Long Term Care and Services in Rural New York: Building a Sustainable and Replicable System

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EXECUTIVE SUMMARY

The fundamental purpose of this project- funded through a grant by the NYS Health Foundation - was to develop a multi-faceted strategic action plan to ensure access to a range of high-quality long term care services and supports (LTCSS) in the Eastern Adirondacks. The current service infrastructure is fragmented, unbalanced, unsustainable and at immediate risk of being further compromised due to financial and other pressures.

Over the past year, a coalition of 30 partner organizations representing the continuum of long-term care providers (i.e. skilled nursing, hospitals, assisted living, senior housing, home health agencies, community service providers, and hospice/palliative care) from the six-county rural region of the Eastern Adirondacks came together to review available data on demographic trends, long-term care utilization patterns, and key determinants of future demand for long term care services.

These discussions resulted in the development of a Long-Term Care Services Demand model and six major recommendations that take into account existing and future challenges of a growing elderly population, lack of transportation options, fewer available informal caregivers, a shortage of health care workers, and an increasing imperative on reforming the health care delivery system to support the Triple Aim of providing better patient care, improved population health, and reducing health care costs.

Recommendations include:

1. ***Increase alternatives to nursing home services*** by promoting the expansion of assisted living for Medicaid-eligible and low-income seniors, and expanding adult day health care and home care access and capacity.
2. ***Address health care workforce availability and preparation for realigned service delivery*** by expanding the consumer directed personal assistance program, creating regional coalitions to address worker recruitment and retention, facilitating better use of professional and paraprofessional skills, and enhancing workforce education and training in care management, technology and other areas.
3. ***Address other service infrastructure issues*** by improving telehealth and telemedicine capacity, expanding hospice and palliative care awareness and access, and pursuing regulatory reforms that will be needed to reconfigure and sustain LTCSS in rural areas.
4. ***More fully develop the concept of Villages for Successful Aging/Medical Villages*** with the goal of efficiently utilizing existing resources and consolidating the essential health, wellness, prevention, care coordination and social programs required for successful aging.
5. ***Promote adoption of health information technology and exchange among LTCSS providers*** and other providers and practitioners to create efficient and effective care delivery programs and services across all sites of care and in the community.
6. ***Increase the Medicaid funding available to rural, essential services*** to assure that nursing home, home health care, adult day care and other services are available within a reasonable distance.

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Background

The six-county Eastern Adirondack region (i.e., Clinton, Essex, Franklin, Hamilton, Warren and Washington Counties) has a rapidly aging population, yet lacks a sustainable system of long-term care services and supports (LTCSS) that is capable of providing its residents with access to services in the most integrated setting appropriate to their needs.

Today, 14.8 percent of the population of this region is over age 65 and 9 percent of these seniors have incomes at or below poverty level. The region is expected to see a 23 percent increase in persons aged 65+ between 2010 and 2020, a rate that is 15 percent greater than Upstate New York as a whole. According to a 2009 regional assessment, if current population trends continue in the next twenty years, the Adirondacks will rival Florida's west coast with the oldest population in America.

Many communities in the region have been designated as medically- underserved areas as well as Health Professional Shortage areas, indicating additional barriers to receiving services. These shortages make it difficult to serve frail elderly residents economically in their homes, recruit sufficient professional and paraprofessional staff, and achieve economies of scale. County-level community health assessments conducted in 2009 and updated in 2011 concluded that access to quality health care and community health supports are top priorities in the region.

This region remains heavily dependent on nursing home care; however, nursing homes in the region are 40 percent smaller on average (i.e., 109 beds vs. 183 beds statewide); have higher occupancy rates (i.e., 95.5% versus 93.7% statewide); have lower patient acuity (i.e., case-mix is 10% lower than the statewide average); and are 60 percent more likely to be losing money on operations than other homes in the State.

The region has had an underdeveloped system of nursing home alternatives. For example, there are only 70 Assisted Living Program (ALP) beds available to Medicaid recipients in the entire 6-county area, with 3 counties having no capacity, and there are only 4 Long Term Home Health Care Programs (LTHHCPs). Affordable senior housing and adult care facilities (ACFs), which serve as platforms for service delivery, are also in short supply in the region. Together, these capacity imbalances have led to the over-reliance on nursing home care.

Recent state initiatives to reduce Medicaid expenditures - including the move to care management for all Medicaid recipients and the Delivery System Reform Incentive Program (DSRIP) – and the increasing financial pressures on acute and LTCSS providers have prompted initial discussions between a number of key health system leaders in the area. There is increasing awareness that a long-term viable solution for the needs of the vulnerable older adult population will require a concerted, organized effort on behalf of all health care providers and other stakeholders that builds upon the region's current infrastructure, partnerships (e.g., Adirondack Rural Health Network, Adirondack Health Institute, Mercy Care for the Adirondacks) and projects (Adirondack Regional Medical Home Pilot).

With a growing number of the region's nursing homes experiencing financial distress, the lack of an integrated, coordinated network of home and community based service (HCBS) alternatives to institutional care and the inevitable growth in older adults who need affordable LTCSS options, there is a pressing imperative to bring together state, county and local stakeholders to develop a rational, sustainable and replicable plan to enhance access to high quality LTCSS.

Activities

The activities of *Building a Sustainable and Replicable System of Long Term Care in the Eastern Adirondacks* were aligned closely with the project work plan and were successfully completed or modified as a result of coalition discussion and feedback. Specifically,

a) The Foundation for Long Term Care (FLTC) staff executed a consulting agreement with Nancy Rehkamp of CliftonLarsonAllen, LLP to facilitate the coalition meetings and community forum and to provide overall project support.

b) A commitment of participation was obtained from a core group of 30 partner organizations to become members of the Eastern Adirondacks Long Term Care Coalition (EALTCC), including representatives from skilled nursing facilities, hospitals, assisted living, senior housing, home health agencies, community based service providers and hospice/palliative care (see Appendix A for a complete list of coalition members).

c) A review and analysis of regional demographic trends, nursing home bed capacity, future bed needs, and availability of other types of long term care services and supports (LTCSS) was undertaken.

d) A Long-Term Care Services Demand Model was developed. This model makes estimates of the demand for five types of long term care services: Adult Day Health, Assisted Living, Home Health, Personal Care, and Skilled Nursing (both short term and long term) by taking into consideration baseline utilization patterns, demographic projections, and a number of key assumptions based on research and group discussion that will impact future demand for services.

e) Three in-person meetings of the EALTCC were conducted along with two conference calls of a sub-group of members. The first meeting of the group (November 2013, Lake Placid) focused on demographic trends, current utilization patterns, and key variables that could influence future demand for long term care services. During the second meeting (March 2014, Lake George), we reviewed our definition of service categories and demand influencers, discussed historical Medicaid long term care utilization trends by county, provided an overview of a baseline demand estimation model taking into account demographic trends only, and discussed potential model variables and assumptions. The third and final meeting of the EALTCC (June 2014, Plattsburgh) focused specifically on the preliminary results of the demand model , key assumptions made, and draft recommendations to be presented at the September symposium.

f) LeadingAge New York staff met with the NYS Department of Health to review and discuss the NYSHealth project and draft recommendations. The general consensus was that our recommendations, while focused specifically on reconfiguring long term care services and supports, aligned and integrated well with the NYS Department of Health North Country Health Systems Redesign Commission's work completed in March 2014[1].

g) A final community forum was planned and conducted (September 2014, Lake George) that brought together a wide variety of stakeholder organizations including long term care service providers in the six county region (nursing homes, assisted living, adult day health care, home care agencies, offices for the aging, senior housing), state associations, CDPAP fiscal intermediaries, payers, local and county officials, and consumer representatives. Over 70 attendees participated in the forum, learned about the project and findings, and participated in a discussion about the draft recommendations. Small group discussions focused on identifying both barriers and enablers to implementing the draft recommendations.

[1] *Toward an Integrated Rural Health System: Building Capacity and Promoting Value in the North Country,* North Country Health Systems Redesign Commission Final Report (April 2014)

Outcomes, Analysis, and Interpretation

In order to more fully understand the complexities and challenges of delivering health care to the older adult population in the six-county Eastern Adirondack region, we first examined demographic trends, reviewed available data on long term and acute care service utilization, and reviewed current, relevant NYS initiatives likely to impact the delivery, access, and payment of long term care services in the near future. Once this analysis was completed, we developed the Long Term Care Services Demand Model, selecting key demand influencers based on the data, research, and group discussion. Using the demand modeling capabilities we tested the sensitivities of assumptions and possible scenarios. Finally, we reviewed the scenarios and the resulting estimates of demand from the Long Term Care Services Demand Model with the coalition members and other stakeholders and developed the final recommendations. Each step in this process is detailed below.

A Review of the Data and NYS Healthcare Reform Initiatives

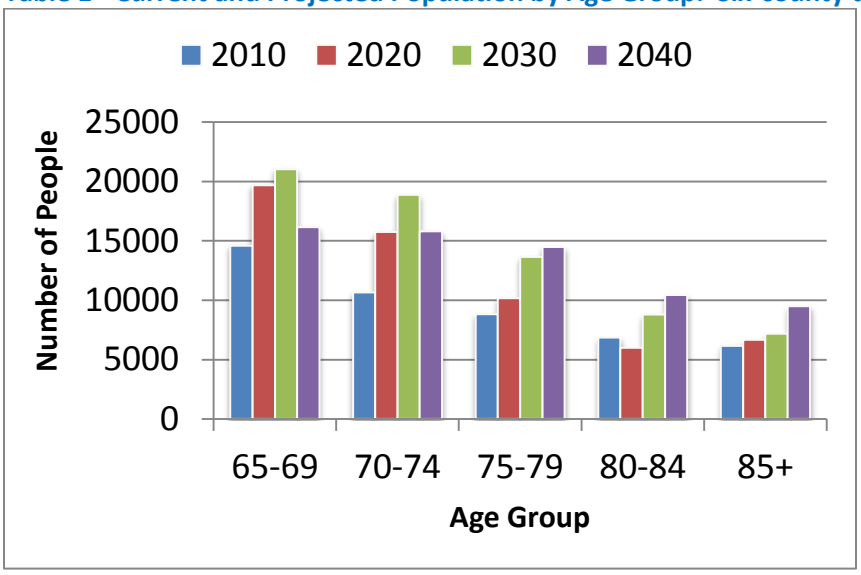
The physical landscape

The six-county Eastern Adirondack region (Clinton, Essex, Franklin, Hamilton, Warren and Washington) is geographically expansive and extremely rural. The region encompasses 7,876 square miles, is home to 305,660 people and has a population density of approximately 38.8 people per square mile as compared to 411.2 people per square mile for the rest of the state. One major highway bisects the region running north to south; otherwise only two-lane roads traverse the region with limited east/west connectors. Even the largest population centers (i.e., Plattsburgh, Glens Falls) have fewer than 20,000 residents. There is a lack of public transportation, broadband internet connectivity and wireless coverage remains spotty, with a recent survey indicating very few communities in this region having complete coverage (Adirondack Regional Assessment Project, 2009), and winters are notoriously long and harsh, making access to high quality health care services even more challenging.

Regional demographic trends

As shown in Table 1, the population aged 65-74 in the six-county region will grow steadily between 2010 and 2030 before starting to decline between 2030-2040, while the "older old" (80+) population climbs slightly between 2010 and 2030 but then shows a significant increase between 2030-2040.

Table 1 - Current and Projected Population by Age Group: Six-county total



Source: Program on Applied Demographics, Cornell University

The median household income varies from a low of $43,673 in Franklin County to a high of $53,877 in Warren County, all below the New York State median income of $56,951 (Table 2). The poverty rate of those 65 and older ranges from 5.3 percent in Warren County to 12.4 percent in both Clinton and Franklin Counties, while the New York State average is 11.5 percent.

Importantly, over 25 percent of the households in the region contain individuals aged 65 or older, and the percentage of householders aged 65+ living alone ranges from 29.2 percent in Washington County to 34.6 percent in Franklin County. Elders living alone are the most at risk of requiring assistance as they age and for longer periods of time.

