Long Term Care Reform: Recommendations for Change

Introduction
The approaching wave of retiring baby boomers will apply severe pressure to California’s long term care system. To help policymakers and others understand the scope of the challenge — as well as point toward solutions — the California HealthCare Foundation (CHCF) sought to examine the recent history of long term care and provide a forum to find ways to move forward.

In the fall of 2006, CHCF conducted an electronic survey and convened two meetings of long term care experts and leaders to assess the progress of implementing the systemic reforms that were recommended in the 1996 Little Hoover Commission Report, Long Term Care: Providing Compassion Without Confusion and to arrive at new recommendations for enhancing care for elderly and physically disabled Californians. Participants in the strategy meetings included consumer advocates, policymakers, regulators, academics, and providers of long term care.

This group of experts found that California has made little progress in achieving the systemic reforms necessary to provide consumer-directed, outcome-based services in the least restrictive setting appropriate for each person. Ten years later, California’s leaders agreed that a person in need of long term care still faces a bewildering maze of policies, bureaucracies, and programs that ultimately result in the premature erosion of quality of life for many individuals.

Key Findings and Recommendations for Change
The CHCF strategy meeting participants singled out three areas in which immediate reform would result in increased consumer satisfaction and more efficient use of state resources.

1 COMPREHENSIVE HEALTH CARE FINANCING REFORM MUST INCLUDE A LOOK AT THE IMPACT OF LONG TERM CARE COSTS.

CHCF strategy meeting participants agreed that changes in long term care financing should be a high priority for the state. Eighty-nine percent of the respondents thought this was among the three highest priorities to address in the very near future.

RECOMMENDATION: Create a state commission to assess the impact of future long term care spending on health coverage in California and examine ways in which the state can maximize its resources.

Health care financing reform is on the legislative agenda at both the state and national level. Unfortunately, none of the current health care financing proposals address the need for comprehensive reform of long term care spending, which will soon strain government-funded health programs. Following the unveiling of the governor’s reform proposal, only one of the invited commentators mentioned the “silver tsunami” facing the state. Although the often-cited demographics of the aging baby boomers do
not seem to motivate reform, they bear repeating. Older Californians are the nation’s fastest growing age group. In just thirteen years, the number of Californians age 65 and older is expected to increase by 71.3 percent, compared to a 28.8 percent increase for the state’s population overall.

Although these older Californians are expected to be healthier than in the past, their sheer numbers will overwhelm state-funded, long term care programs. The cost of providing medical care for those ages 65 and older is more than four times that of serving non-disabled adults. When long term care spending is defined to include nursing homes, community-based personal care services, and assisted living; an individual has about a 50 percent likelihood of needing one or more of these services in his or her lifetime. The likelihood is even greater for those aged 85 and older.

Current Spending Is Greater than Common Perceptions
Total long term care spending has almost doubled in the last ten years, from $7.4 billion in 1995-06 to $13.7 billion in 2005–06. General fund expenditures for long term care account for almost 8 percent of the state’s total general fund budget.

A decade ago, spending for nursing facilities accounted for 53 percent of total long term care expenditures, outstripping less expensive, consumer-preferred home- and community-based services. Fortunately, that trend is reversing due to the provision of alternatives such as in-home supportive services, assisted living, and adult day services. In 2006 community-based care accounted for 61 percent of the total expenditures. Although some states, such as Washington and Oregon, have adopted gatekeeping strategies for nursing home diversion, this shift in spending occurred without an overall strategy on the part of the state of California to divert consumers from nursing facility admission.

Despite this shift, California is still spending a significant amount on nursing home care. At an annual cost of $55,000 per case and a caseload of less than 100,000 Medi-Cal consumers, nursing facility expenditures accounted for $3.2 billion (23 percent) of total state long term care spending in 2005–06. In 2005, the state changed the payment methodology for nursing homes, increasing expenditures by $214 million. The legislation, AB 1629, provided for an additional increase in nursing facility rates of up to 5 percent in 2006–07, and up to 5.5 percent until 2008.

