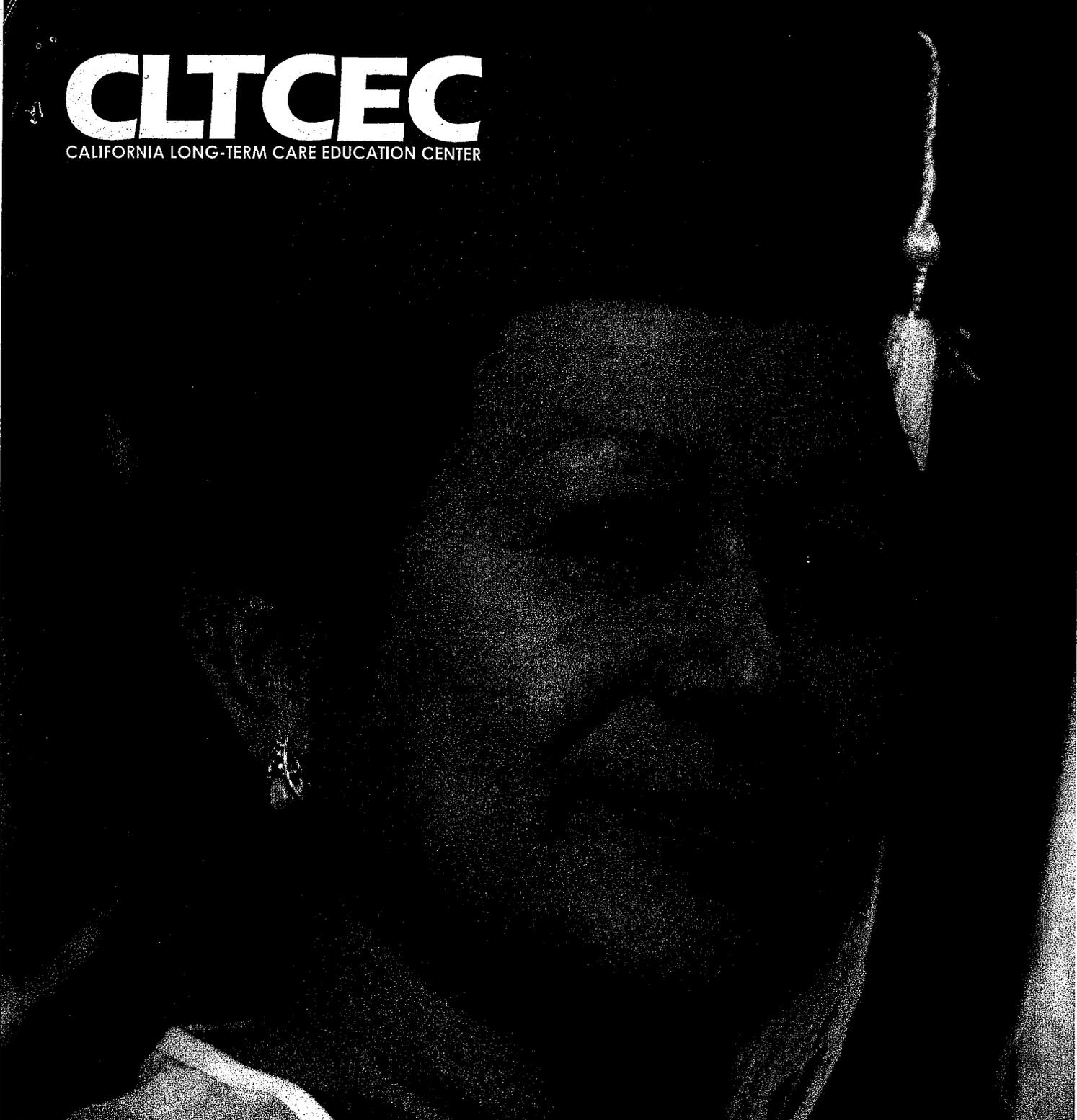


CLTCEC

CALIFORNIA LONG-TERM CARE EDUCATION CENTER



CARE TEAM INTEGRATION AND TRAINING OF HOME CARE WORKERS — IMPACT STUDY

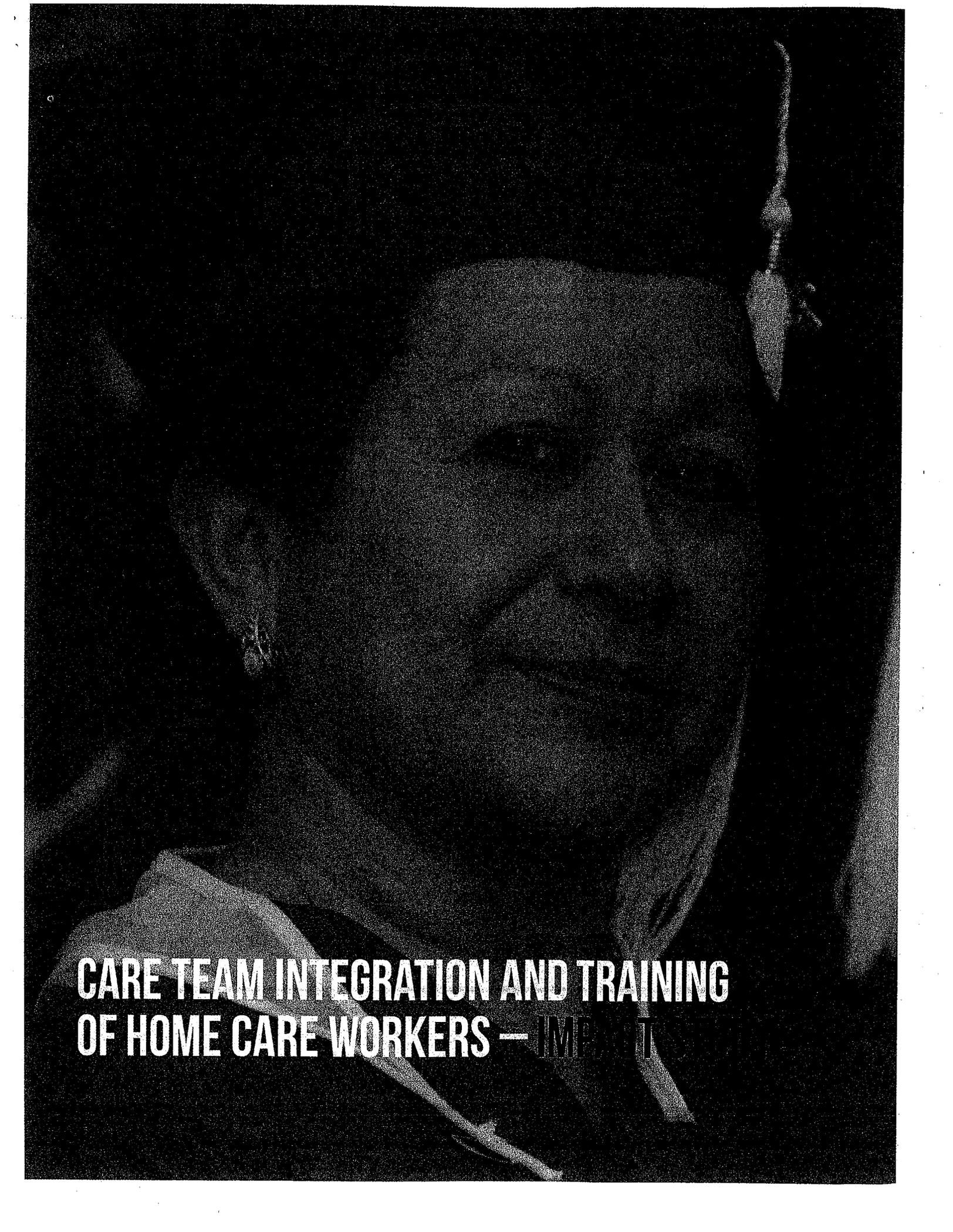
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The CLTCEC greatly appreciates the contributions that many organizations and individuals provided throughout this project. Certainly this endeavor would not have been completed without the dedication of the following partners: Care1st Health Plan, Contra Costa Health Plan (CCHP) with Contra Costa Employment & Human Services Department (EHSD), Health Net, Inland Empire Health Plan (IEHP), L.A. Care Health Plan, Molina Healthcare, SEIU Local 2015, Shirley Ware Education Center, St. John's Well Child and Family Center, SynerMed, and University of California, San Francisco, UCSF School of Nursing.

Lastly, we'd like to thank and acknowledge the IHSS consumers and providers who participated in this project. Their contributions toward this study cannot be emphasized enough. We greatly appreciate the openness by which consumers approached this project, and thank providers for investing in themselves and the consumers they care for as their participation in this project allowed us to prove the impact IHSS workers can have on the health of the consumer.



**CARE TEAM INTEGRATION AND TRAINING
OF HOME CARE WORKERS — IMPACT**

3	Introduction
4	Program Details
5	Target Population
6	Project Model
8	Triple Aim and Workforce Development Outcomes
15	Conclusion: The Future of In-Home Workforce Training
17	Endnotes
18	What Is CLTCEC?

We now know, from many demonstrations of integration of care for people with complex medical conditions, particularly those who receive those benefits through public programs, that the secret sauce to ensure personalized, high touch, compassionate care and quality outcomes we would wish for our own families is the in-home IHSS provider. With appropriate training the IHSS provider can be the skilled front line of a care a coordination team.

—JOHN BAACKES, CEO, L.A. CARE HEALTH PLAN

INTRODUCTION

The California Long-Term Care Education Center (CLTCEC) received a three-year, \$11.8 million Health Care Innovation Award from the Centers for Medicare and Medicaid Services' Innovation Center, established by the Affordable Care Act to test innovative service delivery models, for a pilot project called the *Care Team Integration of the Home-Based Workforce*. This project's innovative contribution to health care was to recast and enhance the role of home care providers through training and integration into the health care system. This project showed that training home care workers is associated with better care, stronger health outcomes and at lower costs through reductions in consumers' use of the Emergency Department and hospitalizations, particularly repeat visits to the Emergency Room

and readmissions to the hospital, which has the potential to create tremendous cost savings to Medicare and Medicaid. Home care providers are in direct and frequent contact with the consumers they care for and are in the unique position to positively impact consumers' health.

