Medical Care Meets Long-Term Services and Supports (LTSS)

Cal MediConnect Providers Summit
January 21, 2015

Moderator: Rebecca Malberg von Lowenfeldt, Director LTSS Practice, Harbage Consulting
Medical Care Meets Long Term Services and Supports

January 21, 2015
Who are dually eligible beneficiaries?

- 1.1 million dually eligible beneficiaries across California

**Age**
- 71% over 65
- 38% over 75

**Demographics**
- 50% White
- 20% Asian
- 16% Hispanic
- 10% Black
- 4% Other
Who are dually eligible beneficiaries? (cont’d)

Multiple Chronic Diseases
- 34% have 1-2 chronic illnesses
- 23% have 3-4 chronic illnesses
- 15% have 5+ chronic illnesses
- 51% have mental impairment

Annual Use of Services
+75% prescription drugs
+50% outpatient hospitalization
+15% inpatient hospitalization
+25% emergency room visit
Why integrate?

- **Pre CCI**
  - Medi-Cal controlled and paid for LTSS, so no incentive or ability for Medicare payers to keep people out of institutional long term care
  - Medicare controlled and paid for office visits, hospitalizations and prescription drugs, so no incentive or ability for the Medi-Cal programs to manage utilization

- **CCI**
  - Cal MediConnect plans assume risk for medical and long term care services, so they are incentivized to provide sufficient and comprehensive services that keep beneficiaries healthy and in the community
How does integration work?

- Cal MediConnect plans provide coverage for both medical care and long term care for recipients who are enrolled in CCI.

- Managed care plans provide coverage for all long term care services for **ALL** dually eligible beneficiaries.
  - Even if they have opted out of CCI.
LTSS in CA – more than just a set of acronyms

IHSS

CBAS

MSSP

SNF
LTSS in California

- Home and Community Based Services: IHSS, CBAS and MSSP
- Institutional Based Services: SNFs

IHSS (In-Home Supportive Services)
- Pays workers to provide personal care, domestic services and paramedical services
- Medical approval required for eligibility
- Hours assessed by county social workers
- Providers are hired, fired, directed, and trained by the recipient
Community Based Adult Services - CBAS

- Centers that provide both rehabilitative and preventive services to delay institutional placement

- Service include:
  - Assessment
  - Professional nursing
  - Physical, occupational and speech therapy
  - Mental health
  - Meals and nutritional counseling
  - Transportation to and from center

- CBAS eligibility determined by Medi-Cal managed care plans
Multipurpose Senior Services Programs (MSSP)

- Provide social and health care management for nursing home eligible beneficiaries who want to remain in the community.

- Services Include:
  - Personal assistance/Adult day care
  - Protective supervision and respite
  - Transportation and meal services

- Eligibility determined by and costs paid for by Medi-Cal managed care plans.
Skilled Nursing Facilities (SNFs)

- Short term rehabilitative care and long term care for people who can no longer live independently

- Impact of CCI
  - Medi-Cal managed care recipients already in skilled nursing are able to stay in the nursing facilities of their choosing (unless they are not up to plan standards)
  - Recipients in need of skilled nursing facility placement must choose a facility within their plan’s network
For more information, visit: www.harbageconsulting.com
or, contact us at: info@harbageconsulting.com
Meeting Custodial Nursing Needs

Los Angeles County
Anthem Blue Cross

- CareMore / Anthem Partnership in LA County
  - Dually Eligible Beneficiaries:
    - CareMore – Medical
    - Anthem – LTSS (IHSS, MSSP, CBAS and Custodial Nursing
  - Medi-Cal Only and Opt Outs:
    - Anthem
  - Partnership creates challenges for providers
Los Angeles County - Challenges

- 10.2 million people
- 1.21 million people 65 or older
- 400,000 dually eligible beneficiaries
- 4,083 square miles
- One of the most culturally diverse counties in the United States
- 360 nursing facilities
- “At least we’re not LA.”
NF Provider Perspective

- Anthem contracts with 200 facilities in LA County
- Continuity of Care
- Nursing Facilities (360) - Billing
  - Five health plans
  - Kaiser
  - PACE
  - Private pay
  - Medicare
- Over the last six months, immersed in value codes, revenue codes, authorization processes, EDI
- It’s messy !!!
LA County (cont.)

