Psychiatric Care of Homebound Elders

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Numbers

- 3.6 million people in the USA age 65 and older are housebound
Epidemiology of Homebound Elderly

- From the Epidemiologic Catchment Area (ECA) study at the New Haven site it was found that almost 30% of the 2,553 elders, or 742 individuals were homebound.
- Psychiatric disorders were higher among elders who report being confined to their home than other elders living in the community, 30% versus 16%, six-month prevalence.
- The most common disorder among the homebound, confined to a bed or chair was cognitive impairment (21.8%), followed by anxiety disorders (9.3%), and affective disorders (2.3%).
- The homebound are more disadvantaged in terms of their physical and socioeconomic functioning than other non-institutionalized elderly.
- The higher rates of disorders among the homebound were consistent with and could be accounted for by their greater physical health problems and, to a lesser degree, their disadvantaged socioeconomic functioning.
Comparison with Non-Homebound

Table 1. Prevalence of Physical and Mental Illnesses in the Homebound Population (Nutrition, Aging, and Memory in Elders (NAME) Study) and Non-Homebound (Framingham Study) Populations

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>NAME Study (Homebound)</th>
<th>Framingham Study (Non-Homebound)</th>
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<tbody>
<tr>
<td>Age, mean ± standard deviation</td>
<td>76.2 ± 8.4^2</td>
<td>76.6 ± 6.0^46</td>
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<tr>
<td>Diabetes mellitus, %</td>
<td>39.0^2</td>
<td>11.4^46</td>
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<tr>
<td>Stroke, %</td>
<td>21.0^2</td>
<td>1.7^46</td>
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<tr>
<td>Hypertension, %</td>
<td>92.0^2</td>
<td>41.1^46</td>
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<tr>
<td>Cardiovascular disease, %</td>
<td>42.5^23</td>
<td>23.6^47</td>
</tr>
<tr>
<td>Body mass index, mean</td>
<td>31.0^2</td>
<td>27.2^48</td>
</tr>
<tr>
<td>Dementia (including Alzheimer's disease), %</td>
<td>31.4^2</td>
<td>0.3^46</td>
</tr>
<tr>
<td>Mild cognitive impairment, %</td>
<td>34.3^2</td>
<td>24^46</td>
</tr>
<tr>
<td>Depression, %</td>
<td>30.0^2</td>
<td>9.4^47</td>
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Impact of Homebound Status

- Cross National Israel Survey of the elderly
- Homebound participants had a significantly higher risk of mortality than their non-homebound counterparts, after controlling for background variables, health, and function.
- Homebound status was related to depressed affect even after controlling for demographics, health, and function.
- In longitudinal analysis, homebound status predicted future depressed affect and ADL and IADL difficulties when controlling for demographics and health,
  - Only IADL prediction was statistically significant when baseline levels of the outcome variable were entered into the regression.
Advantages of In-Home Psychiatric Care

- Psychiatric care in the home implies greater autonomy and control for the patient, especially compared with the alternative of institutional care.
- It is desirable for the patient to remain in the home, as abrupt dislocation may increase the risk of illness and death.
- The cognitively impaired face an additional risk for confusion and falls, due to the lack of their normal environmental cues for orientation and safe ambulation.
Advantages for Evaluation and Treatment

- The clinician has an opportunity to view the patient's home surroundings and the social network engaged in the patient's ongoing care.
  - Reduces the need to rely on second hand history.
- Provides an opportunity to directly observe and measure ADLs and I-ADLs.
  - Including home maintenance, medication compliance, and nutrition.
  - Incontinence, which may be minimized in an interview, may be evident in the home.
- An initial contact in the home allows establishment of rapport in surroundings familiar to the patient.
- Most importantly such assessments allow direct and immediate intervention in emergencies.
Other Benefits of In-Home Care