- **BETTER CARE**
- **BETTER HEALTH**
- **LOWER COSTS**
- **IMPROVED WORKFORCE DEVELOPMENT**

PROGRAM RESULTS

- **Better Care** – Providers were more knowledgeable and skilled in how to care for a person in home after the training. Providers also indicated increased communication with care team by the end of the training.
- **Better Health** – The training was associated with reductions in consumers' use of the Emergency Department and hospitalizations, particularly repeat visits to the Emergency Room and readmissions to the hospital.
- **Lower Costs** – There were possible savings of up to \$12,000 per consumer for members

of one health plan from reduced ER visits and hospitalizations.

- **Improved Workforce Development** – Providers learned new skills, earned CPR/ First Aid certification, and demonstrated core competencies on topics such as infection control and standard precautions, home safety, personal care, body mechanics, diet and nutrition, medications, communication, body systems, and understanding and providing care for common diseases, dementia, behavioral health conditions, diabetes, developmental disabilities, and heart and lung conditions.



PROGRAM DETAILS

6,375 seniors and persons with disabilities in California's In-Home Supportive Services (IHSS) program and their IHSS providers participated in the project. Consumer direction and consent were emphasized as core elements of the training to align with California's consumer-directed model of home care. IHSS providers were trained to serve in an enhanced caregiving role and to be effective members of consumers' care teams by bridging quality in-home care with the health care delivery system. IHSS consumers also received training to activate their participation in their provider's education so they can appropriately self-direct their own care and integration, when possible. By enhancing the role of home care workers, the project made important strides towards achieving the Triple Aim of better care, better health, and lower costs as well as improved the workforce development outcomes of home care workers.

As the aging population grows and there are more people living with disabilities, the demand for

home care workers also increases. More people will require ongoing care, including long-term care, over potentially many more years. IHSS providers, often caring for consumers over many years, can be integral in addressing the increasing prevalence of chronic disease and long-term health issues. The training provides a cost effective avenue to build a qualified workforce to meet the needs of persons with disabilities and seniors, particularly elderly individuals, to remain safe and healthy at home and outside of costly out-of-home care settings.

"[This class] has helped me with my diabetes because [my Provider] has changed the menu now and he includes a lot more vegetables... and now I feel better."

—BEULAH BOWEN, IHSS CONSUMER

TARGET POPULATION

RECRUITMENT

IHSS consumers who met high risk criteria were recruited with their IHSS providers as pairs into the project in Los Angeles (LA), San Bernardino, and Contra Costa Counties. In LA and San Bernardino Counties, consumers qualified for participation by self-identifying as high risk according to a set of high risk criteria.¹ The chief recruitment strategy employed to reach pairs was a field based approach. CLTCEC staff visited pairs in their homes, communicating with them in Spanish, English, Armenian, Korean, Mandarin, and Cantonese. This recruitment approach was adopted because the target population proved hard to reach by conventional methods of phone and mail. In Contra Costa County, CCHP and EHSD, which oversees the IHSS program in the county, jointly identified all eligible consumers who met specified high risk criteria.² EHSD conducted targeted outreach to the pool of potential participants by phone and mail. Home visits or orientations at EHSD were conducted to interested candidates.

PROFILE OF IHSS CONSUMERS IN TRAINING

66% of consumers in the training were 65 or older and 49% were age 75 or older, which points to the frailty of the target population. The majority of consumer participants were female. Spanish was the most common language of consumers followed by English, Armenian, Cantonese, Mandarin, and Korean. 59% of consumers who participated had an IHSS provider who was a family member.

PROFILE OF IHSS PROVIDERS IN TRAINING

The average age of IHSS providers in the training was 52 and the vast majority of providers were female, corresponding to larger trends in the personal care workforce. Akin to the consumers they care for, the most common language for providers was Spanish followed by English, Armenian, Mandarin, Cantonese, and Korean. While there was some variation in providers' educational backgrounds, 44% did not have a high school education. 11% had a Bachelor's degree or higher, highlighting the varied backgrounds of IHSS workers.



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"I am participating with the doctors, nurses and giving them the kind of feedback that a second pair of eyes, besides the consumer herself, that can help follow through what their recommendations are. They [primary care physicians] have what they seen in 15 minutes in a meeting or appointment and they can now get that what happens on a daily basis from an IHSS provider. A trained care provider is an asset."

—LOUIS JAMES, IHSS PROVIDER

PROJECT MODEL

CREATING AN ENHANCED ROLE FOR HOME CARE WORKERS

IHSS providers are in direct and frequent contact with the consumers they care for and are in the unique position to positively impact consumers' health. The project seized on this opportunity and designed a two-part intervention:

- Training IHSS providers with the tools and knowledge to keep consumers safe and healthy at home
- Integrating IHSS providers on to consumer's care teams

After training home care providers, integration with the care team is the next logical step to extend the impact of home care providers' enhanced toolset. As part of the care team, home care providers can help implement care plans and monitor and communicate changes in consumers' health conditions.

Curriculum Development and Training

Using a multi-stakeholder committee process, a consumer-directed Homecare Integration Training curriculum was developed to train IHSS providers to take on the enhanced roles of *Monitor*, *Communicator*, *Coach*, *Navigator*, and *Care Aide*. The training was 17 modules, once per week, and totaled 60.5 hours, plus 13 hours of at-home assignments, with strict attendance benchmarks. To meet the needs of adult learners, a competency-based teaching methodology was used that emphasized role playing, discussion, and hands-on demonstrations of skills. IHSS providers were trained on the following core competencies and on soft skills.

