CBAS: Expanding the Health Home Model for Duals

Community Based Health Home Project

A project of Alliance for Leadership and Education
and California Association for Adult Day Services

Funded by a Grant provided by the SCAN Health Plan, Long Beach CA

SCAN is a nonprofit public benefit corporation dedicated to finding innovative ways to enhance senior's ability to manage their health and to continue to control where and how they live.

Description of Full Dual-Eligibles

- 50% qualified for Medicare initially due to disability rather than age.
- Almost one-fifth of all duals have 3+ chronic conditions.
- Full duals are 3x as likely to have a mental illness compared to Medicare only patients.
- More than 40% use LTSS (includes NF use).
- They make up 13% of Medicare and aged/blind/disabled Medicaid enrollees, but use 34% of total spending.

Source: June 2013. Dual Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies. Congressional Budget Office

"Super Utilizers"

- A disproportionate share of health care spending in the United States is used to provide care to a relatively small group of patients, with 1% of the population accounting for 22% of total health care expenditures annually.[ii]
- The distribution of spending is even more uneven within Medicaid, with just 5 percent of Medicaid beneficiaries accounting for 54% of total Medicaid expenditures and 1% of Medicaid beneficiaries accounting for 25% of total Medicaid expenditures.[iii]
- Among this top one percent, 83% have at least three chronic conditions and more than 60% have five or more chronic conditions.

ii Cohen S and Yu W. The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008-2009. Agency for Healthcare Research and Quality. January 2012.

iii Mann C. Medicaid and CHIP: On the Road to Reform. Presentation to the Alliance for Health Reform/Kaiser Family Foundation. March 2011. Based on FY 2008 MSIS claims data.

CMCS Informational Bulletin - Page 20

iv Kronick R, Bella M, Gilmer T, and Somers S. The Faces of Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions. Center for Health Care Strategies, Inc. October 2007. Available from: http://www.chcs.org/usr_doc/Full_Report_Faces_II.PDF

A Center's Participant Profile

- All participants have 3-5+ chronic conditions
- 100% require skilled nursing services and are NF-eligible
- 60% have medications administered at the Center
- 55% have been diagnosed with dementia
- 56% have a psychiatric diagnosis
- 76% exhibit behavioral symptoms
- 52% regularly receive ADL (Activities of Daily Living) training
- 61% are incontinent or receive related assistance
- 79% are at risk for falling
- 81% use walkers, canes, and/or wheelchairs
- 74% participate in restorative physical and occupational therapies
- 77% experience hearing, vision, or sensory deficits
- 24% have communication deficits
- 63% require a special diet
- 45% require assistance at mealtimes

What is the Community-Based Health Home?

- A comprehensive person-centered care model that allies adult day health care/CBAS to managed care and the PCP to provide improved outcomes for older adults with complex bio-psychosocial needs.

- A 2 year project to provide intervention, support and care coordination through the intensive hands-on effort of an RN Navigator, who can work outside of the ADHC/CBAS center walls.

Funded by the Scan Health Plan Community Giving Program, 2013-2014

Why CBAS as a Health Home?

- 30 years experience managing care for the dual complex population
- Strength of ADHC platform: IDT that is high-touch, consistent, person-centered, expert in combining clinical with social work support, and deep understanding of community resources.
- Mitchell Bill AB 361 includes health home in a community setting

ADHC is designed as a person centered model.

Approaches

1. Serve as a trusted resource for the PCP and MCMC plan for these identified high-risk patients

2. Leverage the in-depth relationships developed with ADHC/CBAS patients with intensive needs to proactively address health concerns and avoid costs.

3. Align practice and outcome measurements to National Committee for Quality Assurance (NCQA) and CMS' quality standards for Health Homes, and achieve evidence-based outcomes, by utilizing our TOPS assessment and outcome measurement system.

