Long Term Care Reform:
Ten Years After Little Hoover

California HealthCare Foundation

ISSUE BRIEF

December 2006

New Research Looks Back and Forward

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.

The underpinning for the research is the widely circulated Little Hoover Commission (LHC) report *Long Term Care: Providing Compassion Without Confusion,* which was released in December 1996. The landmark document contained four general findings and 24 recommendations for improving the availability, access, and quality of long term care. To find out what real progress has been made over the last decade in implementing those recommendations, CHCF looked at the actions that have been taken by the state and surveyed the opinions of California's leaders in long term care to evaluate the effect of these actions. The electronic survey, conducted by Grove Consulting, took place in July and August 2006. (The long term care needs of persons who are developmentally disabled or have chronic mental illness were not addressed in the survey.)

After the survey results were compiled, CHCF convened a meeting of long term care experts and leaders to assess the current situation and arrive at new recommendations for enhancing care for elderly and physically disabled Californians.

The Long Term Care Strategy Group included consumer advocates, policymakers, regulators, academics, and providers "in the trenches." Their charge was to review the state's progress over the last decade and weigh options for the future. (A list of attendees is available at www.chcf.org.)

This issue brief looks at the findings from both phases of this research and introduces strategies for the future. Upcoming leadership meetings will examine and discuss recommendations for improving long term care; those detailed recommendations will be released at a later date at www.chcf.org.

Where We Are and How We Got Here

Findings from the CHCF survey and strategic leadership meeting confirm that efforts to fulfill the Little Hoover Commission recommendations have been, for the most part, inadequate. Although there has been substantial expansion and enhancement of individual services and programs, the state has failed to bring about broad systemic change. Overall, California has not met the aspirations that were expressed in the conclusion of the 1996 LHC report:

> *Most long term care advocates believe that the current level of service is inadequate and that the state's efforts are not well directed. Many people go without adequate care and deteriorate to the point of requiring institutionalization because in-home assistance is difficult to obtain. Others are pushed into costly skilled nursing facilities prematurely because of the perverse financial incentives of government assistance.*

The Commission believes that the state's efforts should focus on consumer-directed, outcome-based assistance in the least restrictive setting appropriate for each person. To achieve this, the state must aggressively pursue federal waivers, reform its own conflicting policies, and increase resources in areas that can help people avoid institutionalization.

Limited Progress Made

Some progress has been made toward improving long term care in California, as outlined in Table 1. During the 1970s, the state was a national leader in innovative long term care programs and services. A number of its innovations spread across the nation. These include the In-Home Supportive Services program (IHSS); Programs for All-inclusive Care for the Elderly (PACE); Adult Day Health Care; Alzheimer's Day Care Resource Centers; and Family Caregiver Resource Centers.

Nevertheless, the outlook for long term care in California is worrisome. Progress toward sustainable, high-quality long term care has stalled, and the state now lags behind many others in implementing the systemic changes that could ensure adequate high-quality care while making better use of Medi-Cal and other resources.

Despite huge expenditures, a person in need of long term care services in 2006 still faces the bewildering maze of policies, bureaucracies, and programs noted by the LHC ten years ago. Strictly regimented funding streams and fragmented service programs still skew decisions toward high-cost options not tailored to the needs and desires of consumers. The fragmented delivery system results in consumers who face a confusing and unnecessarily costly system of care, which ultimately results in the premature erosion of quality of life for many individuals.