Split Funding Creates a Fragmented Delivery System
Split Medicare and Medicaid funding streams create the programmatic silos that result in troublesome consequences for users and for the state. Because the state and federal government each have some component of the long term care system, Medicare and Medicaid often operate at cross purposes, each striving to minimize spending for beneficiaries — regardless of the fact that acute and long term care management of functional and medical problems are often indistinguishable to the long term care patient. For example, since Medicare does not pay for less costly home- and community-based services, older persons often go to nursing homes following a hospitalization, even though an appropriate level of care can be provided in their homes, where they prefer to stay. At the same time, home- and community-based services reduce hospitalization (paid for by the federal government), but the state picks up the tab. This is a perverse incentive.

The lack of a coordinated state approach to long term care spending has profound implications, not only for the individual, but for the Medi-Cal program and the state’s taxpayers. There is no uniform assessment to determine needed health care services, so data cannot be compared across programs. The various program “silos” collect their data independently, and no single entity has oversight for all the programs or their expenditures. While caseloads and costs for nursing home residents can be estimated with accuracy, there is no way to determine unduplicated caseloads and costs for consumers of home-
and community-based services, since many individuals use multiple services. Consequently, policymakers cannot evaluate the total costs, either per case or on an aggregate basis, of providing services in the home. Whether California’s taxpayers are getting their money’s worth is therefore not known.

**The Burden on Private Payers Is Also Underestimated**

The interplay between public and private funding is often overlooked in policy discussions regarding long term care financing. Most long term care is provided by family and friends in the and community; nearly 80 percent of adults who receive long term care at home receive that care exclusively from unpaid caregivers. Informal caregivers provide more care to frail elders on any given day than all the formal services combined; however, that will soon change. Declining fertility rates among baby boomers means the number of younger family members who will be able to care for their parents will decrease. In addition, the paid workforce will also shrink and workforce shortages will increase the costs of caring for the elderly.

Most older people have limited funds to pay for long term care. Many people pay out of pocket for long term care prior to qualifying for Medi-Cal. While “spending down” is common with today’s seniors, most baby boomers have not saved for their retirement needs, much less anticipated the financial burden of long term care. Thus, when this population turns to the state for coverage for long term care, the funding may not be there to cover it.

Relying on long term care insurance products to decrease public spending is not an answer as they represent only about ten percent of long term care funding. Several factors contribute to low levels of purchase. Premium costs are outside the financial reach of most people; by the time they anticipate needing long term care, premiums can be approximately $2,000 per year. These plans have high overhead costs and smaller risk pools. Individuals must pay premiums on their policies for extended periods of time in order to keep them active and a large proportion of those who have purchased long term care insurance allow the policies to lapse within five years of the date of purchase.

**Options for Financing Reform to Be Considered**

Given the future needs of the aging population, the state must grapple with how to pay for long term care in both the near and long term. This will require a comprehensive look at both the public and private financing of long term care and the proposal of innovative solutions that anticipate the impact that the dramatic rise in long term care costs will have on the entire health care financing system.

Short-term options to be explored include alternative delivery systems that blend Medicare and Medi-Cal funding to eliminate the current fiscal incentives that create a bias toward more expensive, less preferable institutional care. There has been some discussion at the national level of “rebalancing” incentives and eliminating the need for waivers so that home- and community-based services are included in states’ Medicaid plans as optional benefits. CMS set up a resource network for states to share their experiences with alternative forms of services and by 2000 began awarding “real systems change grants.” These provided seed money for states to experiment with fundamental alterations in the delivery of services. California received a little more than $3 million for five projects under this grant. In 2002, the federal government launched a five-year program called “Money Follows the Person.” It enables an individual to use the money that otherwise would be paid for nursing home care for community-based services. California was one of 17 states to receive such a grant, which will allow approximately 2,000 nursing home residents to return to their homes within the next five years.

