Caring for Our Dual-Eligibles

The Vital Role of Home and Community Based Services

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Partners in Care Foundation
Annual Case Management Conference

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Agenda

- Key Characteristics of the Dual Eligibles
- What are their service use/spending patterns?
  - How community organizations can address and improve health outcomes and costs
  - Separate strategies for LTSS impacting Medicare and Medi-Cal service use
  - Home & Community Services Network

Reality

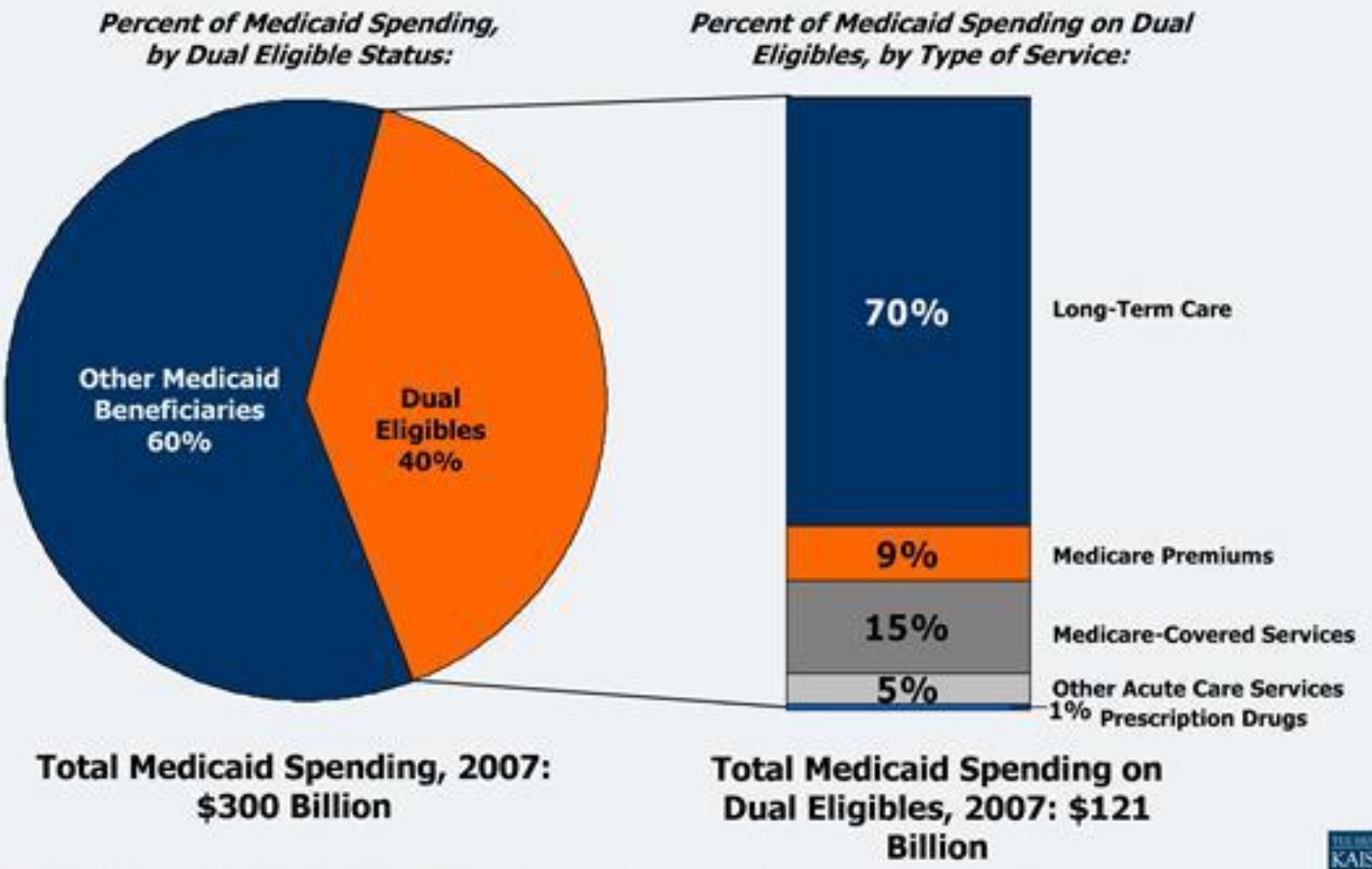
Without major changes in the way the U.S. pays for and delivers health care, total national health spending is projected to rise to $4.6 trillion—or nearly 20 percent of GDP—by 2020.