Implications for People Needing Long Term Care

Many older persons face a sudden event—perhaps a fall or stroke—that causes them and their families to realize that living completely independently is no longer an option. Less often, there is no particular event, but a

Table 1. Actions Taken in Improving Long Term Care in California

ACTION	DESCRIPTION
Executive Order S-18-04	Directed the Health and Human Services Agency to establish the Olmstead Advisory Committee to inform the administration's understanding of the current system of care and recommend priorities regarding diversion, transition, and data collection.
Ombudsman Program funding (2003)	A significant infusion of funds ($1.75 million in 2006) was made available from civil monetary penalties collected from skilled nursing facilities. Funding provided twice-a-year training for ombudsman coordinators. More than 1,000 new volunteers have been recruited in the last three years.
Increased federal funding for caregiving (2002)	Two programs to support caregiving operate in California: 1. The Family Caregiver Support Program administered by the Department of Aging and the 33 Area Agencies on Aging (AAA). The budget for this program is $36 million. 2. Caregiver Resource Centers administered by the Department of Mental Health operate through the network of 11 Caregiver Resource Centers statewide. The budget for this program is $12 million. In some areas, coordination exists between the two programs.
AB 1682 (chaptered in1999)	Required each county to act as an "employer of record" for in-home supportive service personnel for purposes of collective bargaining. The Public Authority model was one option for meeting the "employer of record" requirement. Fifty-six of the 58 counties have established public authorities for the administration of In-Home Supportive Services (IHSS).
SB 2199 (chaptered in 1998)	Enacted enhanced Adult Protective Services in each county, requiring: (1) a continually operational hotline; (2) timely response to all reports of elder abuse; (3) victims of elder or dependent adult abuse to be provided with case management services, including investigation, assessment, and a service plan; (4) the coordination of community resources to provide victims with comprehensive treatment; and (5) emergency services such as shelter, food, and aid. Budget language included a $20 million General Fund increase and an additional $25.3 million augmentation was provided in the 1999 Budget Act.

growing awareness that memory loss or physical decline is endangering a loved one.

Whether or not they have time to prepare, families face a daunting task in lining up the most appropriate services. What they confront is a confusing and uncoordinated collection of programs, each with their own funding streams, eligibility criteria, and levels of service. For the most part, families are left on their own to sort through the options. Physicians and hospital discharge planners are severely limited in the time they can allot to a particular case. Although the state's Area Agencies on Aging offer telephone information and assistance, few people even know of their existence or how to reach them. In any case, most home- and community-based programs are not equipped to respond to a request for assessment within hours — as most hospitals require. In many parts of the state, there is a four-to-six-week waiting list for an assessment by a county social worker for the In-Home Supportive Services program. Differing eligibility criteria means individuals needing long term care may be assessed by three or four separate agencies to enable them to remain at home.

Adding to this confusion is an almost total disconnect between medical and supportive social services. Although the need for an integrated continuum of long term care services has long been apparent, there is little or no communication or coordination between health and social service agencies for the aging consumer. This means it is unlikely that hospital discharge planners have the time or incentive to provide information to inform older persons about services that enable them to return to their homes following a hospital stay.

Implications for State Policymakers

The lack of a coordinated state approach to long term care spending means that consumers (particularly older individuals) often end up in nursing homes, receiving the most expensive, least preferred services. This has profound implications, not only for the individual, but for the Medi-Cal program and the state's taxpayers.

Total long term care spending has grown significantly over the last five years, from about $10.3 billion ($5.3 billion from the General Fund) in FY 2001–02 to almost $14 billion ($7 billion from the General Fund) in FY 2005–06. This represents annual growth of 7.5 percent in overall costs during the time period.

Nursing homes are a still a significant factor in state spending. While there has been some progress toward reversing the trend to institutionalize older persons, the trend persists. At an annual cost of $55,000 per case and a caseload of less than 100,000 Medi-Cal consumers, state nursing facility expenditures accounted for $1.6 billion (23 percent) of total state long term care spending in 2005–06. AB 1629 increased this expenditure in 2005 by $214 million and provided for an additional increase of nursing facility rates of up to 5 percent in 2006–07, and up to 5.5 percent thereafter.

A decade ago, spending for nursing facilities significantly outstripped less expensive, more consumer-preferred home- and community-based services. Fortunately, that trend is reversing due to the provision of alternatives such as assisted living, in-home personal care services, and adult day services. However, the change in spending was achieved largely without an overall strategy on the state's part to aggressively divert consumers from admission to nursing facilities.