- Infection Control & Standard Precautions
- Body Systems
- Oral Care & Dental care
- Home Safety including fall & fire prevention
- Grooming & Personal Hygiene care
- Diet & Nutrition
- Body Mechanics in lifting objects
- Body Mechanics in transferring individuals & understanding supportive devices
- Medications
- Intro to Vital Signs: measure or record vitals, but no diagnoses
- Communication-including teamwork, problem solving
- Roles, responsibilities, & rights

- Environmental Care including making the bed, laundry, etc.
- CPR & First Aid
- Skin Care
- Care Coordination
- Understanding & providing care for:
- common diseases including arthritis, cancer, kidney disease, MS, Parkinson's disease
- heart & lung conditions
- diabetes
- behavioral health conditions
- developmental disabilities
- dementia and Alzheimer's

Consumers also attended two class sessions with their providers to learn about the training and integration. 6,375 IHSS consumer and provider pairs participated in this project—5,749 pairs graduated in LA County, 486 pairs graduated in San Bernardino County, and 140 pairs graduated in Contra Costa County. Upon completion of the training, providers and consumers each received a \$95 stipend.

Care Team Integration of Home Care Providers

In the training, IHSS providers and consumers learn about being integrated on the care team and each module contains an integration activity where providers practice identifying a problem and communicating their observations to the care team through role plays and discussions. Operationalizing integration on the health care delivery side, however, was set back by many practical obstacles, including the resource constraints of health plans, the evolving demands the Coordinated Care Initiative placed on health plans in LA and San Bernardino Counties, and the complexity of the health care system and the barriers this creates for communication and standardization across a multi-lingual population. Several health plans were able to present to classes on the plans' model of care and how to access the plan. In response to challenges, we developed a tool of empowerment for IHSS providers and consumers to use to initiate conversations about integration with case managers and primary care physicians.

EVALUATION DESIGN AND METHODS

The Triple Aim goals were to improve the care IHSS providers deliver to consumers, resulting in better health for consumers and lowering costs to Medicaid and Medicare through reduced emergency room visits, hospitalizations, and average length of stay in a nursing home.ⁱⁱⁱ

To assess the impact of the training on the triple aim, two primary sources of data were collected

"I can now read the labels to make sure the consumer is taking the right dosage at the right time."

—MERI EDJHURYAN, IHSS PROVIDER

and analyzed by our evaluation partner, the University of California, San Francisco: utilization data and survey data. Utilization data from six partner health plans was analyzed in a pre-post methodology. A pre-training baseline period was established to assess differences in utilization between the pre-training and post-training period. Comparison group data for non-trained consumers was analyzed for three health plans. Surveys were also conducted in pre-post design where providers and consumers were surveyed before and after the training program. Survey data collected from providers included job satisfaction, communication with consumers' health care teams, demographics, and satisfaction with the training program. Data collected from consumers included views on integrating providers into the healthcare team and health status.

The project also aimed to improve the workforce development outcomes of IHSS providers, including increasing their knowledge and skills on caring for consumers, career path opportunities, and job satisfaction. To assess the impact of the training on these outcomes, survey data and program data on IHSS providers' completion of training requirements were collected and analyzed.

and 33% in Years 1 and 2 post-training. The ER rate also declined in the comparison group between 2013 and 2015 but was still 6% higher in 2015 than the trained group. The biggest improvement can be seen in the measure for repeat ER visits. ER users in the trained group averaged 6.3 visits pre-training and only 4.8 and 3.7 visits in the first and second years post-training. The same decline is not observed for the comparison group.

TABLE 1: EMERGENCY ROOM VISITS
Contra Costa Health Plan Members with a Trained IHSS Provider

	A	B	C
	Year 0: 12 Months before graduation	Year 1: 12 Months after graduation	Year 2: 13-24 months after graduation
1 # Trained Workers*	136	136	95
2 #ER visits	448	306	115
3 # ER Users	71	64	31
4 Mean ER visits/Trained Workers*	3.3	2.3	1.2
5 Mean visits/ER users	6.3	4.8	3.7
6 % ER users among Trained Workers*	52.2	47.1	32.6

*Trained Workers refers to health plan members whose worker graduated from the training.

TABLE 2: EMERGENCY ROOM VISITS – COMPARISON GROUP
Contra Costa Health Plan Members without a Trained IHSS Provider

	A	B	C	D
	Year 2012	Year 2013	Year 2014	Year 2015
1 # Members	2314	2269	2239	2199
2 # ER visits	4506	8927	7688	5071
3 # ER Users	975	1338	1093	843
4 Mean ER visits/members	1.9	3.9	3.4	2.3
5 Mean ER visits/ER users	4.6	6.7	7.0	6.0
6 % ER users among members	42.1	59.0	48.8	38.3

In CCHP, the average rate of re-hospitalizations declined by 43% by the second year after the training. The trained group had similar readmission rates to the comparison group through the first year post-training. Noticeable differences appeared by the second year after training when this rate dropped to an average of 1.2 IP stays for the trained group while the comparison group rate was relatively unchanged at about an average of 2 IP stays.