Table 2 – Households 65 years and older

County	Median Household Income	% of 65+ Population in Poverty	Households with individuals 65 years and over		Householder living alone 65 years or older	
			Number	Percent	Number	Percent
Clinton	$49,260	12.4	7,882	25.0	3,170	30.6
Essex	$46,629	8.1	5,146	31.6	2,211	32.2
Franklin	$43,673	12.4	4,988	26.2	2,277	34.6
Hamilton	$51,142	8.0	822	36.3	344	31.1
Warren	$53,877	5.3	8,141	29.1	3,354	30.6
Washington	$50,117	7.9	6,801	28.2	2,708	29.2
NYS	$56,951	11.5%	1,925,416	26.3%	765,138	29.6%

Source: American Community Survey: 2008-2102; 2010 Census

As the number of "oldest old" (aged 85 and over) increases over the next 20 years in the Eastern Adirondacks, the number of available caregivers will decrease. The caregiver ratio, defined as females aged 45-64 divided by total population 85 and older, will significantly decline from 7.3 to 1 in 2010 to 4.8 to 1 in 2040 making access to LTCSS in the future even more difficult than today.

In looking at health characteristics in this region, we find higher rates of adults with hypertension, diabetes, smoking and obesity as compared to the rest of upstate New York (Table 3). This higher incidence, and complications from these health conditions, will have major implications for health care utilization and the need for services. At the same time, we note shortages in the health workforce in the North Country for social workers, occupational therapists, and physical therapists in addition to doctors, nurses and paraprofessionals (e.g., personal care assistants, home health aides and certified nursing assistants), all important occupations in serving the needs of the long term care population.

Table 3 – Health Characteristics

Health Status/Health Behaviors	North Country	Upstate
% Adults with Hypertension	33.2	30.4
% Adults with Diabetes	10.4	9.5
% Adults with Asthma	12.6	10.8
% Adults Smoking	23.3	21.1
% Adults Obese	30.5	27.1

Source: 2013 Center for Workforce Studies Health Workforce Planning Guide

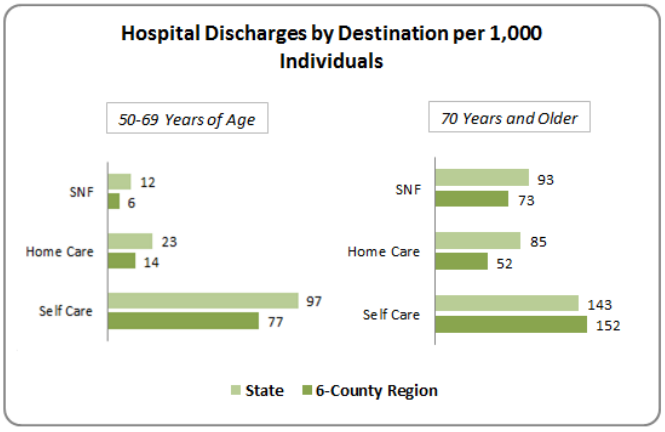
A more detailed analysis of the demographic and health trends of the six-county region can be found in Appendix B.

Current long term care service utilization

Hospital discharges: Older individuals (70+) discharged from hospitals in the six-county region tend to be discharged to home with no services more often than in the rest of the state. Using a comparative measure of discharges by destination per 1,000 individuals (total population), the rate of individuals aged 50 and higher who are discharged to home with home health services in the North Country region is notably lower than the rest of the state. For every 1,000 individuals aged 50 to 69 in the six-county region, 14 were hospitalized and discharged to home care in 2012. This compared to a figure of 23 for the rest of the state.

For those 70+, the gap was even wider: 52 were discharged to home care in the analyzed region compared to 85 statewide. Individuals 70 years of age and older in the six-county region were more likely to be discharged without referral to formal long term care services than in the rest of the state. Figures are based on 2012 Statewide Planning and Research Cooperative System (SPARCS) hospital discharge data and are shown in Table 4 below.

Table 4: Hospital Discharges



Bed need and occupancy: According to the NYS Department of Health's (DOH) 2016 Nursing Home Need Methodology, the six-county region was 432 beds short of the 2,244 needed beds, a 24 percent shortfall (see Table 5). Analysis of bed availability data reported to DOH in 2013 shows nursing home utilization of 95-96 percent in the region, compared to 92-93 percent for New York state overall. Based on 2013 Medicaid Cost Report data, the nursing homes in the North Country served a higher proportion of long term residents. Of those discharged from nursing homes in 2013, 46.3 percent had stayed longer than 30 days. The figure was 41.5 percent in the rest of upstate.

Table 5: 2016 New York State Nursing Home Bed Need

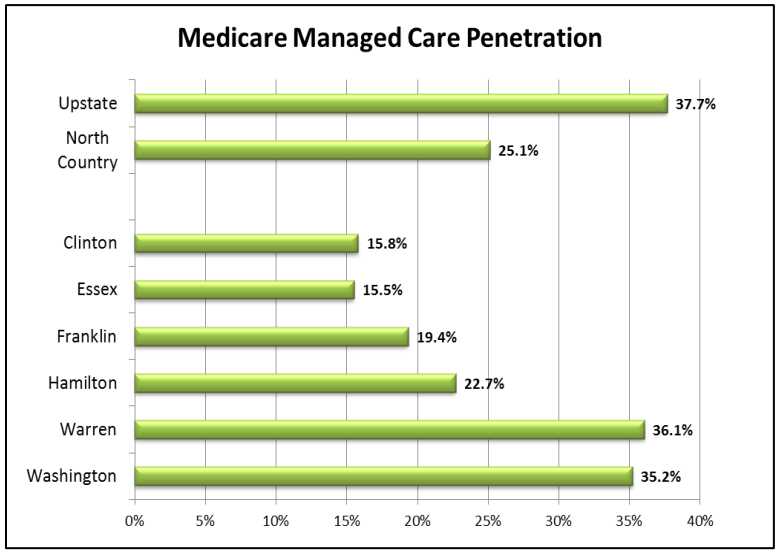
County	2016 Projected Need (Slots)	Current NH Capacity	Unmet Need	2016 NH Shortfall as Percent of beds
Clinton	616	423	193	46%
Essex	368	244	124	51%
Franklin	261	215	46	21%
Hamilton	30	0	30	100%
Warren	417	402	15	4%
Washington	552	528	24	5%
Total 6-county	2,244	1,812	432	24%
All of Upstate	46,601		(2,112)	(4.5%)

Four Adult Day Health Care (ADHC) programs operate in the six-county area with three counties having no ADHC programs at this time. Based on weekly ADHC availability reporting, while the utilization rates varied among programs, the median use rates mirrored state utilization rates which in mid-2014 ranged around 77-78 percent. One program reported utilization above 90 percent for much of 2014. ADHC programs in the North Country served primarily Medicaid clients, the same trend as observed in the rest of upstate New York.

Based on Adult Care Facility (ACF) statistical report data, the region had a total of 667 ACF and 70 Medicaid Assisted Living Program (ALP) beds in 2012. The most recent (2012) ALP and ACF census report shows a 70 percent year-end occupancy in ALP programs (compared to 80 percent for upstate) and 87 percent in ACF overall (higher than the upstate rate of 81 percent).

Medicare and Medicaid: The Medicare managed care penetration rate of 25.1 percent for the six-county region was significantly lower than the 37.7 percent upstate penetration rate. As shown on Table 6 below, while Warren and Washington counties were close to the upstate rate, rates in three other counties were lower than 20 percent.

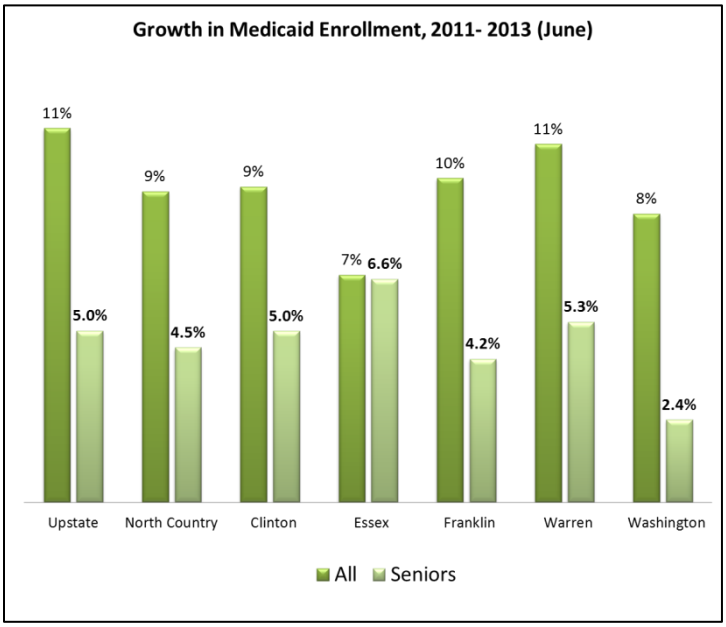
Table 6: Medicare Managed Care



Medicaid managed care penetration rates among those younger than 65 were comparable to other parts of upstate but enrollment for the 65+ population was just beginning with fewer than 100 seniors in Medicaid managed care in 2013. With the exception of Essex County, the growth in Medicaid enrollment was slightly lower in the six-county region for both seniors and non-seniors relative to other upstate areas (see Table 7).

While the age group of the most common Medicaid Certified Home Health Care Agency (CHHA) service user varied by gender and county, Medicaid beneficiaries receiving personal care services were concentrated in the 65+ age group. For CHHAs serving the six county area, Medicaid recipients comprised 22 percent of their clients, while the Medicaid proportion was eight percent in the rest of upstate New York.

Table 7: Growth in Medicaid Enrollment



NYS Landscape

Over the past several years, New York State has implemented a number of major Medicaid Redesign initiatives intended to align with the Institute for Healthcare Improvement's Triple Aim of providing better patient care, improved population health and lower health care costs. The State's overall priorities include reducing Medicaid costs, contracting with and paying fewer entities, assuming less uncertainty and risk for the state, providing "care management for all", integrating Medicaid with Medicare, and realigning the health care delivery system.

Reforms that have begun and will continue to significantly impact the delivery of long term care services in the Eastern Adirondack region include, but are not limited to:

a. Mandatory Medicaid Managed Care Enrollment

Mandatory Medicaid Managed Long Term Care (MLTC) enrollment began on July 1, 2012 in New York City and is being phased in to the rest of the state for those individuals needing community-based long term care services for 120 days or more including personal care, home care, consumer-directed care and adult day health care. It is currently anticipated that all counties, including the six counties in the Eastern Adirondacks, will have mandatory MLTC in place for the community-based population by February 2015, as long as MTLC plan capacity has been established.

Under New York State's most recent proposal, Medicaid recipients who will need permanent placement in nursing homes on or after January 2015 (downstate) and July 2015 (upstate) must join or remain in a managed care plan. Any dual eligible or Medicaid-only recipient already permanently placed in a nursing home prior to those dates will remain in fee-for-service for the duration of his or her stay but any dual eligible new to Medicaid and/or permanently placed after the deadlines must join or remain in a MLTC plan. Any Medicaid-only recipient new to Medicaid and/or permanently placed after the deadline must remain in a "mainstream" Medicaid managed care plan or MTLC, or join a mainstream plan.

b. Delivery System Realignment

The federal government recently awarded New York State an $8 billion Medicaid waiver, using savings generated by Medicaid Redesign Team reforms. Delivery system realignment is a major part of the

waiver, with over $6.4 billion allocated for the Delivery System Reform Incentive Payment (DSRIP) program. The overall goal of DSRIP is to promote community-level collaborations with multiple physical health and behavioral health provider types involved, including long term care and to achieve a 25 percent reduction in avoidable hospital use over five years. DSRIP performing provider systems are expected to be limited to 1-2 per region in the state and have the potential to lead to major delivery system realignment in the future. The Adirondack Health Institute (AHI)- a non-profit organization created to promote, sponsor, and coordinate initiatives and programs that improve health care quality, access and service delivery in the Adirondack region- is leading the DSRIP project application process for the North Country including the six Eastern Adirondack counties. Many long term care and community health providers in the six-county region have partnered with AHI on their DSRIP application and will play an integral role in the success of the projects.

c. Other Coordinated/Collaborative Care Models

Several other coordinated or collaborative care models have been developed and are in various stages of implementation throughout the state, including the North Country, with a common goal of breaking down silos between primary, acute, long term care, social, mental health, behavioral health and disability services and providing more patient-centered care. For example, AHI is one of 33 state-designated Health Homes, a comprehensive care management service model for high-risk Medicaid beneficiaries with one or more chronic conditions. Health homes place a strong emphasis on linking community and social supports with health care, and provide enhanced coordination of medical and behavioral health care. The AHI Health Home operates in partnership with several provider networks (i.e., Hudson Headwaters Health Network, Champlain Valley Health Network) and behavioral health organizations.