In FY 2005–06 estimated state expenditures for home- and community-based services were approximately $4.2 billion, compared to $2.7 billion for institutional care. Home- and community-based services now account for 61 percent of the spending total. Despite state and federal policies that provide incentives for institutional care, nursing home caseloads have remained relatively flat. Even without a coordinated state policy or aligned fiscal incentives, consumers are finding their way to alternatives

that are less costly than nursing home placement. Some 375,000 individuals rely on IHSS at a relatively low cost of approximately $10,000 per case. Although the state does not pay for assisted living (with the exception of a small pilot project), the availability of assisted living services in residential care facilities for the elderly (RCFE) has grown phenomenally (see Table 2).

It is difficult to analyze trends and evaluate the efficacy of various programmatic expenditures for a number of reasons. There is no uniform assessment that compares the functional and medical needs of long term care consumers across programs. The various program silos collect their data independently, and no single entity has oversight for all the programs or their expenditures. Further, the data from the different programs are not always reported by age. While the vast majority of persons in nursing facilities are older, it is estimated that only 40 percent of IHSS consumers are over 65. In addition, while caseloads and costs per case for nursing home consumers 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, whether California's taxpayers and private-pay individuals are getting their money's worth is not known.

Achieving Quality in Long Term Care: What Is Needed Now?

The strategy group meeting was convened to consider a guiding question: "How do we make significant progress on developing sustainable, high-quality long term care in California over the next five years."

Participants in the strategic planning session were asked to prioritize strategies for the state to pursue. The following three ideas emerged:

1. Creating seamless, coordinated, and/or integrated service delivery systems;
2. Moving to an approach that eliminates or decreases the silo effect that current state and federal funding streams create; and
3. Creating quality measures, standards, and accountability that can be used across all programs and services.

While not necessarily new ideas to pursue, these are the critical strategies that have the real potential to transform long term care in California.

In arriving at their recommendations, the participants took into account the 1996 LHC report, as well as

Table 2. Facility, Expenditure, and Caseload Trends, 1996–2006

	EXPENDITURE (in millions)			CASELOAD*		
FACILITY	1996	2000	2006	1996	2000	2006
State Funded Programs						
Nursing Facilities	2,127	2,870	3,255	122,255	73,754	76,506
In-Home Supportive Services	808	1,972	3,811	185,413	248,999	374,986
Adult Day Health Care	1,247	123	418	5,330	18,930	40,800
PACE	17	66	83	683	3,711	2,102
MSSP	22	39	45	2,913	13,847	13,867
TOTAL	6,217	7,070	9,618	315,594	358,241	507,261
Private Long Term Care (estimated)						
Residential Care Facilities for Elderly	1,848	2,497	3,382	102,654	110,970	125,246
Family Caregiving	—	—	—	561,757	637,669	

*Many individuals use multiple services and therefore may be represented in more than one caseload category.

Sources: LAO Analysis of the 2006–2007 Budget Bill, February 2006; Testimony of the Family Caregiver Alliance before the California Senate Subcommittee on Aging and Long Term Care, November 15, 2005; and Department of Social Services, Division of Community Care Licensing.

the innovative strategies developed in other states and programs that have worked on a limited basis in California. They also looked at the results of the 2006 CHCF survey and the inventory of state actions over the past five years. Selected findings from all three reports are referenced alongside the three strategic priorities discussed below.

Strategic Priority 1: Create Seamless, Coordinated, and/or Integrated Service Delivery Systems.

1996 LHC recommendations: The LHC found that the state structure for long term care was not conducive to a coordinated continuum of care, and it failed to focus on consumer-centered services that were the best value and the least restrictive. The LHC recommended consolidating all departments that provide or oversee long term care services into a single entity. It noted that these seven departments had differing eligibility criteria set by statute, and each devised its own assessment procedures and regulations in isolation from other programs. (Unfortunately this situation is unchanged ten years later.)

