



Department of
Health Care Services



Community Based Adult Services (CBAS)
Phase 2 - Managed Care Cutover
Integrated Training Session
with
Phase 2 Managed Care Plans
Phase 2 CBAS Providers
California Dept. of Aging
California Dept. of Health Care Services

September 14th, 2012



Agenda

1. Introductions – Opening Remarks (15 min)
2. CBAS Workflow In Managed Care (20 Min)
3. Health Plans & CBAS (20 Min)
4. CBAS Assessment Process & Tool (60 min)
5. Provider Perspective (30 min)
6. LOS Adjudication Overview (10 min)
7. Closing Remarks (10 min)

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Opening Remarks

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 **CBAS Workflow In Managed Care**

1. CBAS Program & Services Outline
2. Operating Model

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 **Helpful CBAS Factoids**

- CBAS providers deliver services in licensed ADHC centers
- The California Department of Public Health (CDPH) licenses ADHC centers
- The California Department of Aging (CDA) certifies CBAS providers for participation in the Medi-Cal Program
- Information regarding CBAS certification requirements and other program information can be found at:
www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Default.asp
- To contact the CDA CBAS Branch call or email:
(916) 419-7545
cbascda@aging.ca.gov

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 **What is CBAS?**

- **Adult Day Health Care (ADHC) Program** – ended March 31, 2012... a licensed community-based day health program that provided services to older persons and adults with chronic medical, cognitive, or mental health conditions and/or disabilities that are at risk of needing institutional care.
- **Community Based Adult Services (CBAS) Program** - Effective April 1, 2012... has begun under California's "Bridge to Reform" 1115 Medicaid waiver. Same services as the ADHC program with CBAS eligibility standards that are more stringent than ADHC standards. CBAS providers must maintain an ADHC license.
- **The primary objectives of the program are to:**
 - a) Restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities; and
 - b) Delay or prevent inappropriate or personally undesirable institutionalization.
 - c) The Program stresses partnership with the participant, the family and/or caregiver, the primary care physician, and the community in working toward maintaining personal independence.

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CBAS Core & Additional Services

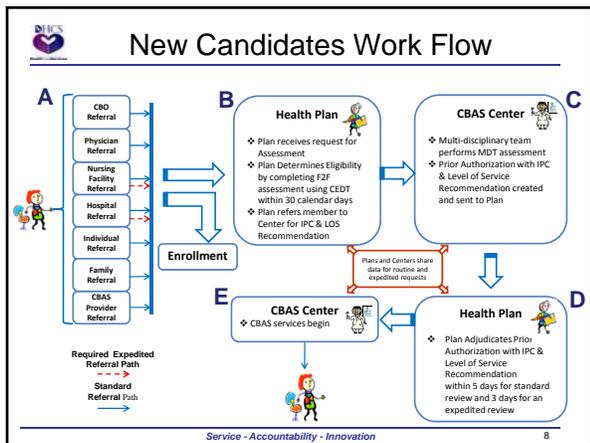
Core Services: each waiver participant shall receive ALL of these services on each day of attendance at the CBAS center:

- Professional nursing.
- Social services and/or personal care services.
- Therapeutic activities.
- One meal offered per day.

Additional Services: each waiver participant shall receive any of the following services specified:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Mental health services.
- Registered dietitian services.
- Transportation to/from CBAS center and participant's place of residence.

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New Candidates – Process Detail (1 of 2)

A. Provider identifies a potential need for CBAS services and submits a request for inquiry to begin the CBAS assessment process

B. Plan schedules Face to Face (F2F) with member using the following process

- Plan acknowledges, in writing, to requestor and member, the inquiry and makes first attempt to schedule F2F within 5 business days.
- Plan makes two additional attempts via telephone to schedule between 5 and 8 business days of request.
- Plan makes final attempt in writing giving the member until 14th calendar day to schedule F2F. If member does not schedule within 14 days from inquiry, plan will send a follow-up letter to member and requestor that if services are still needed a new inquiry must be submitted to begin the process again.

Managed Care Plan conducts Face to Face (F2F) with member using the following guidelines

- Plan must schedule F2F within 14 calendar days.
- F2F must be completed, using CEDT tool, within 30 days from initial inquiry. Approval or denial of eligibility for CBAS to conduct IPC will be sent to the Center within 1 business day of decision.
- Member has the right to choose a center.

