A Collaborative Approach for the Care Management of Geropsychiatric Services

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ABSTRACT
Purpose/Objectives: To share a successful collaborative approach between the medical and behavioral health departments of a managed care organization that improved both utilization rates and management for health plan members with dementia.
Primary Practice Setting: Acute care hospitals
Findings/Conclusions: There was a significant reduction in subsequent hospital admits, beddays, and emergency department visits for this population resulting in a substantial financial savings. Patient outcomes, as well as patient and caregiver satisfaction, was improved.
Implications for Case Management Practice: Prior to the implementation of this pilot, there was a gap in services for health plan members experiencing dangerous behavioral issues associated with their dementia diagnosis. Case management of this population was difficult because of the limited options available in our market area. This innovative program afforded a nontraditional approach to inpatient care that maximized case management possibilities for this population.

Key words: case management, dementia, geropsychiatric, managed care

The management of health plan members with dementia is difficult under the best of circumstances. However, when the diagnosis involves associated combative and aggressive behaviors, it often threatens their personal safety, living situation, and caregivers. This scenario is further complicated by a lack of coordination between the medical and behavioral health insurance benefits for determining financial responsibility for this care.

This article discusses a collaborative approach between the medical and behavioral health departments of a managed care organization that recognized the need to improve both the utilization management and health outcomes for this subgroup of Medicare advantage plan members. The “Gero-Psych Pilot Program” extended over 3 years and saved more than $2 million by providing care in a more cost-effective manner.

A Literature Search was conducted on the Professional Case Management Web site and PubMed Web site using the terms dementia and managed care, Alzheimer’s disease and managed care, geriatric psychiatric hospital, and discharge planning. Although there are numerous managed care initiatives and case management programs that have demonstrated significant improvement in key utilization measures, we found nothing pertaining to the basic concept of this article.

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The care provided to the members with dementia was suboptimal and characterized by a lack of appropriate treatment and often delays in services. The majority of local EDs were ill-equipped to manage these elder members with dementia. Treating ED physicians often experience undue pressure, both internal and external, to admit these members to the medical unit without an obvious “medically necessary” reason. Frequently, while in the ED environment, the member with dementia would be relegated to the secured psychiatric holding area that was truly designed for seriously mentally ill patients. Because of lack of sufficient knowledge and experience with this population, treating ED physicians often used sedation as a key component of most treatment protocols for managing the behavioral issues. Drugs like haloperidol (Haldol) and lorazepam (Ativan), which are known to be contraindicated in the treatment of older adults, were commonly used for managing the behavioral outbursts that were often viewed as dangerous. However, often, these same medications would mask the combative and aggressive behaviors allowing the patient to return home only to have the disruptive actions resume once the medication was metabolized. These confounding issues raised concerns about quality of care, personal safety, and overall patient and family comfort.

In addition, once in the ED setting, any member with dementia who was insured through our health plan became embroiled in a struggle between medical and behavioral benefits of the insurance coverage. Per the health plan “Evidence of Coverage,” behavioral issues associated with an underlying dementia diagnosis, such as Alzheimer’s, are managed under a member’s medical benefits and are not covered under the behavioral health coverage. Once a behavioral evaluation was completed in an inpatient setting and it was determined that no true psychiatric diagnosis was indicated, the disposition of the patient remained the responsibility of the medical side of the insurance company.

However, the presence of behavioral outbursts primarily associated with dementia does not meet health plan criteria for an admission to an acute care hospital. The process caused a high level of frustration for all involved including the member, the family, the provider, and the hospital. Moreover, these members with dementia generally returned to their prior placement without proper follow-up. The ensuing result was a vicious cycle of repetitive ED visits, inadequate treatment, and added stress to scarce community resources. To address the problem, the health plan revised the mixed service policy, as it was open to interpretation and was unclear in delineating financial responsibility between the medical and behavioral side of insurance coverage.

The health plan case management team observed the phenomenon of repeat ED visits and analyzing associated claims data, questions began to surface regarding our current utilization and case management practices for this subgroup of members. Because dementia is considered a medical condition (per the insurance benefits’ definition), perhaps admission under the medical benefit to a geropsychiatric unit could be authorized. By so doing, these members may realize improved health outcomes under the treatment of a geriatric psychiatrist. The team believed that by developing a collaborative approach to this member population, the health plan would realize improved care outcomes while limiting inappropriate and inadequate hospital and ED utilization.

Discussions with all levels of health plan leadership ensued, including legal and risk management to share utilization data and seek agreement to develop a pilot program to test our hypothesis. Once internal approval was secured, we began meeting with a contracted hospital that had a 40 bed inpatient geropsychiatric unit.