The 1996 report also recommended the state adopt a multi-pronged strategy for coping with the projected rising demand for and cost of long term care services. It suggested that departments be required to pursue federal options that infuse flexibility into programs and funding.

Actions taken by the state: California has taken limited action over the past five years to address these recommendations. Proposals for structural reforms that would encourage the use of home- and community-based services have met with failure in the legislature or have not been implemented by the administration.

- **AB 1040** (signed by the governor in 1994) required the Department of Health Services to establish up to five long term care pilot projects to integrate the delivery and funding of institutional and home- and community-based long term care services. To date no pilots have been established.
- **SB 1339** (failed passage in 1999) would have created a single assessment tool for evaluating the needs of older persons and persons with disabilities and established the Area Agencies on Aging as the single point of entry to long term care services for older persons.
- **AB 3019** (failed passage in 2006) would have required the California Health and Human Services Agency, in consultation with specified entities, to develop and test the Community Options and Assessment Protocol (COAP) to minimize duplication and redundancy of multiple assessments for home- and community-based services and connect consumers under the Medi-Cal program.
- **SB 953** (2002) directed the Health and Human Services Agency to develop a coordinated system of care through Care Navigation and Cal Care Net, a self-directed, statewide Internet-based application that links local information systems. The bill was signed by the governor but has yet to be implemented.
- **AB 43** (2003), **SB 1671** (2004), **Acute and Long Term Care Integration Governor's Budget Proposal** (2005), and **Access Plus/Access Plus Choices Governor's Budget Proposal** (2006) are the four successive proposals to integrate acute and long term care delivery systems. They have all failed passage.

CHCF survey findings and discussion: There was strong consensus that legislative and programmatic actions taken to improve coordination among departments to support a continuum of services have had little impact.

The need to promote a seamless continuum of services was viewed by 69 percent of expert respondents as

being the highest priority among the seven LHC recommendations for encouraging the use of community-based services to prevent people from premature deterioration and institutional placement. However, there was no uniform agreement on the best approach to achieve this goal. About half of respondents thought that actions taken in the past five years to address this recommendation had made some impact, while one-quarter thought they had made no impact. In addition, 71 percent of respondents thought that action was needed urgently in the next two to three years. Clearly this was of great concern.

There were 30 responses to an open-ended question related to community-based services, and most of those stressed the importance of integrating services and supporting non-institutional care. Several recommended shifting away from skilled nursing facilities toward home- and community-based services that delay or prevent institutionalization. Some comments called for supporting the development and expansion of care models like PACE and proposed acute and long term care integration programs.

Survey respondents strongly felt there is a need for better coordination and oversight in the administration of services as an essential part of providing a seamless continuum. In fact, this topic elicited comments from over half of the respondents. In the order of the number of mentions, respondents wanted:

- More and better coordination, integration, and fewer silos (whether via consolidated state departments or not);
- More use of financing mechanisms that support alternatives to nursing homes;
- Greater focus on outcomes, quality, and performance measurement leading to better efficiency and accountability; and
- More leadership, vision, and culture change.

In 1996, the LHC called for consolidation of departments as a means of improving coordination of service delivery. While the vast majority of CHCF survey respondents thought that action to improve access and delivery of services on this recommendation was urgently needed, there was disagreement on whether consolidation of departments versus better integration of services would be the best approach.

Proponents for consolidation of departments believe that putting all long term care services under one umbrella would facilitate the development of uniform assessment, eligibility, and regulatory standards. One clear advantage of consolidation would be more effective oversight of long term care spending. As it now stands, budget committees in the legislature take up each department's programs and expenditures as a separate item. No single entity in the legislature or in the administration is responsible for making coordinated policy decisions regarding the efficacy of one long term care program over another.