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 **New Candidates – Process Detail** (2 of 2)

C. CBAS Center Completes & Submits Prior Authorization Request

1. Receives authorization from Plan to conduct IPC/LOS assessment
2. CBAS center multi-disciplinary team performs assessment
3. Prior authorization request, including IPC with Level of Service recommendation is created and sent to Plan.

D. Plan receives Prior Authorization request from CBAS center, which includes a completed IPC and Level of Service recommendation. Plan will handle recommendation through existing prior authorization process which includes:

1. Plan will approve, modify or deny prior authorization request within 5 business days, in accordance with Health and Safety Code 1367.01
2. If Plan cannot make a decision within 5 business days a 14-day delay letter will be sent to the member and center.
3. Plan notifies Center within 24 hours of decision. Plan notifies member within 48 hours of decision.

E. CBAS services begin

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 **New Expedited Candidates – Detail** (1 of 2)

A: Nursing Facility or Hospital identifies a potential need for *expedited* CBAS services within the discharge plan and provider submits a request for inquiry to begin the CBAS assessment process. Expedited process will be conducted with 5 business days.

B: Managed Care Plan schedules Face to Face at the Nursing Facility or Hospital with member/facility immediately

Managed Care Plan conducts Face to Face with member using the following guidelines

1. Plan must complete F2F within *5 business* days.
2. F2F must be completed, using CEDT tool, within *5 business* days from initial inquiry. Approval or denial of CBAS eligibility to conduct IPC will be sent to the Center within 1 business day of decision.
3. Member has the right to choose a center.

C: CBAS Center

1. Receives approval from Plan to conduct IPC assessment
2. CBAS center multi-disciplinary team performs IPC assessment
3. Prior authorization request, including IPC with Level of Service recommendation is created and sent to Plan.

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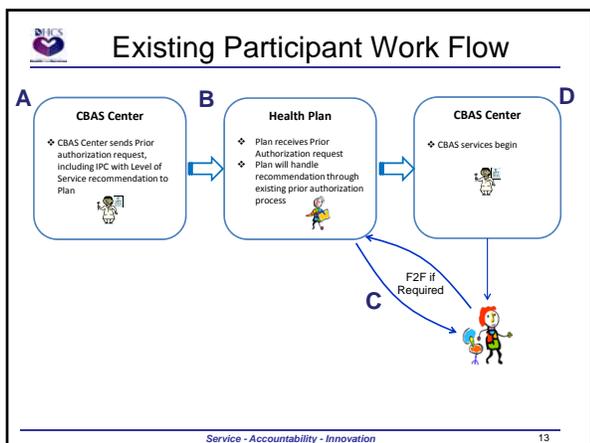
 **New Expedited Candidates – Detail** (2 of 2)

D. Plan receives Prior Authorization request from CBAS center, which includes a completed IPC and Level of Service recommendation. Plan will handle recommendation through existing prior authorization process which includes:

1. Plan will approve, modify or deny prior authorization request within 72 hours, in accordance with Health and Safety Code 1367.01(h)(2)
2. Plan notifies Center within 24 hours of decision. Plan notifies member within 48 hours of decision.

E. CBAS services begin

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Existing Participants – Process Detail

A. CBAS Center Re-Assesses participant and sends Prior authorization request, including IPC with Level of Service recommendation is created and sent to Plan.

B. Plan receives Prior Authorization request from CBAS center, which includes a completed IPC and Level of Service recommendation. Plan will handle recommendation through existing prior authorization process which includes:

1. Plan will approve, modify or deny prior authorization request within 5 business days, in accordance with Health and Safety Code 1367.01
2. If Plan cannot make a decision within 5 business days a 14-day delay letter will be sent to the member and center.
3. Plan notifies Center within 24 hours of decision. Plan notifies member within 48 hours of decision.

C. To deny or decrease the Prior Authorization request, the plan must conduct a F2F with the member.

1. Process must be completed in accordance with Health and Safety Code 1367.01 and ensure timelines are met.

D. CBAS services begin

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L.A. Care and CBAS

Facilitator:
 Eddie Calles, Director, Provider Network Operations

September 14, 2012

L.A. Care HEALTH PLANS
 For a Healthy Life

Celebrating 15 Years 1997-2012

L.A. Care's Mission Statement

To provide access to quality health care for Los Angeles County's vulnerable and low-income communities and residents, and to support the safety net required to achieve that purpose.