Centers for Medicaid & Medicare Services: Projections based on National Health Expenditures (January 2011)

Root Causes of Current Crisis

- Fragmentation
- Communication
- Financial Silos
- Turf
- Unclear provider/patient/family roles and responsibilities

Medicaid Expenditures for Dual Eligibles, 2007



SOURCE: Urban Institute analysis of data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

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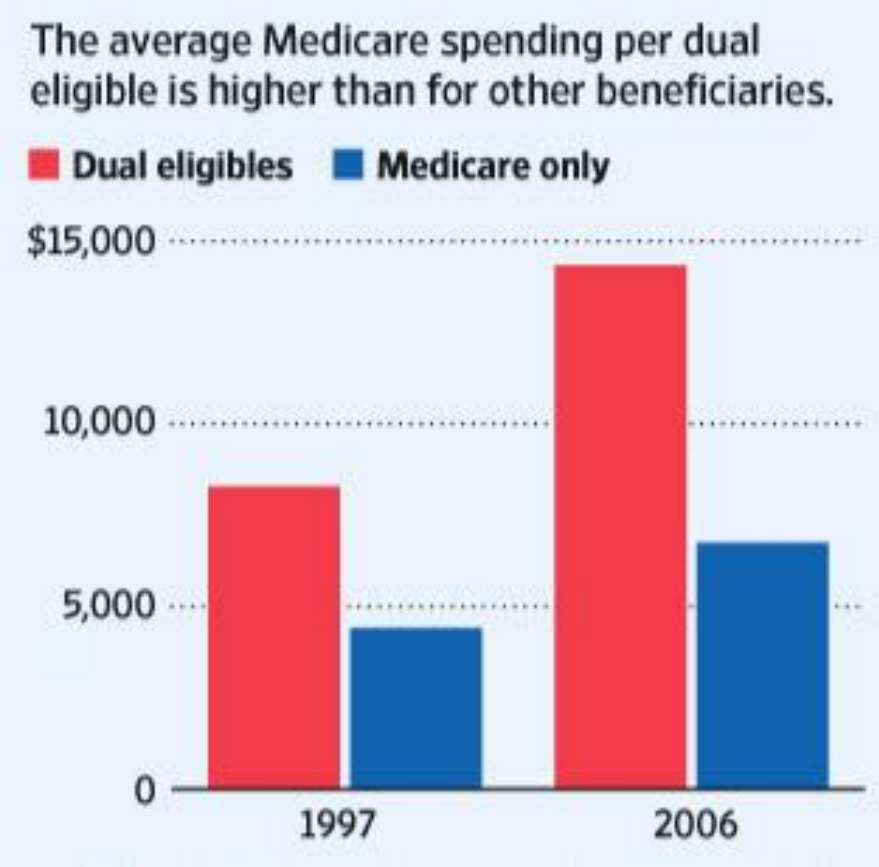
Duals Demonstration Project – New Arenas of Capitation

- Total financial responsibility for the full continuum of Medicare and Medi-Cal services will now include:
  - medical care
  - behavioral health services, and
  - long-term services and supports (LTSS):
    - In-Home Supportive Services (IHSS)
    - Community-Based Adult Services (CBAS)
    - Multipurpose Senior Services Program (MSSP)
    - Skilled nursing facilities
- Social supports help dual eligible beneficiaries maintain health and live at home as long as possible

What is Long Term Care?