A number of states have successfully integrated delivery systems by allowing participating health plans to provide care coordination services that arrange and pay for both
medical care and supportive services. These programs have resulted in improved care and lower overall costs. In California, the PACE program has provided a model that should be expanded. This capitated model has high client satisfaction and reduces costs over fee-for-service care. Additionally, in 2003, the Medicare Modernization Act allowed Medicare Advantage plans to become certified as Special Needs Plans (SNPs) to serve persons who are dually eligible. Many private-sector health plans operating in California, alert to the growing senior population, moved immediately to become certified as SNPs; however without a change in state statute, none of them offers long term care services. This has the potential to reduce the fragmentation that is evident in long term care.

In addition to examining ways to decrease unnecessary spending, California must examine more comprehensive strategies to ensure adequate financing of long term care. While increasing the use of home- and community-based services, improving long term care insurance products, and employing other innovative ideas (such as the use of reverse mortgages) must be explored, these ideas are short-term fixes that tinker at the margins. The current Medicaid welfare model that leaves many people with unmet service needs and perversely requires individuals to impoverish themselves to qualify will not adequately address the problem in the near future. Healthy debate must address the following issues:

- Should there be a private, public, or mixed model of financing?
- Should at least some part of the solution be universal or voluntary?
- How closely to retirement benefits or disability insurance should long term care financing be tied?

One option that has gained some traction is the creation of a broad-based public insurance product, financed by premiums that will spread the financial risk associated with long term care costs in such a way that ensures universal participation and guarantees consumer choice of purchased services.

2 MONITOR CARE PROVIDED IN RESIDENTIAL CARE FACILITIES

Creating quality measures that can be used across all programs was considered by participants of the long term care strategy meeting to be one of the highest priorities to achieving sustainable, high-quality long term care in California over the next five years. Long term care experts agree that standards for care that span licensing categories should be adopted. It has even been proposed that standards of care should be the same irrespective of licensure category. For example, if an individual needs an indwelling catheter, the requirements for care should be the same regardless of whether the person resides in a nursing home, an assisted living setting, or is being cared for by an individual from a home health or hospice agency or In-Home Supportive Services.

Achieving this level of consistency in measuring the quality of care across settings is a huge undertaking. Charged with targeting a short-range achievable goal, the experts focused on the collection of data regarding the care provided in residential care facilities (RCFs) as an important step in protecting elderly and disabled consumers.

**RECOMMENDATION:** Require residential care facilities (RCFs) to report annually to the Department of Social Services on resident characteristics, staffing levels, facility characteristics, and costs and require DSS to report, in a centralized location, this information and, additionally, to report on complaints and deficiencies.

**Information Available to PolicyMakers and Consumers Is Lacking**

Surprisingly little is known about this industry that provides vital services to individuals who are among the oldest and frailest members of society. The California
HealthCare Foundation provides a Web site (calnhs.org) with information for the public regarding nursing homes and RCFs. Information regarding RCFEs, however, is limited to the number of beds, type of clients served, whether the facility offers a locked or alarmed unit, and the ownership type and name of the owner. On the other hand, information provided to the public about nursing homes includes data about staffing, facility wages, compliance with state and federal regulations, clinical care, and services offered. The equivalent information for RCFEs is simply not available.

Strategy meeting participants noted that many persons currently living in RCFEs would have been cared for in nursing homes ten years ago. The state has less data and information about residential care facilities than any other type of long term care provided in the state. This is largely because seniors and persons with disabilities pay for this type of care out of pocket. With the exception of a very small pilot project, Medi-Cal does not pay for care in these facilities.

To find a facility that meets their needs, consumers must have adequate information to make an informed choice. Many of the quality panel experts pointed out that more comparison information is available for buying a car than for choosing a provider. From a policy perspective, consumer advocates maintain that DSS should collect and centralize information to enable trends in care to be tracked and analyzed to ensure adequate oversight and resident safety.

The Department of Social Services licenses several kinds of residential care facilities (see sidebar) however, the genesis of this recommendation lies in the extraordinary growth of assisted living, which is provided in residential care facilities for the elderly (RCFEs). This paper focuses on those facilities and the care provided in them. However, the experts proposed that the requirement for facility reporting should extend to all types of residential care facilities.

### The Growth of Assisted Living
Assisted living is not a licensing category in California; rather it is an informal designation that is used by the general public for care that is provided in an RCFE. California’s licensure of RCFEs dates back to 1985. Although an improvement over the previous community
care licensing of board and care, at the time RCFEs provided little more than room, board, supervision, and assistance with activities of daily living to residents who did not require on-site health care.