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Who is L.A. Care Health Plan?

- Medi-Cal Managed Care plan serving L.A. County since 1997
- HMO, Grant-funder, Policy and public health leader
- The nation's largest public health plan
 - More than one million members, including Medi-Cal and Medicare



www.lacare.org

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Not Just an HMO

- **L.A. Care:**
 - ✓ Strengthens the health care safety net.
 - ✓ Is a policy leader.
 - ✓ Is a public agency.
 - ✓ Is governed by a stakeholder Board of Governors.
 - ✓ Is community-accountable.
 - ✓ Provides community investments and grants to improve community health.



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Structure and Formation

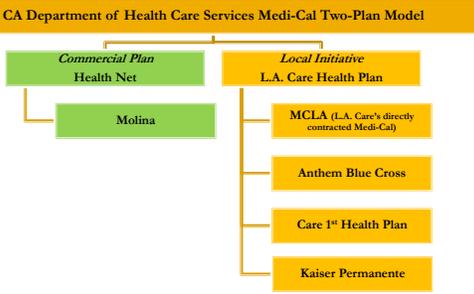
- Pursuant to SB 2092, the L.A. County Board of Supervisors adopted a resolution establishing L.A. Care in October 1994
- Separate Health Authority - Local Initiative
 - Subject to many public entity requirements
 - Community/stakeholder input
- Knox Keene licensed April 1997



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L.A. County's Two-Plan Model

CA Department of Health Care Services Medi-Cal Two-Plan Model




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L.A. Care Membership

Product Line	Membership (August 2012)
Medi-Cal	
• Plan Partners	650,568
• MCLA	335,198
Healthy Families (CHIP) (May 2011)	
• Direct HF product	11,323
• Subcontracted/CHIP	5,446
Healthy Kids	
• Ages 0-5 (Funded by First 5 LA)	1,492
• Ages 6-18 (Funded by L.A. Care and others)	10,053
Medicare Advantage Special Needs Plan (SNP)	1,735
<i>Total</i>	1,014,080



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L.A. Care in the Community

- Since 2000, L.A. Care has invested over \$121.5 million in CHIF, CHI health coverage, sponsorships and other community programs
 - CHIF has funded nearly 275 projects for over \$35 million, benefitting over 130 community clinics, organizations, and the Los Angeles County Departments of Health Services and Public Health (2000-2010)
 - Over \$86.5 million directed to the Children's Health Initiative (CHI), expanding coverage to 50,000 children (2000-2010)



1 25

Regional Community Advisory Committees (RCACs)

- 11 RCACs, one for each geographic region that L.A. Care serves
 - Each RCAC comprised of up to 35 members, with a majority of consumers and consumer advocates
- Established in 1996
- Ensure strong connections to community stakeholders
- Report to L.A. Care Board through Executive Community Advisory Committees (RCAC Chairs)
- Advise L.A. Care regarding member needs
- Provide information on regional health issues that impact L.A. Care members



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Commitment to Quality

- Incentive programs
 - Physician
 - Provider group
 - Plan Partner
- Patient centered medical home pilot
- Disease management
- Care management
- Health education



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L.A. Care: Serving Seniors and People with Disabilities

- Launched Medicare Advantage Special Needs Plan in 2008
- Transitioned 100,000 seniors and people with disabilities to our managed care plan from 2011 through 2012
- Provided accessible equipment grants to 83 community clinics
- Conduct onsite inspections of 1,200+ doctor's offices to ensure accessibility
- Provide member materials in alternative formats, interpreter services and ASL video
- 24/7 member services phone number and nurse advice line
- Conduct disability training for all L.A. Care staff
- Offers health education and physical fitness classes for seniors and people with disabilities at Family Resource Centers and Independent Living Centers



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Verifying Eligibility Online

- Request Login Setup** from your assigned Provider Relations Specialist or email providerrelations@lacare.org. Please provide Organization Name and Address. List the individuals requiring access including full name, title, email and phone number.
- Each individual will receive an email with username, password and link to activate account.
- Eligibility Verification will be accessible through www.lacare.org/providers