The Patient Centered Medical Home (PCMH) is another care coordination model being tested and implemented throughout the state. This model emphasizes preventive care and active management and coordination of care for people with chronic conditions by ensuring each patient has a trusted primary care physician. The Adirondack Region Medical Home Pilot began in 2010 and employs the PCMH model to deliver and coordinate health care services in the rural Adirondack counties. Primary care providers receive increased payment for services in exchange for expanded responsibility for coordinating care, providing preventive care and managing chronic conditions.

Finally, Accountable Care Organizations (ACOs) seek to improve the delivery of health care through the creation of networks of providers that work together to deliver coordinated care to a defined population of patients. In January 2014, CMS selected the Adirondacks ACO as one of 123 newly formed Medicare ACOs. The network currently consists of more than 450 participating primary and specialty clinicians and covers approximately 30,000 Medicare beneficiaries in Franklin, Clinton, Essex, Hamilton, Warren, Washington and Northern Saratoga counties of New York as well as two counties in Vermont.

North Country Health Systems Redesign Commission

In December 2013, the NYS Department of Health created the North Country Health System Redesign Commission with the goal of providing recommendations that would lead to an effective, integrated health care delivery system for all communities in the North Country. The Commission was led by three health care experts and included representatives of business, patients, providers, and other community stakeholders from the North Country.

Monthly public forums were held from December 2013 through March 2014 where stakeholders representing all aspects of healthcare (e.g. primary care, payers, long term care, behavioral health, hospitals, clinics, community-based organizations, etc.) presented their analyses and perspectives to the Commission and at the

end of March 2014, the Commission completed their final report[2]. Recommendations included the promotion and support of the Advanced Primary Care model across the North Country, integrating behavioral health services into primary care settings, developing telehealth services, and focusing on recruiting and retaining primary care practitioners. In addition, the concept of "Skilled Care Campuses/Medical Villages" was discussed in the report as recognition of the need to develop a continuum of community-based long term care services with financial incentives to place residents in the least restrictive appropriate care setting using existing underutilized health care infrastructure.

Long Term Care Services Demand Model

The demographic data and other information collected and analyzed were used to inform the development of the Long-Term Care Services Demand Model (the "Model"). The Model, developed by LeadingAge New York, makes estimates of demand for five types of long-term care services in six counties of New York State (Clinton, Essex, Franklin, Hamilton, Warren, and Washington):

1. Adult Day Health Services
2. Assisted Living Program (ALP)
3. Home Health Services
4. Personal Care Services
5. Nursing Home Services (long stay and short stay)

Methodology

The demand model starts with an estimate of the population and their use of services by age cohort and gender. For each of the services for which the model creates estimates of future demand, a series of assumptions about factors such as how the incidence of poverty for those 65+, or what changes may occur to funding services, or how changes in preferences for community based services will occur, etc. are tested with the model. The Model estimates the services in its proper unit of measurement (claims, visits, beds, etc.).

The Model was not developed to provide forecasts of demand. Instead, the Model was designed to make estimates under a set of specific assumptions. This approach involved deriving the proportion of each population group receiving each type of service based on historical data, making baseline estimates based on projected population growth, and adjusting the baseline estimates according to the assumed impact of a series of variables (demand determinants).

The Model was developed to be flexible and extendable. Existing variables and their estimated impact can be adjusted and new variables can be added so that the Model is capable of producing estimates of demand under different "scenarios". The main features of the Model's architecture are:

- Baseline estimates based on professionally produced population projections.
- Projections produced for each and every population group defined by gender and age.
- Potential determinants of demand can be added into the model or taken out of the model depending on the scenario.
- Effect of demand determinants is allowed to be variable over time.
- Effect of one demand determinant can be dependent on the effect of other demand determinants.
- Estimates of each type of services can be adjusted, extended, or customized independent of the effect of or on other types of services.
- Estimates for each geographic area and population group can be adjusted, extended, or customized independent of the effect of or on other geographic areas or other population groups.

[2] *Toward an Integrated Rural Health System: Building Capacity and Promoting Value in the North Country,* North Country Health Systems Redesign Commission Final Report (April 2014)

Demand Influencers and Model Assumptions

As described above, the Model was designed to make estimates under a set of specific assumptions which included not only population growth, past, and current service utilization but also other key demand influencers the coalition felt would impact future demand for long term care supports and services such as the implementation of mandatory managed care, the growth of other care management programs, availability of caregivers, the number of older adults living alone, etc. The assumptions were reviewed and discussed at length with the coalition members during the March meeting in Plattsburgh. The topic generated lively discussion and debate since we not only needed to agree on a reasonable number of variables to include in the model but also to come to consensus on whether each variable: 1) increased demand; 2) decreased demand; or 3) had no effect on each of the 5 service lines in the model. After the group discussion, LeadingAge NY staff conducted additional research (e.g. literature searches, impact of demand influencers in other states, etc.), and finalized the variables for inclusion in the model.

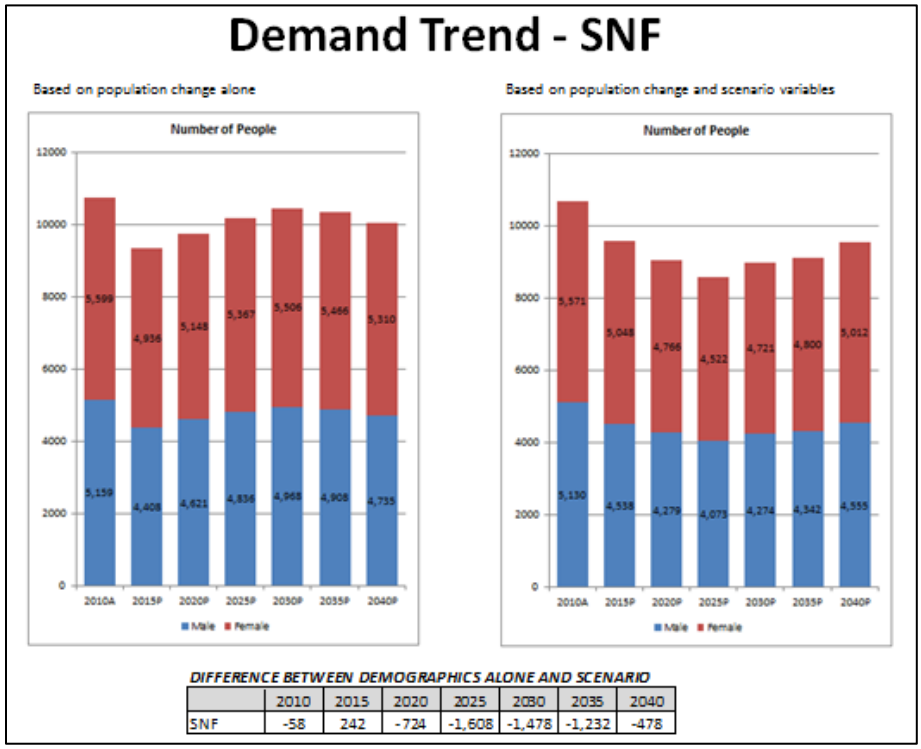
Each demand influencer (i.e. variable) included in the Model is described here along with the assumptions made on how that variable is expected to influence future demand.

1. Population growth - with the exception of a decline between 2010 and 2015, the projected growth in the 65+ population between 2015 and 2035 will increase the demand for most health care services including acute care, nursing home, home care, home and community based services and other long term care services.
2. Implementation of mandatory Medicaid managed care - the implementation of mandatory Medicaid managed care for the community-based and nursing home long term care populations will change the utilization of long term care services, increasing the likelihood that recipients will be placed in the least expensive and restrictive setting, and funding some services not previously covered or traditionally provided under Medicaid.
3. Growth of other care management programs – the growing penetration of Medicare Advantage plans and other care management models (e.g. ACOs, PCMHs), and the implementation of DSRIP will result in reduced hospitalizations and correspondingly lower use of post-acute services and delayed need for long term care services.
4. Decrease in informal caregivers - the decrease in the number of available informal caregivers will increase the demand for some health care services including home care, adult day health care, assisted living, and other HCBS (e.g. home-delivered meals, housekeeping, and transportation).
5. Increase in number of individuals 65+ living alone - an increase in the percentage of individuals 65+ living alone will increase the demand for home care, adult day health care, and other community- based services and will bolster the demand for residential care that nursing homes and ALPs provide.
6. Increase in number of individuals 65+ in poverty - an increase in the percentage of 65+ in poverty will result in increased enrollment in Medicaid among seniors in the region and increased demand for Medicaid-funded services, and greater demand for affordable senior housing.

Key Findings from the Model

We compared a baseline ("as-is") scenario using population growth estimates from Cornell's Applied Demographics Program and current service utilization data with a scenario that incorporates all of our demand influencers for each service line. Results are summarized in Charts 1 – 5.