LA County Data

• Membership to date (10/23/14):
  • 260 MMP custodial nursing (CareMore)
  • 240 MLTSS custodial nursing (Anthem)

• 2,500 - Estimated total membership for MLTSS custodial nursing

LA County Need

• Anthem needs to create a strategy to:
  ▪ “Manage” the MLTSS custodial nursing population in order to reduce members’ unnecessary ED and hospital use and ensure a high quality of care
  ▪ Prevent adverse health care events
New LA County Strategy

- Focus on custodial NF
- Divide into geographic areas
- Build personal relationships
- Create cost savings and efficiencies in the delivery of care to NF members
- Reduce provider abrasion
- Provide a point of contact
- Reduce wait times
- Be responsible to interact and create relationships with all LTSS service providers in their area (CBAS, NF, MSSP)
## Role of Service Coordinators in NF

<table>
<thead>
<tr>
<th>Service Coordinator Functions</th>
<th>Quality</th>
<th>Contractual</th>
<th>Cost of Care</th>
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<tbody>
<tr>
<td><strong>Case Management</strong></td>
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<tr>
<td>Provide case management &amp; service coordination services</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Review member health records (MDS 3.0)</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Identify preventable health conditions</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>Engage in IDT meetings for members with high ED and hospital use</td>
<td>X</td>
<td>X</td>
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<tr>
<td><strong>Quality of Care</strong></td>
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<td></td>
</tr>
<tr>
<td>Identify NFs with high quality of care</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Encourage placement in NFs with high quality of care</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td><strong>Deinstitutionalization &amp; Discharge Planning</strong></td>
<td></td>
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<tr>
<td>Identify members for discharge and community placement</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>Assist the NF, member and family in coordinated discharge planning</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td><strong>Administrative</strong></td>
<td></td>
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<tr>
<td>Create a positive working relationships with NFs</td>
<td></td>
<td>X</td>
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<tr>
<td>Provide on-site authorizations</td>
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<td>X</td>
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<tr>
<td>Resolve issue that arise between Anthem and the NFs</td>
<td></td>
<td>X</td>
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LA County MLTSS NF Staffing and Qualifications

• Current Anthem Service Coordinators: 14¹
  • 12 RNs (2 have NF experience)
  • 2 LCSWs
• Anthem Service Coordinators when fully staffed: 25²
  • New SCs will be RNs and have NF experience
• Staffing ratio (SC to member) - 1:100 (membership 2,500)
• Service Coordinators to also focus on CBAS, MSSP and IHSS

¹. These are existing positions, not new positions.
². These positions are in the current budget already.
Outcomes for Anthem Service Coordinator Model (cont.)

• Reduce provider abrasion
• Create a focused, quality-driven provider network
• Outcomes of the network:
  ▪ Better relationship with NFs in each geographic area
  ▪ Better end-of-life care planning, use of durable power of attorney and POLST form
  ▪ Ability to partner on quality improvement programs
  ▪ Reduction in unnecessary transfer from NF to hospital (INTERACT)
  ▪ Collaborative discharge planning with less adverse events
Outcomes for Anthem Service Coordinator Model

- Reduce by 10% number of NF preventable conditions
  - 59% of adverse events in NF were preventable (OIG of HHS)
- Focus 5 preventable conditions:
  - Dehydration
  - UTI
  - Skin breakdown and pressure ulcers
  - Preventable falls
  - Medication errors
- Reduce by 25% NF custodial transfers to ED and hospital
  - 50% of NF to hospital admissions are avoidable (Journal of American Geriatric Society)
ROLE OF NURSING FACILITIES IN CARE INTEGRATION

JOE DIAZ, JR.
REGIONAL DIRECTOR
CALIFORNIA ASSOCIATION OF HEALTH FACILITIES
JDIAZ@CAHF.ORG
DIAZHEALTH@AOL.COM
(800) 824-7074
THE ROLE OF NURSING FACILITIES IN CARE INTEGRATION

• INSURE THE EFFECTIVE IMPLEMENTATION OF SENATE BILL 1008 (CHAPTER 33, STATUTES 2012) AND;

• SENATE BILL 1038 (CHAPTER 45, STATUES 2012)

BOTH MEASURES REPRESENT THE FOUNDATION UPON WHICH CAL MEDICONNECT WAS BUILT. THEY ARE BASED ON THE PREMISE THAT THEY WILL REDUCE COSTS AND INCREASE THE QUALITY OF CARE FOR MEDICARE-MEDICAID ENROLLEES IN CALIFORNIA.