A secure geropsychiatric behavioral health milieu is designed to address the unique physical and emotional needs of adults, 50 years of age or older. It offers short-term treatment to stabilize patients who are experiencing a mental health crisis that cannot be treated in an outpatient setting. For safety reasons, geropsychiatric settings are locked, and patients are closely monitored by staff. After an assessment, patients are provided with an individualized treatment plan. Services are provided by a team consisting of a psychiatrist, medical doctor, licensed clinical social worker (SW), registered nurse, and nursing assistant as well as a rehabilitation therapist and dietician, as needed. Daily milieu in structured services may include
management of medical conditions, medication management, dietary consults, recreational therapy, psychotherapy (individual, family, and group), education for patients and families on diagnosis, treatment and medication compliance plus assistance with discharge planning including financial issues. Meals are taken in a common group area and patients are able to wear their own clothes rather than hospital gowns. Given the intense nature of the setting, phone use and visiting times for family and friends are very limited. Upon discharge to the appropriate level of care such as independent living or alternative setting, patients received aftercare from a psychiatrist for medication monitoring.

Through the partnership with the health plan and the hospital, the pilot program structure was developed by physician and case management leadership within the two organizations. The program was started in spring of 2005, and after realizing positive patient outcomes from the first dozen cases, a formal standard operating procedure was developed and implemented systemwide in January of 2006. The basic procedure has been revised several times over the past 4 years and remains the hallmark of the health plan for appropriately assessing, triaging, treating, and case managing our members with dementia who need psychiatric care to address their behavioral issues.

**Admission Criteria**

Health Plan members who may benefit from an inpatient medical geropsychiatric unit stay must meet all the following health plan criteria:

- Verification that the primary diagnosis is dementia through review of medical history, mental status assessments, and diagnostic studies.
- Exhibit the inability for self-care coupled with combative or aggressive behaviors that are prohibiting them from returning to their current living environment.
- Demonstrate a clear indication that the individual is able to participate in the social milieu of the program and able to benefit from medication adjustment and monitoring to assist in stabilizing the behaviors.
- Completion of an examination by a contracted Health Plan physician to rule out any medical problem(s) that may be causing or contributing to the behavioral outburst (for example, urinary tract infection or electrolyte imbalance).

The last criterion was based on our historic experience that the ED physicians are focused on immediate triage and disposition of the patient. For this reason, they may choose to admit a patient to a geropsychiatric unit without looking at the whole picture. The goal of involving a contracted health plan physician was to ensure a thorough history, and physical assessment occurs to rule out any physiological cause(s) for the behavioral change before disposition of the patient to an inpatient geropsychiatric unit. Furthermore, involving a contracted provider ensures that collaboration with the insurance-based case manager (CM) occurs early in the hospital stay.

**Admitting Process**

Once it is determined that the patient meets all the aforementioned admission criteria, the health plan assists in transferring the member to the geropsychiatric facility. There are two distinct departments within the managed care organization that take primary ownership of this program: Continuity of Care (COC) and the Access Center (AC). Assignment to the COC or AC team for initial assessment and review for possible geropsychiatric admission is determined by member’s point of entry into the medical system.

If a member is already admitted into the acute care setting, the COC department facilitates the assessment and transfer. The COC department is the health plan’s hospital-based case management unit that is responsible for utilization management and care transition activities for members admitted to the acute care setting. The COC SW is the primary CM for any geropsychiatric admits. They review all of the documentation, including the history and physical, current medications, key laboratory work, formal legal hold, and physician progress notes to ensure that the member meets all health plan criteria for this program. The COC CM works collaboratively with the COC department medical director when indicated for concurrence with the plan of care. The COC CM then sends the clinical information to the receiving geropsychiatric facility to review prior to acceptance into the unit. Once the member is accepted, the COC CM will arrange for the transfer and communicate case particulars to all involved parties.

The second department that could be assigned to assist with a geropsychiatric admission is the AC. The AC is the managed care organization’s 24/7 operational support team. Their focus is members who present to
the ED but do not meet medical criteria for the acute care setting. The AC staff completes the same clinical assessment as the COC CM to ensure that the member meets all health plan criteria. If admission is indicated, they will facilitate the transfer of care. The AC’s 24/7 availability allows the health plan to facilitate these evaluations and subsequent admissions if indicated after hours and on weekends.

