

# Dual Eligibles – Nuts and Bolts

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April 27, 2013  
CALTCM 39<sup>TH</sup> Annual Meeting

# Disclosure

I have no relevant financial relationships with commercial interests to disclose.

# Learning Objectives

At the end of this program participants will be able to:

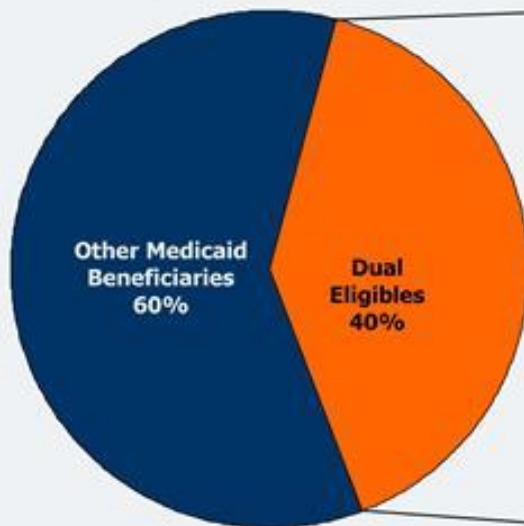
- Describe one payment shift for Medicare and Medi-Cal, both medical and long term care and Long Term Supports and services
- Describe three elements of the standing programs serving frail older adults who are moving under managed care
- Describe two key components in assessment and the resulting care plan for home and community benefits to remain independent, living at home with services

# Agenda

- Key Characteristics of the Dual Eligibles
- Service utilization and expense patterns
  - The role community organizations have in addressing and improving health outcomes and cost
  - Separate strategies for LTSS impacting Medicare and Medi-Cal service use
  - Home & Community Services Network

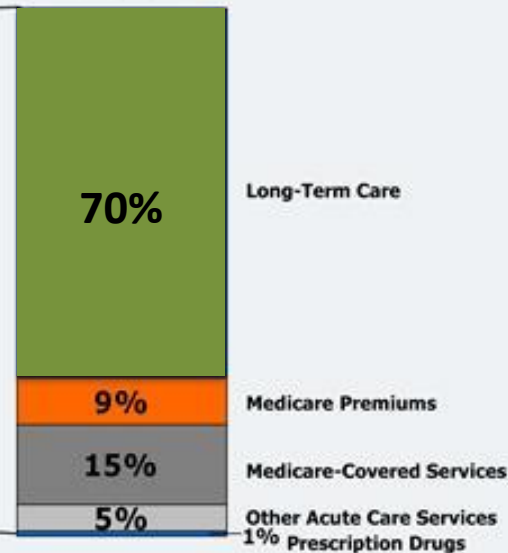
# Medicaid Expenditures for Dual Eligibles, 2007