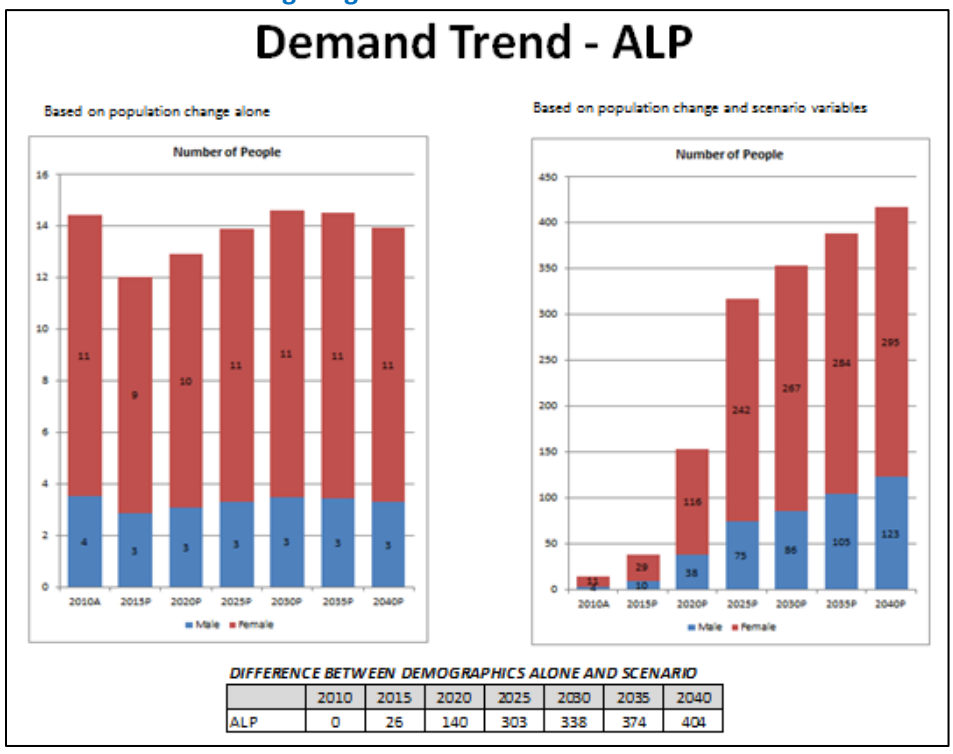
Chart 1 – Skilled Nursing



DIFFERENCE BETWEEN DEMOGRAPHICS ALONE AND SCENARIO

	2010	2015	2020	2025	2030	2035	2040
SNF	-58	242	-724	-1,608	-1,478	-1,232	-478

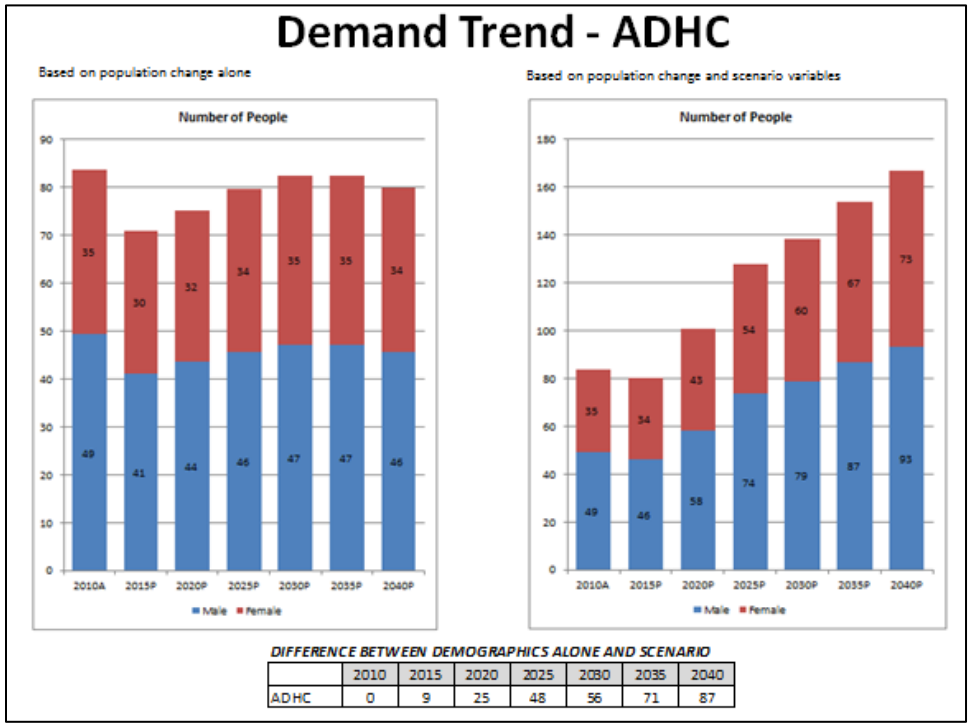
Chart 2 – Assisted Living Program



DIFFERENCE BETWEEN DEMOGRAPHICS ALONE AND SCENARIO

	2010	2015	2020	2025	2030	2035	2040
ALP	0	26	140	303	338	374	404

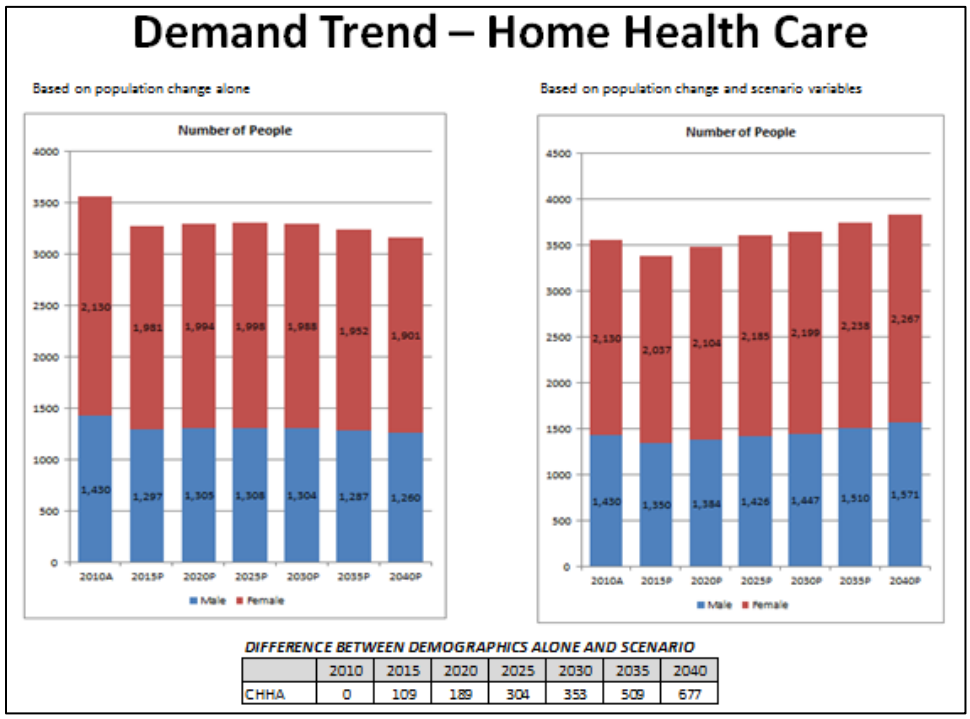
Chart 3 – Adult Day Health Care



DIFFERENCE BETWEEN DEMOGRAPHICS ALONE AND SCENARIO

	2010	2015	2020	2025	2030	2035	2040
ADHC	0	9	25	48	56	71	87

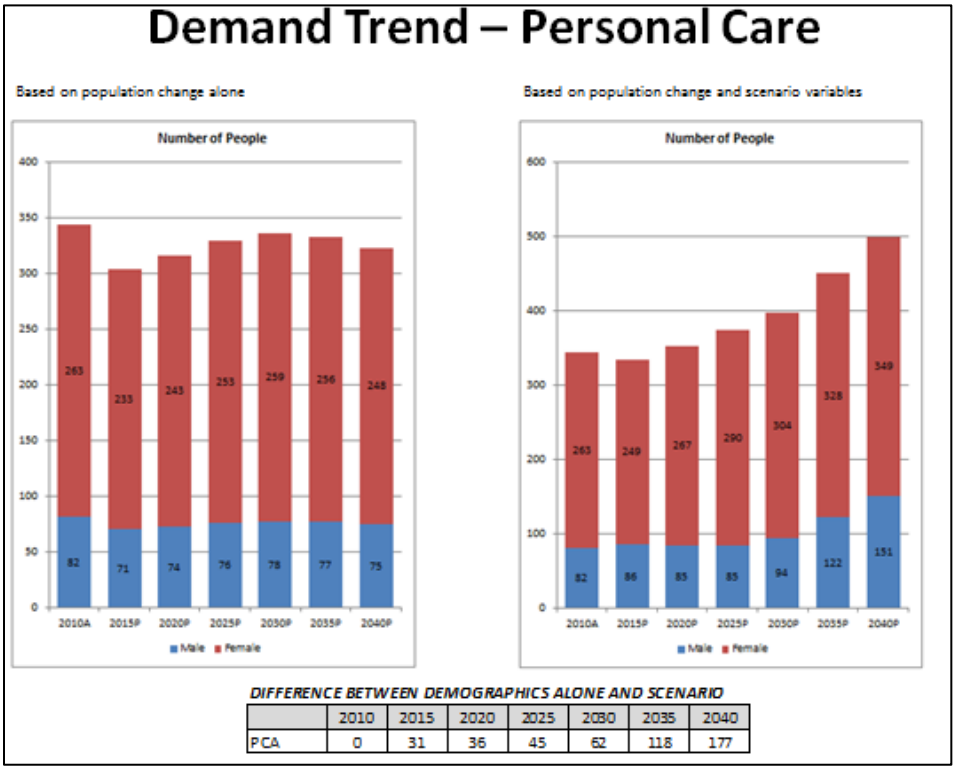
Chart 4 –Home Health Services



DIFFERENCE BETWEEN DEMOGRAPHICS ALONE AND SCENARIO

	2010	2015	2020	2025	2030	2035	2040
CHHA	0	109	189	304	353	509	677

Chart 5 – Personal Care Services



DIFFERENCE BETWEEN DEMOGRAPHICS ALONE AND SCENARIO

	2010	2015	2020	2025	2030	2035	2040
PCA	0	31	36	45	62	118	177

Although slight variations in the estimates for future demand of long term care services by county and service line exist based on the Model results, two general conclusions were found:

1. Demand for nursing home services in the six county Eastern Adirondack region will increase between 2010 and 2015 and then begin to decrease between 2015 and 2040.
2. There will be an increase in demand for all non-nursing home services in the model between 2015 and 2040 (i.e., ALP, home health care, personal care and adult day health care).

Recommendations

Based on our analysis of the data, the results of the Model, an assessment of governmental policy changes and other environmental factors, and extensive discussions with coalition members we make the following six recommendations:

1. ***Increase alternatives to nursing home services*** by promoting the expansion of assisted living for Medicaid-eligible and low-income seniors, and expanding adult day health care and home care access and capacity. The projected population growth for adults 80+ in the region is expected to decline by about 3 percent between 2010 and 2020 and then grow by more than 25 percent in each of the following two decades. Current estimates show that there are already shortages of nursing home beds, assisted living units and adult day health slots in some or all counties in the region. This recommendation includes creating the array of services and facilities to ensure adequate access to and funding for affordable senior housing and community medical and non-medical based services allowing individuals to age in place, engage in the community and lead purposeful lives.
2. ***Address health care workforce availability and preparation for realigned service delivery.*** The current availability of home health staff is one reason this region sees about 40 percent fewer patients referred to home health following acute care than the state average. The caregiver ratio will also decline by about 35 percent from 2010 to 2030 and then remain flat through 2040. This recommendation

proposes interventions that enhance the ability to serve older adults in their homes by expanding the consumer directed personal assistance program, creating regional coalitions to address worker recruitment and retention, facilitating better use of professional and paraprofessional skills, and enhancing workforce education and training in care management, technology and other areas.

3. ***Address other service infrastructure issues.*** Currently some areas of the North Country are not able to maximize the use of telehealth or technology due to limited internet and broadband access limiting opportunities to increase efficiencies through technology. This recommendation includes improving telehealth and telemedicine capacity, expanding hospice and palliative care awareness and access, and pursuing regulatory reforms that will be needed to reconfigure and sustain LTCSS in rural areas.
4. ***More fully develop the concept of Villages for Successful Aging/Medical Villages*** with the goal of efficiently utilizing existing resources and consolidating the essential health, wellness, prevention, care coordination and social programs required for successful aging. Based on the projected elderly population growth and an estimated 30 miles or 45 minute maximum drive time for area elders, we believe there is a need for four to five Villages which would be co-located with existing senior living campuses. These Villages would have a wide array of both medical and non-medical services that are easily accessible.
5. ***Promote adoption of health information technology and exchange among LTCSS providers*** and other providers and practitioners to create efficient and effective care delivery programs and services across all sites of care and in the community. Currently, LTCSS providers have limited access to health information prior to transfer and in the community on clients they serve; the acute care providers and community physicians also do not have access to information on ongoing services provided by LTCSS providers. This recommendation focuses on innovative ways to provide an elder with a personal health record that is comprehensive and easily accessible by all care team members.
6. ***Increase the Medicaid funding available to rural, essential services*** to assure that nursing home, home health care, adult day care and other services are available within a reasonable driving distance (e.g. within 30 miles or 45 minutes). Providers who meet the essential services definition or have a certain percentage (TBD) of total services provided to Medicaid beneficiaries would be provided a supplemental payment to compensate them for the higher costs per unit associated with small size and/or geographically dispersed patient volume.

Communication and Dissemination

Presentations

A Roadmap to a Rational, Sustainable, and Replicable System of LTC Services in the Eastern Adirondacks: Symposium on September 30, 2014

LeadingAge New York staff and Nancy Rehkamp, project facilitator, presented and discussed project results to approximately 70 stakeholders including representatives from nursing homes, hospitals, assisted living, adult day health care, hospice and palliative care, academia, local and state legislators, home and community based providers, etc. Attendees broke up into small groups, facilitated by LeadingAge NY staff, to discuss draft recommendations and provide input on the key enablers and challenge of implementing those recommendations. The final report incorporates comments and suggestions from this symposium.