Opponents of consolidation believe that moving the various departments into a single entity would not necessarily yield better coordinated care. One commenter voiced this objection: "Discussions about consolidation have not included the important but tough questions about data infrastructure, local administration, target populations, locus of control, quality of providers, interface with health care systems, and establishment of uniform and measurable outcomes. Shouldn't these questions be answered (or at least acknowledged) before rearranging the boxes on the organizational chart?"

Providing one-stop services for customers was also viewed as a high priority by many of the survey respondents. Actions taken to implement this recommendation were seen by half of respondents as having some impact, and by 32 percent as having no impact. Just over half of respondents thought this recommendation needed to be addressed in the near future. Many stakeholders advocated adopting a gate-keeping program similar to

that used by the State of Washington. In Washington, all persons in need of long term care (whether funded publicly or privately) are assessed for their suitability to remain independent through the use of home- and community-based services. No one can be admitted to a nursing home without such an assessment.

Other stakeholders advocated a "no wrong door" approach using an assessment instrument across all programs as the coordinating mechanism—while allowing consumers to be more self-directed in choosing care options.

Consolidating services for customers and the adoption of a multi-pronged strategy to cope with the increasing cost and demand for services were ranked a high priority.

Strategic meeting recommendations: Despite repeated legislative failures over the past decade, the meeting participants strongly advocated the adoption of integrating mechanisms for long term care services. Two proposals were advanced to shift the incentives from institutional care toward home- and community-based care. The first proposal is more modest and is likely to be implemented (with the endorsement of the Olmstead Advisory Committee) in the near future. The second proposal, which involves much deeper systemic change, would be more subject to turf battles from groups who prefer the status quo.

Proposal: Optimize choice for consumers by effectively intervening in transitions from one care setting to another.

Hospitalization can be a turning point in the lives of seniors, whose 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 families with a list of nursing homes. Information and advice about home-based services, eligibility, and caregiver support is difficult to find. 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. Patients and families are left on their own to identify the mix of services that might best support continued independence. Because there is no ongoing monitoring of services once the person leaves the hospital, unnecessarily poor outcomes and re-hospitalization often result.

The California Health and Human Services Agency (CHHSA) is taking an important step by issuing an RFP, titled "Improving Access to Long-Term Support Services: Development of CommunityLink Resource Centers." This portion of a larger grant focuses on disabled persons of all ages. It would establish two CommunityLink Resource Centers to serve as a focal point for access to home- and community-based services. The resource centers would:

- Target individuals in the community and in acute-care hospitals who are at risk of institutionalization and establish connections to home- and community-based services, including affordable and accessible housing options and transportation alternatives;
- Provide assistance and information for individuals, caregivers, and families regarding home- and community-based services, local transportation alternatives, and housing options; and
- Provide outreach and training to consumers, caregivers, community organizations, and others regarding home- and community-based services.

Proposal: Create fully integrated service delivery systems.

This proposal focuses on "integrating mechanisms" that cut across programs and departments. Previous legislative proposals would have blended Medicare and

Medicaid funding streams into a single capitated rate for the provision of all acute care, primary care, prescription drugs, nursing facility care, and home- and community-based services. Those legislative proposals would have permitted (on a pilot basis) participating health plans to provide care coordination services for seniors and disabled persons to arrange and pay for health care and supportive services by a single entity operating on a regional basis. A number of states have successfully implemented integrated delivery systems. However, consumer advocates and labor in California have been uncomfortable with the notion of including seniors and disabled persons in managed care in general, and the inclusion of IHSS in the capitation rate in particular. Lack of agreement has contributed to the defeat of integration proposals in four successive years.

Although this proposal incorporates many of the integrating mechanisms that were contemplated with the acute and long term care pilots, it calls for a more incremental approach. If fully adopted, these mechanisms would help ensure that seniors and persons with disabilities receive the home- and community-based services they need on a timely basis. Rather than focusing on regional delivery systems for the integration of services, the proposal would provide mechanisms for ensuring that eligibility, assessment, and regulatory requirements would be consistent across the continuum of care.