The new licensure category included both the smaller board and care facilities as well as the larger and more sophisticated assisted living that may provide care to 100 or more residents. Currently there are more than 6,500 facilities caring for more than 150,000 residents in California. It is estimated that 70 percent of these facilities are six beds or fewer. Regulating facilities that range in size from six beds to more than 100 presents the state with challenges because of the large number of facilities and the range of care provided in those facilities.

What Is Assisted Living?
For years, residential care/assisted living was understood as a level of care somewhere between complete independence and nursing home care. At its core, assisted living refers to services provided in conjunction with housing for persons who cannot or choose not to live independently. In the past, nursing homes were often referred to as a medical model in contrast to the supportive social model of the RCFE.

However, over the years many modifications have been made to licensing statutes that govern these facilities to accommodate residents’ and family members’ desire to “age in place.” Once a housing option for relatively healthy older persons, these facilities now provide health care services to a population that is increasingly frail, more dependent, and more similar to those in nursing homes. Indeed many of today's nursing home residents would have been cared for in a hospital twenty years ago and assisted living facilities accommodate many who would have been cared for in a nursing home.

Modern RCFEs are hybrid between social models of care and institutions, such as nursing homes, which deliver medical care on a 24-hour basis. In California, assisted living facilities, in-home supportive services, and nursing homes are competitors for the same clients. Over the past decade the number of nursing facility days has stayed virtually the same, while the age 85+ population rose an astonishing 42.3 percent. This demonstrates that many of those previously cared for in nursing facilities are taking advantage of alternatives such as RCFEs, even when they must pay out of pocket for the care.

Balancing a Home-like Setting with the Necessary Resident Protection
The introduction of increasingly sophisticated health services in RCFEs has strengthened the argument that the same care is provided in a nursing home as is provided in a residential care setting. However, assisted living

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**Consumer Protection Questions About RCFEs**

Unlike nursing homes, there is no federal oversight for residential care facilities for the elderly. States may set their own standards of care. Increasingly, consumer advocates are asking the following questions of state licensing agencies:

- What health care conditions can be accommodated in an assisted living facility?
- What level of staffing is considered adequate?
- What obligation does a facility have to meet a particular health care need?
- What conditions can justify a resident being discharged against his or her will?
- What training is required of facility staff members providing direct care?
- What health care expertise is required for facility staff members?
- What minimum number of direct-care staff members is required?

providers have been anxious to protect the flexibility and associated lower costs of this model of care from the highly prescriptive regulations that nursing homes are subject to. Consumer advocates note that less professional staff, fewer regulatory requirements, and less monitoring by the state creates the potential for significant care and safety problems.

State policymakers must balance the goal of sufficient flexibility in the provision of care so that residents can age in place, with the assurances that residents receive adequate and appropriate quality of care.

California's RCFE Standards: Health and Medical Care

California's statutory and regulatory standards for RCFEs have evolved over time to keep pace with the assisted living industry's willingness to accommodate residents with greater care needs. For example, a decade ago, RCFEs were not permitted to care for terminally ill residents. A resident with an identified terminal illness would have been discharged to a nursing facility or acute care hospital. In 1992 the statute was changed to allow residents who had resided in an RCFE for a minimum of six months to receive hospice services in the facility. In 2002, the statute was again amended to permit any resident to receive hospice services at any time after admission to the facility. Facilities must first obtain a hospice waiver to retain a patient needing this type of care.

However, it is not known how often this new statutory provision is used. Because residential care facilities are not required to report this information, it is unknown what the implications and outcomes are of these various policy decisions.

Incidental medical care may be provided in an RCFE through a home health agency, and the licensee and home health agency must agree in writing on their respective responsibilities. RCFE regulations prohibit the admission or retention of persons with stage 3 or 4 pressure ulcers; naso-gastric tubes; gastrostomies; tracheostomies; and staph or other serious infections. Residents who depend on others to perform all activities of daily living cannot be admitted and must be discharged if they deteriorate to total dependency. On the other hand, while bedridden individuals are disqualified from remaining in the facility, a bedridden individual may be admitted if “fire safety requirements are met, alternative methods of protection are approved, or if the facility has appropriate and sufficient staff, mechanical devices, and safety precautions.