RN Navigator Role

1. Focus on care transitions, changes in patient status (bio-psycho-social), close monitoring and close collaboration with ADHC IDT and MCMC Plan.
2. Navigate outside of center for Medi-Cal, Medicare, community resources, CBAS IDT and caregiver on behalf of patient, especially those without Plan CM.
   - Facilitate unified decision-making for person-centered care for those in CM as well as those without Plan CM.
3. Hands-on "high touch" care - extension of CBAS IDT, including PCP orders and PCP/Specialist communication
   - Liaison with Plan
   - Frequent home visits
   - Accompany patient to PCP/specialist visits
   - Work with discharge planner at NF or hospital on care transitions
   - Ad hoc RN assessment, as needed (home or center)
4. Application of uniform assessment tools, protocols and best practices

Initial Target Population

- Dual eligibles in 6 counties who are 65 years or older and:
  - Authorized by MC Plan as eligible for CBAS at one of the 7 project sites.
  - Identified by the CBAS MDT as high risk using project criteria and team judgment
  - Red flags are:
    - Living alone with cognitive impairment or psych condition
    - Abrupt changes in health, mental or cognitive condition
    - Changes in caregiver or living status
    - Absences from the CBAS Center
    - Care Transitions

Patient Risk Factors

- Multiple chronic conditions
- Polypharmacy/Medication mismanagement
- Clinical depression/Mental Health
- Self-neglect
- Poor judgment/risky decision-making
- Living alone/isolation
- History of falls
- Challenging behaviors
- Family / caregiver conflict

CBHH Patient Profile

Upon Admission to CBHH:	Jan 2014 N=105
Female	**73%**
Male	**27%**
Ave. Age	**79**
Ave. # Meds (upon admission)	**10.59**
Ave. # Meds (monthly)	**9.54**
Lives alone	**44%**
# of Chronic Conditions	**8.79**
% w/Social Risk Factors	**93%**
% w/Risk for Institutionalization	**88%**
% w/Use of ED/Hospital (past 12 mos)	**65%**

Comparison of CBHH & Duals Conditior

	CBHH N=89	DHCS Duals in CCI Counties
Hypertension	**86.7%**	**80%**
Hyperlipidemia	55.2%	67%
Diabetes	**56.2%**	**45%**
Arthritis	34.29%	44%
Coronary Atherosclerosis	18.1%	33%
COPD	8.57%	24%
Osteoporosis	**38.1%**	**24%**
Congestive Heart Failure	11.43%	18%
Mood Disorder	**41.9%**	**16%**
Alzheimer's / Dementia	**53.3%**	**15%**
Stroke	**23.8%**	**15%**
Cancer	5.7%	13%
Asthma	6.7%	12%
Schizophrenia	2.9%	5%

CBHH Source:
Jan. 2014 CBHH Project Patient Data

DHCS Source:
Medi-Cal's Coordinated Care Initiative Combined Medicare & Medi-Cal Cost, Utilization, and Disease Burden Nov. 2012 DHCS - Research and Analytic Studies Section

Benefit of Project for CCI

- Partner and help shape innovative CBAS Health Home model for specialized intensive services for high risk/high cost Plan members. CBAS as service modality with RN-N as liaison to Plan.
- Joint focus on cost avoidance/high touch care for complex/high cost dual members.
- Learning collaborative among centers and with Plan - mutual exchange of best practices as CCI project rolls out (PHP as a best practice example).
- Test uniform assessment tools/practices piloted by CBAS Project sites.
  - TOPS tools adapted to this population
  - Identify key measures for Plan reporting requirement to DHCS/CMS (NCQA, NQF, HEDIS)

Care Collaboration

1. MOU to define roles and relationship
   "Constellation of Resources" Form
2. I.D high risk/cost duals to refer to CBHH project.
3. Partnership re: Individual Care Team (ICT) meetings.
4. Timely communication & help from RN-N re: Member health status, need for DME, supplies, transportation, etc. in coordination with CM and/or U.M.
5. Direct in-person communication with Medicare PCP, who is not part of Plan's CMC network.
6. Other potential to be explored with each Plan

Data Sharing/Outcome Opportunities

1. Data sharing and metrics at patient level.

2. Analysis of cost/utilization outcomes pre-and post - CBHH intervention (usual care v. CBHH).

3. Comparison of claims data from Medi-Cal and Medicare to actual data/records collected by CBHH Project.

4. TOPS patient/outcome data available to CM on line.

TOPS TRACKING OUTCOMES FOR PROGRAM SUCCESS

The patient centered outcome system for community-based adult day services

TOPS (Tracking Outcomes for Program Success) is cloud-based outcome measurement system and benchmarking tool developed under a grant from the California Community Foundation in 2009-2010 and piloted among 8 Adult Day Programs and Adult Day Health Centers in Los Angeles County.