Components of this proposal include:

- Legislating presumptive eligibility in the hospital to fast-track the provision of home- and community-based services on discharge;
- Adopting a statewide, standardized assessment instrument and protocol;
- Reducing the regulatory barriers (including funding streams) that impede the portability of services;
- Creating a new assessment infrastructure and preadmission screening that would be required prior to admission to a nursing facility;
- Expanding eligibility for IHSS;
- Expanding programs like the five PACE initiatives to other parts of the state, and expanding the current population served to include persons who are not yet eligible for nursing home admission;
- Creating a single consolidated department for home- and community-based care; and
- Creating regional service delivery systems.

This proposal represents deep system change. Adoption of a uniform assessment instrument alone has significant challenges and would be resisted by groups who have allegiance to the particular assessment instrument with which they are familiar.

Strategic Priority 2: Move to an Approach that Eliminates or Decreases the Silo Effect of State and Federal Funding Streams.

1996 LHC recommendations: The commission found that the state structure for long term care oversight was not conducive to a coordinated continuum of care. Its report recommended a multi-pronged strategy for coping with the expected rising demand for and cost of long term care services. It called for a requirement that departments involved in long term care pursue federal waivers and options that would infuse flexibility into programs and funding.

Much of the fragmentation in long term care service delivery can be traced to the split between federal and state funding for Medicare and Medicaid and differing eligibility requirements for services. The federal Medicaid program requires states to provide institutional benefits to all eligible persons and permits states to make community-based services available through waivers of federal Medicaid rules. There has been 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. However, there has been no guidance to states from the federal government to achieve significant reform.

Split funding streams create the programmatic silos that result in troublesome consequences for users and for the state. For example, Medicare beneficiaries are generally entitled to a 100-day post-acute skilled nursing benefit, but Medicare does not pay for home- and community-based services, such as adult day health care or personal care services in the home. Therefore, many people go to nursing homes even though they would prefer a home- or community-based care alternative. At the same time that home- and community-based services reduce hospitalization (paid for by Medicare), the state picks up the tab.

In 1996, when the LHC report was written, few states had combined funding streams into a single capitated payment rate, which could provide the spending flexibility that allowed for seamless delivery of services. In California, with the exception of programs like PACE, little had been done to overcome the problems of dual funding. However, the 2003 Medicare Modernization Act provided for 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 are able to offer long term care services to dual eligibles.

Actions taken by the state: In its strong promotion of waivers, the 1996 LHC report said: "The state has been slow to embrace opportunities to escape federal micromanagement, lagging behind other states in applying for and securing waivers. Although the process for securing waivers is lengthy, it is an investment the state must make if it is to create a long term care system that focuses on consumer needs rather than one that is driven by artificial—and often conflicting—program restraints. Waivers are a key tool for shifting long term care services away from high-cost, medically intensive models to consumer-preferred, lower-cost community-based social models of care."

A decade later, California's resistance to creating or expanding waiver programs has remained. However, there are a few exceptions:

- **AB 499** (chaptered in 2000) required DHS to develop a Medi-Cal assisted living benefit federal waiver program to test the provision of assisted living services as an alternative to receiving services in a nursing facility. Implementation of this pilot program has been exceedingly slow. Although the statutory language calls for the evaluation of the program on or before January 2003, DHS only started contracting with participating facilities in 2006.
- **The IHSS Personal Care Services Waiver** (2004) made virtually the entire IHSS program, including "residual program" beneficiaries, eligible for federal funding. The speed with which the administration moved to secure this considerable influx of federal matching dollars demonstrates that waivers can be obtained when there is sufficient political will.

CHCF survey findings and discussion: There was strong agreement among CHCF survey participants that changes in funding mechanisms should be a very high priority for the state. Many respondents argued for using the available reimbursement mechanisms (e.g., waivers) for programmatic innovations, thus paving the way for better delivery of services.