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Claims Process

- Submission Guidelines:**
 - L.A. Care must have W-9 on file to ensure claims will be processed
 - W-9 may be faxed to (213) 438-5732 Attn: Provider Relations
 - Forms accepted
 - CMS 1500 – Professional Services
 - UB 04 – Institutional/Facilities Services
 - Authorization Number **must be included** on claim for processing
 - Submission Timelines
 - Initial claim** submission within 6 months from date of service
 - Appeal submission within 12 months from date of service
- All **Paper Claims** submitted to L.A. Care must be mailed to:

L.A. Care Health Plan
Attn: Claims Department
P.O. Box 811580
Los Angeles, CA 90081
- Electronic Claims** are accepted via officially.com, mdxnet.com or ssimed.com
 - Payor Identification is LACAR.
 - Enable Access by faxing W-9 Form to (213) 438-5732 Attn: Provider Relations RE: Electronic Claim Activation



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Upcoming Provider Education

- L.A. Care will be holding additional educational sessions to review:
 - Eligibility Verification
 - Prior Authorization
 - Claims and Payment
 - Plan Resources
- Dates and times to follow



1 10

Duals Pilot Coordinates Benefits

Duals Demonstration Pilot – One Coordinated Set of Benefits, Not Two

- **Medical Care**
 - ✓ Doctor and Specialist Visits
 - ✓ Lab Work
 - ✓ X-Rays
- **Hospital Stays and Emergency Care**
- **Prescription Medications**
- **Behavioral Health**
- **Medical Equipment and Supplies**
- **Long Term Care**
 - ✓ Skilled Nursing Facilities
- **Long Term Services and Supports (LTSS)**
 - ✓ In-Home Supportive Services (IHSS)
 - ✓ Community Based Adult Services (CBAS)
 - ✓ Multipurpose Senior Services Program (MSSP)
- **Non Emergency Transportation**
- **Home- and Community-Based Services**



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L.A. Care Department Contacts

- Provider Relations 213-694-1250 x 4121
- Automated Eligibility 866-522-2736
Verification
- Member Information 888-839-9909

ProviderRelations@lacare.org



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Questions & Discussion

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Additional Managed Care Member Resources

Managed Care members have access to:

- A. MMCD Office of the Ombudsman**
 - Serves as an objective resource to resolve issues between Medi-Cal managed care members and managed care health plans.
 - Conducts impartial investigations of member complaints about managed care health plans.
 - Helps members with urgent needs.
- B. Plan Member Services Departments**
 - A service from the health plan to assist with questions or member needs.
- C. Health Plan Member Grievance Processes**
 - A multi-step grievance process beginning with the plan
 - The plan process can occur concurrently with a fair hearing
- D. Normal State Fair Hearing process**
 - Members may request a fair hearing if they have a complaint about how their benefits or services were handled or if their services were denied or modified
 - Hearings are conducted by an Administrative Law Judge

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Additional Managed Care Member Resources

- E. Cultural and Linguistic Services**
 - Provide written materials in threshold languages in the Health Plans' county
 - Written member informing materials provided in alternative formats upon request (Braille, large size font and audio)
 - Provide language translation services for all languages

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 **Resources Available for CBAS Providers**

Managed Care providers have access to:

A. A provider grievance process... Providers have a process with each plan to address:

- Grievances
- Appeals
- Denials
- Payment issues

B. Provider Relations

- Provider Relations contact at each plan
- A Managed Care provider manual including authorization and payment guidelines

C. Provider Training

- Regular, on-going training regarding the Medi-Cal Managed Care program and services to members
- On-going training on specific plan guidelines

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 **CBAS Assessment Process
&
CBAS
Eligibility
Determination
Tool**

A New Era

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 **Outline**

- 1. Eligibility Overview –**
 - Understand what is in law regarding CBAS... at a High level
 - Categories, medical necessity steps, mapping to CEDT, what part of current CEDT is still valid
 - Provide a knowledge base for what is requested on the CEDT
 - ADHC Eligibility Criteria: Welfare and Institutions Code, Section 14525
 - Medical Necessity Criteria: Welfare and Institutions Code, Section 14526.1 (d)
 - Required Core Services: Welfare and Institutions Code 14550.5
- 2. Lessons Learned**
- 3. Answer Questions**

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 **Understanding the Law**

1. There are specific eligibility and medical necessity criteria in the Welfare and Institutions Code that must be met for each CBAS Eligibility Category.
2. Questions that need to be asked in order to meet that criteria have been included in the CEDT form.