- Encompasses a wide array of medicine, social, personal and supportive and specialized housing services
- Social and environmental factors are crucial to determining full positive impact of medicine
- Needed by people who have lost some capacity for self-care
- Care at home or in a nursing home
- Most who need LTC are over age 76 (63%)

America's Dual Eligibles



Sources: Centers for Medicare and Medicaid Services; Kaiser Family Foundation, Medicare Payment Advisory Commission

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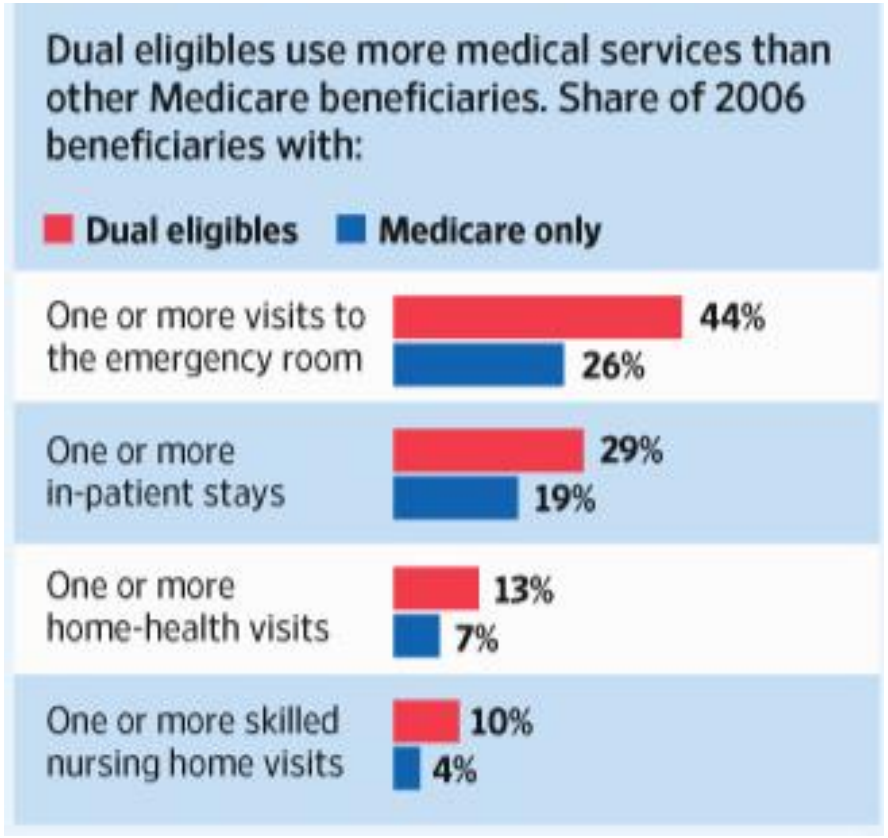
Why the Costs are so High

- For Medicare the reason for high costs among duals is the **elevated need for acute care** resulting from increased prevalence of chronic disease associated with age, disability, poverty and **need for innovations in care and self-care**
- Medical interventions alone are not enough
- With targeted evidence-based interventions at home, much better results can be achieved

America's Dual Eligibles



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How Home and Community Services Address and Improve Health Outcomes

- Gaps in care, lack of coordination/communication
- Multiple, complex chronic conditions
  - Evidence-based enhanced self-care programs (e.g, Chronic Disease Self Management (CDSMP), Diabetes Self Management (DSMP)
- Complex medications/adherence (HomeMeds℠)
- Multiple ER visits/avoidable hospitalizations
- Post-hospital support to avoid readmissions
- Nursing home diversion/return to community
- In-home palliative care in last year of life

How to Best Care for the Duals to Achieve Optimal Health Outcomes

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The Triple Aim for Improvement