It remains to be seen whether waivers for home- and community-based programs will continue to be required by the federal government. There is no doubt that the process for submitting waivers for federal approval is time-consuming and a bureaucratic burden. Some of

DHS' reluctance to submit additional waivers has been attributed to scarce personnel resources following lean budget years. However, respondents were uniformly supportive of using innovative funding approaches to secure expansion of home- and community-based services.

Strategic meeting recommendations: Overcoming the barriers presented by federal and state funding requirements is a significant challenge, but one the meeting participants strongly endorsed. Integrating Medicare and Medicaid financing is the only way to eliminate the institutional bias inherent in the system and to ensure that consumers receive the services of their choice. Legislators and their staff, focused on state spending, often ignore the perverse incentives created by dual funding streams.

Proposal: Create a more holistic approach to financing long term care.

Components of this proposal include:

- Reforming the current California Long Term Care Insurance Partnership to reduce Medi-Cal expenditures for long term care in the future;
- Creating a Long Term Care Commission to review state expenditures and make recommendations for more effective approaches;
- Improving data collection and analysis to track the actual costs and use of various programs;
- Increasing the states's share of the Federal Medi-Cal Assistance Percentages (FMAP);
- Creating a new entitlement for disabled people;
- Improving private financing of long term care by increased use of long term care insurance; and
- Advocating change of federal policies to eliminate the duality of funding streams.

Strategic Priority 3: Create Quality Measures, Standards, and Accountability for Use Across all Programs and Services.

1996 LHC findings: Federal mandates for skilled nursing facilities brought improved quality monitoring, but many issues remained unresolved and others developed as the role of these institutions shifted to a higher level of care. The LHC report recommended that the governor and legislature strengthen the opportunities, incentives, and requirements for high quality performance by skilled nursing facility (SNF) staff.

Actions taken by the state: Most actions focused on providing staff in adequate numbers for the higher acuity found in today's nursing homes. In addition, the state mandated increased training of staff around specific issues such as dementia and elder abuse.

- **AB 1107** (chaptered in 1999) provided for a 5 percent wage pass-through to nursing home staff and an enhanced staffing ratio (from 2.9 to 3.2 hours per resident day). The previous ratio calculated the hours per resident day by doubling the hours that licensed staff worked. The new 3.2 ratio eliminated this doubling, resulting in more certified nursing assistants in facilities.
- **AB 1629** (chaptered in 2004) imposed a quality assurance fee on skilled nursing facilities and provided that the funds be made available to draw down a federal match in the Medi-Cal program. The increased federal funding provides additional reimbursement to facilities to increase wages and salaries, which leads to a more stable workforce.
- **AB 1731** (chaptered in 2000) added ten hours of classroom training as part of the pre-certification training program required by facilities and added resident abuse prevention, recognition, and reporting requirements to the 100 hours of supervised on-the-job training clinical training for certified nursing assistants.

- **AB 1347** (chaptered in 2001) required CNAs employed by a SNF to complete at least two hours of dementia-specific training as part of the facility's orientation program; required SNFs and intermediate care facilities (ICFs) to develop a dementia-specific training component within the existing orientation program to be implemented no later than July 1, 2002; and required CNAs employed by a SNF or ICF to complete five hours of dementia-specific training per year, as part of the facility's in-service training.

CHCF survey findings and discussion: The highest-ranked priority was strengthening high-quality performance by skilled nursing facility staff.

The CHCF survey found mixed opinions about the efforts to strengthen high-quality performance. AB 1107 was viewed as having moderate impact by 35 percent of respondents and extensive impact by 19 percent. Forty-three percent thought that the increased training in recognizing and reporting abuse had some impact, while legislation enacted to promote career opportunities for geriatric nurses and assistants were viewed by many as having no impact. Nearly 90 percent thought it was very or moderately important to address this recommendation in the next two to three years.

