

Master Plan for Aging Recommendation Form

To submit your recommendation, fill out as many of the fields below as possible. It is fine to leave some blank. Recommendations can be submitted at engage@aging.ca.gov. Initial recommendations are requested to be submitted by December 13, but they may be submitted after this date as well.

Issue Statement: [State the problem your recommendation will address. Insert links to reports where appropriate.]

California's 1,200 skilled nursing facilities (SNFs) serve the healthcare needs of hundreds of thousands of elderly and disabled Californians each year. More than 80 percent are there for short-term rehabilitation (generally three months or less). SNFs serve a wide range of the health, medical, and social needs of their residents and patients. But they are limited under state law as to some services that they can provide and most often have to transport fragile elderly and disabled residents to other facilities and clinics for specialized services.

- **MPA Framework Goal:** *Health and Well-Being. We will live in communities and have access to services and care that optimize health and quality of life.*

MPA Framework Objective: [Insert which objective/s from the framework this recommendation addresses.]

Recommendation:

- *Increase access to needed Long Term Care Services and Supports (LTCSS) through innovating the type of services available within the four walls of a skilled nursing facility.*

Target Population and Numbers: [Describe groups of Californians impacted by this recommendation, with numbers if available.]

- *All short-term and long-term patients/residents of SNFs (up to about 400,000 in any given year).*

Detailed Recommendation:

- *Many LTC services necessary for nursing home residents require undue disruption to the lives of SNF residents themselves. Most of these disruptions are caused by SNFs not being able to integrate ancillary services and supports into their operational structures due to licensure requirements. Some examples where a resident must be transported to other ancillary service providers or where access to other ancillary providers is severely limited due to time and distance considerations include but are not limited to:*

- *Infusions*
 - *Dialysis*
 - *Laboratory Services*
 - *X-ray services*
 - *Primary Care Services*
 - *Therapy services*
 - *Respiratory Therapy Services.*
- *LTC services necessary to treat the residents typically found in nursing homes are changing as the complexity of the care being provided to residents is also increasing. The typical resident today is very similar to the resident that used to be part of an Adults and Pediatrics level of care within an acute care hospital. And the patient/resident acuity levels of SNFs will likely continue to increase over time, especially if reforms contemplated by the Master Plan and CalAIM result more elderly Californians being cared for at home or in alternative settings.*
 - *SNFs should be in a similar way as acute care providers and should be able to integrate their licensure with other ancillary services provider types so that care can meet triple aim goals: care is provided at the right time and in the right place and at the best price.*
 - *For example in the case of dialysis, this is usually an all-day process where the resident must be transported to a dialysis facility. If dialysis services were integrated within the four walls of the nursing facility, then all of this disruption could be minimized and the quality of life for the resident could improve. Additionally, the services could be provided at a lower cost.*
 - *Similarly, other services, especially infusions, lab, and X-ray could easily be provided within the nursing home, reducing transportation of residents and saving thousands of dollars per occurrence over the cost of similar services provided within an acute care hospital.*
 - *Primary Care services are now available at many assisted living facilities in California, and similar integration is needed in skilled nursing facilities as the patients are sicker, more disabled, and also vulnerable to trauma when transported to and from ancillary service providers. Timely access to primary care services is problematic within nursing facilities. Typically patients are shipped out to their appointments which is both time consuming and costly.*
 - *Many re-hospitalization scenarios could be prevented if ancillary services and supports were better integrated within the skilled nursing facility infrastructure. For example, a patient has breathing problems is usually transported to an emergency room for treatment and possibly admitted until the patient is stabilized. Respiratory therapy services could be integrated within the operational structure of a nursing home, thereby preventing the need for an inpatient stay.*

Evidence that supports the recommendation: [Add links or summaries of research evidence that support the recommendation.] *TO COME*

Examples of local, state or national initiatives that can be used as an example of a best practice: [Provide any available links and sources.] *TO COME*

- **Local:**
- **State:**
- **National:**
- **Other:**

Implementation: [Insert actions state agencies, legislators, counties, local government, or philanthropy can take to move this recommendation forward. Some of the entities listed below may or may not be applicable to each recommendation.]

- **State Agencies/Departments:** *California Health and Human Services Agency, Department of Public Health, Department of Health Care Services, Department of Finance*
- **State Legislature:** *Potential (pending)*
- **Local Government:**
- **Federal Government:** *Potential (pending)*
- **Private Sector:**
- **Community-Based Organizations:**
- **Philanthropy:**
- **Other:**

Person-Centered Metrics: Individual measures of inputs or outcomes that can be used to measure the recommended action's impact on people. *TO COME*

Evaluations: [How will we know that the recommended action is successful once it has been implemented?]

- **Short-term (by 2020):**
- **Mid-term (by 2025):**
- **Long-term (by 2030):**

Data Sources: [What existing data can be used to measure success or progress?]: *TO COME*

- Existing data sources: [specify datasets, variables, and data owner/location]
- Suggestions for data collection to evaluate implementation of this goal when no data sources exist:

Potential Costs/Savings: [insert any research, actuarial analysis or other evidence of the cost of this recommendation or potential savings]

TO COME

Prioritization: [How would you prioritize this issue in importance relative to other needs/priorities – e.g., low, medium, high): *HIGH*

Name of person(s)/organization submitting recommendation:

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Date of submission:

12-17-19