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**Presentation to the California State Assembly Committee on Aging and Long Term Care
Assemblywoman Mariko Yamada, Chair
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Chairwoman Yamada and Distinguished Assembly Members:

Thank you for inviting me to share my concerns about the closure of California's Adult Day Health Care programs and the consequences for their 35,000 enrollees.

I am an academic geriatrician at UC Davis Medical Center, and ADHC's senior and disabled adult clients are a lot like the patients in my own geriatrics clinic. These are complex and challenging patients with multiple medical, functional, and psychosocial problems, and they are at high risk for ER visits and hospitalizations.

In Great Britain, Canada, and the United States, adult day care has played an important role in the panoply of community-based long-term-care whose role, we must recall, is not simply to prevent or delay institutionalization but to improve the quality of life of frail seniors, disabled adults, and their family caregivers through optimizing functional status, helping with chronic disease management, and providing unmet service needs. I am very concerned that the Dept of Health Care Services' plans for transitioning current ADHC members into alternative services are inadequately developed and will leave major service gaps for many former enrollees that could jeopardize their well-being. And there are no plans to address the needs of the thousands of individuals who would have been eligible for ADHC after December 1.

According to the California Dept of Aging, the purpose of ADHC is "to delay or prevent institutionalization and maintain individuals in their homes and communities for as long as possible." That's clearly important to patients and to the state budget, but we have learned that adult day care is not a simple substitute for institutionalization. The VA Adult Day Health Care Evaluation Study in 1993 showed that the use of community-based long-term care, including adult day care, was paradoxically an independent predictor of nursing-home placement. Twelve years later McCann and colleagues found that every additional day spent in adult day care was associated with a 33% increased relative risk of nursing-home placement for men and a 9% increased relative risk for women. Is this a failure of adult day care? Not really. Some caregivers choose ADHC as a step along the road to institutionalization, rather than as a detour. The social resources offered by ADHC's may actually make it easier for a caregiver to institutionalize a family member by providing guidance, validating the caregiver's needs, and allowing the caregiver time to look for the right facility. That's not a failure – it's good social support.

Research has revealed important risk factors for institutionalization that ADHC *is uniquely suited* to address. Cohen-Mansfield and colleagues showed that depression in the day-care *client* as well as the *client's* lack of socialization significantly predicted nursing-home placement. Depression in older persons is highly under-diagnosed in primary care because of its often subtle presentation without overtly depressive symptoms. Being confined to the home with little interaction or stimulation contributes to depression. Adult day care provides activities and socialization, and has the ability to screen for depression and objectively monitor the

effectiveness of treatment in a way that sporadic patient contact in ambulatory care just can't replicate.

Caregiver burden has also been shown to significantly predict institutionalization. ADHC can do wonders for reducing caregiver burden, especially for the caregivers of persons with dementia. A recent systematic review of predictors of nursing-home placement in dementia showed that caregiver stress was consistently a major predictor in nearly all the studies examined (Gaugler, 2009). In a study comparing ADHC-using dementia caregivers to a comparable group of control dementia caregivers, the ADHC caregivers had substantially less caregiver overload and depression at 3 and 12 months of follow-up. There's another compelling reason why reducing caregiver burden is crucial: we have shown in a population-based study of seniors that older caregivers of spouses living at home and experiencing caregiver strain had a 63% greater chance of dying over 4 years than non-caregiving controls (Schulz and Beach, 1999).

It is naïve and simplistic to think that moving Medi-Medi ADHC clients into managed-care programs will enable comparable services to be provided or that former clients will reap similar benefits. At the present time, the only senior HMOs in California that incorporate community-based long-term-care services are the social HMO, SCAN, in Long Beach and On Lok in San Francisco. Will the enhanced per-month capitation rate for former ADHC clients promised by the DHCS lead to community-based long-term care services that can match what ADHC provided? That seems unlikely, and all of California's managed-care plans except SCAN and On Lok lack the necessary training, experience, and resources in community-based long-term care. Let's review some of the services that will be compromised.