**CONCURRENT REVIEW AND CARE TRANSITIONS**

Throughout the admission, the COC staff works collaboratively with the facility’s case management department, the unit psychiatrist, and the health plan medical director. The COC CM has primary accountability and oversight for both utilization management and discharge planning. While on the unit, the COC CM is the key contact for the patient, family member, the patient’s legal guardian, or next of kin. A key focus of the case management assessment is to evaluate the safety and effectiveness of the patients’ current living situation. Often, the admission is the trigger that warrants considerations of a new placement option, such as a group home or a nursing home that specializes in dementia care. In these instances, facilitating a safe care transition posthospitalization is a key aspect of the COC CM’s role.

Another important aspect of the COC CM’s involvement entails collaboration with our contracted behavioral health provider, Behavioral Healthcare Options. It operates as a managed behavioral health organization, providing a full range of mental health services to public and private sectors, third party administrators, self-insured groups, and managed care organizations. Behavioral Healthcare Options assists in securing prior authorizations and follow-up appointments for the member with a contracted psychiatrist. Often times, follow-up care can be scheduled with the same provider that managed the patient during their hospital stay. Typically, the psychiatrist will continue to provide care to the member for a period of 4 to 6 months postdischarge. This follow-up includes ongoing patient assessment, including medication monitoring and titration. All follow-up visits with the psychiatrist are reimbursed under the member’s behavioral health benefit.

**METHODS**

One method for measuring the effectiveness of the geropsychiatric program is to assess whether usage of the acute hospital and ED visits have declined after admission into the program. Table 1 highlights these outcome measures, which include number of hospital admissions and ED visits pre- and postintervention. These data points were compared from the 6 months preceding admission to 6 months postadmission.

**RESULTS**

Of the 148 members admitted to the medical geropsych program between May 2005 and September 2008, 81 met the analysis criteria of having continuous health plan enrollment 6 months pre- and postintervention. Because of the small sample size and non-normal distribution of measure, the Wilcoxon test was used to statistically compare pre- and postutilization. As indicated in Table 1, the results illustrate significant decreases in key measures.

**DISCUSSION AND LESSONS LEARNED**

Albeit the study sample size was small, the lessons learned were many and definitely contributed to our success. We discuss them below in detail.

**Securing Buy-In From Senior Leadership**

Many great ideas and programs are never implemented, because senior leadership approval was not secured. The success of this program was based on our ability to identify the inherent value for key stakeholders. Once this was accomplished, we were able to create a compelling argument as to how our proposed program would address the same, the value proposition being that the program would reduce inappropriate utilization of ED and subsequent hospital admissions.

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Utilization Comparison Pre–Post Enrollment</th>
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<tr>
<td><strong>Six-Months Preprogram</strong></td>
<td><strong>Six-Months Postprogram</strong></td>
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<tr>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Hospital admission</td>
<td>1.33</td>
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<tr>
<td>Emergency department visits</td>
<td>6.70</td>
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admits. Furthermore, it would improve patient and family/caregiver satisfaction, for the patient would experience less wait time in ED awaiting final disposition and, if the patient’s condition warranted, an inpatient stay, the treatment plan would be more effective in managing the behaviors.

Our compelling argument was built by sharing historical utilization data for health plan members identified as having a dementia diagnosis. The utilization of high-cost resources (ED and hospital) for these identified members was disproportionately higher when compared to members without a dementia diagnosis. Key facts that were also emphasized included the following:

a) These members were already accessing care and at the time of the ED encounter;

b) Often the member’s current living situation/support system was overstressed or inadequate and required CM intervention; and

c) Improving the overall experience of accessing care for these patients and their families would enhance our patient satisfaction, which is always a strategic goal for health plan leadership.

**Standard Admission Criteria**

Living with a dementia or Alzheimer’s disease for both the patient and the family or caregiver can often be extremely difficult and may even become overwhelming. However, this program was not to be used as the solution for every patient that presented to the ED with a dementia diagnosis. Therefore, the process of developing a robust set of admission criteria was paramount to the program success. The process of developing the criteria set was a collaborative effort between the medical and behavioral health project members including the medical directors from each department. The criteria would not only guide decisions related to admissions, but would also help to clarify issues in claim payment disputes. Once a clear set of criteria was established, it governed all utilization management decisions. The criteria allowed for consistency in treatment authorizations from health plan medical directors and eventually in prior authorization requests from contracted community providers concerning geropsychiatric admissions. Moreover, the standard criteria set is believed to have improved both internal and external partnerships, as its use has minimized the confusion that historically accompanied geropsychiatric admits.

**Education and Training**

Often the area of education and training is underestimated in terms of time and intensity requirements and undervalued in terms of contribution to program outcomes. Our training plan involved multiple health plan departments (COC, AC, claims, prior authorization, and senior management); contracted physician groups—both primary medical groups and hospitalist groups (MDs that practice in a hospital); and external stakeholders including area hospitals, ED providers, skilled nursing facilities, and the geropsychiatric unit staff. Key focus areas for initial education and training included the following:

1. admission criteria stressing the ALL-inclusive aspect of this criteria;
2. key contacts for authorization and case management;
3. care transition pathway including outpatient follow-up program postdischarge; and
4. chief responsibilities of health plan and geropsych unit care managers.