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 **Legally Acceptable**

1. Welfare and Institutions Code, 14525 and 14526.1, and 14550 and 14550.5
2. Settlement Agreement
3. California Bridge to Reform Demonstration Waiver, Special Terms and Conditions, Page 44 - 56

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 **CBAS Eligibility Criteria – 5 Categories**

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Steps of Assessing Eligibility

Points to Remember

- A. Meet "ADHC Eligibility" & "Medical Necessity" criteria
- B. Incremental Needs Assessment
- C. ADL/IADL Compromises Identified (Cat 2 & 4)
- D. Community Support Mitigations Captured
- E. Risk of Institutionalization characterized
- F. Summarized Need for CBAS Services
- G. Outcome Aligned with Assessment Detail

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Mapping Process to CEDT Section

A •DO NOT USE – For Original Transition Only
B •DO NOT USE – For Original Transition Only
C •DO NOT USE – For Original Transition Only
D •DO NOT USE – For Original Transition Only
E •Diagnoses & Medications
F •Medication Administration
G •ADL / IADL's
H •Assistive / Sensory Devices
I •Systems Review
J (Part 1) •Current Care Plan & Circumstance Description
J (Part 2) •Comments / On-Site Review Findings
K •Reviewer Determination

- A. Incrementally Capture Needs & Qualifications ... acknowledge every section!
- B. Summarize Why or Why Not a Need for Daily CBAS Services in "J" (part 2)
- C. Make sure the "Reviewer Determination" path is clearly documented

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The 5 Categories of CBAS Eligibility

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ADHC Eligibility Criteria
Welfare and Institutions Code, Section 14525

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Eligibility Criteria

Must meet all 3 of the following criteria to qualify for CBAS:

(Welfare and Institutions Code, Section 14525)

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Eligibility Criteria
Welfare and Institutions Code, Section 14525(a)

1 of 3

The person is 18 years of age or older

and has one or more chronic or post acute medical, cognitive, or mental health conditions,

and a physician, nurse practitioner, or other health care provider has, within his or her scope of practice, requested ADHC services for the person

(The term ADHC is still in statute and referenced in the Bridge to Reform 1115 Demonstration Waiver)

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 **Eligibility Criteria**
Welfare and Institutions Code, Section 14525(c)

2 of 3

The person requires ongoing or intermittent protective supervision, skilled observation, assessment, or intervention by a skilled health or mental health professional

to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive, or mental health condition.

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 **Eligibility Criteria**
Welfare and Institutions Code, Section 14525(d)

3 of 3

The person requires adult day health care services, as defined in Section 14550, that are individualized and planned,

including, when necessary, the coordination of formal and informal services outside of the adult day health care program to support the individual and his or her family or caregiver in the living arrangement of his or her choice and

to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services, or placement in a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care.

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 **Eligibility Criteria**
Welfare and Institutions Code, Section 14525(e)

3 of 3 continued

Any person who is a resident of an intermediate care facility for the developmentally disabled-habilitative shall be eligible for adult day health care services if that resident has disabilities and a level of functioning that are of such a nature, that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.

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ADHC Medical Necessity Criteria

Welfare and Institutions Code, Section 14526.1 (d)

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Must meet all of the following criteria to qualify for CBAS:

(Except for participants residing in an intermediate care facility/developmentally disabled-habilitative)

(Welfare and Institutions Code, Section 14526.1(d))

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Medical Necessity Criteria

Welfare and Institutions Code, Section 14526.1 (d) (1)

Assess Needs for Chronic Qualifying Conditions (Dx, Meds, etc.)

The participant has one or more chronic or post acute medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization:

(A) Monitoring
(B) Treatment
(C) Intervention




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Medical Necessity Criteria
Welfare and Institutions Code, Section 14526.1(d)(2)

For Category 2 or 4 ONLY:

(A) Limitations in the performance of two or more activities of daily living or instrumental activities of daily living/ or one or more from either ADL's or IADL's.

(B) A need for assistance or supervision in performing the activities identified as related to the condition or conditions that qualify the participant for ADHC. That assistance or supervision shall be in addition to any other non-adult day health care support the participant is currently receiving in his or her place of residence.