*Percent of Medicaid Spending, by Dual Eligible Status:*



**Total Medicaid Spending, 2007:  
\$300 Billion**

*Percent of Medicaid Spending on Dual Eligibles, by Type of Service:*



**Total Medicaid Spending on  
Dual Eligibles, 2007: \$121  
Billion**

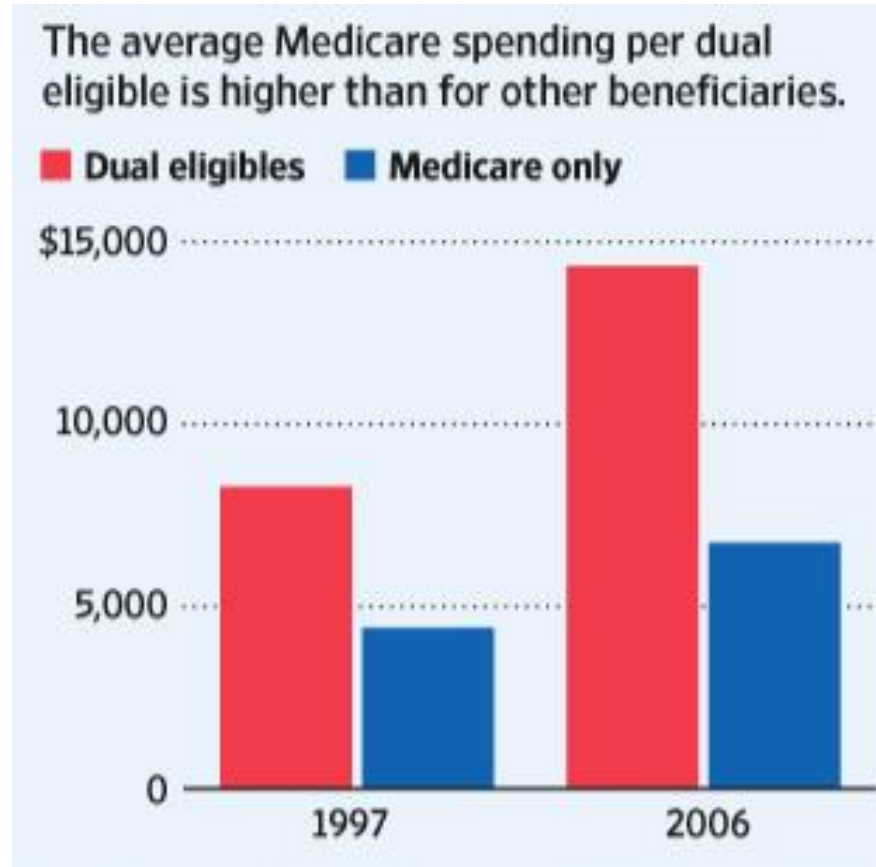
SOURCE: Urban Institute analysis of data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.



# Duals Demonstration Project – How the Risk Will Shift

- 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)
    - Nursing facilities when needed
- Social supports help dual eligible beneficiaries maintain their health and live at home as long as possible

# America's Dual Eligibles



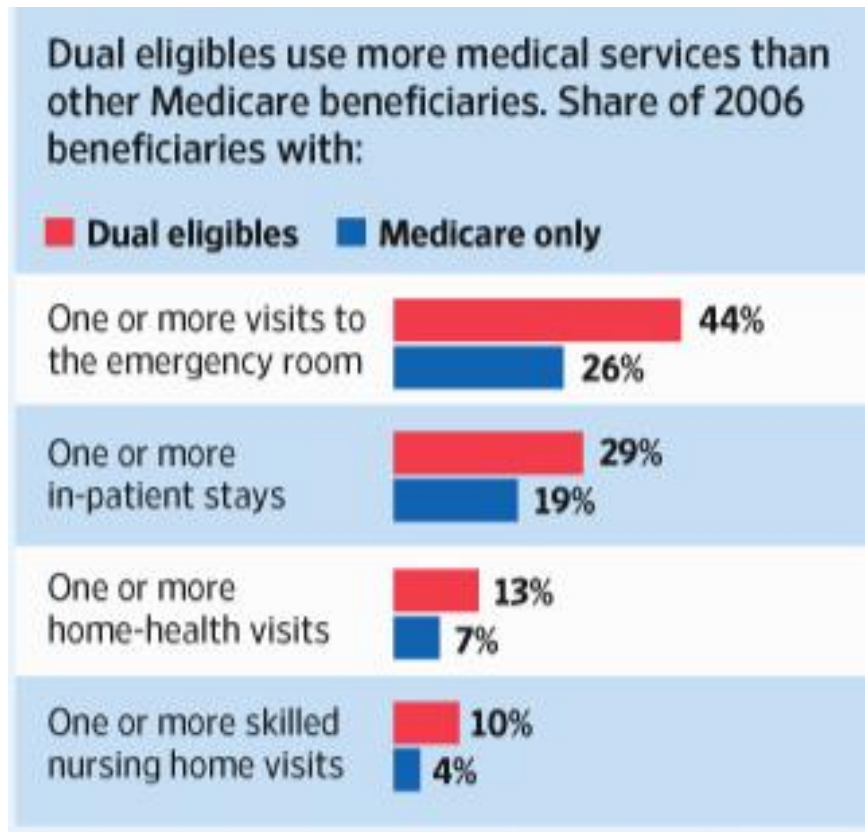
Sources: Centers for Medicare and Medicaid Services; Kaiser Family Foundation, Medicare Payment Advisory Commission

# 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



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

# America's Dual Eligibles

Many hospitalizations of dual eligibles are potentially avoidable, one study showed.