Washington, Warren and Hamilton Counties Long Term Care Coalition meeting on September 24, 2014

Linda Spokane, Vice President for Research & Analytics, presented an overview of the Eastern Adirondacks project and draft recommendations to the local Long Term Care coalition during their quarterly meeting. The coalition consists of many home and community-based long term care service organizations and they provided good feedback on the recommendations and discussed workforce and transportation challenges in the region.

DSRIP Presentation to the Adirondack Health Institute on April 8 and 10, 2014

LeadingAge NY staff, Dan Heim and Diane Darbyshire, was invited to present to North Country providers on DSRIP as part of an AHI convened meeting to bring local providers together for possible participation in a North Country DSRIP Performing Provider System (AHI eventually became the lead DSRIP PPS in that region). The LeadingAge New York presentations brought the perspective of the coalition's work on this project to the discussion for the group to consider in identifying possible DSRIP priorities and partnerships.

North Country Health Systems Redesign Commission meeting on January 21, 2014

Dan Heim, Executive Vice President of LeadingAge New York, presented an overview of the Eastern Adirondacks Long Term Care project to the North Country Health Systems Redesign Commission to update them on the progress of the EALTCC, discuss the project timeline, and ensure that recommendations made by the EALTCC would be considered by the Commission.

Meetings

On September 11, 2014, LeadingAge New York staff briefed the NYS Department of Health on the project and resulting draft recommendations. There was consensus that many of the recommendations were consistent with the North Country Health Systems Redesign Commission report, especially the Commission's recommendations made around long term care.

On December 3, 2014, LeadingAge New York staff participated in a joint conference call with the NYS Office for the Aging, Mercy Care for the Adirondacks, Essex County Office for the Aging, Franklin County Office for the Aging, and the Association on Aging in New York to discuss Mercy Care's report *Community Empowerment Plan: Giving and Receiving Care in the Adirondacks*. During the call, LeadingAge NY staff presented the draft recommendations from the Eastern Adirondacks Long Term Care project, several of which support efforts by Mercy Care and the county Offices for the Aging to increase state funding for community-based, non-medical supportive service services to the elderly.

The Future

The formidable challenges of rural health service delivery have arguably increased since the great recession. The North Country's rural economy has suffered as the overall population declines and the percentage of those aged 65+ increases. Historically, residents are poorer and less likely to be insured, there are fewer physicians, dentists, pharmacists, nurses, mental health and other health professionals per 1,000 people and access to services is further compromised by the weather and terrain of the area. To continue evolving opportunities and creating solutions, we recommend that the coalition members who have worked to develop this report continue meeting to ensure they are engaged, informed and proactive in developing policy and advocacy recommendations in three key areas:

1. ***Create a sustainable funding stream that assures continued availability of services that are reasonably accessible to North Country residents***. This would include a rural Medicaid rate add-on which:
    a. provides enhanced Medicaid funding for long term care providers including home health agencies, nursing homes, assisted living programs, and Consumer Directed Personal Assistance Programs;
    b. recognizes the unique needs and challenges of providing care in a remote, rural area including increased transportation costs, and difficulty recruiting, training and retaining workforce; and
    c. provides funding for infrastructure development needs that support integrating care across the continuum including electronic communications, common documentation tools, etc.

2. ***Increase funding for non-medical supportive services to maintain elders in their own homes longer as they increase in frailty, and promote safe and healthy living environments***. To achieve this goal, we recommend state funding increases for programs offered through the NYS Office for the Aging (e.g., the Expanded In-home Services for the Elderly Program (EISEP), Community Services for the Elderly (CSE), non-emergency transportation) and waivers of all applicable county financial matching requirements. These actions would be expected to decrease the current 6-9 month wait list for some of these services, and forestall or prevent the need for more costly Medicaid-funded services

3. ***Create Villages for Successful Aging***. Villages for Successful Aging or Medical Villages are a new and innovative model developing around the country that more completely supports older adults in the community and/or in senior housing as they age. We recommend that villages be developed in this region using existing, underutilized long term and acute care infrastructure to create comprehensive campuses that consolidate the essential health, wellness, prevention, care coordination and social programs required for successful aging in the community. The existing facilities can be converted to support independent living, assisted living, community-based meals programs, adult day health care, community socialization opportunities, additional assessment, outpatient, behavioral and urgent care clinic locations and other services that support individuals managing their chronic conditions and frailty in the community. These communities would co-locate community services and health providers providing easier access and greater opportunity for integration and coordination of care.

Appendix

Appendix A: Eastern Adirondack Long Term Care Coalition Members

Appendix B: Demographic and Health Trends of Six-County Region

Appendix C: EALTCC Meeting Presentation in Plattsburgh on June 2, 2014

Appendix D: Symposium Presentation in Lake George on September 30, 2014

Appendix A

EASTERN ADIRONDACKS LONG TERM CARE COALITION (EALTCC)

ADIRONDACK HEALTH
2233 State Route 86
Saranac Lake, NY 12983

ADIRONDACK HEALTH INSTITUTE
9 Carey Road
Queensbury, NY 12804

ADIRONDACK TRI-COUNTY NURSING & REHABILITATION CENTER
112 Bowl Road
North Creek, NY 12853

ALICE HYDE MEDICAL CTR.
133 Park Street
Malone, NY 12953

CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER
75 Beekman Street
Plattsburgh, NY 12901

CLINTON COUNTY CONCEPTS OF INDEPENDENT CHOICES
82 Sharron Avenue
Plattsburgh, NY 12901

CLINTON COUNTY NURSING HOME
16 Flynn Avenue
Plattsburgh, NY 12901

CLINTON COUNTY OFFICE FOR THE AGING
135 Margaret Street
Plattsburgh, NY 12901

ELDERPLAN
6323 Seventh Avenue
Brooklyn, NY 11220

ESSEX COUNTY OFFICE FOR THE AGING
Water Street
Elizabethtown, NY 12932

FORT HUDSON HEALTH SYSTEMS, INC.
319 Broadway
Fort Edward, NY 12828

FRANKLIN COUNTY – MASSENA INDEPENDENT LIVING
41 Pearl Street
Malone, NY 12953

FRANKLIN COUNTY NURSING HOME
184 Finney Boulevard
Malone, NY 12953

FRANKLIN COUNTY OFFICE FOR THE AGING
355 West Main Street
Malone, NY 12953

HAMILTON COUNTY PUBLIC HEALTH NURSING SERVICE HOME HEALTH AGENCY
P.O. Box 250
Indian Lake, NY 12842

HAMILTON/WARREN COUNTIES CONCEPTS OF INDEPENDENT CHOICES
845 Central Avenue
Albany, NY 12206

HUDSON HEADWATERS HEALTH NETWORK
9 Carey Road
Queensbury, NY 12804

HERITAGE COMMONS RESIDENTIAL HEALTH
1019 Wicker Street
Ticonderoga, NY 12883

HIGH PEAKS HOSPICE & PALLIATIVE CARE
309 County Road
Saranac Lake, NY 12983

HORACE NYE HOME
81 Park Street
Elizabethtown, NY 12932

HOSPICE OF THE NORTH COUNTRY
3909 State Route 11
Malone, NY 12953

INTER-LAKES HEALTH, INC.
1019 Wicker Street
Ticonderoga, NY 12883

IROQUOIS HEALTHCARE
17 Executive Park Drive
Clifton Park, NY 12065

LAKE FOREST SENIOR LIVING COMMUNITY, INC.
8 Lake Forest Drive
Plattsburgh, NY 12903

NATIONAL CHURCH RESIDENCE
8 Elizabeth Street
Whitehall, NY 12887

SOUTHERN ADIRONDACK INDEPENDENT LIVING CENTERS (SAIL)
71 Glenwood Avenue
Queensbury, NY 12804

TAKING CONTROL MASSENA INDEPENDENT LIVING CENTER (MILC INC.)
41 Pearl Street
Malone, NY 12953

TERRACE AT THE GLEN
71 Longview Drive
Queensbury, NY 12804

WARREN/HAMILTON COUNTIES OFFICE FOR THE AGING
1340 State Route 9
Lake George, NY 12845

WASHINGTON COUNTY CARES OFFICE FOR AGING & DISABILITY RES.
383 Broadway
Fort Edward, NY 12828

Appendix B: Demographic and Health Trends of Six-County Region

Demographics

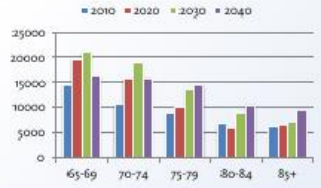
Population Density

County	Population	# Square Miles	Persons per Square Mile
Clinton	81,654	1,038	79.1
Essex	38,961	1,794	21.9
Franklin	51,795	1,629	31.7
Hamilton	4,778	1,717	2.8
Warren	65,538	867	75.8
Washington	62,934	831	76.1
New York State	19,570,261	47,126	411.2

Source: 2010 Census

Current and projected population by age group: six-county total

The population for the six counties will grow about 2.3% from 2010 to 2020, but grows at a decreased rate of about 1.9% from 2020 through 2030.



Age Cohorts	Population				Annual Population Growth		
	2010	2020	2030	2040	2010-2020	2020-2030	2030-2040
65-69	14,588	19,659	21,018	16,140	3.48%	0.69%	-2.32%
70-74	10,641	15,733	18,852	15,782	4.79%	1.98%	-1.63%
75-79	8,824	10,159	13,626	14,467	1.51%	3.41%	0.62%
80-84	6,846	5,987	8,777	10,422	-1.25%	4.66%	1.87%
85+	6,160	6,647	7,172	9,494	0.79%	0.79%	3.24%
Total 65+	49,069	60,205	71,475	68,345	2.27%	1.87%	-0.44%

Source: Program on Applied Demographics, Cornell University

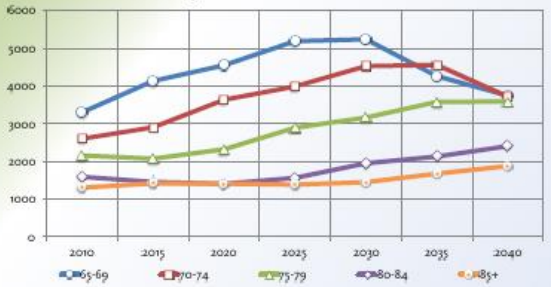
Current and projected population by age group

- Essex County

Source: Program on Applied Demographics, Cornell University

Current and projected population by age group

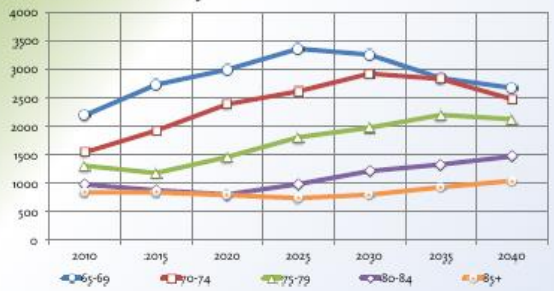
- Clinton County



Source: Program on Applied Demographics, Cornell University

Current and projected population by age group

- Franklin County



Source: Program on Applied Demographics, Cornell University

Appendix B: Demographic and Health Trends of Six-County Region

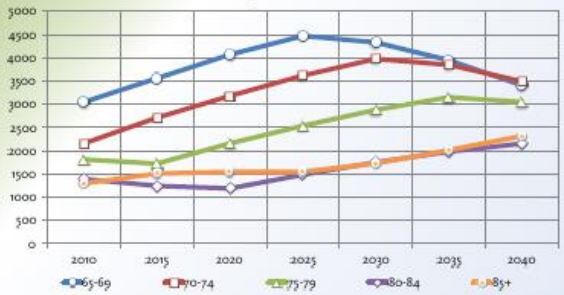
Current and projected population by age group