- It has been recently modified as the basis for measuring health home outcomes and benchmarking within the Community-Based Health Home.
- Tools are evidence-based and some were modified for this population.
- Aligns with NCQA standards
- Is required for CBHH but not exclusively for CBHH
- Requires training and 8 hours per week for data entry
- Will be made available this year to other CAADS Members who enroll to be part of the TOPS family.

Gwen Uman, RN, Ph.D, of Vital Research, Los Angeles is the project consultant.

NQF Domains that CBAS Addresses for Improved Health Outcomes

1. Quality of Life
2. Care Coordination
3. Mental Health and Substance Abuse
4. Screening and Assessment
5. Structural Measures (in process)

Source: June 2012. National Quality Form Report: Measuring Healthcare Quality for the Dual Eligible Beneficiary Population

TOPS Domains

- Participant Health
- Cognitive Functioning
- Psychosocial Functioning
- Caregiver Needs
- Participant Satisfaction
- Caregiver Satisfaction
- To come: Patient Activation Measure

Screening Tools in Eight Languages

1. Chinese
2. English
3. Farsi
4. Korean
5. Russian
6. Spanish
7. Tagalog
8. Vietnamese

1. ADLs and IADLs
2. Nutritional Risk
3. CAGE-AID (substance abuse)
4. Fall Risk assessment
5. Pain assessment
6. Loneliness scale
7. Quality of Life scale
8. Geriatric Depression Scale
9. Orientation-Memory-Concentration scale
10. Caregiver Needs (Burden)
11. Participant Satisfaction
12. Caregiver Satisfaction

Participant Scorecard

ADP

Reporting Period: January – March 2009

Total Participants Served During Period: 10

PHYSICAL HEALTH STATUS		ALL CENTERS
Health Care Utilization		
Participants w/ ER Visits	20% (2/10)	21% (18/87)
Participants w/ Hospitalizations	20% (2/10)	20% (17/87)
Average # of Dr. Visits per Participants	7.4	2.2
Health Status		
Participants w/ Swallowing Problem	10% (1/10)	10% (9/87)
Participants w/ Systolic BP>140	10% (1/10)	19% (17/87)
Participants w/ Diastolic BP>90	0% (0/10)	0% (0/87)
Participants w/ Moderate to High Pain (>3)	30% (3/10)	32% (28/87)
Health Risk		
Participants w/ 9 or more meds	10% (1/10)	17% (15/87)
Participants w/ high risk of falling	90% (9/10)	85% (74/87)
Participants with low nutritional risk	0% (0/10)	30% (26/87)
Participants w/ moderate nutritional risk	50% (5/10)	40% (35/87)
Participants w/ high nutritional risk	50% (5/10)	30% (26/87)

PSYCHOSOCIAL STATUS		ALL CENTERS
Participants Clinically Depressed	50% (5/10)	30% (26/87)
Participants Lonely	20% (2/10)	10% (9/87)
Participants w/ Poor Quality of Life	20% (2/10)	25% (22/87)

FUNCTIONAL AND COGNITIVE STATUS		ALL CENTERS
Functional Status		
Participants w/ Moderate to Severe Dependence in:		
Average ADL's (Overall)	40% (4/10)	30% (26/87)
Eating	50% (5/10)	38% (33/87)
Transferring	70% (7/10)	60% (52/87)
Walking	90% (9/10)	76% (66/87)
Toileting	50% (5/10)	60% (52/87
Cognitive Status		
Participants w/ no impairment	40% (4/10)	25% (22/87)
Participants w/ *mild* impairment	0 (0/10)	35% (30/87)
Participants w/ *moderate* impairment	0% (0/10)	10% (9/87)
Participants w/ *severe* impairment	40% (4/10)	30% (26/87)

PARTICIPANT SATISFACTION		ALL CENTERS
Participants Perceiving Program as Effective	56% (4/8)	67% (58/87)
Participants Perceiving Program of High Quality	73%(6/8)	85% (74/87)
Participants Would Recommend to Relative/Friend	67% (5/8)	96% (84/87)
Participants Satisfied Overall	100%(8/8)	90% (78/87)
Participants Able to Remain at Home	100%(8/8)	83% (72/87)

Room for Notes/Other Information.

PROJECT ADVISORY COMMITTEE

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