- Improving the individual experience of care
- Improving the health of the population
- Reducing the per capita costs of care

Dr. Donald Berwick- 2008

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Hot Spotting

- **High costs come from specific target groups, where the investment of a new intervention yields better health and quality of life outcomes while driving down costs**
- Target Medi-Cal, keeping people out of nursing homes and……
- Impact Medicare more directly by reducing ER, hospital admissions and readmissions

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Medicare Hotspotting

- Target evidence-based interventions to high risk patients with resolvable issues:
  - HomeMeds
  - In-Home Care Coordination to address basic needs
  - Post-hospital coaching
  - Nursing home diversion
  - In-Home Palliative Care

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Medi-Cal Hotspotting

- Community based services network to reduce isolation, assure access to physician, food, transportation, personal care, safe setting
- In-home care coordination for high risk of decline – ongoing supports:
  - In Home Supportive Services (IHSS); CBAS (community based adult services – was ADHC)
  - -- MSSP – avoid nursing home; delay nursing home
  - --In-home palliative/Hospice

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Functional decline drives dependence

- Comprehensive in-home “eyes and ears” for medical team identifies key areas of risk that can lead to health decline, medical emergency or other crises
- Addressing these can stabilize and prevent decline
- Services may include environmental modification to support in face of frailty

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Fragmented Community Services

- Area Agencies on Aging/ senior centers and core services
- Caregiver Resources Centers
- In-home Supportive Services (IHSS)
- Adult day health/Community-Based Adult Services (CBAS)
- MSSP – nursing home diversion

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Community Care Approaches at Home

- Care at home can sustain independence
- Comprehensive in-home assessment identifies risks, basis to craft and in-home careplan
- Currently MSSP offers County-wide coverage
- Credentialed, contracted purchase system for in-home care/environmental modification

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Activities of Daily Living (ADLs)

- Personal care activities people engage in every day
- Fundamental to caring for oneself to maintain personal independence
- Assessment determines level of care/ assistance needed
- Certifies LTC level of care/payment level

ADL Functions

- ADL Functions
  - Bathing
  - Dressing
  - Grooming
  - Mouth care
  - Toileting
  - Transferring bed/chair
  - Climbing stairs
  - Eating

Each function is rated to determine level of support required:

-INDEPENDENT

-NEEDS SOME HELP

-VERY DEPENDENT

-CANNOT DO

Instrumental Activities of Daily Living (IADLs)

- Related to independent living
- Valuable for evaluating level of disease
- Determinant of person's ability to care for themselves and their environment

IADL Functions

- IADL Functions
  - Shopping
  - Cooking
  - Managing medications
  - Using the phone and looking up phone numbers
  - Doing housework
  - Doing laundry
  - Driving or using public transportation
  - Managing finances

Each function is rated to determine level of support required:

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Home and Community Network Services Model

Purchased Services
(Credentialed Vendors)

- Safety devices, e.g., grab bars, w/c ramps, alarms
- Home handyman
- Emergency response systems
- In-home psychotherapy
- Emergency support (housing, meals, care)
- Assisted transportation
- Home maker (personal care /chore) and respite services
- Replace furniture /appliances for safety/sanitary reasons
- Heavy cleaning
- Home-delivered meals – short term
- Medication management (HomeMeds)
- Special needs required to maintain independence

Referred Services

- AAA
- IHSS
- Community Based Adult Services (formerly Adult Day Health Center)
- Regional Center
- Independent Living Centers
- Home Health
- In-Home Palliative Care
- Hospice
- DME
- Families / Caregivers Support Programs
- Senior Center Programs
- Evidence-based Health Impacting Self-Care programs
- Long-term home-delivered meals
- Housing Options
- Communication Services
- Legal Services
- HICAP
- Ombudsman
- Benefits Enrollment for services (ie food stamps)
- Money management
- Transportation
- Utilities
- Volunteer services

