Question & Answer (Q&A): Promising Practices for Meeting the Behavioral Health Needs of Dually Eligible Older Adults Webinar

Webinar participants asked the following questions during the Q&A portion of the 2018 Geriatric-Competent Care webinar, Promising Practices for Meeting the Behavioral Health Needs of Dually Eligible Older Adults, held on August 2, 2018. Please note, the responses in this document have been edited slightly for clarity. The webinar recording, slides, and transcript can be found on the Resources for Integrated Care website:
https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Behavioral_Health_Needs

Featured Webinar Speakers:

- Neha Jain, MD, Assistant Professor of Psychiatry, University of Connecticut School of Medicine
- Molly Rees Gavin, MSW, President, Connecticut Community Care, Inc.
- Sabrina Wannamaker, MA, LPC, LPC/S, Clinical Manager, Absolute Total Care
- Andrea Lovell, Family Caregiver

Q1: Why are individuals who are dually eligible for Medicare and Medicaid uniquely vulnerable to behavioral health needs? Could some of this be attributable to the effects of poverty?

Resources for Integrated Care: Dually eligible beneficiaries may be characterized as uniquely vulnerable to behavioral health challenges due to the compounding effects of poverty. The relationship between behavioral health issues and poverty can be cyclical—poverty increases the risk of behavioral health problems, and having a mental health illness or substance use disorder increases the likelihood of experiencing poverty.[1, 2] Individuals who suffer from behavioral health conditions - such as depression, anxiety, or substance use disorder - may experience social isolation or employment challenges, which can continue the cycle of poverty. Access to adequate treatment for behavioral health conditions may also be a challenge for those in poverty[3] due to transportation issues or difficulty in taking time off from a job.

Q2: How can staff work with dually eligible older adults who may be resistant to accepting assistance?

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[1] Anakwenze, U., & Zuberi, D. (2013). Mental health and poverty in the inner city. Health & social work, 38(3), 147-157.
[2] Hudson, C. G. (2005). Socioeconomic status and mental illness: tests of the social causation and selection hypotheses. *American journal of Orthopsychiatry*, *75*(1), 3-18.
[3] McKay, M. M., Lynn, C. J., & Bannon, W. M. (2005). Understanding inner city child mental health need and trauma exposure: Implications for preparing urban service providers. *American Journal of Orthopsychiatry*, *75*(2), 201-210.

Molly Rees Gavin: It is important to remember that some members may be resisting our support because of prior negative experiences they have had with medical care and social support systems. Sometimes we explore whether their questioning of our role and motivation is actually a coping mechanism.

Overall, we should not be afraid of this resistance. It is not something that we should turn away from, but rather use in our intervention with the member and recognize that it can take a long time to build trust with some individuals. We may need to start with small interventions and small examples of our support. For example, this can be as simple as showing up at a member's house at the time you told them you would be there.

Q3: The prevalence of late-life depression for dually eligible older adults at 19 percent seems low. Do you think late-life depression is underdiagnosed?

Dr. Neha Jain: Although mild forms of depression, such as dysthymia and subsyndromal symptomatic depression, are more common among older adults, studies demonstrate that diagnosis and treatment of late-life depression may be inadequate. Screening older adults for depression with tools such as the Geriatric Depression Scale (GDS) can increase the frequency of recognition and treatment.

Q4: What is the most common side effect of multiple electroconvulsive therapy (ECT) treatments?

Dr. Neha Jain: The most common effect of multiple ECT treatments is cognitive impairment. The three most basic types of cognitive impairment that may be caused by ECT are:

1. Acute confusion
    - Disturbance of consciousness, which resolves within a few days
2. Anterograde amnesia
    - Decreased ability to retain new information, which typically resolves within two weeks
3. Retrograde amnesia
    - Loss of memory for recent events around the time of ECT
    - Some memories of events prior to the course of ECT may return, while others may not

Six months after ECT, 30 to 55 percent of individuals report memory loss.[4] However, for many older adults, cognitive performance improves after ECT as their depression improves. As such,

[4] S Carney, P Cowen, K Dearness, & J Eastaugh. (2003). Efficacy and safety of electroconvulsive therapy in depressive disorders: A systematic review and meta-analysis. The Lancet, 361(9360), 799-808. doi:10.1016/S0140-6736(03)12705-5

multiple ECT treatments can effectively treat depression among older adults, but it is important to consider the potential side effects when deciding on treatment options.