Some medical conditions are restricted and regulations specify the circumstances under which residents may receive care for the following conditions: administration of oxygen; catheter care; colostomy or ileostomy care; contractures; diabetes; enemas or fecal impaction; incontinence of bowel and bladder; injections; intermittent positive pressure breathing machine; stage 1 and 2 pressure sores; and wound care.

Residents may be discharged if the facility lacks the capacity to provide adequate services; if the resident's need for services is beyond the scope of the facility's license; or if the resident violates the conditions of the admission agreement.

In general consumer advocates believe that assisted living standards must be strengthened to guarantee a reasonable level of quality. Providers, on the other hand, fear replication in RCFEs of the overly prescriptive standards that may have improved quality of care but have diminished the quality of life for nursing home residents.
ENHANCING HOSPITAL DISCHARGE PLANNING WOULD LEAD TO SMOOTHER TRANSITIONS BETWEEN SETTINGS

The need to promote a seamless continuum of services was viewed by 69 percent of expert respondents as being the highest priority to prevent people from premature deterioration and institutional placement. The long term care strategic leaders recommended legislation that optimizes choices for consumers by intervening in transitions between the hospital and other care settings. Although many of the long term care experts would advocate for financing and system delivery that fully integrates health care with the social services necessary to support the independence of older people, such proposals have been defeated in California. Improving transitions between hospitals and other care settings is a more modest proposal for creating coordinated delivery of services — and one that would appreciably ease the stress of accessing needed services for significant number of older persons.

In addition, strategy meeting participants noted that improving care transitions conforms to the spirit and requirements of the Olmstead decision. In 1999, the U.S. Supreme Court issued a decision that states are obliged by the Americans With Disabilities Act to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services. While the facts of the Olmstead decision revolved around two institutionalized women who desired to transition back to the community, policymakers and consumer advocates were quick to conclude that it is simpler to prevent long term institutionalization than to transition institutionalized persons back to the community. Diversion is an important component of California’s Olmstead plan and better discharge planning could result in more patients avoiding institutionalization.

RECOMMENDATION: Improve transitions from hospitals to home- and community- based services by strengthening discharge planning.

The need to divert patients from very expensive, less desirable nursing home care to home- and community-based long term care services has been a long-standing priority for many who work in long term care operations or policy. A common occurrence is a sudden event, such as a fall, or a medical crisis, such as a stroke or pneumonia, that prevents a person from continuing to live completely independently. Hospitalization can be a turning point in the life of an older person; physical and mental health often deteriorates after discharge. As hospital stays have shortened, discharge planning has decreased in many hospitals — often to the point of simply providing patients and their families with a list of nursing homes in the area.

Adding to this confusion is the almost complete disconnect between health and social services for the aging consumer. Unlike the transfer agreements that formalize patient transitions between hospitals and nursing facilities, the relationship between hospitals and home- and community-based providers is informal or non-existent. California has a number of alternatives to nursing home care including Adult Day Health Care, MSSP, and Linkages case management programs; In-Home Supportive Services; and other supportive services, including transportation, home delivered meals, specialized transportation, and family caregiver supports. However, patients and families are left on their own to identify the mix of services that might best support continued independence.

Information and advice about home-based services, eligibility, and caregiver support is rarely provided by discharge planners — more often these services come to caregiver’s attention through friends or Web sites. Occasionally, knowledgeable physicians provide families with referrals. In addition, each of the services and
programs have their own funding streams, eligibility criteria, and levels of service. Differing eligibility criteria mean the individuals needing long term care may be assessed by three or four different agencies to enable them to remain at home.

Even if family members are able to line up the constellation of services for an older person, service needs that were not apparent when the older person was in the hospital often surface upon returning to home. Because there is no ongoing monitoring of services once the person leaves the hospital, unnecessarily poor outcomes and re-hospitalization often result.