Area Agencies on Aging and Sponsors of MSSP Offer Best Strengths

- Area Agencies on Aging – crucial safety net
- MSSP sponsors can evolve expanded home care expertise
- Scaling up from solid base and clinical infrastructure safer than “reinventing”
- Scaling best led by neutral community player, not health care entity
- Partners in Care and AAAs offer best base

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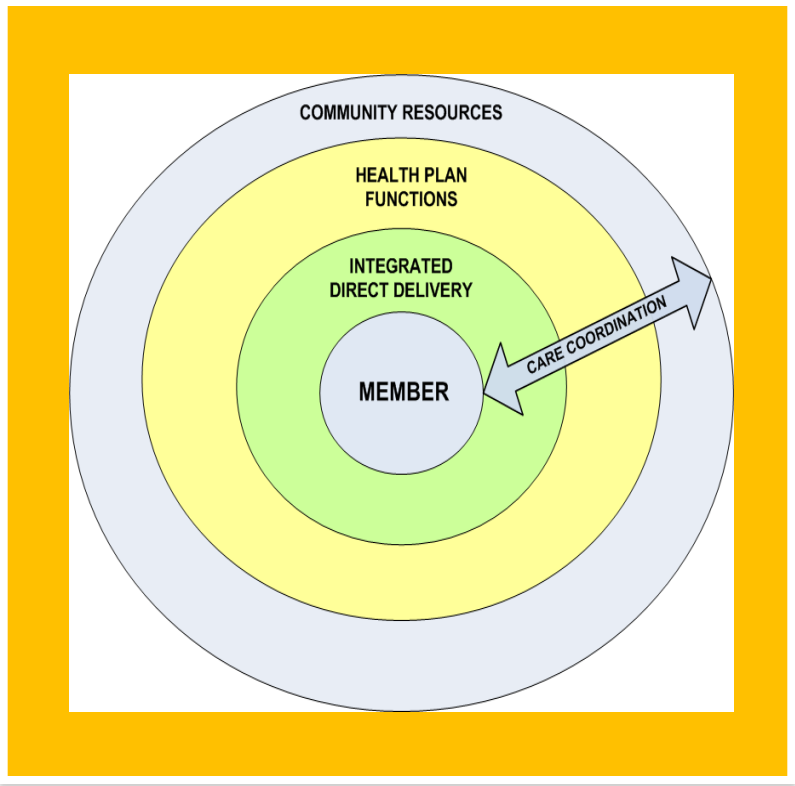
Home and Community Services Network - Key Elements

- Full geographic coverage of L.A. County - one portal for all
- Credentialed contractors for purchase of home and community-based services and personal care
- Common data system
- Strong business case – CM on pmpm + purchase services
- MSSP model is prototype
  - Build on base of 3,400 clients/170 care coordination staff – RNs and Social Workers in 7 locations-
  - Cost effective, proven, and uniform model of care
- Arrange and purchase services on fixed budget/contracts
- Tiered in-home care management models possible

How We Work Together

- Home and Community Services Network
  - A proposed model for purchase of services care coordination through a central portal
- Key Elements:
  - Contracted networks and linked partnerships
  - County-wide Community Care Management
  - Administrative simplicity with full access to both arrange and purchase credentialed community care resources

Together – We Can Manage the Duals



Health Plan Functions

- Enrollment and disenrollment/UM & CM
- Claims and Data Analysis
- Coordinating Medicare & Medicaid

Integrated Direct Delivery

- Different facility needs – primary care clinic integrated with behavioral health institution
- Coordination of referrals, appointments, care mgmt., clinical best practices, staff, clinical records
- Clinical integration with health plans/community

Community Resources

- Care coordination/in-home support
- Access to Public benefits/IHSS/CBAS
- Transportation, food assistance, housing
- EB Targets -- meds /palliative /coaching /self-care

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The Time is Now

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