LONG-TERM SERVICES AND SUPPORTS

SHAPING THE DELIVERY SYSTEM TO PLAN FOR MEMBERS WITH NEEDS OF LONG-TERM SERVICES AND SUPPORTS

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DHCS
California Department of HealthCareServices

SHAPING THE DELIVERY SYSTEM

- Topics of Discussion:

  - Understanding the characteristics of a high cost population
  - Targeting the populations with "impact-able" health outcomes
  - Service delivery: key components and organization of delivery systems
  - Role of CCI and housing: new partnerships
  - Measuring outcomes

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SKILLED NURSING FACILITY RESIDENT CHARACTERISTICS

Characteristics

- Total Population = 62,573 with LTC Aid Code
  Age 65+ = 75% of total population
  Age below 65 = 25% of total population

Disease Profile

- Hypertension, Dementia, Diabetes, Mood Disorders, Atrial Fibrillation, Stroke, Chronic Obstructive Pulmonary Disease and Congestive Heart Failure

Measures

- Disease Burden Score = 3.7 Average
- ADL Limitations = 3.0 – 3.7
- Cognitive Limitations = 46 – 55% of Total Population

SNF TRANSITIONS CHARACTERISTICS

Characteristics

- **Transitions since 2009 = 2,000+**
- **Age 18 – 64 = 70%**
- **Age 65+ = 22%**
- **Age under 18 = 8%**

Disease Profile

- **Physically disabled couple with one or more chronic conditions and mental health / substance abuse history**
- **Wheelchair bound, diabetes, depression, chronic obstructive pulmonary disease**

Measures

- **Disease Burden Score = 2.5**
- **ADL Limitations = 2.0 – 2.7**
- **Cognitive Impairments = 25% of Total Population**

COST CHARACTERISTICS

Skilled Nursing Residents		
	Average Annual Cost	Average Monthly Cost
Skilled Nursing Total	**$51,795**	**$4,316**
Medical Expenses	**$13,944**	**$1,162**
• Physician, pharmacy, hospital, other		
Total Costs	**$65,739**	**$5,478**

Home and Community-Based Residents		
	Average Annual Cost	Average Monthly Cost
HCB Services	**$20,212**	**$1,684**
• Skilled nursing, personal care (including IHSS), care management, habilitation, etc.		
Medical Expenses	**$6,441**	**$537**
• Physician, pharmacy, hospital, other		
Total Costs	**$26,653**	**$2,221**

COORDINATING CARE FOR THE LTSS POPULATIONS

- What to look for of the various populations with long-term chronic care needs?

Population	Data / Resources
Nursing Facility (NF) residents	• Frequent ER/Hospital Use • NF Minimum Data Set (MDS) Assessment
Nursing Facility residents who can be cared for in community settings	• Rehabilitation stay to long-term stay • NF MDS Assessment
Community populations in IHSS, CBAS or those not receiving LTSS	• IHSS, CBAS Assessments • Frequent ER/Hospital Use
Chronically Homeless/Superutilizers	• Frequent ER/Hospital Use • Mental Health referrals
End of Life or Palliative Care	• Physician referrals

ORGANIZING DELIVERY SYSTEMS

- Strategies and service arrangements

Population	Organized Delivery
NF residents with frequent ER/hospital admissions	• Improving on-site primary care • NF as clinical partners: training and on-site management
NF residents who can be cared for in community settings	• Transitional care planning • Housing destination: home, residential care facility, independent housing • Post transition care management: primary care, chronic care nursing, supervision, personal care, chore services
Community populations with IHSS, CBAS or those not receiving LTSS	• Primary care and ongoing care management • Chronic care nursing, organized LTSS providers around care plans
Chronically Homeless/Super-utilizers	• Housing provider as partners • Housing project based delivery systems: PCP assignment, chronic care nursing, on-site case management, personal care services
End of Life Palliative Care	• Patient and family education • Advance Directive • Ongoing care management

NEW PARTNERSHIP WITH HEALTH PLANS THROUGH THE COORDINATED CARE INITIATIVE

Opportunity to coordinate care:

- Medical care
- Integrated long-term services and supports (LTSS):
  - **In-Home Supportive Services (IHSS)**
  - **Community Based Adult Services (CBAS)**
  - **Multipurpose Senior Services Program (MSSP)**
  - **Nursing home care**
- Coordination county mental health and substance use programs

CCI Goals:

- Empower people to achieve their health goals.
- Help people stay in their homes -- and stay out of the hospital and nursing home.
- Improve health outcomes.
- Improve care coordination across all health care and social services.
- Increase quality of care.
- Bend the health care cost curve.

NEW PARTNERSHIP WITH HOUSING PROVIDERS

Types of housing arrangements

- Independent living in publicly subsidized housing
  - Rental subsidy allowing plan members to pay one third of income towards monthly rent;
  - Arranged through HUD and other locally established housing vouchers
- Assisted living arrangements
  - Adult Residential Care Facilities or Residential Care Facility for the Elderly;
  - Resident and Facility room, board and care arrangements;
  - Selection of facilities
- Naturally occurring communities
  - Senior Housing; public housing projects
  - Organizing project based service delivery systems

MEASURING OUTCOMES

- Structure and process measures related to:
  - Ability to target and engage specific populations
  - Organization of care management and providers around target populations
  - Education of members and families, training of providers, policies and procedures
- Outcome measures
  - Satisfaction of members, families and providers
  - Reduction of utilization of ER, hospital, short and long-term NF placements
  - Increase utilization of primary care, chronic care nursing, care management, personal care and chore services, and housing prior to NF use and/or placement
  - Reduction of overall health care cost of the target populations

QUESTIONS?

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