TABLE 3: INPATIENT HOSPITAL STAYS
Contra Costa Health Plan Members with a Trained IHSS Provider

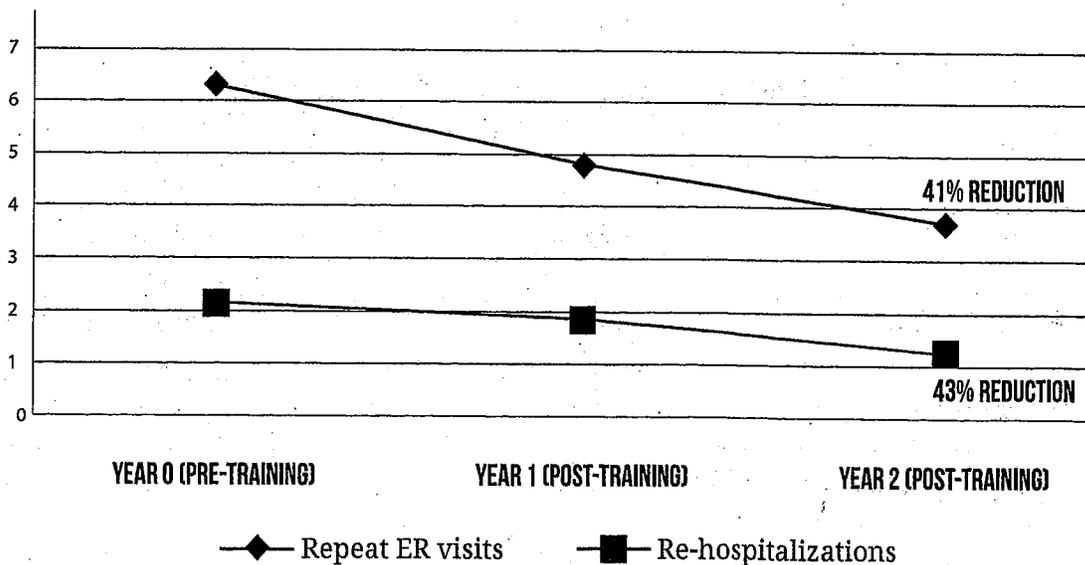
	A	B	C
	Year 0: 12 Months before graduation	Year 1: 12 months after graduation	Year 2: 13-24 months after graduation
1 # Trained Workers*	136	136	95
2 #IP stays	64	57	14
3 # IP Users	31	31	12
4 Mean IP stays/Trained Workers*	0.5	0.4	0.1
5 Mean IP stays/IP users	2.1	1.8	1.2
6 % IP users among Trained Workers*	22.8	22.8	12.6

*Trained Workers refers to health plan members whose worker graduated from the training.

TABLE 4: INPATIENT HOSPITAL STAYS – COMPARISON GROUP
Contra Costa Health Plan Members without a Trained IHSS Provider

	A	B	C	D
	Year 2012	Year 2013	Year 2014	Year 2015
1 # Members	2314	2269	2239	2199
2 #IP stays	665	1335	938	597
3 # IP Users	392	642	443	303
4 Mean IP stays/members	0.3	0.6	0.4	0.3
5 Mean IP stays/IP users	1.7	2.1	2.1	2.0
6 % IP users among members	16.9	28.3	19.8	13.8

Reduction in Average Repeat ER Visits and Hospitalizations for Contra Costa Health Plan



“We strongly believe in the crucial role that IHSS providers play in supporting this population to live in settings of their choice while improving their health outcomes. Through the comprehensive training this initiative provided to IHSS workers, more than 6,000 Californians in need of extra care have been able to live happier, healthier and more independent lives from the comfort of their own home.”

—RICHARD CHAMBERS, PRESIDENT, MOLINA HEALTHCARE OF CALIFORNIA

Encouraging trends on repeat hospital admissions suggest a modest training effect for trained LA Care members. The average rate of repeat IP use in the comparison group was 1.6 versus 1.2 in the trained group. There were no reductions in average repeat ER visits in both groups.

TABLE 5: INPATIENT HOSPITAL STAYS
LA Care Members with a Trained IHSS Provider

	A	B	C
	Year 0: 12 Months before graduation	Year 1: 12 months after graduation	Year 2: 13-24 months after graduation
1 # Trained Workers*	1896	1896	577
2 # IP stays	271	191	40
3 # IP Users	184	132	33
4 Mean IP stays/Trained Workers*	0.1	0.1	0.1
5 Mean IP stays/IP users	1.5	1.4	1.2
6 % IP users among Trained Workers*	9.7	7.0	5.7

*Trained Workers refers to health plan members whose worker graduated from the training.

TABLE 6: INPATIENT HOSPITAL STAYS – COMPARISON GROUP
LA Care Members without a Trained IHSS Provider

	A	B	C	D
	Year 2012	Year 2013	Year 2014	Year 2015
1 # Members	38,277	42,769	42,761	42,750
2 # IP stays	7,307	9,215	9,591	7,294
3 # IP Users	4,417	5,548	5,695	4,627
4 Mean IP stays/members	0.2	0.2	0.2	0.2
5 Mean IP stays/IP users	1.7	1.7	1.7	1.6
6 % IP users among members	11.5	13.0	13.3	10.8