TODAY THESE MEASURERS WILL AFFORD NURSING FACILITIES THE OPPORTUNITY TO PROMOTE GREATER UNDERSTANDING OF:

(1) CARE COORDINATION, HEALTH RISK ASSESSMENTS AND CONNECTIONS BETWEEN HEALTH PLANS AND PROVIDERS TO IMPROVE CARE FOR ENROLLEES IN CAL MEDICONNECT; AND

(2) OPPORTUNITIES FOR EFFECTIVE PROVIDER COMMUNICATION AS A VITAL COMPONENT TO THE SUCCESS OF THE PROGRAM.
NURSING FACILITIES WILL HAVE AN IMPORTANT ROLE IN HELPING TO FACILITATE A CONSISTENT APPROACH TO TRANSITIONAL CARE PLANNING FOR COMPLEX PATIENTS.

A NUMBER OF INNOVATIVE NF PROGRAMS ARE UNDERWAY IN CALIFORNIA WHICH INCLUDE:

1. A FOCUS ON PATIENT-CENTERED CARE WITH STRONG MECHANISMS IN PLACE FOR PATIENT/FAMILY VOICE TO BE HEARD.

2. A COMMITMENT TO BUILD ON EXISTING DELIVERY ORGANIZATIONS AND LEVERAGE CURRENT CAPACITY AND BEST PRACTICES.

3. REPRESENTATION ACROSS SECTORS WITH JOINT ACCOUNTABILITY FOR ATTAINMENT OF RESULTS.

4. COMMON TARGETS AND METRICS TO SUPPORT IMPLEMENTATION AND EVALUATION.
BENEFITS OF EFFECTIVE TRANSITIONAL CARE PLANNING AND INSURING THE CONTINUITY OF CARE BY NURSING FACILITIES.

a. PROMOTE HIGHER QUALITY AND SAFE CARE ACROSS THE HEALTH CARE CONTINUUM.

b. PROMOTE EARLY IDENTIFICATION AND ASSESSMENT OF PATIENTS REQUIRING ASSISTANCE WITH PLANNING FOR DISCHARGE.

c. FACILITATE COLLABORATION WITH THE PATIENT/SUBSTITUTE DECISION-MAKER, FAMILY AND HEALTH CARE TEAM, INCLUDING THE PRIMARY CARE PROVIDER, TO FACILITATE TRANSITIONAL CARE THAT IS FULLY INTEGRATED.

d. RECOMMEND OPTIONS FOR THE CONTINUING CARE OF THE PATIENT AND REFER TO OTHER LEVELS OF CARE PROGRAMS OR SERVICES THAT MEET THE PATIENT’S ASSESSED NEEDS AND PREFERENCES.

e. FOSTER RELATIONSHIPS WITH COMMUNITY AGENCIES AND CARE FACILITIES TO IMPROVE COORDINATION OF CARE, ADDRESS GAPS IN SERVICE DELIVERY AND IMPROVE TRANSITION PLANNING.

f. PROVIDE SUPPORT AND ENCOURAGEMENT TO PATIENTS AND FAMILIES DURING THE STAGES OF ASSESSMENT AND TRANSITION.

g. OPTIMIZE THE APPROPRIATE USE OF HEALTH SYSTEM RESOURCES BY DELIVERING APPROPRIATE ARE IN THE RIGHT PLACE AT THE TIME.
NURSING FACILITIES WILL INCREASE THEIR ROLE IN LONG-TERM CARE INTEGRATION AND ENSURE QUALITY CONTINUITY OF CARE BECAUSE:

1. HOSPITALS ARE INCENTIVIZED TO PARTNER WITH SNFS THAT ARE COMMITTED TO REDUCING AVOIDABLE READMISSIONS.

2. UNDER PROTECTING ACCESS TO MEDICARE ACT OF 2014:
   • READMISSION RATES WILL GO PUBLIC ON NURSING HOME COMPARE.
   • AN ALL-CAUSE, ALL-CONDITION READMISSION MEASURE WILL BE ANNOUNCED BY OCTOBER 2015.
   • IN OCTOBER OF 2016, VALUE BASED PURCHASING PROGRAM FOR NURSING HOMES GOES INTO EFFECT.