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Medical Necessity Criteria
Welfare and Institutions Code, Section 14526.1(d)(3)

The participant's network of non-adult day health care center supports is insufficient to maintain the individual in the community, demonstrated by at least **ONE** of the following:

(A) Participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision

(B) Participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the Participant

(C) Participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the Participant

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Medical Necessity Criteria
Welfare and Institutions Code, Section 14526.1(d)(4)

A high potential exists for the deterioration of the Participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if adult day health care services are not provided.

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Medical Necessity Criteria
Welfare and Institutions Code, Section 14526.1(d)(5)

The Participant's condition or conditions require adult day health care services specified in subdivisions (a) to (d), inclusive, of Section 14550.5, on each day of attendance, that are individualized and designed to maintain the ability of the Participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalizations.

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Required ADHC Core Services
Welfare and Institutions Code, Section 14550.5

Required ADHC Core Services

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Required ADHC Core Services
Welfare and Institutions Code, Section 14550.5

ADHC shall offer, and provide directly on the premises, in accordance with the Participant's plan of care,

and subject to authorization pursuant to Section 14526,

the following **core services** to each Participant during each day of the Participant's attendance at the center:

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 **Required ADHC Core Services**
Welfare and Institutions Code, 14550.5(a)

One or more of the following (5) professional nursing services:

1. Observation, assessment, and monitoring of the participant's general health status and changes in his/her condition, risk factors, and the participant's specific medical, cognitive, or mental health condition or conditions **upon which admission to the ADHC was based.**
2. Monitoring and assessment of the participant's medication regimen, administration and recording of the Participant 's prescribed medications, and intervention, as needed, based upon the assessment and the Participant's reactions to his/her medications.
3. Oral or written communication with the participant's personal health care provider, or the participant 's family or other caregiver, regarding changes in the participant 's condition, signs, or symptoms.
4. Supervision of the provision of personal care services for the participant, and assistance, as needed.
5. Provision of skilled nursing care and intervention, within scope of practice, to participant, as needed, based upon an assessment of the participant, his or her ability to provide self-care while at the ADHC, and any other health care provider orders.

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 **Required ADHC Core Services**
Welfare and Institutions Code, Section 14550.5(b)

One or both of the following core personal care services or social services:

1. One of both of the following personal care services:
 - (A) Supervision of, or assistance with, activities of daily living or instrumental activities of daily living.
 - (B) Protective group supervision and interventions to assure participant safety and to minimize the risk of injury, accident, inappropriate behavior, or wandering.
2. One or more of the following social services provided by the ADHC social worker or social worker assistant:
 - (A) Observation, assessment, and monitoring of the participant's psychosocial status
 - (B) Group work to address psychosocial issues
 - (C) Care coordination

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 **Required ADHC Core Services**
Welfare and Institutions Code, Section 14550.5(c)

At least one of the following therapeutic activities provided by the ADHC center activity coordinator or other trained ADHC center personnel:

1. Group or individual activities to enhance the social, physical, or cognitive functioning of the participant.
2. Facilitated participation in group or individual activities for those participant's whose frailty or cognitive functioning level precludes them from active participation in scheduled activities.

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Required ADHC Core Services
Welfare and Institutions Code, Section 14550.5(d)

One meal per day of attendance, unless the participant declines the meal or medical contraindications exist, as documented in the participant's health record, that prohibit the ingestion of the meal.

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CBAS Eligibility Determination Tool

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The CEDT "Tool"

❖ 4 Page Tool
❖ "Approved"
❖ Required for all F2F Asmts

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Using Lessons Learned

9. **Box G needs to be the results of what you see or read in the medical records.**

If necessary, use additional pages to explain or describe what the participant is doing but make sure you put the person's name and date on the additional paper.

10. If ADL's/IADL's are validated by doctor's progress notes, history and physical, nursing or therapy notes, etc.,

...indicate such either next to the box or in the explanation area

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Using Lessons Learned

11. **Box I needs to be completely filled out, or marked as not applicable.**

12. Incontinence is an important factor. Don't skip it. If there is a problem, document it. If there is not a problem, indicate such.

13. Anything that you read when you are reviewing the records regarding these systems should be entered on this form.

14. Remember, the person looking at the CEDT for information on the participant has to figure out ...

if you didn't document it,
did you not see anything,
OR
did you miss something?

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Using Lessons Learned

11. **Box I needs to be completely filled out, or marked as not applicable.**

12. Incontinence is an important factor. Don't skip it. If there is a problem, document it. If there is not a problem, indicate such.