**Total hospitalizations for dual eligibles, 2005**  
**958,837**

Potentially avoidable hospitalizations

**382,846, 40%**



## For potentially avoidable hospitalizations

Average length of stay

**6.7 days**

Average cost to Medicare

**\$7,846**

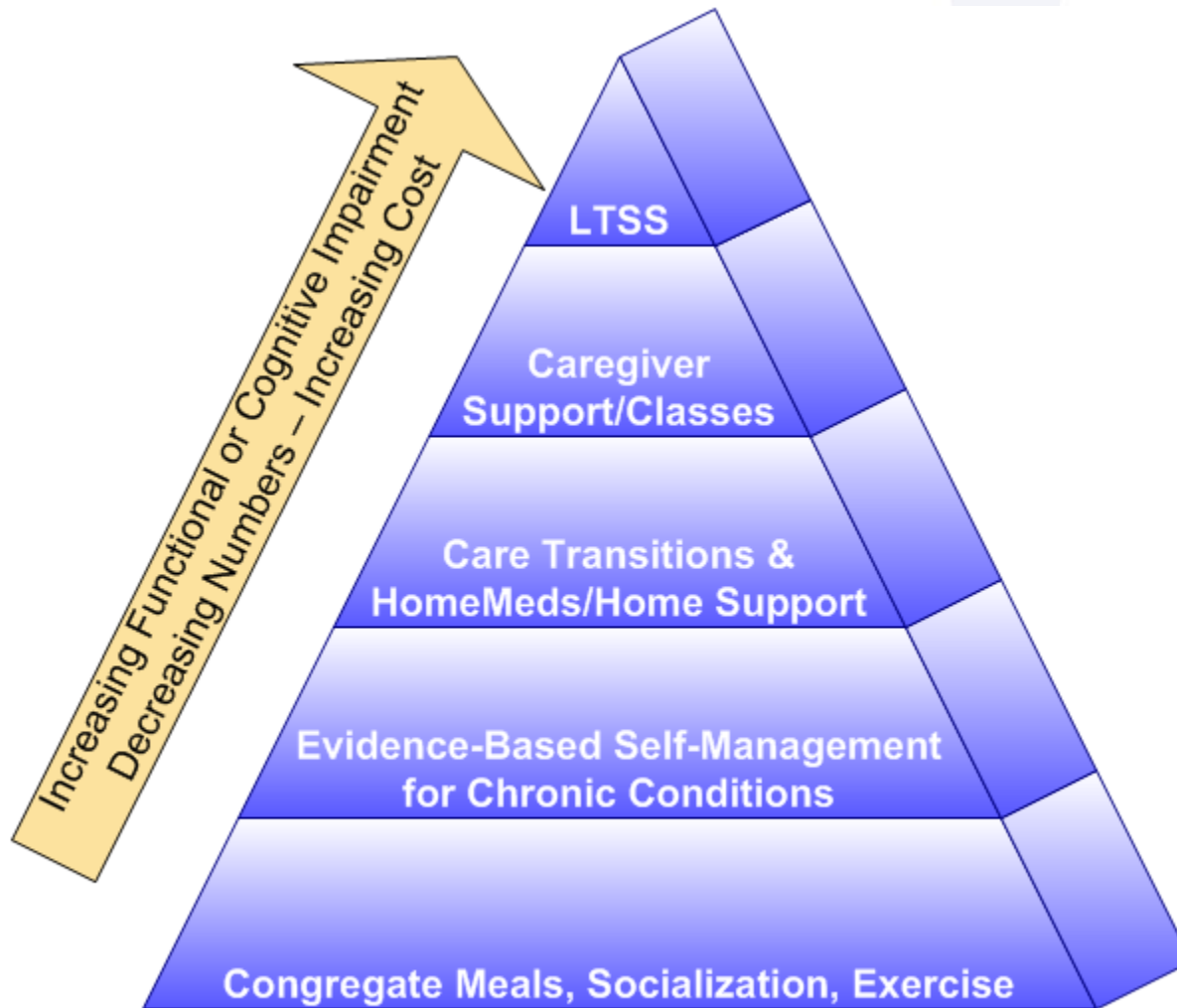
Average cost to Medicaid

**\$321**

# How Home and Community Services Address and Improve Health Outcomes

- 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<sup>SM</sup>)
- Multiple ER visits – gaps in care/communication
- Post-hospital support to avoid readmissions
- Nursing home diversion/return to community
- In-home palliative care in last year of life