Q5: What is the largest communication barrier among providers involved in the care of Andrea's mother? What are some of the communication strategies that you noticed worked well?

Neha Jain: As a physician, I find time constraints to be the largest barrier to communication. If I am seeing an individual in a 30-minute visit, then I am using that time to talk to the individual and build a treatment plan. The communication between different providers across various disciplines occurs at other times, which can be a challenge. I am lucky to be in a practice where I am able to carve time out for additional communication, but that may not be the case for all providers. However, it is important for providers across the board, whether they are case managers, social workers, therapists, or physicians, to set aside time to complete those phone calls or emails. Additionally, electronic health record portals are a great way to ease communication, especially between providers and caregivers.

Andrea Lovell: It is overwhelming, as a caregiver, to coordinate all of my mother's care and the coordination between providers. It is important for providers to ensure that the family knows how to reach them with any questions or concerns. I also appreciate how Dr. Jain prepares her colleagues to be in a position to step in, if necessary. This is helpful because it is difficult to continually repeat five years of information to a provider who is not familiar with my mom.

Q6: What is a normal caseload for the case managers at Absolute Total Care? Is there a difference in caseloads between telephonic and field case managers?

Sabrina Wannamaker: Caseloads for both telephonic and field case managers vary based on risk level and acuity. We try to balance high acuity and low acuity cases to average 65 cases per care manager. This number applies to all populations.

Q7: How do health plans engage primary care providers in the care planning process? Are primary care providers responsive to sharing care plans with other providers?

Sabrina Wannamaker: Case managers fax care plans to primary care providers' offices and send invitations for Integrated Care Team meetings, though the providers may not engage. In the more complex cases, the case managers will attend appointments with members in an effort to build provider engagement. They may also reach out to providers' offices to discuss clinical information as it relates to compliance, medication, or complications that the member may be experiencing.

Q8: How does Absolute Total Care identify a primary case manager for each member?

Sabrina Wannamaker: The primary case manager is the lead for each member's care. To determine the appropriate primary case manager, we identify the most significant clinical need for each member at the time of initial assessment. After an assessment of this need, as well as an assessment of the member's overall physical and behavioral health status, case managers have a consultation meeting to determine the best approach and services for each individual member. Once this plan is developed, we decide who will lead the case moving forward. From that point, providers communicate with this lead, and the lead will then relay information to the member.

The primary case manager can also change over time based on the immediate needs of the member. For example, we can assign a member diagnosed with diabetes and schizophrenia a behavioral health clinician as their primary case manager, and a physical health nurse as their secondary case manager. However, if the member is appropriately taking psychotropic medication to manage their schizophrenia, but their diabetes appears to be uncontrolled, the physical health nurse can become the primary case manager while the behavioral health clinician becomes their secondary case manager. The case managers will continue consultation with each other and the interdisciplinary care team for the duration of the case.

Q9: Is there an impact on cost of care associated with Absolute Total Care's integrated care approach?

Sabrina Wannamaker: Although we have not analyzed cost of care associated with the integrated care approach, current literature supports reduction in inpatient admissions and emergency department utilization, improvement in mortality, and positive return on investment.

Q10: How do you work through transportation barriers in instances when transportation is limited or the individual lives in an area that does not provide public transportation?

Sabrina Wannamaker: Absolute Total Care utilizes a transportation vendor and has a team of social workers who assist in identifying alternate transportation arrangements when needed.