SUMMARY OF ER AND HOSPITAL USE, ALL PLANS

Contra Costa		Year Prior to training	1 year post training	2 years post training	
<i>Trained Group</i>	ER visits/member	3.3	2.3	1.2	
	Repeated ER visits	6.3	4.8	3.7	
	IP stays/member	0.5	0.4	0.1	
	Repeated IP stays	2.1	1.8	1.2	
<i>Comparison</i>	Observation Year	2012	2013	2014	2015
	ER visits/member	1.9	3.9	3.4	2.3
	Repeated ER visits	4.6	6.7	7.0	6.0
	IP stays/member	0.3	0.6	0.4	0.3
	Repeated IP stays	1.7	2.1	2.1	2.0
LA Care		Year Prior to training	1 year post training	2 years post training	
<i>Trained Group</i>	ER visits/member	0.4	0.3	0.2	
	Repeated ER visits	2.5	2.1	1.9	
	IP stays/member	0.1	0.1	0.1	
	Repeated IP stays	1.5	1.4	1.2	
<i>Comparison</i>	Observation Year	2012	2013	2014	2015
	ER visits/member	0.5	0.6	0.4	0.3
	Repeated ER visits	2.6	2.7	1.9	1.5
	IP stays/member	0.2	0.2	0.2	0.2
	Repeated IP stays	1.7	1.7	1.7	1.6
Health Net		Year Prior to training	1 year post training	2 years post training	
<i>Trained Group</i>	ER visits/member	0.04	0.03	0.01	
	Repeated ER visits	2.0	2.2	1.0	
	IP stays/member	0.02	0.03	0.01	
	Repeated IP stays	1.3	1.4	1.1	
<i>Comparison</i>	Observation Year	2012	2013	2014	2015
	ER visits/member	0.06	0.08	0.08	0.04
	Repeated ER visits	2.7	2.3	2.5	1.9
	IP stays/member	0.01	0.04	0.03	0.05
	Repeated IP stays	1.5	1.2	1.5	1.3
Molina		Year Prior to training	1 year post training		
<i>Trained Group</i>	ER visits/member	0.2	0.1		
	Repeated ER visits	3.0	1.7		
	IP stays/member	0.1	0.1		
	Repeated IP stays	2.2	1.9		
Care 1st		Year Prior to training	1 year post training		
<i>Trained Group</i>	ER visits/member	0.3	0.2		
	Repeated ER visits	2.0	1.7		
	IP stays/member	0.14	0.09		
	Repeated IP stays	1.5	1.3		
IEHP		Year Prior to training	1 year post training		
<i>Trained Group</i>	ER visits/member	0.8	0.4		
	Repeated ER visits	3.3	2.1		
	IP stays/member	0.3	0.2		
	Repeated IP stays	1.8	1.6		

“Without integration, we will not receive the respect that we need to have to represent [our] consumers, from anyone else on the care team. [Integration] is so important. Once you understand how the system works, your integration into the system becomes a much smoother process to help the consumer. We are literally becoming the lynchpin in the whole medical process and making it easier for the doctors and nurses to do their jobs.”

—PERCY TOLTON, JR., IHSS PROVIDER

3. LOWER COSTS

These improvements to health, measured by fewer visits to the ER and hospitalizations, are potentially leading to substantial cost savings to Medicaid and Medicare. The biggest source of potential cost savings are for consumers who have repeat ER visits and hospitalizations.

In CCHP, the data showed reduced ER visits and hospital stays for consumers in the training compared to consumers not in the training. The cost savings associated with training participation could be as high as \$12,000 per trainee.

In LA Care, the data show encouraging results on repeat admissions for consumers in the training compared to consumers not in training. The cost savings associated with the decline in repeat hospitalizations in the trained group could be up to \$19,200 for consumers with a hospitalization.

4. IMPROVED WORKFORCE DEVELOPMENT OUTCOMES

Providers indicated high levels of satisfaction with the training and felt more prepared, knowledgeable, and skilled to do their jobs as previously mentioned.

Demonstrated Ability to Perform Class

Competencies. All providers who graduated from the training were CPR/First Aid certified and passed at least 80% of their competency checks. In these competency checks, providers demonstrated skills and knowledge gained in the training to instructors.

High Rates of Retention in Classes. 86% of providers who attended at least one class went on to graduate from the training. Once providers attended a class, they were very likely to complete the course.

“This project gave my provider and I an opportunity to educate ourselves about better ways to care for me. Plus it taught us a lot of tips on what to do to prevent things from getting worse. I had less visits to the hospital or ER as a direct result of our participation in this program!”

—DEBORAH MILES, IHSS CONSUMER





CONCLUSION: THE FUTURE OF IN-HOME WORKFORCE TRAINING

TRAINING IMPROVES CARE AND SAVES MONEY

Important strides were made towards enhancing the roles of IHSS providers in improving the lives of IHSS consumers. The data suggests there are training group savings resulting from a reduction in ER visits, particularly repeat ER visits; and a reduction of hospital stays, again particularly from readmissions to the hospital.

Contra Costa Health Plan's results were used as the 'gold standard' and the direction of improvement in the other plans is consistent with CCHP albeit with limitations around missing data in these plans. The reductions in ER visits and hospitalizations in CCHP, while based on the experience of 95 consumers, suggest that the cost savings associated with training could be as high as \$12,000 per consumer. These positive findings warrant further testing and refinement of the training and integration model.

"I am happy to see there is a training for IHSS workers that respects consumer directed care and has the opportunity to improve health outcomes."

—GREG THOMPSON, EXECUTIVE DIRECTOR, PASC

MAXIMIZING THE IMPACT

Widespread benefits could be amassed by making the training available and accessible to more of the state's approximately 500,000 IHSS consumers and providers. To maximize impact, targeting training for IHSS consumers who are high utilizers of the ER or hospital services and their IHSS providers would be rather clear-cut and could yield observable results.