Approximately one-third of respondents thought that enhancing the state's enforcement capability was the highest priority. Comments in the narrative were mixed, with several suggesting that strict enforcement and the use of steep fines were effective, and others asserting that punitive approaches were ineffective and did not encourage innovation or problem-solving. Several noted that statutory and regulatory reforms had not created better nursing homes.

Strategic meeting recommendations: The participants endorsed the concept that standards for measuring quality of care be universally adopted across all programs. In addition, the group called for replacing "process" standards—which focus on adherence to facility regulations—with "outcome" measures, which are more centered on the needs of individuals.

Proposal: Improve the quality of care across-the-board.

Components of this proposal include:

- Agreeing on core measures for each service element in the long term care continuum;
- Creating uniform definitions for standards and practice;
- Identifying an appropriate host for data collected;
- Adopting a plan to integrate data reporting that is useful to consumers as well as health care professionals;
- Implementing a universal electronic assessment and data collection system that can be used throughout the continuum of care;
- Adopting minimum educational standards for the workforce;
- Redesigning enforcement and oversight to drive quality;
- Adopting a personal health record that is portable across the long term care system;
- Creating transparency through the public reporting of quality data; and
- Adopting workforce and training standards.

What's Ahead

While the past decade has been marked with some successes, legislative and administrative actions have mostly enhanced or expanded current programs. The CHCF survey and strategic meeting participants gave California low marks for progress toward the delivery of long term care services that appear seamless to the consumer; that contain the costs associated with burgeoning caseloads; and that hold programs

accountable for providing quality health and social support services.

The recommendations developed by the meeting participants represent the best thinking of experienced long term care leaders in California; some are groundbreaking, others are a synthesis of best practices from other states and champions at the local level.

The next steps, if California is to serve the growing senior demographic adequately and use precious resources effectively, will be to focus on broad systemic change. As one strategic meeting participant said, "Don't tinker at the margin and stop wasting time."

Realistically, immediate wholesale restructuring of long term care services is unlikely. However specific incremental actions can be effective building blocks for the long term care system that California needs.

Recognizing that sustained leadership will be necessary to support systemic change, CHCF will reconvene the leadership group in December 2006 to identify priorities that lay the foundation for system building in each of the three areas identified in this issue brief. Summaries of those meetings will be disseminated on www.chcf.org.

Summary of Key Survey Findings

Findings among experts in long term care identified the priorities listed in Table 3. Opinion was varied as to the extent to which the state's actions had translated into progress toward the LHC recommendations. However, most were considered urgent.

Table 3. LHC Recommendations Given the Highest Priority Rankings

RECOMMENDATION	Impact of State Actions on Fulfillment of Recommendation	Importance of Addressing Within the Next 2 to 3 Years
Priority 1		
Allow more seamless delivery of services.	46% some impact 25% no impact	71% very important
Provide one-stop service for customers.	48% some impact 32% no impact	54% very important 34% moderately important
Priority 2		
Pursue federal waivers and financing options.	48% some impact 29% moderate impact	62% very important 27% moderately important
Adopt multi-pronged strategy to address increasing cost and demand for services.	49% some impact 37% no impact	72% very important 22% moderately important
Consolidate departments.	45% some impact 37% no impact	49% very important 25% moderately important
Priority 3	Ratings of impact were mixed:	
Strengthen high-quality performance by skilled nursing facility staff.	Wage increases to stabilize workforce: 35% moderate impact Training: 43% some impact Workforce development: 32% no impact	46% very important 39% moderately important
Shift care in LTC settings toward preventive model.	35% some impact 35% no impact	47% very important 31% moderately important
Restructure policies/rates for residential care facilities.	36% some impact 38% no impact	57% very important 28% moderately
Provide clarity/consistency in enforcement and revamp regulatory structure.	No state action to rate.	42% very important 28% moderately important

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