- Hamilton County

Source: Program on Applied Demographics, Cornell University

Current and projected population by age group

- Washington County



Source: Program on Applied Demographics, Cornell University

Current and projected population by age group

- Warren County

Source: Program on Applied Demographics, Cornell University

Income and Poverty Profile

County	Median Household Income	% of 65+ Population in Poverty	Households with individuals 65 years and over	
			Number	Percent
Clinton	$49,260	12.4	7,882	25.0
Essex	$46,629	8.1	5,146	31.6
Franklin	$43,673	12.4	4,988	26.2
Hamilton	$51,142	8.0	822	36.3
Warren	$53,877	5.3	8,141	29.1
Washington	$50,117	7.9	6,801	28.2
NYS	556,951	11.5%	1,925,416	26.3%

Source: Program on Applied Demographics, Cornell University

Health Characteristics

Health Status/Health Behaviors	North Country	Upstate
% Adults with Hypertension	33.2	30.4
% Adults with Diabetes	10.4	9.5
% Adults with Asthma	12.6	10.8
% Adults Smoking	23.3	21.1
% Adults Obese	30.5	27.1

Mortality/Cases per 100,000 population	North Country	Upstate
Chronic Lower Respiratory Disease Mortality	59.0	52.9
Heart Disease Mortality	218.8	240.0
Diabetes Mortality	22.6	20.0

Source: 2013 Center for Workforce Studies Health Workforce Planning Guide

Health Workforce

Health Occupations, per 100,000	North Country	Upstate
All Physicians	233	259
Primary Care Physicians	98	100
Dentists	46	62
Physician Assistants	57	88
Nurse Practitioners/Midwives	60	94
Registered Nurses	1,317	1,372
Licensed Practical Nurses	589	528
Occupational Therapists	33	52
Physical Therapists	72	86
Respiratory Therapists	16	31
Social Workers	114	190

Source: 2013 Center for Workforce Studies Health Workforce Planning Guide

Appendix B: Demographic and Health Trends of Six-County Region

Caregiver Ratios
Projection for six-county region

Age Group	2010	2015	2020	2025	2030	2035	2040
15-64	210,180	206,471	200,075	191,772	183,390	178,067	174,079
Female 45-64	44,815	44,594	41,995	38,060	35,278	34,402	34,340
65-69	14,588	17,912	19,659	21,554	21,018	18,034	16,140
70-74	10,641	12,821	15,733	17,228	18,852	18,366	15,782
75-79	8,824	8,478	10,159	12,464	13,626	14,862	14,467
80-84	6,846	6,200	5,987	7,151	8,777	9,579	10,422
85+	6,160	6,687	6,647	6,570	7,172	7,173	7,174
Caregiver Ratio	7.3 to 1	6.7 to 1	6.3 to 1	5.8 to 1	4.9 to 1	4.8 to 1	4.8 to 1
NYS	6.9 to 1	6.7 to 1	6.7 to 1	6.4 to 1	5.7 to 1	4.9 to 1	4.5 to 1

Appendix C: EALTCC Meeting Presentation in Plattsburgh on June 2, 2014

A Roadmap to a Rational, Sustainable and Replicable System of LTC Services in the Eastern Adirondacks

EALTCC Meeting
Plattsburgh, NY
June 2, 2014

Demand Model

- Changes in demand for five major long term care services
- Baseline utilization patterns
- Demographic projections
- Scenario based on demand variables
- Key is change over time- magnitude and trend
- Measure is individuals needing service-intensity an important additional consideration

Today's Agenda

- Review preliminary results of demand model
- Discuss our key assumptions
- Provide updates on major policy initiatives
  - DSRIP
  - BIP
  - Mandatory managed care
  - FIDA: Integrated Care for the Dual Eligibles
- Review preliminary recommendations for final report (group discussion)
- Discuss logistics, agenda and invitation list for September 30th symposium

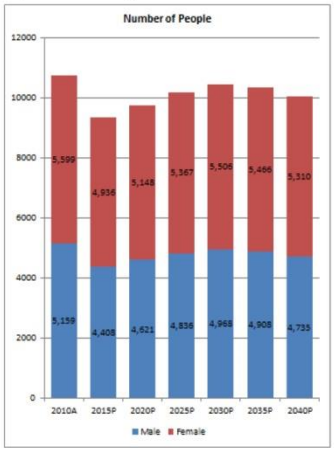
Demand Model – Scenario Variables

- Implementation of Medicaid managed care and care coordination models
- Mandatory managed long term care for recipients of Medicaid LTC services
- Decrease in supply of informal caregivers
- Increase in percentage of seniors living alone
- Rise in the poverty rate

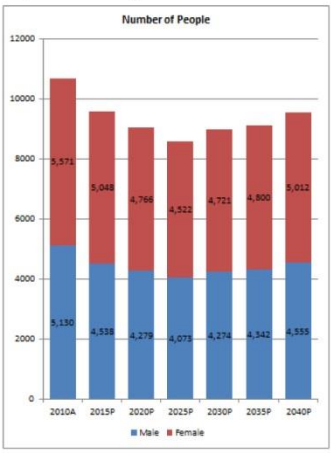
Appendix C: EALTCC Meeting Presentation in Plattsburgh on June 2, 2014

Demand Model - SNF

Population change



Population change with scenario variables



DIFFERENCE BETWEEN DEMOGRAPHICS ALONE AND SCENARIO

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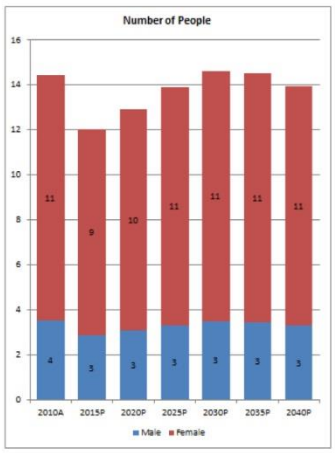
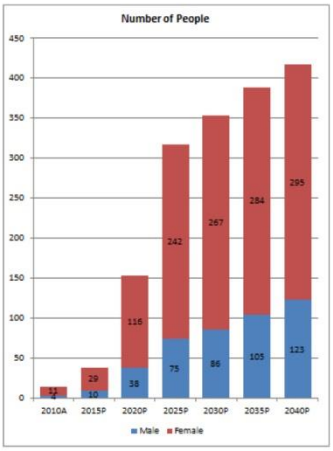
5

Demand Model - ALP

Population change



Population change with scenario variables



DIFFERENCE BETWEEN DEMOGRAPHICS ALONE AND SCENARIO

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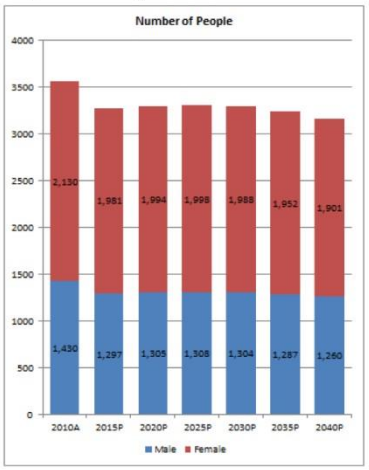
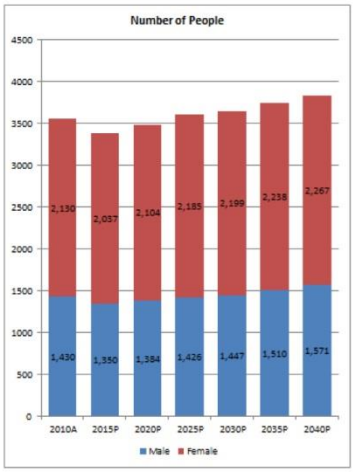
Appendix C: EALTCC Meeting Presentation in Plattsburgh on June 2, 2014

Demand Model – Home Health Care

Population change



Population change with scenario variables



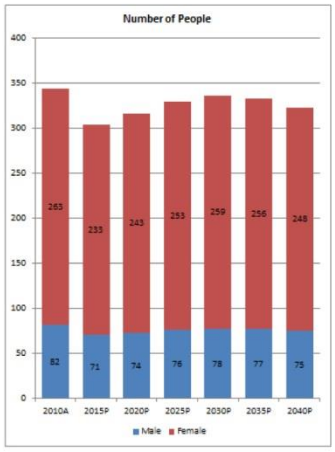
DIFFERENCE BETWEEN DEMOGRAPHICS ALONE AND SCENARIO

	2010	2015	2020	2025	2030	2035	2040
CHHA	0	109	189	304	353	509	677

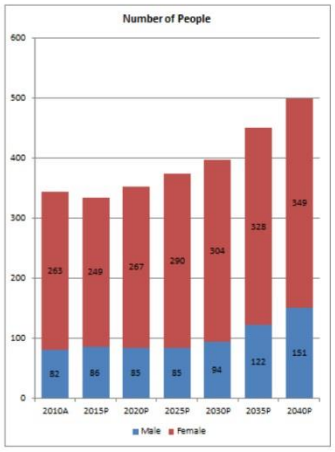
7

Demand Model – Personal Care

Population change



Population change with scenario variables



DIFFERENCE BETWEEN DEMOGRAPHICS ALONE AND SCENARIO

	2010	2015	2020	2025	2030	2035	2040
PCA	0	31	36	45	62	118	177

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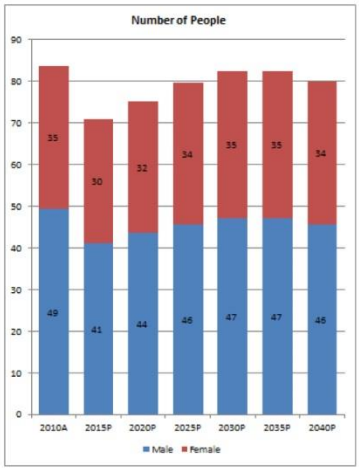
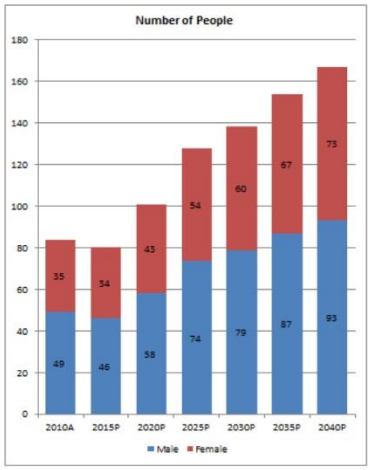
Appendix C: EALTCC Meeting Presentation in Plattsburgh on June 2, 2014

Demand Model - ADHC

Population change



Population change with scenario variables



DIFFERENCE BETWEEN DEMOGRAPHICS ALONE AND SCENARIO

	2010	2015	2020	2025	2030	2035	2040
ADHC	0	9	25	48	56	71	87

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Key Demand Assumptions

Key Assumption #1: With the exception of a decline between 2010 and 2015, the projected growth in the 65+ population between 2015 and 2035 will increase the demand for most health care services including acute care, skilled nursing facility, home care, home and community based services and other long term care services.

Key Assumption #2: The implementation of mandatory Medicaid managed care for the community-based and nursing home long term care populations will change the utilization of long term care services moving recipients to the least expensive and restrictive setting funding some services not previously covered.

Key Assumption #3: Growing penetration of Medicare Advantage plans and other care management programs (e.g. ACOs, PCMHs) will reduce hospitalizations and the use of post-acute services and delay the need for long term care services.

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Appendix C: EALTCC Meeting Presentation in Plattsburgh on June 2, 2014

Key Demand Assumptions

Key Assumption #4: The decrease in the number of available informal caregivers will increase the demand for some health care services including home care, adult day health care, assisted living, and other home and community based services (e.g. home-delivered meals, housekeeping, transportation) .

Key Assumption #5: An increase in the percentage of individuals 65+ living alone will increase the demand for the services listed under Key Assumption #4 above and will bolster the demand for residential care that nursing homes and assisted living programs provide.

Key Assumption #6: An increase in the percentage of 65+ in poverty will result in increased enrollment in Medicaid among seniors in the region and increased demand for Medicaid-funded services, and greater demand for affordable senior housing.