- The possibility of home management of the non-responder to inpatient treatment.
- The home environment may also facilitate family therapy and an opportunity to address neglected medical problems, as well as provide training and educational opportunities.
- Mobile teams are excellent resources to train students in the health and human service professions, who then later contribute to care delivery.
Potential Economic Benefits of In-Home Treatment

- Numerous studies have been published on home treatment and assertive case management for the chronically mentally ill non-geriatric population.
  - While most of these studies have demonstrated a reduction in psychiatric hospitalizations, reduced hospital lengths of stay, greater stability of the mental disorder, and improved overall functioning, it is not known whether such an approach actually saves total health care costs.
Economic Benefits to Treat Elderly at Home

- Several in-home psychiatric treatment programs for the elderly have claimed economic efficiency.
  - Without providing data or a description of the program, an elderly outreach program in Iowa provided mental health services at one-half the cost of private practice.
  - Other studies have demonstrated that home management may reduce psychiatric hospitalizations by as much as 60%.
  - Reductions in mortality rates also have been demonstrated.
  - Home care visits even by non-physicians have been demonstrated to improve the cognitive functioning of the elderly and to lower the risk for assisted living facilities.

- This suggests that treatment in the home also may reduce medical costs and medical hospitalizations, in addition to psychiatric morbidity.
Elderly that Can Benefit from in Home Psychiatric Care

- The elderly mentally ill population that can potentially benefit from psychiatric care in the home is not homogeneous, but can be divided into four groups:
  - 1) Those who are homebound for psychiatric reasons.
  - 2) Those who are homebound as a result of medical problems.
  - 3) Those who are homebound for both psychiatric and medical reasons.
  - 4) Those who are not homebound, but are non-compliant with follow-up or will not go to traditional psychiatric settings.

- The degree of homeboundness among this population varies from being entirely homebound to those who go out frequently.
Morgan & Wieman Classification

- Alternative classification of geriatric patients who benefit from psychiatric home visits:
  - 1) Those who are fully homebound requiring both medical care and sustenance at home.
  - 2) Those who are partially homebound and go out for either medical care or sustenance, while receiving other services at home.
  - 3) Those who go out for both medical care and sustenance.

- They found that the elderly mentally ill requiring home visits were equally divided among these three groups.
Models of Delivering Mobile Psychiatric Care to the Elderly

- The unifying themes of these models:
  - Reliance on the home visit.
  - The goal of maintaining the patient in the community.
  - Providing evaluations.
  - Initiating appropriate treatment and support services.
Crisis Team

- Such a team provides assessment, referral, and possibly acute management in the home.
- These teams often consist of a psychiatric nurse, social worker, psychiatrist, mental health aides, and sometimes a psychologist.
- The crisis team may hospitalize or treat until conventional outpatient treatment can be established.
  - Rarely provides case management or long-term follow-up in the home.
- This approach is reactive rather than preventive.
  - Unlikely to reduce cost or institutionalization in the long run.
- Ill equipped to deal with the comorbid medical conditions found in the geriatric population.
Mobile Mental Health Team without a Psychiatrist

- These programs provide psychosocial and environmental assessment and intervention, and case management.
- The staff includes geriatric specialists, social workers, psychologists, mental health aides, and often psychiatric nurses.
- Some of these programs have an explicitly anti-psychopharmacological bias, which may be due to the practical difficulties in monitoring drug treatment when there is no physician on the team.
  - Another explanation may be a belief that elderly patients are unreliable in taking medications, so the risk of giving psychopharmacological agents to mentally and medically compromised individuals in an unsupervised setting is unacceptably high.
Mobile Psychiatric Team without General Medical Backup

- This type of program is similar to the one just discussed, except that a psychiatric consultant is available.
  - The consultant, however, does not necessarily do house calls with the team on a routine basis.
  - This service delivery approach is common among community mental health centers and usually is oriented toward chronically mentally ill persons of varying ages.