Enhancing and strengthening the discharge planning process is an incremental step toward creating a delivery system that appears seamless to the consumer. From a policy perspective, improving discharge planning could result in decreased spending. Poorly executed transitions are associated with inefficiencies and duplication of tests and services that needlessly increase the cost of care by leading to greater use of hospital, emergency, post-acute, and ambulatory services.

Other Models for Transitioning Consumers to Home
Many participants advocated adopting a gate-keeping program similar to that used by the State of Washington. Since the mid-1980s, the state of Washington has been a leader in creating a comprehensive long term care system that combines policy development, regulation, licensing, payment, and management of all services in one state agency. The system adopted by Washington is frequently referred to as “a single point of entry.”

Components of this model include:

- **A standardized initial assessment.** A sophisticated, computerized assessment tool is used by nurses and social workers to determine functional ability, develop care plans that reflect consumer preferences, and authorize payment for services. A resource algorithm converts information on activities of daily living, treatments, skin conditions, and cognitive impairment into hours of service.

- **Case Management.** The state Administration on Aging assigns a case manager to any person admitted to a nursing home within seven days of admission to inform them of their right to decide where they will live and to discuss their preferences, projected care needs, and the support available in the community. After this meeting, a transition plan is developed.

- **Support for Transition Expenses.** Several financing mechanisms support maintenance of an existing residence or reestablishment of a residence. Among the funding mechanisms is a discharge allowance that provides up to $816 in state general revenues to help a beneficiary move from a nursing home, hospital, or residential care facility to a less restrictive setting.

**California’s Current Non-system**
In many respects, the term health care system is a misnomer. There are few mechanisms in place for coordinating care across settings, and often no single practitioner assumes responsibility during patients’ transitions. Currently, regulatory or accrediting bodies pay little attention to transitions.

**State Requirements**
California Health and Safety Code 1262.5 and .6 require hospitals to make appropriate arrangements for those patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. In addition, hospitals are required to provide patients transferring to nursing facilities with a transfer summary that includes the patient’s diagnosis, hospital course, pain treatment and management, medications, treatments, dietary requirements, rehabilitation potential, known allergies, and treatment plan. For patients returning to home or other settings, hospitals are required to provide information regarding each medication dispensed.
Federal Medicare Conditions of Participation
The federal Medicare Conditions of Participation (42 CFR 482.43) requires hospitals to have discharge planning processes in effect that evaluate, at an early stage of hospitalization, the likelihood of a patient needing post-hospitalization services and of the availability of those services. The evaluation must include the patient’s capacity for self-care or of the possibility of the patient returning to the environment from which he or she entered the hospital.

Additional federal standards include: (1) arranging for the initial implementation of the patient’s discharge plan; (2) counseling for the patient and family members to prepare them for post-hospital care; (3) the inclusion of a list of skilled nursing facilities or home health agencies that participate in the Medicare program and that serve the geographic area; and (4) documentation that discharge planners have informed the patient or their family that they have the freedom to choose among participating Medicare providers and, whenever possible, respect patient and family preferences when they are expressed.

Finally, the standards require hospitals to reassess their discharge planning process on an on-going basis.

State and Federal Standards Leave Much to Be Desired
While most hospitals subscribe to the philosophy that “discharge planning begins on admission,” there are a number of reasons why the discharge planning process fails to deliver the help that patients and families need. Currently, discharge planning is not a reimbursable service. And, although not synonymous, in most hospitals discharge planning and utilization review are interrelated functions. Medicare prospective payment and managed care provide strong incentives to limit the length of stay in hospitals, decreasing the amount of time that discharge planners have to spend with families to conduct thorough assessments of patient needs and desires and to line up the appropriate mix of support services. Given these limitations it is often easier to recommend nursing home placement.