Respite: Plans are supposed to "assess the medical and social support needs of the beneficiaries and find appropriate providers" or refer them to outside services that can meet those needs. This includes "facilitating" additional hours of service from IHSS. IHSS recipients are currently getting hours cut and IHSS itself is in jeopardy of defunding! An unskilled IHSS worker theoretically can provide time for the caregiver to leave the home, but an unskilled IHSS worker cannot assess medical conditions or provide group activities and socialization. Do we want our children or grandchildren to be baby-sat in front of the TV cooped up inside the home, or be stimulated in day care? Don't we want the same for our parents as for our kids?

Case management: Although it is in the financial interest of managed care to efficiently case manage chronic medical conditions, the ability to do this is compromised by the usually long intervals between clinical and telephone encounters. Nothing substitutes for frequent direct assessment by an ADHC nurse of conditions like congestive heart failure (a major cause of hospitalization), chronic lung disease, diabetes, chronic wounds, hypertension, the behavioral complications of dementia, depression, weight loss and failure to thrive, and the response to prescribed therapy for an acute infection or illness. These nurses are the eyes and ears of the primary-care provider and a great asset in disease management that we'll lose. Without timely collaboration with ADHC nurses, many of the aforementioned conditions can lead to avoidable doctor and ER visits, as well as unnecessary hospitalizations. The VA Adult Day Health Care Evaluation Study found that patients randomized to adult day care had lower outpatient clinic expenses, suggesting that ADHC-based medical monitoring can reduce medical-care costs for their clients.

Rehabilitation and the maintenance of physical functioning: Impaired mobility and disability in basic self-care abound among ADHC clients. Medicare Part A funds post-hospitalization transitional care and rehabilitation in nursing homes, while Part B funds rehabilitation for home-bound Medicare recipients. Both of these benefits are short-term; neither cover the maintenance

of physical function. This is exactly what the rehab component of ADHC can do. Since patient disability is a significant risk factor for institutional placement, especially with older caregivers, maintenance of physical function is crucial.

Nursing-home use: ADHC may not prevent as much long-term custodial care as was originally hoped. Nonetheless, many older patients are admitted to nursing homes following hospitalization for rehabilitation, and are discharged back home when they reach goal or a plateau of improvement. At discharge to home, many patients' functional status is marginal. ADHC-based rehab can build on or maintain gains made in the SNF, and may allow families to take their loved ones out of the nursing home sooner, or to risk taking them out, rather than moving them into custodial care.

The DHCS' plan mentions that the managed-care organization might "choose to provide...services...through a contract with a former ADHC." Separate from managed care, DHCS also proposes that ADHC centers might receive waivers to perform in-home operations like case management, nursing, and personal care services, as well as to provide waiver services in the center itself. Now this is interesting! How many ADHC's will be left around with which to contract? The DHCS wants to reformat the activities of surviving ADHC centers while adding layers of bureaucracy and red tape (at additional expense) when there is no objective evidence to support the benefits or cost-effectiveness of these new services.

ADHC's are perfectly suited to provide for managed care what they currently provide to the broader medical community. Standardized, formalized collaboration of ADHC's with managed care, not their dissolution, makes enormous sense, and would provide managed care with access to existing programs instead of starting from scratch. The creation of new standards and protocols for programmatic integration won't work if managed care plans have the option of not linking with ADHCs. Moreover, ADHCs need a predictable client base to project budgets. If the current costs of ADHC could be shared between the state and managed care, there still could be a net cost savings for California. And this would provide, on a state-wide basis, an opportunity for ADHC's to systematically expand refine their goals, targeting of clients, procedures, and outcomes assessment in order to improve the quality of care of the most vulnerable patients and their caregivers.

Integrating ADHC with managed care seems a lot like a return to social HMO's, a state-wide expansion of concepts pioneered by On Lok and SCAN. California has an opportunity to save money, be a leader in health-care innovation for seniors and persons with disability, AND to save ADHC. But, please, let's go about any change in the *status quo* in a thoughtful, systematic, step-by-step manner that first employs empirical methods to develop demonstration projects that collect data on health outcomes and cost effectiveness, so that integrated healthcare for seniors and disabled adults in California can be a success, not a mess. Let's not waste resources, at the expense of the taxpayer and vulnerable dependent adults' welfare, to build a new long-term-care model when the key parts already exist and work.

Thank you!