Mental Health Services for Californians with Alzheimer's Disease

A presentation by Cordula Dick-Muehlke, Ph.D. and Susan DeMarois
to the California Health and Human Services Agency,
Alzheimer's Disease and Related Disorders Advisory Committee
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Special Thanks to Our Author and Many Contributors

Cordula Dick-Muehlke, Ph.D., is a licensed clinical psychologist who has dedicated the past 32 years to bettering the lives of people with Alzheimer's disease and their families.

Dr. Dick-Muehlke previously served on the CHHS Alzheimer's Disease Advisory Committee, including 5 years as chair, and led the Care and Support workgroup for development of the Alzheimer's Disease State Plan.

Why Focus on this Population?

The Need is Pronounced

- 97% of individuals with Alzheimer's disease experience behavioral and psychological symptoms that complicate their care, increase costs, and decrease quality of life
- As cognitive impairment advances, symptoms that may emerge include: agitation, verbal and/or physical aggressiveness, delusions, hallucinations, disinhibition, hyperactivity (wandering, pacing, rummaging), and sleep disturbances

Why Focus on this Population?

The Issue is Persistent

- First examined in SB 639 Report (2003)
- Reinforced in the Alzheimer's State Plan (2011)
- Presented to committee by Janet Yang, Ph.D. (2016)

The Outcomes are Poor and Costly

- Documented rise in Medi-Cal hospital and NF days
- Medicaid spending is 19 times higher for beneficiaries with Alzheimer's disease

The Challenge is Growing

- 37.7% increase in population size to 840,000 Californians by 2025
- 58.7% increase in Medi-Cal spending on dementia over next decade to $4.9 billion annually

Reorienting Our Thinking

- What are the unique characteristics and needs of persons with dementia?
- What are the behavioral and psychological changes associated with dementia?
- What are the appropriate services, supports, and interventions?
- Where are the gaps and system failures?

Our Approach to the Paper

Background research

- Review of statute, policies, procedures, program guidance, journal articles and AD Advisory Committee reference materials

Key informant interviews

- County mental health and health plan employees, Alzheimer's Association staff, families, subject matter experts

Reorienting Our Thinking

- People with dementia experience an intertwined set of neurological, medical, and mental health conditions
- Behavioral and psychological symptoms are treatable
- Psychological and psychosocial interventions have benefits
- Health care systems must start addressing the needs of people with dementia

Key Findings

- SB 639 caveat – "as *resources are available"* – is a roadblock
- Bifurcated funding fosters inconsistencies among 58 counties
- Medical necessity criteria differ for county and managed care mental health services
- Urgent/crisis care is a glaring gap in coverage
- Early needs are under-identified

A lot of “ifs” on the road to mental health services for the person with MCI or Alzheimer’s disease

