substance abuse treatment programs that are also covered entities as defined by the Privacy Rule. ***For additional criteria please see question 10 of the Applying the Substance Abuse Confidentiality Regulations FAQs by clicking on the link below.***

- Programs may not use or disclose any information about any patient unless the patient has consented in writing (on a form that meets the requirements established by the regulations) or unless another very limited exception specified in the regulations applies. Any disclosure must be limited to the information necessary to carry out the purpose of the disclosure.

Appendix C: Confidentiality of Alcohol and Drug Abuse Patient Records

- ***Please visit the link below for consent form criteria*.**
- Substance Abuse Confidentiality Regulations FAQs - http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs
- Consent Form Criteria - http://www.integration.samhsa.gov/operations-administration/Consent_Law_Comparison_Table.pdf

Appendix D: Community Resources

- Visit the FIDA portal for a full list of resources for providers to access when needed.
- The listing of resources includes such services as:
  - Housing, Health, Aging, Homelessness, Nutrition, WIC, Ryan White, Resources and Assistance for people with disabilities, Legal Assistance, Cell Phone Services, Food Stamps, Medicaid, Medicare, Social Security, Financial and Tax Assistance, Food Bank, Adult/Child Protective Services, Assisted Living, Court Ordered Services, Domestic Violence Services, Mental Health and Substance Abuse Services, Red Cross, Blood Services, Suicide prevention, etc…

TEST Questions

Behavioral Health

- ***Behavioral Health services are covered at no cost to the participant.***
- True or False

- ***Psychosis is associated ONLY with Schizophrenia.***
- True or False

- ***Routine screening for Substance Use Disorders is a best practice.***
- True or False

Test Answer Key

Question	Answer
Behavioral Health services are covered at no cost to the participant.	*True*
Psychosis is associated ONLY with Schizophrenia.	*False*
Routine screening for Substance Use Disorders is a best practice.	*True*