13. Anything that you read when you are reviewing the records regarding these systems should be entered on this form.

14. Remember, the person looking at the CEDT for information on the participant has to figure out ...

if you didn't document it,
did you not see anything,
OR
did you miss something?

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 **Using Lessons Learned**

19. **Box K is only partially applicable. NO Categorically or Presumptively Eligible findings are appropriate. (see Category Crosswalk on next page)**

20. **For the assessor, the determination should have a clear pathway to the conclusion**

21. **For the QA Reviewer, document why you are agreeing or disagreeing with the Assessor's determination.**

22. **For the 2nd Level Reviewer, no disagreeing determination should go without a rationale.**

23. **Any, and all, reasons used to disagree with a determination should be written down in the Comments.**

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 **Mapping Categories in Current Form**

<p>Category 1</p> <p>Category 2</p> <p>Category 3</p> <p>Category 4</p> <p>Category 5 (write on form)</p> <p>↓</p> <p>Developmentally Disabled, as defined through Regional Center Criteria</p>	<p>→ Categorically Eligibility (DO NOT USE)</p> <p>→ Presumptively Eligibility (DO NOT USE)</p> <p>→ Nursing Facility Level A (NF-A) or above</p> <p>→ Organic, Acquired or Traumatic Brain Injury and/or Chronic Mental Illness PLUS demonstrated need for assistance or supervision with at least 2 of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management and hygiene OR 1 ADL/IADL listed above and money management, accessing resources, meal preparation or transportation.</p> <p>→ Alzheimer's disease or other dementia: moderate to severe Alzheimer's disease or other dementia characterized by the descriptors of, or comparable to, Stages 5, 6 or 7 Alzheimer's disease.</p> <p>→ Mild Cognitive Impairment including moderate Alzheimer's disease or other dementias characterized by the descriptors of, or comparable to, Stage 4 Alzheimer's disease. Plus demonstrated need for assistance or supervision with at least 2 of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management and hygiene.</p>
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 **Thank you for your time.....**

Thank you for your time.....

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Provider Perspective

- Brief ADHC 101
- Building the IPC & Level of Service Recommendation
 - Key Elements
- Workflow Barriers & Optimization

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ADHC 101

- Model of Care
 - Individualized and Person-Centered Care Utilizing the Multidisciplinary Team (MDT) and IDT approaches
- Definition of MDT
 - Utilize expertise of multiple skilled disciplines to achieve desired outcomes
- Target Populations & Specialty Programs within ADHC
 - Seniors, MH, DD, TBI, Alzheimer's, Skilled Therapy, Skilled Nursing
- Ethnic Diversity and Language Capacity
- Hours of Operation
 - Program Hours
- Basic Program Services
- Typical ADS Patient Profile

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Health Services

- **Licensed Nurses (RN, LVN):** GT, Catheter Care, Dressings, Skilled Nursing Services, Blood Glucose Monitoring & Intervention, Blood Pressure Monitoring
- **Chronic Disease Management:** Assessment, Monitoring & Early Intervention of Chronic/Unstable Conditions
- **Medications:** Administration, Teaching, Set-up, Management
- **Health Education & Training:** Caregiver, Patient
- **Care Coordination:** PCP, Specialists, Pharmacy, Health Plan
- **Pharmacy Consultation:** Facility Standards, Patient evaluation as requested
- **Personal Care Services:** ADL's & hygiene overseen by licensed staff

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Therapy/Rehabilitation

- **Physical Therapy & Occupational Therapy:** Assessment of functional capacity & rehab potential; Pain Modalities (heat, cold, paraffin) Strengthening/ Balance/ Coordination, Gait & Balance Training, Endurance, ADL/IADL Training, Fall Prevention Programs; Life Skills
- **Speech Therapy:** Preliminary dysphasia evaluation, staff training; cognitive/linguistic therapies & training (i.e. expressive aphasia)
- **Psychiatric Consultation:** Counseling; MH referral
- **Maintenance Program:** Daily exercise; active/passive ROM; may include- ambulation, treadmill, stationary bike, ergometer, pulleys