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MAJOR POLICY INITIATIVES AFFECTING LONG TERM/POST-ACUTE CARE SERVICES

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Delivery System Reform Incentive Payment (DSRIP) Program

- DSRIP is a key component of the state's Medicaid Redesign Team federal waiver
- Key objectives are to reduce hospitalizations by 25% over 5 years and create a more integrated service delivery system
- DSRIP will create regional Performing Provider Systems (PPSs) around the state.
- Each PPS will have 5-10 projects
- Providers in the PPS receive an incentive payment for achieving objectives

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DSRIP

- North Country DSRIP project overview

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Appendix C: EALTCC Meeting Presentation in Plattsburgh on June 2, 2014

Balancing Incentive Program (BIP)

- Authorized by Section 10202 of the Patient Protection and Affordable Care Act of 2010
- Assists states to provide quality care to individuals in the most appropriate, least restrictive settings
- BIP is an optional program available to states
- States receiving BIP funds must implement the following 3 structural changes
  - Establish a No Wrong Door/Single Entry Point eligibility determination and enrollment system;
  - Develop Core Standardized Assessment Instruments for determining eligibility for non-institutionally-based LTSS; and,
  - Develop a Conflict-Free Case Management System

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Balancing Incentive Program (con'd)

- Department of Health, in collaboration with OPWDD, SOFA, OMH, submitted a BIP application to CMS in 2012.
- New York State was awarded $598.7 million over three years in March 2013.
- Goal: To enhance community-based services and supports and to redistribute resources from institutional to community-based settings under the State Medicaid Program
- BIP RFA – Due March 2014; Awards made June 2014.

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Mandatory MLTC Enrollment of HCBS Population

- Mandatory population: dual eligible, aged 21+, need community-based LTC services for 120 days or more
  - Includes personal care, home care, consumer-directed care and adult day health care
  - Excludes certain waiver programs and Medicaid assisted living programs for now
- Mandatory enrollment began in 2012 in NYC for any new cases meeting the mandatory definition
- People have 60 days to choose an MLTC plan, and are auto-enrolled if they do not
- Phase-in to other areas of state between now and Dec. 2014 as MLTC plan capacity is established

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Mandatory MLTC Enrollment of HCBS Population (cont'd)

2014 MLTC Transition Timeline

Month	Counties
April 1	Columbia, Putnam, Sullivan, Ulster
May 1	Rensselaer, Cayuga, Herkimer, Oneida
June 1	Greene, Schenectady, Washington, Saratoga
July 1	Dutchess, Montgomery, Broome, Fulton, Madison, Schoharie, Oswego
August 1	Warren, Delaware, Niagara, Otsego, Chenango
September 1	Essex, Clinton, Franklin, Hamilton
October 1	Jefferson, Lewis, St. Lawrence, Steuben, Chautauqua, Cattaraugus, Alleghany
November 1	Yates, Seneca, Schuyler, Tioga, Cortland, Chemung
December 1	Genesee, Ontario, Livingston, Orleans, Tompkins, Wayne, Wyoming

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Appendix C: EALTCC Meeting Presentation in Plattsburgh on June 2, 2014

Enrollment of Nursing Home Population

- Under NYS's latest proposal*, Medicaid recipients who will need permanent placements in nursing homes must join/remain in a managed care plan:
  - *Beginning July 2014 (downstate**) and Jan. 2015 (upstate**):* Any dual eligible or Medicaid-only recipient already permanently placed in a nursing home **will remain in the fee-for-service program** for the duration of his/her stay
  - Any dual eligible new to Medicaid and/or permanently placed after July 2014 (downstate) or Jan. 2015 (upstate) **must join or remain in a MLTC plan**
  - Any Medicaid-only recipient new to Medicaid and/or permanently placed after July 2014 (downstate) or Jan. 2015 (upstate) **must remain in a mainstream Medicaid managed care plan or MLTC or join a mainstream plan**

* - Subject to CMS approval, which is still pending.
** - "Downstate" is the FIDA region of NYC, LI and Westchester; "upstate" is all other areas.

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FIDA: Integrated Care for the Dual Eligibles

- Fully Integrated Duals Advantage (FIDA) is a federally approved demonstration to integrate care for recipients eligible for both Medicaid and Medicare
- FIDA will be conducted in NYC, Long Island and Westchester County
- Comprehensive benefits encompassing Medicaid and Medicare covered services
- NYS planning for voluntary and "passive" enrollment of the mandatory MLTC population (e.g., those needing 120+ days of community-based LTC services or nursing home care) into FIDA plans:
  - Passive enrollment means beneficiary will be enrolled but can opt out of the Medicare managed care product at any time. Beneficiary remains in MLTC if he/she opts out of FIDA

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FIDA: Integrated Care for the Dual Eligibles (cont'd)

- Demonstration begins Oct. 2014:
  - ***October 2014:*** begin accepting voluntary enrollments for dual eligibles who need community-based LTC services greater than 120 days and for dual eligibles in nursing homes.
  - ***January 2015:*** begin process of passive enrollment for dual eligibles who need community-based LTC services greater than 120 days and for dual eligibles in nursing homes.
- Demonstration scheduled to end Dec. 31, 2017, but may be extended
- NYS wishes to expand the initiative to other areas of the State

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RECOMMENDATIONS

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Appendix C: EALTCC Meeting Presentation in Plattsburgh on June 2, 2014

Recommendation #1: Expand Alternatives to Nursing Homes

- Promote the expansion of assisted living for Medicaid-eligible and low-income seniors
  - Capital
  - Regulatory relief
- Expand Adult Day Health Care access and capacity
  - Create small, community-based ADHC centers
  - Expand social adult day care where sustainable
  - Seek funding from NYSOFA/Area Offices on Aging
  - Medicare reimbursement (legislation pending)

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Recommendation #2: Address healthcare workforce shortages/other capacity constraints

- Expand consumer directed program
  - Provide more education, support, and resources to providers, beneficiaries, families and caregivers
  - Incentives to students from local nursing and other health related programs to become personal assistants
- Improve telehealth capacity
  - Broadband coverage to rural areas
  - Cellular device technology and low-tech solutions (i.e. telephone calls)
  - Vital sign monitoring and medication reminders, telepharmacy for medication reconciliation
  - Funding for start-up investment and ongoing costs for telehealth units

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Recommendation #2: Address healthcare workforce shortages/other capacity constraints (cont'd)

- Create regional coalitions to address recruitment and retention of health care workers
  - Small business support (e.g. auto repair, grocery discounts)
  - Tuition discounts at local colleges
  - Day care, after-school program, summer program discounts, or preference in accessing limited slots
  - Provide opportunities for advancement
- Expand hospice and palliative care access and capacity
  - Education and awareness for patients, families and health care providers

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Recommendation #3: Increase the availability of affordable senior housing

- Strengthen partnerships between affordable senior housing providers and community based organizations that provide supportive services (i.e. congregate meals, home-delivered meals, transportation, information and referral, caregiver support, etc.)
- Increase the number of service coordinators
- Additional capital for renovations/new construction
- Consider mixed use facilities that can serve individuals with diverse financial circumstances and service needs

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Appendix C: EALTCC Meeting Presentation in Plattsburgh on June 2, 2014

Recommendation #4: Develop Plan for NH Sustainability and Reconfiguration

- More fully develop the concept of Senior Communities and/or Medical Villages to more efficiently utilize existing resources (i.e. facilities, space and staff)
- Discuss regulatory and rate reforms that will be necessary to reconfigure system and promote sustainability

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Community Forum

- Present results of our draft recommendations, obtain input and discuss next steps to a broader stakeholder group that includes:
  - Consumer representatives
  - All long term care service providers in the six county region (NHs, ACF/AL, ADHC, home care agencies, OFAs, senior housing)
  - State Associations (e.g. NYSHFA, HANYS, HCA, AAA, Iroquois)
  - Rural Development Corporations/Housing Authorities
  - Chambers of Commerce
  - CDPAP Fiscal Intermediaries
  - Payers (e.g., insurers)
  - State Legislators
  - Local and county officials
  - DOH and Governor's office staff
  - Department of Labor
  - BOCES, SUNY and community college representatives
  - Other?

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PLANS FOR FINAL MEETING: A COMMUNITY FORUM

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Save the Date!

- Date: September 30, 2014
- Location: Fort William Henry Conference Center, Lake George, NY
- Time: 10:00am – 1:00pm

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Appendix D: Symposium Presentation in Lake George on September 30, 2014

A Roadmap to a Rational, Sustainable, and Replicable System of LTC Services in the Eastern Adirondacks

LeadingAge New York

1

Today's Discussion

- Project overview
- Review key North Country demographics and current state initiatives
- Review Demand Projection model and major findings
- Discuss draft recommendations and obtain feedback
- Next steps

3

We gratefully acknowledge the NYS Health Foundation, the members of the Eastern Adirondack Long Term Care Coalition, the NYS Department of Health and other key stakeholders who provided invaluable information, feedback and financial support to make this project possible.

NYS HEALTH FOUNDATION

NEW YORK state department of HEALTH

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Project Overview

Clinton
Essex
Franklin
Hamilton
Warren
Washington

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Appendix D: Symposium Presentation in Lake George on September 30, 2014

Grant Objectives

- Assess demand and supply of long-term care supports and services (LTCSS) in the 6-county Eastern Adirondacks region
- Identify the needed configuration of services in the region and develop an action plan to rebalance those services
- Pursue opportunities to enhance operational efficiencies and promote financial stability
- Pursue regulatory flexibility targeted towards the needs of the region
- Timeframe: October 1, 2013 – September 30, 2014

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Grant Key Deliverables

1. A core group of partner organizations and their governance bodies – The Eastern Adirondacks Long Term Care Coalition (EALTCC)
2. A long-term care supports and services needs assessment and service gaps analysis for the region
3. A draft strategic action plan that addresses the needs assessment and service gaps analysis
4. A community forum where the draft strategic action plan will be presented and discussed with a larger stakeholder group
5. A final version of the strategic action plan

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EALTCC Members

- Skilled nursing facilities
- Hospitals
- Adult care facilities/assisted living
- Adult day health care programs
- Senior housing
- Home and community-based services
  - County Offices for the Aging
  - CHHAs
  - LTHHCPs
  - Consumer directed programs
- Hospice/Palliative care
- Managed care
- Hudson Headwaters Health Network
- Adirondack Health Institute
- Iroquois Healthcare Alliance

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Summary to Date

- Held three coalition meetings
  - November 2013 (Lake Placid) – background and demographics
  - March 2014 (Lake George) – Demand Projection model assumptions
  - June 2014 (Plattsburgh) – Demand Projection model results and draft recommendations
- Met with NYS DOH to review draft recommendations
- Reviewed draft recommendations with sub-group of coalition members
- Planned for today's symposium

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Appendix D: Symposium Presentation in Lake George on September 30, 2014

Key Demographics in the Eastern Adirondacks

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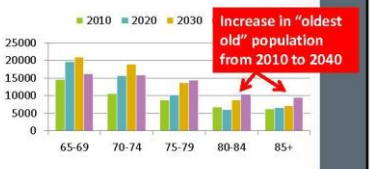
Current and Projected Population by Age Group: Six-County Total

The population for the six counties will grow about 2.3% from 2010 to 2020, but grows at a decreased rate of about 1.9% from 2020 through 2030.