3. PATIENTS MAY SELECT SNFS FOR THE POST-ACUTE RECOVERY THAT HAVE LOWER READMISSION RATES.

4. AVOIDING UNNECESSARY READMISSIONS WILL IMPROVE THE QUALITY OF LIFE FOR THE RESIDENTS SERVED BY SNFS.

5. LOWER READMISSIONS WILL REDUCE MEDICAL COMPLICATIONS ASSOCIATED WITH TRANSFERS.

6. ELIMINATING AVOIDABLE READMISSIONS WILL IMPROVE OUTCOMES AND INCREASE THE POTENTIAL FOR RETURN TO THE PRIOR LEVEL OF FUNCTION.
CHALLENGES FACING NURSING FACILITIES IN THE IMMEDIATE FUTURE.

- SNFS will be competing for patients
- In addition to regulatory compliance and oversight, facilities will be graded on their best practices
- Length of stay
- Outcomes
- Avoidable hospitable readmissions
- Quality measures
- Patient satisfaction and referrals
- Facility appearance and design
- Data driven
- Advance in technology
- Trained professionals
CHALLENGES AND POTENTIAL TRENDS PROVIDERS MAY EXPERIENCE IN THE FUTURE.

• BLURRED OR SEAMLESS CONTINUUM
• INDUSTRY CONSOLIDATION/MORE STRATEGIC ALLIANCES
• ASSISTED LIVING “MARKET CORRECTION”?
• WAIVERS ALLOWING MEDICAL SERVICES IN NON-MEDICAL SETTINGS
• NEW/INNOVATIVE DELIVERY SYSTEMS
• DECLINE IN FORMAL CARE?
• SHIFTING/REDUCED ENTITLEMENTS
• MANAGE CARE TURBULENCE
• FORMERLY “PRIVATE PAY” RATES DECIDED BY THIRD PARTY PAYERS”
• COMPLETE ELIMINATION OF PRIVATE PAY FEE-FOR-SERVICE
• DISCOUNTED FEE-FOR-SERVICE
• REDUCTION AND/OR ELIMINATION OF CARE MIX REIMBURSEMENT
• REDUCTION AND/OR ELIMINATION OF REIMBURSEMENT FOR PER CASE/EPISODE
• FULL AND NON-NEGOTIABLE CAPITATION RATES
Cal MedConnect Providers Summit

Wednesday, January 21, 2015
Role of Nursing Facilities In Care Integration

Joe Diaz, Jr.
Regional Director
California Association of Health Facilities

jdiaz@cahf.org
diazhealth@aol.com
(800) 823-7074
St. John’s Well Child and Family Center

In-Home Support Service Integration Pilot Program

Becca Sussman, MPH
Associate Director of Programs & Grants Management
St. John’s Well Child and Family Center

- St. John's Well Child and Family Center (St. John’s)
  - Independent 501(c)(3) network of Federally Qualified Health Centers in Los Angeles, California
  - Serves patients of all ages through eleven independent and school-based health centers spanning Central and South L.A. and Compton
  - Provides primary medical, dental, mental health, and social support services to uninsured, underserved and economically disadvantaged people in Los Angeles
  - In 2014, served 61,891 patients through over 227,318 visits
Healthcare Delivery System for Seniors/Persons with Disabilities (SPD)

- SPD – Medi-Cal designation
- Eligible for In Home Support Services (IHSS)
- 2011 – Transition of Medi-Cal SPD patients from FFS model to Managed Care
  - Assignment to primary care medical homes
- IHSS Providers hired and employed by the patient
  - 60% of IHSS providers in L.A. County are family members (SEIU-ULTCW)
- No required training or experience for IHSS providers
St. John’s IHSS Integration Pilot Program

Funded by Tides Foundation/Center for Care Innovations and SEIU-ULTCW
Program Goal:

• To improve integration of care and health outcomes for seniors and persons with disabilities in South Los Angeles who utilize home health care services (IHSS).
The Intervention: IHSS Integration Program

- **Component 1:** Training for IHSS providers
  - 6 week training (25 hrs) + CPR/First Aid certification
  - Formative research included IHSS providers, patients, clinicians