# Stratify Services for Increasing Needs

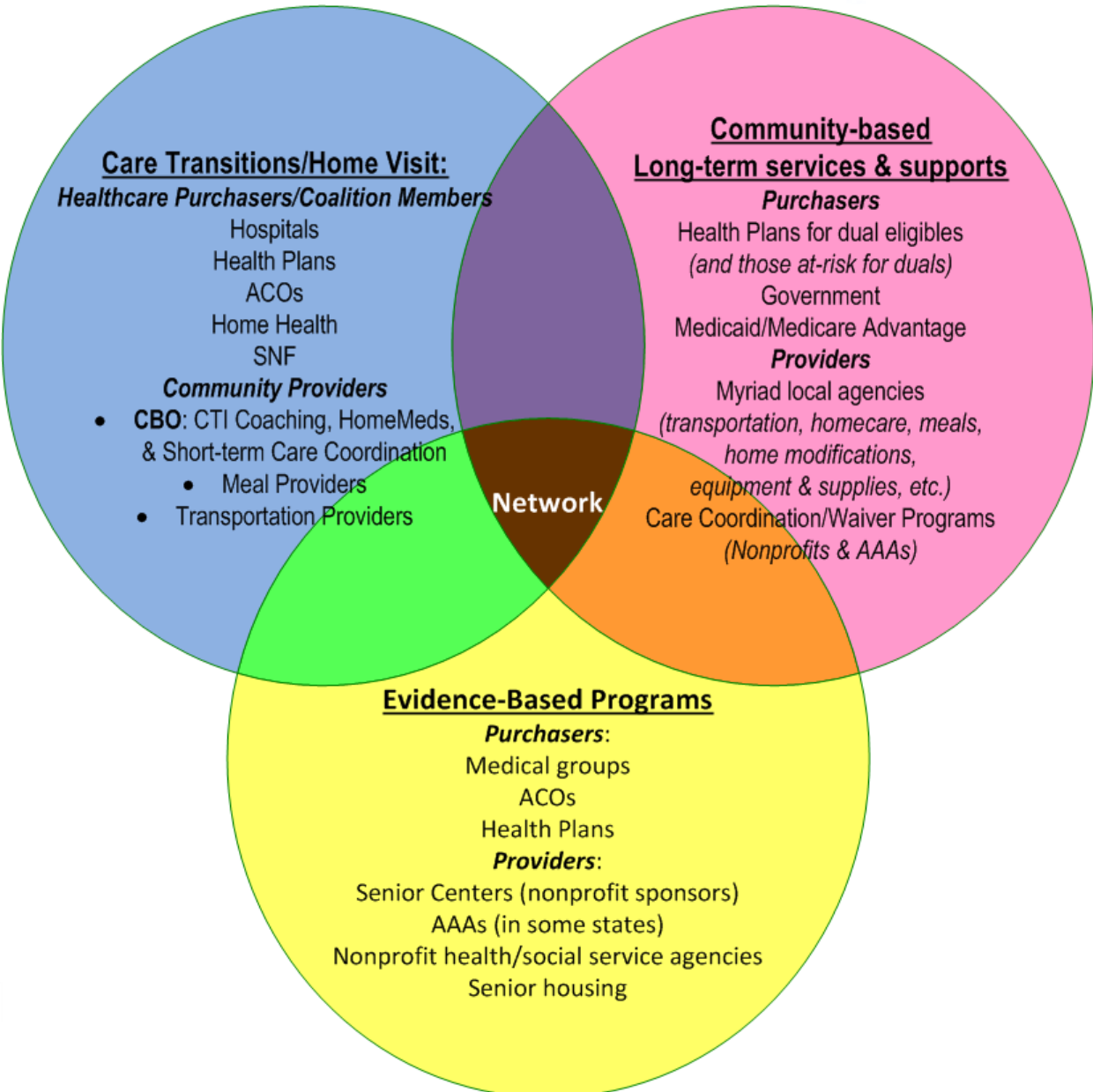


**Continuum of Home and Community-Based Services for Older Adults**



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

# Community Agencies = crucial partners



# 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

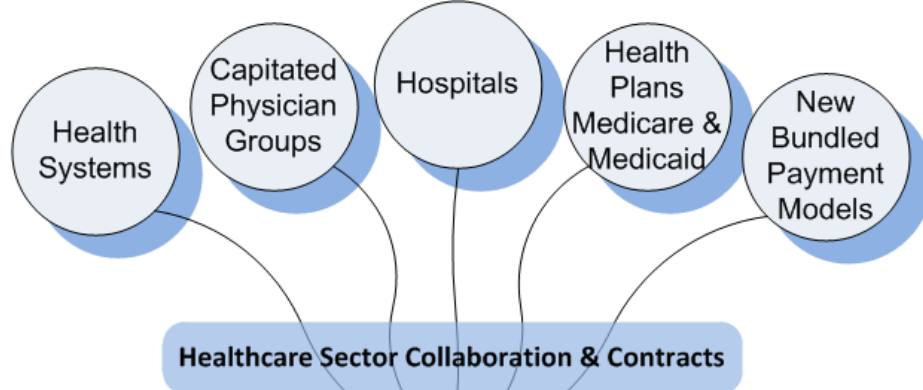
# What is Long Term Care?

- 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%)

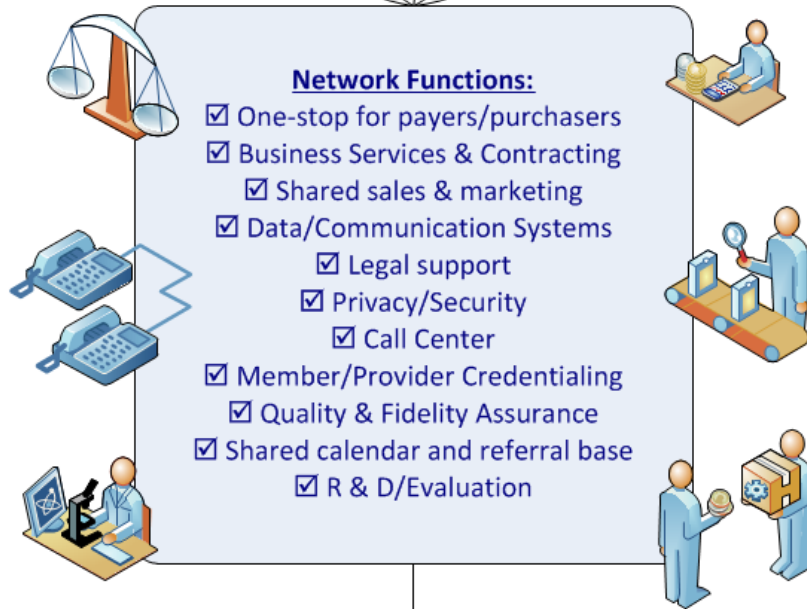


# Implication for Nursing Home

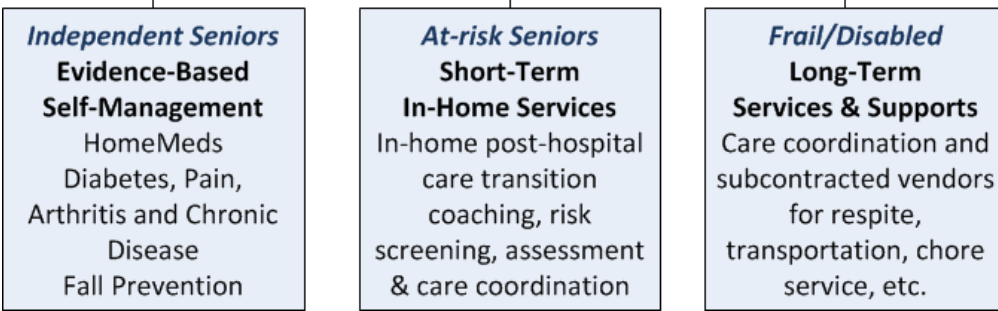
- Impact of focus on readmission
  - 30% of readmissions comes from nursing homes
- Focus on information transfers
- New staffing patterns
- Weekend coverage



# Networks for Integrating Healthcare with Community-based Organizations



## 3 Portfolios of Social Services



# 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:

**-INDEPENDENT**

**-NEEDS SOME HELP**

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# Home and Community LTC System Helps Avoid Nursing Home Placement