Components of Enhanced Discharge Planning
The experts convened by CHCF concluded that enhanced standards for discharge planning are needed to ensure better transitions between care settings. Although not all patients are at risk for adverse events following discharge, all patients need as much information as possible to ensure that transitioning from one setting to another has the greatest possibility of success. The discharge planning process would be improved by shifting the concept of patient discharge to that of a patient transfer with continuous management and by establishing protocols in the following areas:

- **Assessment of patient preferences.** Often the biases of the medical community (for example the tendency to put patient safety before restoring independence) influence discharge decisions. Researchers at USC concluded that the services that patients and their families know about bias their decisions. Current assessments are not designed to increase the probability that respondents can answer the questions in an informed manner. Providing information to patients and their families about all the available options for living arrangements prior to making discharge decisions would ensure an informed choice rather than reinforce institutional bias.

- **Assessment of service needs.** Ideally assessment of the service needs would occur after living arrangements were determined. It is possible to deliver the same set of medical services to someone living at home, in residential care, or in a nursing home. Development of the service plan should take into account the person’s medical needs, functional needs, social and care giving supports, and, financial situation and health care coverage.

- **Written service plans.** A written discharge service plan should accompany the patient to the next setting. In collaboration with the patient and family
members, a service plan should be developed that details the services and activities that are planned for the first month of the person’s discharge, including a clinical summary of the patient’s stay, medications that have been prescribed, physician and therapy appointments for follow-up, delivery of durable medical equipment, and, for those returning home, other services such as chore service and home-delivered meals.

- **Communication across settings.** Discharge planners should be required to communicate with both professional and informal caregivers across all settings. Discharge planners routinely give nursing facilities information (both by phone and in written summaries) regarding patients’ medical and functional needs and physician orders for medications and treatments. The same information should be given to home- and community-based service providers upon discharge.

- **Availability.** Discharge planning staff should be available to the patient, caregiver, and receiving institution or community-based service organization for 72 hours to discuss the service plans or concerns the patient may have.

- **Training of discharge planners.** Many hospital discharge planners have little exposure to the care delivery sites that they routinely send patients to. Hospitals should require discharge planners to meet with care managers of receiving institutions and agencies routinely to enhance communication and respond to the needs of chronically ill patients.

- **On-going monitoring.** Within a month of discharge, hospital staff should conduct surveys to determine the effectiveness of service plans and to monitor the capability of the agencies and institutions to provide care for persons with chronic medical needs.

**Conclusion**

The three major recommendations of the strategy meeting participants offer concrete direction for improving long term care in California.

First, without changes in long term care financing, the aging population will create on-going pressure for Medicaid to further increase long term care spending. Currently the debate around reforming health care describes a “broken system.” Without a comprehensive look at long term care spending, current proposals, as laudable as is the goal of universal coverage, will flounder in a few short years as spending for the elderly increases. The window of time in which to avoid a crisis is narrowing. A comprehensive plan that anticipates future needs could maintain high quality in the system and insure choice and independence for consumers.

The question of who pays for enhanced standards of care also needs to be addressed. States such as Washington have found that using state personnel to assess patients prior to admission and to develop service plans for home- and community-based placement have resulted in a decrease in nursing facility spending. If hospitals are required to provide enhanced services, it is understandable that the costs of such services will need to be addressed.

Second, recognizing that neither good policy decisions nor consumer choice are adequately supported by existing trend data on assisted living, the long term care experts at the CHCF strategic meeting advocated that all RCFEs report annually to the Department of Social Services on complaints, deficiencies, resident characteristics, staffing levels, facility characteristics, and costs. It goes without saying that it is not enough to accumulate data; it must be made available to the public in a format that makes it easy to compare facility characteristics and performance.

Lastly, post acute service providers are keenly aware of the limitations of current discharge planning. The work group convened by CHCF wanted to strengthen
both the standards and process involved for people transitioning across settings. However, responsibility for greater ease of transfers does not lie just with the hospitals that are sending patients to another setting. Home- and community-based long term care providers who wish to ensure that older persons are able to avoid institutionalization have a responsibility as well. Many agencies have not equipped themselves to be responsive to the needs of the hospital and have not made the effort to form collaborative relationships with hospitals. Many agencies have long waiting times for admission to their services. Most don’t have people on call over the weekend. Improved care transitions require both hospitals and community-based organizations to understand each others needs to increase communication — both around the service needs of specific patients and the strategic needs of each organization.

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