<table>
<thead>
<tr>
<th>1. IHSS System</th>
<th>6. Activities of Daily Living</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Life Quality</td>
<td>7. Home Safety/Fall Prevention</td>
</tr>
<tr>
<td>3. Paraprofessional Medical Services</td>
<td>8. Mobility and Transferring</td>
</tr>
<tr>
<td>5. Mental Health</td>
<td>10. CPR/First Aid Certification</td>
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</table>
The Intervention: IHSS Integration Program

- **Component 2**: Incorporate IHSS providers of elderly and disabled (SPD) patients of St. John’s into clinic-based, patient-centered care
  - IHSS providers present at medical visits
  - Care coordination by the IHSS Coordinator
    - Regular contact
    - Linkage to necessary medical, ancillary and other health-related services
    - Ready access to clinic providers
Program Participants

• 97 pairs of St. John’s’ SPD patients and IHSS providers
• Recruited from St. John’s patient population
  • Identified by: medical providers, IHSS Coordinator outreach
• Participation: 4 months
Evaluation and Outcomes
Evaluation:

• The Triple Aim - Population Health, Patient Experience and Healthcare Cost

• What were the major objectives of this program?
  • Increase patient satisfaction
  • Improve health outcomes of patients
  • Reduce unnecessary healthcare utilization
  • Improve communication between providers of SPD patients (primary care, IHSS)
Domain – Population Health

Measure: Health-related quality of life

• Measured at enrollment (baseline) and monthly thereafter until end of program participation.

• Results: 67% of patients reported improvements in health-related quality of life at the end of program participation.

(Source: CDC HRQOL Questionnaire Unhealthy Days Index)
Increased Number of Healthy vs. Unhealthy Days Reported by Patients

Average number of reported Unhealthy Days versus Healthy Days in previous month (30):

**UNHEALTHY DAYS:**

Baseline: 25.3 days  
Program End: 15 days

**HEALTHY DAYS:**

Baseline: 4.7  
Program End: 15 days
Other Population Health Measures

• Self-rated health
• Patient health-status reported by IHSS provider
• Functional status (ADLs) – change in # ADLs performed
Domain – Patient Experience

Measure: PATIENT SATISFACTION with overall medical care

• Patient satisfaction with overall care increased by 13.4%.

(Source: PSQ-18 – RAND)
Patient Satisfaction (Subscales):

• General Satisfaction: + 12.8%
• Technical Quality: +18.0%
• Interpersonal Manner (Patient/Provider): + 7.7%
• Communication (Patient/Provider): +10.6%
• Financial Aspects: +10.9%
• Time Spent With Doctor: + 7.5%
• Accessibility and Convenience: +19.1%
Other Measures of Patient Experience

- IHSS provider participation in training
- Knowledge related to IHSS training
- IHSS presence in patient medical visits
- Contacts with IHSS Coordinator
## Domain – Healthcare Cost

**Measure: Hospitalizations/ER visits**

<table>
<thead>
<tr>
<th>Monthly Rate of Hospitalizations and ER Visits</th>
<th>Monthly Rate (Aggregate)</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline (previous 12 months)</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Outcome (4 months in program)</td>
<td>2</td>
<td>-53%</td>
</tr>
<tr>
<td><strong>ER Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline (previous 12 months)</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Outcome (4 months in program)</td>
<td>3.25</td>
<td>-54%</td>
</tr>
</tbody>
</table>
Domain: Healthcare Cost

Measure: Medication Adherence

40.2% improvement in medication adherence among participating patients

(Source: Morisky, Medication Adherence Questionnaire)
Conclusions: Contributions of Training and Integration

• Improved IHSS providers’ ability to identify and meet patient health needs outside of the clinic setting
• Improved patient experience and satisfaction with healthcare among SPD patients
• Improved health status and reduced unnecessary hospitalizations and ER visits for a complex population of elderly and disabled patients
Discussion

• Most important parts of program:
  • Training
  • Improved communication between IHSS and clinic-based care providers

• How do we know which program components made the difference?

• Making the evaluation more robust
  • Self-reported data (on small N) not validated with objective measures
  • Longer period of observation
  • Could we include more robust metrics?
  • Formal biostatistical analysis
  • More data remains that could be analyzed
Questions and Discussion