“Implementing the education program would really catapult California ahead of the other states in terms of finding a more cost effective way to improve the health needs of our senior population.”

—LAPHONZA BUTLER, SEIU LOCAL 2015, PROVISIONAL PRESIDENT

COLLABORATION IS KEY

Future efforts should focus on ensuring training is coupled with a plan to achieve full integration into the health care system, which must be invested in the home care workforce and play a prominent role in integration, including in developing the infrastructure to facilitate integration and to measure its impact. Partnerships that bridge the home care and health care fields are crucial to realizing full integration.

Meaningful collaboration between the consumer, the home care worker, and the rest of the care team can amplify the impact of training and has the potential to show demonstrable effects on consumers' health, health care use, and costs. The data indicate that many providers are already communicating with members of consumers' care teams and providers have exhibited receptiveness to integration in the classroom, showing they are prepared to be part of the shifting paradigm towards increased coordination and integration.

To build upon this, care team members must be informed on the potential impact that training could have on the home care provider's ability to partner with them, developing a plan for integration and providing additional direction and training as necessary.

Contra Costa Health Plan has long acknowledged the need for a trained workforce of In Home Supportive Services care providers. The CMMI grant provided the resources to offer high quality comprehensive training to IHSS caregivers of Contra Costa Health Plan members at risk of needing emergency care and/or hospitalization. Better trained IHSS caregivers help strengthen our ability to improve health outcomes for some of our most vulnerable members.

—PATRICIA TANQUARY, CEO, CONTRA COSTA HEALTH PLAN

The training has positively impacted the quality of life and work of home care workers and the consumers they care for and the potential for training and integration to translate to better health and cost savings is tremendous.

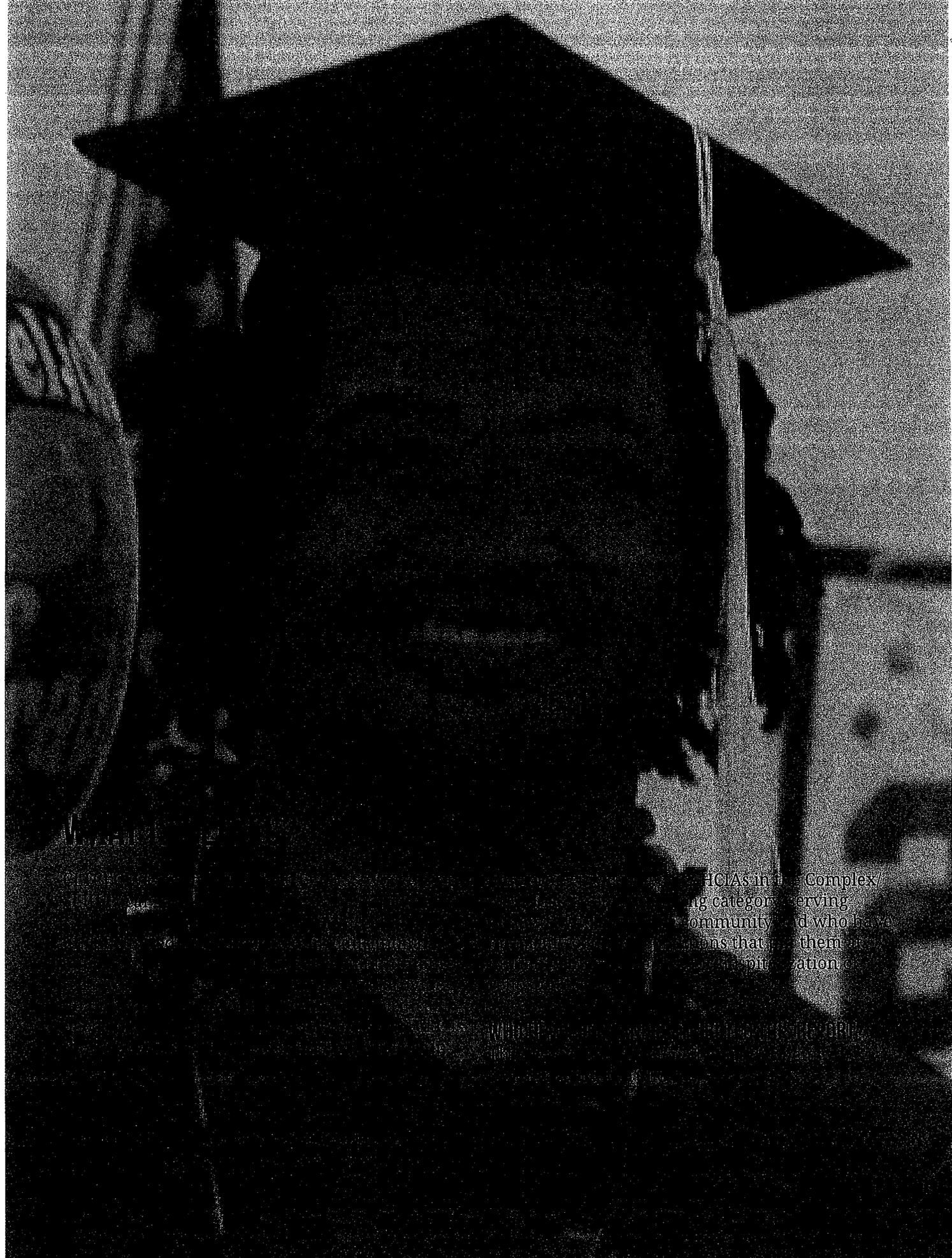


¹In LA and San Bernardino Counties, CLTCEC was unable to identify the target population of high risk consumers directly. Through CLTCEC's partnership with SEIU Local 2015, we identified IHSS providers who were members of its union and reached consumers through them. Consumers then qualified for participation by self-identifying as high risk according to high risk criteria.