If cognitive impairment identified

If behavioral and psychological symptoms recognized

If referral to mental health professional made and pursued

If mental health professional knowledgeable/skilled in dementia

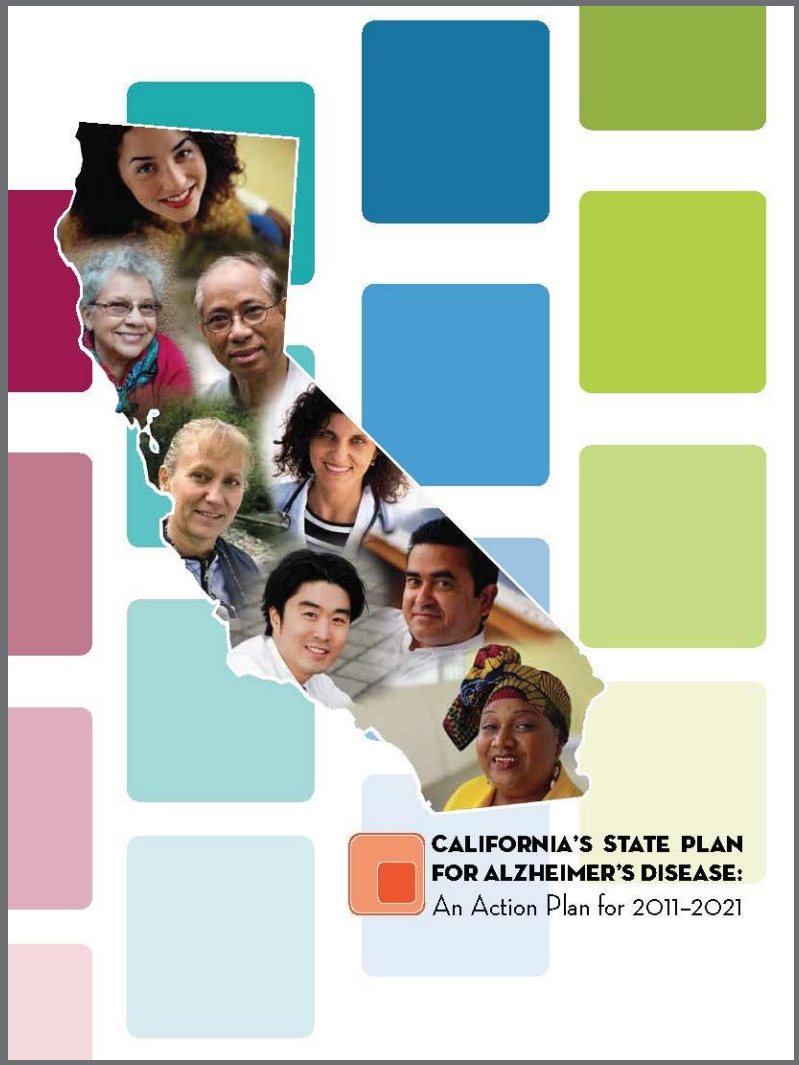
If person viewed as able to benefit

Crisis Mental Health Care is Missing

Outpatient Mental Health Services			
		Primary Financial Responsibility	
Type of Service	**Benefit Coverage**	**Patient meets criteria for MHP specialty mental health services^**	**Patient does NOT meet criteria for MHP specialty mental health services**
Pharmacy	**Medicare**	Health Plan	Health Plan
Partial hospitalization / Intensive Outpatient Programs	**Medicare**	Health Plan	Health Plan
Outpatient services within the scope of primary care	**Medicare**	Health Plan	Health Plan
Psychiatric testing/ assessment	**Medicare**	Health Plan	Health Plan
Mental health services§ *(Individual and group therapy, assessment, collateral)*	**Medicare**	Health plan	Health Plan
Mental health services§ *(Rehabilitation and care plan development)*	**Medi-Cal**	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Medication support services§ *(Prescribing, administering, and dispensing; evaluation of the need for medication; and evaluation of clinical effectiveness of side effects)*	**Medicare**	Health plan	Health Plan
Medication support services§ *(instruction in the use, risks and benefits of and alternatives for medication; and plan development)*	**Medi-Cal**	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
Day treatment intensive	**Medi-Cal**	County	Not a covered benefit for beneficiaries not meeting medical necessity criteria
			Not a covered benefit for

Four Barriers to Access

1. Stigma, Stigma and Stigma
2. Dementia capacity, competency, and capability
3. Funding streams are bifurcated resulting in disjointed services
4. Lack of home and community-based services



These Barriers Have Consequences

"Significant human and financial resources are spent on NOT treating behavioral and psychological symptoms of dementia, escalating costs."

Medi-Cal Data

Top 5% in LTSS:

Dementia (20.4%)

Top LTSS Acute Hospital Admissions:

434.76/1,000 for psychoses

Avg. LOS = 21 days

ER use in CCI for BH

Up to 10.3/1,000

Change the Lexicon – Change the Outcomes

- Instead of “carving out” begin to ***integrate within***
- Instead of explaining why AD isn’t covered, start asking, **“How should it be covered?”**
- Medi-Cal is a bigger umbrella than ever – Mental Health Services Division, Coordinated Care Initiative/Cal MediConnect, waiver programs

Immediate Opportunities for Action

1. Clarify existing coverage criteria and communicate current Medi-Cal funding policy
2. Pilot test specialty services for this population in new Medicaid waiver programs
3. Revitalize Alzheimer's Day Care Resource Centers to support moderate to severely impaired older adults at greatest risk
4. Invest in early detection and diagnosis

Questions & Comments

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