

## LTC Hearing

### 1. Capacity:

- In spite of having the largest older adult population in the nation, California now has fewer facilities, beds and residents per day than it did in 1990
- We rank lower than most states in beds, utilization and spending on facility services
- LTC facility services are continually evolving to fill a narrowing niche for post acute rehab, medically complex care and a small population of chronic care patients

### Right now:

- California facilities have about 116,000 beds; serve about 300,000 patients per year
- Occupancy is 85% - actually declined since last year's HCB reductions
- Capacity has been well managed and that trend will continue

### In the future:

- California's greatest population growth will be 85 years and older - the most likely LTC services users
- Many will outlive their support systems; coping with this reality will tax the entire continuum
- Assuming realistic advances in medical science technology and continued development of services to allow aging in place, we expect facility capacity to remain stable
- Also expect resident needs to continue to intensify

### 2. Admission:

- Lets face it – no one wants to give up their independence and go to a nursing facility
- Consensus needs to be reached by Doctor, discharging hospital staff and admitting nursing home staff for an admission to occur
- Medicare requires a 3-day stay and a care plan that involves “active care” not available in the community
- Medi-Cal requires a condition that meets medical necessity criteria as determined through three separate processes: TAR; Pre Admissions Screening & Resident Review; MDS
- Managed Care Plans also use criteria and case management specifically designed to minimize facility care

### In the future:

- If you buy into the benefit of community-based, you must also agree that patients that do end up in facilities will be increasingly more demanding

- Selection process could intensify under the CMS 1115 Waiver request, local integration initiatives or other systemic changes

### **3. Discharge:**

- Ideally, discharge planning starts at admission facilities; patients are routinely assessed for projected LOS and discharge potential as part of initial and ongoing MDS process
- Just as no one wants to enter a facility – few want to stay and no payer wants to keep them in any longer than necessary
- Daily, weekly, monthly, quarterly reassessments by payers, physician, facility and family
- 58% are out in a month – most out within 3-months; only 8% are there for more than a year

### **Right now:**

- Facilities are required under AB 1629 to determine if resident has a preference to return to community and if there is a social support system in place
  - Facilities address this preference in the ID team care planning process
  - Provide resident or responsible party info on community resources
  - Help residents get in touch with existing programs
  - Programs have emerged to help link residents to services: MSSP, Independent living Centers, Alzheimer’s Resource Center, California Community Transitions, etc.

### **In the future:**

- Attention to this issue will increase this year as new federal MDS 3.0 Care and Assessment requirements are implemented
  - 5 items are specifically coded to discharge planning in the Resident’s Overall Expectation section
  - Resident response to direct question will trigger a referral to a local contact agency within 10-days and follow-up care planning
  - State must have such local agencies in place by the October 2010 implementation of MDS 3.0
  - This process will be formalized for the first time and will become a measurable part of the basic function of a facility
- The challenge will be to ensure that resources are available in every community and that residents, facilities and other caregivers are linked in. This is an area that we can all agree deserves additional focus

As the industry “right sizes” capacity and the nursing home role narrows, residents will become more challenging and payment levels even more critical.

- We have made major strides in securing payment systems that recognize individual facility dynamics:

- Medicare Rugs
- Medi-Cal AB 1629
- We are concerned about ensuring that adequate resources will continue to be available and the role government plays in determining the quality of care in our facilities
  - 2/3 are Medi-Cal
  - 12-15% are Medicare

**In the future:**

- It is essential to maintain stability in the payment systems so that facilities can continue to meet ever evolving patient needs and concentrate on integration, coordination and quality

**4. Quality:**

- California out performs national averages in key quality measures for infections, weight loss, locomotion decline, depression, anxiety and use of psychotropic's
- Customer satisfaction is relatively high, 87% patients; 82% family rate care excellent or good and are willing to recommend facility
- While we still have more complaints and more deficiencies than we would like, still some errors and an occasional failure – overall system is focused on quality

**Right Now:**

- Quality First – National pledge and support system for enhancing quality
- Advancing Excellence – Collaborative technical assistance in pursuit of quality
- Quality Improvement Organizations – Regional Health Services advisory groups in California working on pressure sores and use of restraints
- Quality Factor Workgroup – CAHF-initiated effort to identify key Quality measure to assess improvement facility performance
- Collaborative efforts at training, targeted care improvement and culture change

**In the future:**

- We expect to do more of this, not only because of the enormous amount of external oversight, rating systems, and whatnot, but because our customers (both payers and residents) will demand it.
- In addition to general angst over the cost of care, the move from frugal post depression era expectations to a population of baby-boomer consumers who expect everything will also drive quality.

**5. Closing:**

- I think we can all agree that developing the resources and support necessary to maximize community based alternatives must be a top priority for the future
- Creating more coordination among the various components of the continuum is also a critical objective
- However, we need to use caution when comparing California to other states – we are miles ahead of most and Dr. Hendrickson’s suggestion that we follow states like Pennsylvania is way out of line
- We must remember that no matter how many or how few, whether they are post acute chronic or end stage and whether they are there for a short or long stay, patients in California facilities deserve quality services
- While we all work to build home and community based services and to minimize reliance on facility care, it is also our responsibility to make sure that people who do end up in a facility get the care they critically need

*February 4, 2010*