²EHSD and CCHP are agencies of Contra Costa County government, with longstanding interdepartmental agreements for sharing consumer data for mutual clients.

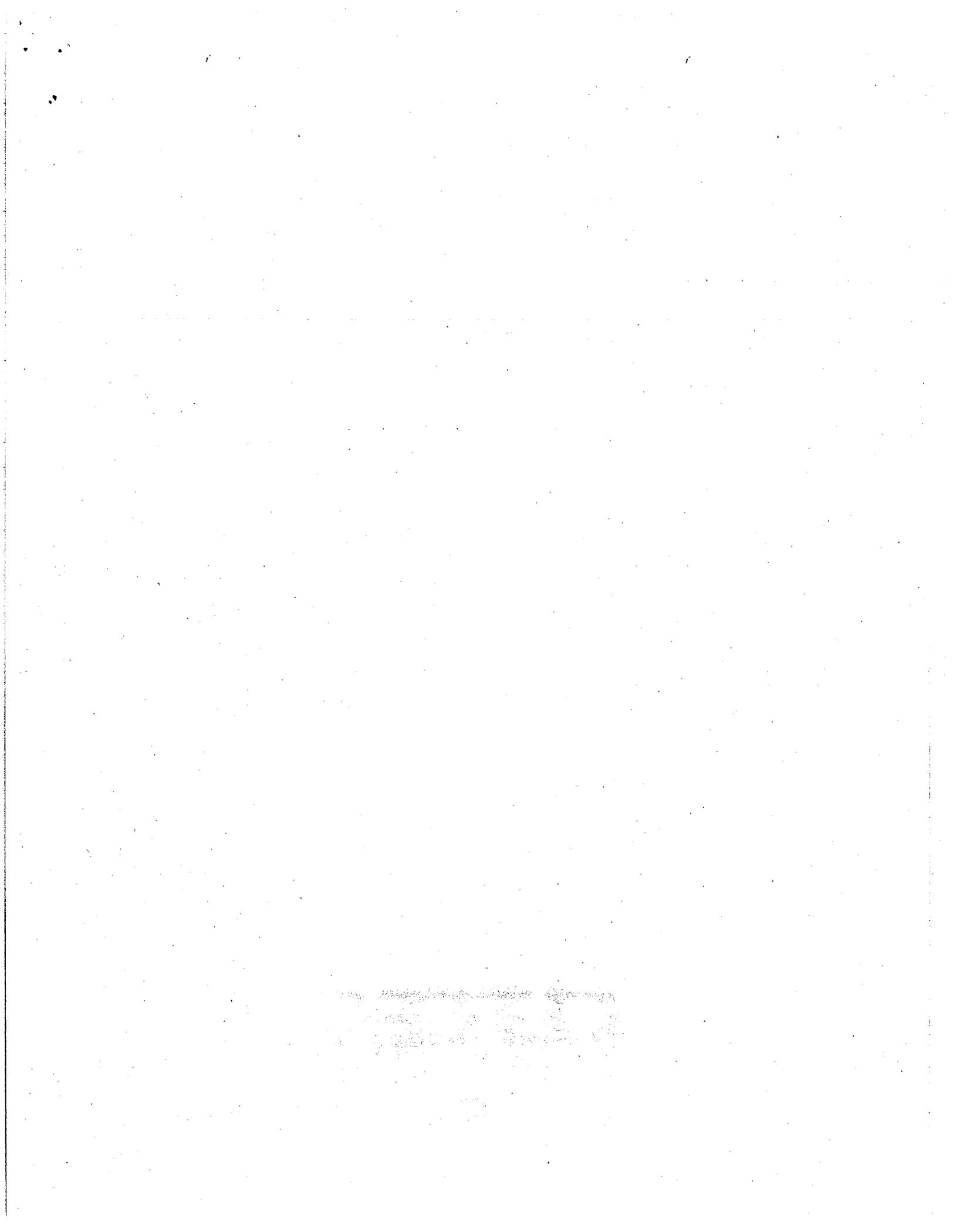
³Nursing home length of stay was not measured in the analysis because the health plan data associated with nursing homes did not include all nursing home expenditures.

⁴Of the six health plans analyzed, we consider Contra Costa Health Plan's (CCHP) results as the 'gold standard' because all consumers in Contra Costa County met high risk criteria based on health plan service use data and IHSS data whereas consumers in LA and San Bernardino Counties self-identified as high-risk. CCHP's high risk consumers also experienced rates of utilization in line with a previous statewide study on IHSS recipients, suggesting the data was relatively complete. Data for LA Care, Health Net, Molina, Care1st, and IEHP generally replicate the direction of CCHP's results at a lower magnitude. The utilization rates for members of these plans in LA and San Bernardino Counties are uncharacteristically low and may be due to missing claims data. LA Care's data appeared to be the most robust of these plans based on its utilization rates and sample size.



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