- These teams hesitate to provide psychopharmacological intervention, even when a psychiatrist has done an assessment in the home.
  - As these programs do not include a geriatric medicine practitioner, they may be uneasy about drug-drug and drug-disease interaction.
  - In a review of such a program, only two of 26 active patients with major depression received pharmacological treatment.
    » The lack of drug treatment was based on the team's concern that it would be unsafe, given the severity of the patient's medical problems.
  - The geriatric patients who do receive psychopharmacological intervention in programs with this model frequently are chronically mentally ill individuals well known to the mental health system.
Medical Mobile Team

- These teams are run by primary care physicians, general practitioners, internists, or nurse practitioners.
  - They usually include medically oriented nurses, social workers, and geriatric specialists.

- The psychiatrist, if included, acts as a consultant, doing assessments and acute, but not long-term, management.

- These programs often screen and refer individuals with mental illness elsewhere.

- This model is typical of many visiting nurse services.
Multidisciplinary Psychiatric Mobile Team I

- These programs offer the most comprehensive services; they are literally "clinics on wheels".
  - The clinic on wheels can provide assessment, acute intervention, as well as case management.
  - Some are also able to provide crisis intervention, and, if needed, long-term treatment, while others refer emergencies to a crisis team or a psychiatric hospital.

- Such teams are comfortable using psychopharmacological agents in addition to psychotherapy, and can address both the medical and the psychiatric needs of the homebound population.
  - The team encourages individuals who are not medically homebound and whose psychiatric problems are stable to obtain traditional psychiatric outpatient services.
  - Teams can offer medical follow-up to those patients who are noncompliant with outpatient primary care and monitor medication compliance by regular physical examinations, EKGs, and blood tests.
Multidisciplinary Psychiatric Mobile Team II

- These multidisciplinary teams include a psychiatrist, an internist, social workers, mental health aides, and often a geriatric specialist, nurse, and an occupational/physical therapist.

- The psychiatrist evaluates every patient enrolled in the program and schedules routine follow-up visits in the home.

- The social worker provides individual and family psychotherapy to those who could benefit, as well as case management.

- Such comprehensive programs often can treat individuals who otherwise would have required acute psychiatric hospitalization, as well as provide preventive mental health care.
Medicare Guidelines for Psychiatric Homecare I

- Current Medicare guidelines would exclude many individuals who may benefit from in-home psychiatric care.
- Medicare requires that the elderly client be suffering from a diagnosed psychiatric disorder that necessitates active treatment in an institution.
  - Thus, the focus of treatment is primarily on acute exacerbations and not on chronic problems or maintenance treatment, unless there continues to be a continued skilled need.
- Medicare stipulates that the client be homebound, thereby excluding those who may need services because they are non-compliant with treatment or follow-up in the traditional setting.
Medicare Guidelines for Psychiatric Homecare II

- Have an Axis I Major psychiatric diagnosis and have one of the following:
  - Discharge from a psychiatric facility
  - A recent crisis or suicide attempt
  - An exacerbation of psychiatric symptoms
  - A sudden change in behavior
  - The need for Decanoate injections
  - A new or changes medication regime that must be monitored closely
  - A recent diagnosis of a psychiatric disorder

- Require skilled, intermittent services

- Requires care which is reasonable and necessary to the treatment of the illness

- Be under the care of a physician (psychiatrist or medical physician)

- Be homebound

- A reasonable expectation must exist that goals will be achieved
Availability of Psychiatric Homecare

- Unfortunately, comprehensive mental health programs cannot be implemented in many states due to restrictive regulations for eligibility for home health aide or homemaker services.

- Services such as light housekeeping, shopping, meal preparation, laundry and personal care assistance often are essential to maintain the elderly at home.

- At times, 24-hour home care is necessary.