- Care at home can sustain independence
- Comprehensive in-home assessment identifies risks, basis to craft an in-home careplan
- Currently 6 separate MSSP agencies across LA County offer care in the home to Medi-Cal beneficiaries
- Purchase or arrange for in-home care/environmental modifications as needed

# What Our Network of Services Can Provide

## 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 (i.e., food stamps)
- Money management
- Transportation
- Utilities
- Volunteer services



# AAAs and Sponsors of MSSP Offer Best Strengths

- Area Agencies on Aging – crucial safety net
- Community agency 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

# How We Work Together

- Home and Community Services Network
  - A proposed model for experienced in-home care coordination through a central portal
- Key Elements:
  - Contracted, credentialed network of trusted vendors and linked partnerships
  - Community Care Management including in-home
  - Administrative simplicity with full access to both arrange and purchase community care resources

# 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
- Linked data systems
- Strong business case
- MSSP and AAA models are 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
- Ability to scale up and differentiate
  - Tiered care management models possible

# A Key Problem – Medications at Home

- Medication Errors at home are:
  - **Serious:** They cause approximately 7,000 deaths per year in the US
  - **Costly:** Annual cost of drug-related illness and death exceeds \$170 billion
  - **Common:** Up to 48% of community-dwelling elders have medication-related problems
  - **Preventable:** At least 25% of all harmful adverse drug events are preventable

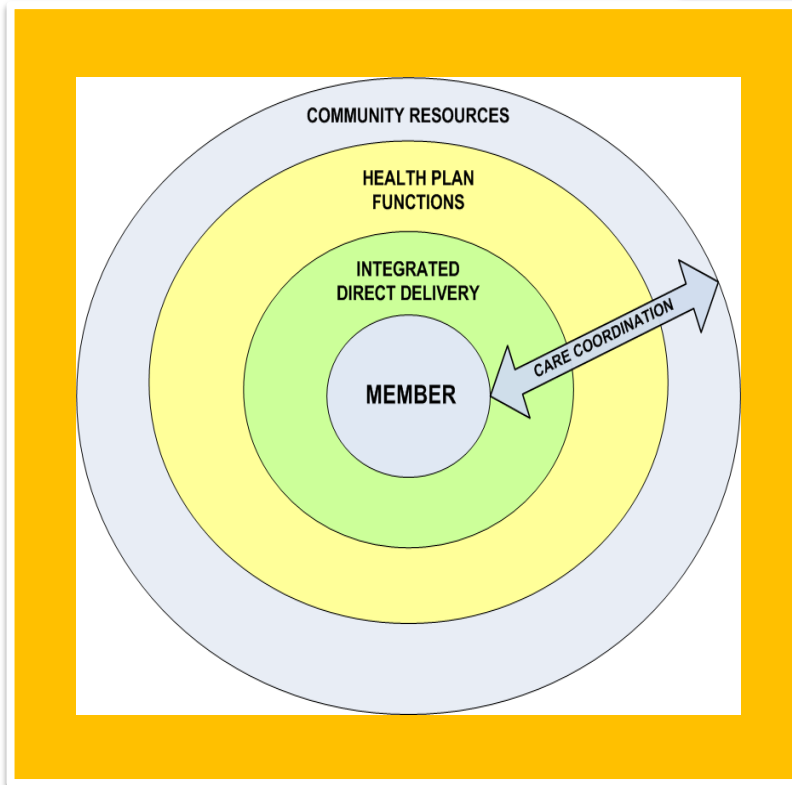
# A Solution – HomeMeds

- **In-home collection** of comprehensive medication list, how each drug is being taken, plus vital signs, falls, symptoms, and other indicators of adverse effects
- **Use of evidence-based protocols** and processes to screen for risks and deploy consultant pharmacist services appropriately – chosen for physician response
- **Computerized medication risk assessment** and alert process with comprehensive report system
- **Consultant pharmacist** addresses problems with prescribers

# Evidence-based programs

- Stanford Chronic Disease Self-Management (including online, Spanish, Arthritis, Pain, Diabetes, HIV versions)
- Fall Prevention
  - Matter of Balance & Healthy Moves
- Depression/Mental Health
  - Healthy IDEAS & PEARLS
- Physical Activity
  - EnhanceFitness, Fit & Strong
- Medication Safety
  - HomeMeds

# 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

# The Time is Now

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Homemeds.org