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Social Services

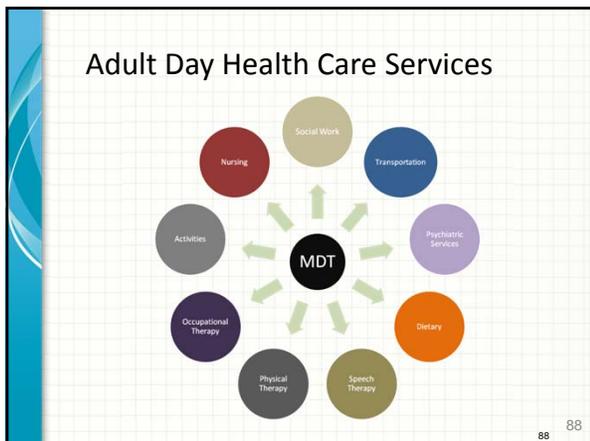
- **SW Assessment:** Cognitive testing (i.e. MMSE, SLUMS). Geriatric Depression Scale, caregiver stress.
- **Home Evaluation:** Safety, teaching & recommendations for DME (i.e. grab bars); evaluation of adequacy & capacity of support systems
- **1:1 Patient Support:** Personal, Housing, Appointments
- **Referrals & Caregiver Support:** MSSP, IHSS, MOW, community/neighborhood/regional programs
- **Support & Educational Groups:** Staff, Community Presentations (i.e. Fire, Bet Tzedek, Alzheimer's Assoc.), Caregiver Support Groups.

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Therapeutic Activities & Meals; Transportation

- **Activities:** Gross & Fine Motor Skills, Cognitive Stimulation, Group/ Individual Activities & Socialization
- **Transportation:** To/From Facility; Transportation coordination for outside services
- **Meals:** Registered Dietician (patient consultation available), ADA, Renal, Low Fat/Low Sodium; At least one daily

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- ### ADHC Patient Profile Data
- % with 3+ chronic diagnoses: 100%
 - Average # Chronic Diagnoses: 6
 - Percentage with 6 or more dx: 77%
 - Cardiovascular: 72%
 - Dementia: 54%
 - Diabetes: 31%
 - Mental Illness: 38%
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- ### Patient Profile Continued
- % need of assistance with ADL's: 67%
 - % assistance with med management: 97% and 55% med management provided at Center
 - % with 6 or more meds: 84% 6 or more meds with average of 10 meds.
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Dual Population Needs

- 37% have both chronic conditions and functional limitations
- No single entity responsible for ensuring they get services and supports they need
- Requires biopsychosocial approach
- ADHC/CBAS model of care unique because provides bridge between medical support, LTSS, and community.

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IPC Development & Level of Service Recommendation – Key Elements

- Person-centered care based on biopsychosocial assessment
- Team looks at combination of chronic conditions, skilled and unskilled needs, functional impairments and caregiver support that place people at high risk for institutionalization
- Team evaluates what formal and informal LTSS are present, effectiveness of support systems, and the additional services needed.

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IPC Development and Level of Service Recommendations (Continued)

- Risk factors critical to developing level of service
- Care coordination needs and linkage between medical and community neighborhood
- Optimizing functional independence and reducing secondary disabilities
- Level of service considers both patient and caregiver needs that place them at high risk for institutionalization
- Utilizes unique skills of IDT to provide care, facilitate transdisciplinary approach, and reduce duplication of services.

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Workflow Barriers & Optimization

- Referral process today pre-transition
- CEDT tool originally designed for post IPC review
- Initial screening identifies probable participant but MNC is currently established via MDT assessment process
- Timeliness of History & Physical
- Timeliness of MCMC F2F & CEDT completion
- Care coordination between ADHC & Health plan
- Post transition COHS example

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Level Of Service Adjudication

A. When requesting the number of days per calendar month, the provider must ensure that the request is related to the participant's problem(s) and the number of days needed to carry out the IPC.

B. When determining the appropriate number of days per calendar month to authorize, consider the following five factors (next slide):

Service - Accountability - Innovation

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Level Of Service Adjudication

1. Overall health condition of the participant, relative to the participant's ability and willingness to attend the number of days
2. Frequency of services needed
3. The extent to which other services currently being received by the recipient meet the recipient's needs
4. If the personal health care provider or CBAS center physician has requested a specific number of days
5. When requesting the number of days per calendar month, the provider must ensure that the request is related to the participant's problem(s) and the number of days needed to carry out the IPC.

Service - Accountability - Innovation

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Closing Remarks

Service - Accountability - Innovation 97



Thank You!

Service - Accountability - Innovation 98