- Private home care agencies are a growing industry filling part of the void left by the lack of state-funded services, but for many individuals with mental illness these private agencies are not affordable.
Programs to Assist States in Providing Home Health Services

- Title XVII of the Social Security Act has provisions for short-term home health care under Medicare for the disabled and persons 65+.
- For those who are indigent, Medicaid assists in providing home health care and adult day care under title XIX of the Social Security Act.
- States may provide personal home care through the Supplemental Security Income Program for indigent disabled and those aged 65+.
- The Social Service Block Grant assists states in providing home delivered meals and homemakers for people with incomes up to 115% of the state's median income.
- Title III under the Older Americans Act provides for home delivered meals, home health care, chore services, and friendly visiting for persons over age 60.
- The Older Americans Act allows a broader range of elderly individuals to receive homecare services.
- The degree to which each state offers benefits to its elderly population varies under these programs.
Many states no longer include dementia among the mental disorders eligible for psychiatric services, as it does not fall under the domain of their Department of Mental Health.

- Although most states claim to offer treatment for dementias with behavioral complications, their reluctance to manage uncomplicated cases may result in reduced access for those with associated behavioral problems.

Individuals with dementia or cognitive deficits and secondary behavioral problems, and who may require assessment as well as psychopharmacological management, are among those who could benefit from home psychiatric home visits.
Mental Health Services in Homecare and Home Nursing Agencies in Rhode Island

- Of the 54 agencies that were contacted, 53 responded to the survey.
  - 18 homecare agencies and 35 nursing agencies.

- The facilities were asked what they did when they identified one of their patients as having a psychiatric problem?
  - Of the nursing and home care agencies interviewed, 25.7% and 27.8% respectively said they would refer the individual to their primary care physician.
  - Referrals to a mental health specialist: 44.3% of nursing agencies and 33.4% of homecare agencies.
  - The remainder of the facilities stated that they would refer the client with psychiatric problems to either a social service agency or simply notify the family.
Mental Health Services in Homecare and Home Nursing Agencies in Rhode Island II

- Only a small percentage, 25.7% of the nursing agencies and 22.2% of the homecare agencies reported that they themselves could provide some sort of mental health services to individuals identified who needed assistance and treatment.

  - Only 22.9% of nursing agencies reported having a psychiatric nurse on staff.
Mental Health Services in Homecare and Home Nursing Agencies in Rhode Island

To clarify the issue regarding what actions agencies took with individuals identified with mental health problems, they were asked more specifically if they would refer to a psychiatrist or mental health clinic.

- 40% of the nursing agencies and 44.4% of the home care agencies stated that they would not.
- One-fifth of the nursing agencies were able to identify a particular psychiatrist who manages their patients.
- Only one of the homecare agencies identified a psychiatrist who works with their clients.

  » Of the psychiatrists who work with these agencies, 44.4% provided follow-up and not just a one-time consultation; and only three of the nine psychiatrists identified, conduct house calls.
  » In addition, only one-third of these psychiatrists provided consultation to the nursing staff over the telephone.
Mental Health Services in Homecare and Home Nursing Agencies in Rhode Island IV

As the patients seen by these agencies were homebound and frequently unable to arrange their own transportation, the question of access and accessibility to home care agencies was also investigated.

- Most of the nursing agencies (57.1%) and one-third of the home care agencies reported they would help arrange transportation for their patients to see their psychiatrist.
Many of the agencies will not accept clients with a primary identified psychiatric problem (55.6% of the nursing agencies and 54.3% of the homecare agencies).

- There is however, a distinction made by many of the agencies with dementia and a psychiatric problem.

Almost seventy-nine percent of the agencies did not consider dementia to be a psychiatric problem.

- When behavioral problems, such as yelling, hitting and other forms of agitation appeared in the clients, 28.6% of the nursing and 27.8% of the home care agencies would refer the individual to a primary care physician.
  
  » Of the nursing agencies (25.8%) and only 5.6% of the home care agencies would refer such individuals to a mental health specialist.
  
