

# 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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# 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

# 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			Home and Community-Based Residents		
	Average Annual Cost	Average Monthly Cost		Average Annual Cost	Average Monthly Cost
Skilled Nursing Total	<b>\$51,795</b>	<b>\$4,316</b>	HCB Services	<b>\$20,212</b>	<b>\$1,684</b>
			<ul style="list-style-type: none"> <li>Skilled nursing, personal care (including IHSS), care management, habilitation, etc.</li> </ul>		
Medical Expenses	<b>\$13,944</b>	<b>\$1,162</b>	Medical Expenses	<b>\$6,441</b>	<b>\$537</b>
<ul style="list-style-type: none"> <li>Physician, pharmacy, hospital, other</li> </ul>			<ul style="list-style-type: none"> <li>Physician, pharmacy, hospital, other</li> </ul>		
Total Costs	<b><u>\$65,739</u></b>	<b><u>\$5,478</u></b>	Total Costs	<b><u>\$26,653</u></b>	<b><u>\$2,221</u></b>

# 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	<ul style="list-style-type: none"><li>• Frequent ER/Hospital Use</li><li>• NF Minimum Data Set (MDS) Assessment</li></ul>
Nursing Facility residents who can be cared for in community settings	<ul style="list-style-type: none"><li>• Rehabilitation stay to long-term stay</li><li>• NF MDS Assessment</li></ul>
Community populations in IHSS, CBAS or those not receiving LTSS	<ul style="list-style-type: none"><li>• IHSS, CBAS Assessments</li><li>• Frequent ER/Hospital Use</li></ul>
Chronically Homeless/Superutilizers	<ul style="list-style-type: none"><li>• Frequent ER/Hospital Use</li><li>• Mental Health referrals</li></ul>
End of Life or Palliative Care	<ul style="list-style-type: none"><li>• Physician referrals</li></ul>

# ORGANIZING DELIVERY SYSTEMS

- Strategies and service arrangements

Population	Organized Delivery
NF residents with frequent ER/hospital admissions	<ul style="list-style-type: none"> <li>• Improving on-site primary care</li> <li>• NF as clinical partners: training and on-site management</li> </ul>
NF residents who can be cared for in community settings	<ul style="list-style-type: none"> <li>• Transitional care planning</li> <li>• Housing destination: home, residential care facility, independent housing</li> <li>• Post transition care management: primary care, chronic care nursing, supervision, personal care, chore services</li> </ul>
Community populations with IHSS, CBAS or those not receiving LTSS	<ul style="list-style-type: none"> <li>• Primary care and ongoing care management</li> <li>• Chronic care nursing, organized LTSS providers around care plans</li> </ul>
Chronically Homeless/Super-utilizers	<ul style="list-style-type: none"> <li>• Housing provider as partners</li> <li>• Housing project based delivery systems: PCP assignment, chronic care nursing, on-site case management, personal care services</li> </ul>
End of Life Palliative Care	<ul style="list-style-type: none"> <li>• Patient and family education</li> <li>• Advance Directive</li> <li>• Ongoing care management</li> </ul>

# 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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