After initial education and training was completed, we established biweekly meetings with our external partner (geropsychiatric unit) to evaluate recent admissions for effectiveness of inpatient intervention, as well as any operational barriers that we experienced during care transition(s).

**3 C’s: Collaboration/Coordination/Communication**

The 3 C’s are the underpinning of any successful care transition program. And although they sound easy enough to attain, they often may be challenging and/or elusive. Our project team understood the importance of the 3 C’s and always utilized these case management tools, either it was a patient/family conference or it was a joint operating committee meeting with hospital and health plan administration.

To begin with, our collaborative efforts were internally focused while we secured consensus for program development and revised current utilization
and case management processes. Once this was accomplished, we turned our attention to our external partners: the geropsychiatric unit staff and hospital leadership from the ED. Collectively we created CM protocols that addressed admissions, continued stay, and discharge planning. We believed that our ability to develop these care coordination protocols with frontline clinical providers (CMs and MDs) contributed significantly to the program success. This coordination allowed external stakeholders to actively participate in the program content and, as a result, create shared ownership for program success from the beginning. Regularly scheduled meetings were also held to evaluate care coordination activities and make modifications when needed.

Last, but not certainly the least, is communication, a process that cannot be underestimated or be overdone. Our communication linkages were numerous and diverse and included various health plan departments, medical director leadership, contracted care facilities, and physician groups. Initial communication introduced admission criteria, contact information for key health plan, and geropsychiatric unit staff and crucial program components. As admissions occurred, our COC SW CM also attended the weekly interdisciplinary team meetings to obtain clinical updates and discuss discharge-planning needs. As mentioned previously, many of these patients required an alternate living arrangement upon discharge, so communication regarding patient’s care transition back to the community was critical for the outpatient portion of program adherence.

Clearly, care transitions as the name implies, requires true collaboration in care coordination and constant communication to ensure success. With a strong focus on each of these constructs, we were able to overcome departmental and organizational barriers, strengthen internal and external partnerships, and implement a care-effective and cost-effective program.

**Pilot Program Containment**

Although the health plan has multiple contracts for geropsychiatric services, we opted to limit our pilot to one facility that had both an ED and inpatient unit. This allowed us to tightly manage utilization and to ensure that admissions were consistently meeting the “all inclusive” criteria. Containing the pilot to one geropsychiatric unit also afforded the health plan CM time to attend on-site interdisciplinary rounds and patient/family conferences. Having our health plan CM assume such an active role in the discharge planning was great for staff unit morale and for building a positive relationship between the two entities.

**Interorganizational Delineation of Duties**

As discussed earlier, the pilot program was a collaborative effort between many departments and across several organizations. To clarify roles and responsibilities for each stakeholder, we developed a “delineation of duties.” This document listed each care management activity and identified who had primary/shared accountability to complete an individual task. Committing this to writing helped tremendously in the early days of the project to clarify roles and redirect staff questions or concerns. Overtime, the delineation of duties needed to be revised; yet, it still remains one of the important case management tools for managing this “sensitive” care transition program.

**SUMMARY**

In closing, our pilot program was predicated on the belief that the traditional methods of managing health plan members with dementia-related behavioral issues were ineffective. This belief, coupled with our thinking “outside the box,” provided us the motivation for creating a collaborative pilot program with a focus on patient-centered care at the forefront. The initial dramatic outcomes realized by this pilot program resulted in the development and approval of a health plan standard operating procedure in September of 2006. We have subsequently expanded our program’s geropsychiatric inpatient network to include two freestanding facilities. Our thought process in extending the network was to admit our members to the least restrictive environment whenever possible. Patients that required no medical treatments, such as intravenous fluids or ongoing physical or occupational therapy, could be directed to a freestanding facility as opposed to the more sterile and institutional setting of the hospital unit. This revision to the program has resulted in further improvement to our member and caregiver satisfaction and has also increased our cost savings associated with these contracted facilities. In the Las Vegas community, this program has established the health plan as a well-respected authority in the geropsychiatric treatment realm. Today, we continue to be recognized for our innovation and quality of care in the care management of these most unfortunate plan members and families.

Ellen Aliberti, RN, CCM, MS, is a seasoned managed care leader, who has more than 25 years of case management experience within managed care organizations. She has an extensive background in clinical process improvement and has led many interdisciplinary teams focused on developing programs and
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