  » Twenty percent (20%) of the nursing agencies and 50% of the homecare agencies basically would notify family members to take care of the problems.

» The remainder of the agencies would refer to social service agencies.
Mental Health Services in Homecare and Home Nursing Agencies in Rhode Island

- If dementia was suspected for the first time in an individual and not previously diagnosed, most of the nursing agencies would refer to a mental health specialist.
  - 45.7% to a psychiatric nurse, 5.7% to a mental health center; 27.8% of the homecare agencies would recommend referrals to a psychiatric nurse.
  - The primary care physician was seldom used (2.9% of the nursing agencies and 5.6% of the homecare agencies).
  - A sizable percentage of the agencies stated they would take no action (31.4% nursing and 38.9% homecare).
  - The remainder would notify family members or social services agencies about their concerns.
Depression in Homebound Elders

- Depression increases the risk for hospitalizations
- Depression increases risk for falls
- Homecare nurses need to be trained in identifying depression
  - Home health nurses have difficulty making accurate assessments of depression among older home care patients. Inaccuracy in assessment of depression by home health nurses is a significant barrier to treatment in this elderly homebound population.
  - Training can improve referrals and care
  - Often vital clinical information is missing during the transfer from
Predictors of Depression

- 10% develop in one year new onset depression
- In a multivariate analyses factors were associated with onset of depression
  - worse self-rated health
  - more somatic depressive symptoms
  - greater number of activities of daily living
  - greater decline in ADL functioning from baseline to 1 year
Cognitive Impairment

- Rates of undetected cognitive impairment is high
- Non-detection was as high as 17%
- Caregiver burden
  - Most caregivers want the person to remain at home
### Ethical Issues

**Table 3. Common Ethical Challenges Encountered in Mobile Psychiatric Treatment of Homebound Elderly Patients**

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<tr>
<th>Ethical Challenge</th>
<th>Clinical Example</th>
<th>Approach to Resolution</th>
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<tr>
<td>Establishing the treatment contract versus the right to refuse treatment</td>
<td>Uncooperative manic or paranoid patient who is refusing evaluation, noncompliant with medications, and wandering the streets</td>
<td>Assess safety &lt;br&gt;Rapidly collect further information &lt;br&gt;Assess decisional capacity &lt;br&gt;Consider emergency petition</td>
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<td>Protecting confidentiality versus patient protection</td>
<td>Patient with personality disorder, gross neglect of personal/apartment hygiene, leading to neighbors inquiring of treatment team about progress</td>
<td>Maximize discretion in visibility of home visits &lt;br&gt;Do not disclose personal information &lt;br&gt;Encourage neighbors to take a pragmatic, problem-solving approach, rather than an adversarial one</td>
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<tr>
<td>Protecting autonomy versus asserting beneficence</td>
<td>Patient with chronic schizophrenia and long-standing desire to live independently, now unable to safely manage medications</td>
<td>Explore options for supervising medication administration at home &lt;br&gt;Consider patient preference in choosing new living arrangement</td>
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<td>Treatment termination versus open-ended treatment</td>
<td>Alcohol-dependent patient repeatedly refusing to engage in alcohol treatment</td>
<td>Assess commitment to treatment &lt;br&gt;Explain treatment options as well as consequences of not engaging in treatment &lt;br&gt;Assess safety &lt;br&gt;Provide contact information for alcohol treatment programs &lt;br&gt;Consider discharge from mobile treatment</td>
</tr>
<tr>
<td>Cost versus benefit of care</td>
<td>Medically complex and illiterate patient with depression, mild cognitive impairment, and no family involvement, requiring weekly visits for a year</td>
<td>Assess patient needs and available resources &lt;br&gt;Maximize patient enrollment in available social service programs &lt;br&gt;Recall that ideal care may be expensive and that investing heavily in supportive living now may produce large monetary savings later &lt;br&gt;Enroll patient in program that provides broad range of services and not only billable ones</td>
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