

LONG TERM CARE INTEGRATION PRIMER

The Way It Is Now:

Acute and Long Term Care (LTC) Services for people with chronic care needs are fragmented by: source of payment, type of client, type of provider, source of regulatory oversight, and geography. Each agency or institution tries to provide good quality care independently.

The present system is built around existing institutions and funding sources. Providers and funding sources are the decision makers.

Medical, social and supportive services, and residential facilities are separate entities with little or no communication. Categories of aged, physically disabled, developmentally disabled, mentally ill, and HIV/AIDS have separate systems, with little or no communication between them.

Consumers, who may be very debilitated, face a confusing array of providers, requirements, application forms, assessments, transportation issues, etc.

Because case management is most often tied to particular programs, when consumers are hospitalized or have to stay in a nursing home, their community services case manager may lose touch.

Services are provided by multiple agencies, each of which determines eligibility, performs an assessment, prepares a care plan, and keeps separate records.

Care is fragmented, with multiple fee-for-service providers who do not share information about clients/patients. Consumers may be given medicines or treatments that interact in negative ways because providers are not aware of each other's existence or activities.

Integrated LTC System:

Long Term Care is viewed as a connected system of acute and long term health and social services and is aimed at supporting consumers to have the best possible quality of life (as consumers define quality of life). Institutions work together to provide top quality care.

The system is built around consumer needs and preferences while maintaining cost neutrality. To the greatest extent possible, **the consumer is the primary decision-maker.**

The system **brings together medical care** (e.g. hospital, physician therapy, pharmacy, skilled nursing) **supportive services**, (e.g.housekeeping, personal care, meals, transportation) **and housing** for those with chronic (ongoing or of long duration) care. Healthcare is integrated.

Consumers perceive a single point of access (regardless of funding sources) for the services they need and want.

Case management is consumer-centered and follows the consumer through all levels of care and all types of services, including both medical and social services. Providers coordinate their services via case managers across levels and locations of care.

The network of providers is accessed from a central point. Resources are not wasted in doing the same activity at multiple agencies. Central intake and record keeping minimize duplication and maximize communication.

Providers have access to information on all care and services provided to each consumer via case management database. Each provider has access to all relevant information in a consumer's medical record, with on-line outcome indicators.

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The Way It Is Now:

The fee-for-service approach may encourage providing more care (and incurring more costs) than is needed. Managed care organizations are given incentives to provide less care than may be required. Individual programs and funding sources can benefit from shifting costs to other programs and funding sources.

There are numerous service gaps. Many areas completely lack adult day care, hospice, and assisted living programs. In many cases services are not available to low-income people. There is often no choice of providers.

Clients may be institutionalized because home-based interventions can not be reimbursed under Medi-Cal or Medicare.

Health and social Services providers must put substantial effort into finding and securing funding from many different funding sources both public and private.

The desire to avoid increasing the total public cost of LTC has resulted in a situation in which the status quo is maintained and no changes or innovations are possible. The system can not improve; it is frozen "as is."

Integrated LTC System:

Economic incentives to over-treat or withhold care are removed. **Programs are coordinated** so that there are no incentives to shift costs; Care is given according to consumer needs, not cost savings.

The system is complete—all services needed by people with chronic health conditions are available and provided regardless of location, qualification (aged, disabled, etc.) and income.

Flexibility allows the local LTCI system **to offer consumers access** to appropriate alternative services that may not be available through mainstream Medi-Cal, Medicare, or specialized programs.

Funding sources are pooled into a single payment to a managed care organization (which can be a private enterprise or a state agency, new or existing). Most public LTC dollars will be received and allocated by a single agency in each county.

The system promotes innovation and prevention in order to improve people's quality of life while controlling the total public cost of long term care.



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Chart created by the California Center for Long Term Care Integration and adapted by the AARP California State Office with permission.

The California Center for Long Term Care Integration is a collaborative effort of UCLA and USC to assist the state and counties of California in their efforts to integrate funding and access to health care and supportive services for their aged, blind and disabled citizens, according to the provisions of AB-1040 (1995).

AARP is a nonprofit membership organization dedicated to addressing the needs and interests of persons 50 and older. Through information and education, advocacy and service, we seek to enhance the quality of life for all by promoting independence, dignity and purpose.

FOR ADDITIONAL COPIES OF THIS CHART Please contact the California Center for Long Term Care Integration by phone at (213) 821-5340 or by e-mail at cltci@usc.edu



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