Age Cohorts	Population				Annual Population Growth		
	2010	2020	2030	2040	2010-2020	2020-2030	2030-2040
65-69	14,588	19,659	21,018	16,140	3.48%	0.69%	-2.32%
70-74	10,641	15,733	18,852	15,782	4.79%	1.98%	-1.63%
75-79	8,824	10,159	13,626	14,467	1.51%	3.41%	0.62%
80-84	6,846	5,987	8,777	10,422	-1.25%	4.66%	1.87%
85+	6,160	6,647	7,172	9,494	0.79%	0.79%	3.24%
Total 65+	**49,069**	**60,205**	**71,475**	**68,345**	**2.27%**	**1.87%**	**-0.44%**

Source: Program on Applied Demographics, Cornell University

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Population Density

County	Population	# Square Miles	Persons per Square Mile
Clinton	81,654	1,038	79.1
Essex	38,961	1,794	21.9
Franklin	51,795	1,629	31.7
Hamilton	4,778	1,717	2.8
Warren	65,538	867	75.8
Washington	62,934	831	76.1
New York State	19,570,261	47,126	411.2

Source: 2010 Census

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Income and Poverty Profile

County	Median Household Income	% of 65+ Population in Poverty	Households with individuals 65 years and over	
			Number	Percent
Clinton	$49,260	12.4	7,882	25.0
Essex	$46,629	8.1	5,146	31.6
Franklin	$43,673	12.4	4,988	26.2
Hamilton	$51,142	8.0	822	36.3
Warren	$53,877	5.3	8,141	29.1
Washington	$50,117	7.9	6,801	28.2
NYS	**$56,951**	**11.5%**	**1,925,416**	**26.3%**

Source: Program on Applied Demographics, Cornell University

Drives demand for Medicaid services

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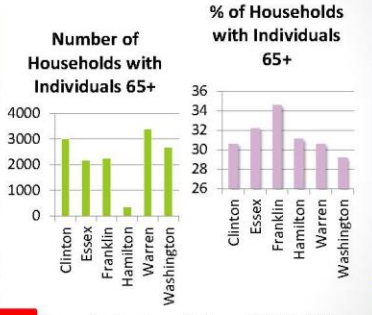
Percent of 65+ Living Alone

County	Householder living alone 65 years or older	
	Number	Percent
Clinton	3,170	30.6
Essex	2,211	32.2
Franklin	2,277	34.6
Hamilton	344	31.1
Warren	3,354	30.6
Washington	2,708	29.2
Total	14,064	31.2%



Living alone is risk factor for poorer overall health

Sources: American Community Survey: 2008-2012; 2010 Census

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Health Workforce

Health Occupations, per 100,000	North Country	Upstate
All Physicians	233	259
Primary Care Physicians	98	100
Dentists	46	62
Physician Assistants	57	88
Nurse Practitioners/Midwives	60	94
Registered Nurses	1,317	1,372
Licensed Practical Nurses	589	528
Occupational Therapists	33	52
Physical Therapists	72	86
Respiratory Therapists	16	31
Social Workers	114	190

Shortage in LTCSS-related occupations

Source: 2013 Center for Workforce Studies Health Workforce Planning Guide

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Health Characteristics

Health Status/Health Behaviors	North Country	Upstate
% Adults with Hypertension	33.2	30.4
% Adults with Diabetes	10.4	9.5
% Adults with Asthma	12.6	10.8
% Adults Smoking	23.3	21.1
% Adults Obese	30.5	27.1

Higher rates of these conditions have major implications on demand for services

Mortality/Cases per 100,000 population	North Country	Upstate
Chronic Lower Respiratory Disease Mortality	59.0	52.9
Heart Disease Mortality	218.8	240.0
Diabetes Mortality	22.6	20.0

Source: 2013 Center for Workforce Studies Health Workforce Planning Guide

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Caregiver Ratios
Projection for six-county region

Age Group	2010	2015	2020	2025	2030	2035	2040
15-64	210,180	206,471	200,075	191,772	183,390	178,067	174,079
Female 45-64	44,815	44,594	41,995	38,060	35,278	34,402	34,340
65-69	14,588	17,912	19,659	21,554	21,018	18,034	16,140
70-74	10,641	12,821	15,733	17,228	18,852	18,366	15,782
75-79	8,824	8,478	10,159	12,464	13,626	14,862	14,467
80-84	6,846	6,200	5,987	7,151	8,777	9,579	10,422
85+	6,160	6,687	6,647	6,570	7,172	7,173	7,174
Caregiver Ratio	7.3 to 1	6.7 to 1	6.3 to 1	5.8 to 1	4.9 to 1	4.8 to 1	4.8 to 1
NYS	6.9 to 1	6.7 to 1	6.7 to 1	6.4 to 1	5.7 to 1	4.9 to 1	4.5 to 1

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Appendix D: Symposium Presentation in Lake George on September 30, 2014

The New York Landscape

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NYS Policies, Responses and Implications

- Medicaid Spending/Redesign
- Managed Care
- Other Coordinated /Collaborative Care Models
- Delivery System Realignment

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The State's Medicaid Redesign Priorities

- Reduce Medicaid costs
- Less uncertainty and risk for the state
- Contract with, and pay, fewer entities
- "Care management for all"
- Integrate Medicaid with Medicare
- Access federal investment
- Delivery system realignment

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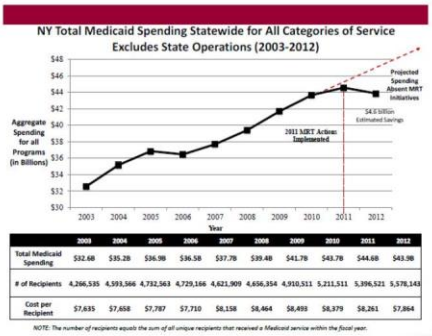
Medicaid Spending

- Began to turn the corner in 2012



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total Medicaid Spending	$32.6B	$35.2B	$36.9B	$36.5B	$37.7B	$39.4B	$41.7B	$43.7B	$44.6B	$43.9B
# of Recipients	4,266,535	4,593,566	4,732,563	4,729,166	4,621,909	4,656,354	4,910,511	5,211,511	5,396,521	5,578,143
Cost per Recipient	$7,635	$7,658	$7,787	$7,710	$8,158	$8,464	$8,493	$8,379	$8,261	$7,864

NOTE: The number of recipients equals the sum of all unique recipients that received a Medicaid service within the fiscal year.

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Medicaid Redesign in Action

- Adding more services to managed care benefits
- Requiring more recipients to join "mainstream" Medicaid managed care
- Requiring more LTC recipients to join managed long term care plans
- Enroll dual eligibles in integrated Medicare/Medicaid managed care plans starting in 2015
- Use health homes, medical homes and ACOs to coordinate care and network services
- Enroll nearly all Medicaid recipients in managed care/ coordinated care models by 2017
- **Within 5 years,** requiring 90% of all Medicaid payments from managed care plans to providers to be "value based"

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Mandatory MLTC Enrollment Plan

- Mandatory population: dual eligible, aged 21+, need community-based LTC services for 120 days or more
  - Includes personal care, home care, consumer-directed care and adult day health care
  - Excludes certain waiver programs and Medicaid assisted living programs for now
- Mandatory enrollment began July 1, 2012 in NYC for any new cases meeting the mandatory definition
- People have 60 days to choose an MLTC plan, and are auto-enrolled if they do not
- Phase-in to other areas of state between now and Feb. 2015 as MLTC plan capacity is established

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Mandatory MLTC Enrollment Plan

2014-2015 MLTC Transition Timeline

Month	NEW SCHEDULE
August	Dutchess, Montgomery, Broome, Fulton, Schoharie,
September	Delaware, Warren
October	Niagara, Madison, Oswego
November	Chenango, Cortland, Livingston, Ontario, Steuben, Tioga, Tompkins, Wayne
December	Genesee, Orleans, Otsego, Wyoming
January	Chautauqua, Chemung, Seneca, Schuyler, Yates Allegany, Cattaraugus
February	Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, St. Lawrence,

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Managed Care Enrollment of the Nursing Home Population

- Under NYS's latest proposal, Medicaid recipients who will need permanent placements in NHs must join/remain in a managed care plan:
  - Beginning Jan. 2015 (downstate) and July 2015 (upstate): Any dual eligible or Medicaid-only recipient already permanently placed in a NH will remain in FFS for the duration of his/her stay
  - Any dual eligible new to Medicaid and/or permanently placed after Jan. 2015 (downstate) or July 2015 (upstate) must join or remain in a MLTC plan
  - Any Medicaid-only recipient new to Medicaid and/or permanently placed after Jan. 2014 (downstate) or July 2015 (upstate) must remain in a mainstream Medicaid managed care plan or MLTC or join a mainstream plan

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Appendix D: Symposium Presentation in Lake George on September 30, 2014

FIDA: Integrated Care for Duals

- Fully Integrated Duals Advantage (FIDA) is a federally approved demo to integrate care for Medicaid/Medicare eligibles
- Will be conducted in NYC, Long Island and Westchester County
- Comprehensive benefits encompassing Medicaid and Medicare covered services
- NYS planning for voluntary and "passive" enrollment of the mandatory MLTC population into FIDA plans:
  - *Jan. 2015:* Voluntary enrollment for adults in Bronx, Kings, Nassau, New York, Queens, and Richmond counties
  - *April 2015:* Passive enrollment in the 6 counties; voluntary enrollment for adults in Suffolk and Westchester counties
  - *July 2015:* Passive enrollment in Suffolk and Westchester
  - *Dec. 2017:* End of demonstration
- Eventual plan is to go statewide with this initiative

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Other Medicaid Redesign Initiatives

- NYS is seeking to utilize managed care to address the needs of other Medicaid recipients
  - Special needs Health and Recovery Plans (HARPs) for individuals with significant behavioral health needs
  - Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs) for individuals needing specialized developmental disabilities services
- The state has received a "Balancing Incentive Program" grant of up to $600 million over 3 years
  - NYS must assure that at least 50% of its LTC Medicaid funding goes towards community-based vs. facility-based services
  - Implement key structural reforms
- Supportive housing has emerged as a key enabler of redesign
  - Address high cost Medicaid beneficiaries
  - Olmstead community transition plan
  - Focused state funding for rental subsidies, pilots and capital

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Other Coordinated/Collaborative Care Models

- Health homes (HHs) provide care management of health, behavioral health and social supports for Medicaid beneficiaries
- Patient centered medical homes (PCMHs) use primary care physicians to coordinate care and follow patients across settings
- Accountable Care Organizations (ACOs) are provider-led legal entities that monitor patient care across multiple care settings for overall cost and quality for a defined population
- These models begin to break down silos between primary, acute, LTC, social, mental health, behavioral health and disability services

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Delivery System Realignment

- MRT Waiver is the blueprint for provider integration and delivery system realignment, with funding over 5 years as follows:
  - $500 million for Interim Access Assurance Fund – stop-gap funding for financially distressed and public hospitals
  - $6.42 billion for Delivery System Reform Incentive Payment (DSRIP) – including planning grants and provider Incentive payments
  - $1.08 billion for Health Home development and investments in LTC, workforce and enhanced behavioral health services
- DSRIP overall goals:
  - Promote community-level collaborations with multiple physical health and behavioral health provider types involved, including LTC
  - Achieve a 25% reduction in avoidable hospital use over 5 years
- DSRIP projects are expected to:
  - Be hospital-led in most cases
  - Be limited to only 1-2 projects per region of the state
  - Potentially lead to major delivery system realignment in the future
  - Affect all payers, not just Medicaid/safety net

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Appendix D: Symposium Presentation in Lake George on September 30, 2014

Role of LTCSS Providers in North Country Health System Redesign

- LTCSS providers offer critical services:
  - Chronic disease management
  - Prevention and health promotion services
  - Post-acute services to help reduce hospital readmissions
  - Comprehensive assessments, care planning and care coordination
  - Facility-, community- and home-based services and supports
  - Home health, adult day health and personal care services on a long term basis
- The success of many new models of care delivery and payment will depend on relationships and partnerships between LTCSS providers and hospitals, primary care providers, behavioral health providers, payers and others.

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Major Factors Influencing LTCSS Providers in the North Country

- Reimbursement constraints
- Changes in payment and healthcare delivery
- Implementation of new models of care
- Workforce/informal caregiver availability
- Access to practitioner/professional services
- Geography and proximity
- Lack of technology resources
- Diseconomies of scale

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LTCSS Demand Projection Model

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Goals and Methodology

- Develop an interactive model to estimate demand for long term care supports and services in 6-county region taking into account key influencers
- The model takes into consideration:
  - Changes in demand for five major services (nursing home, assisted living program, home health care, personal care and adult day health care)
  - Baseline utilization patterns
  - Demographic projections
  - A number of key assumptions based on research and group discussion

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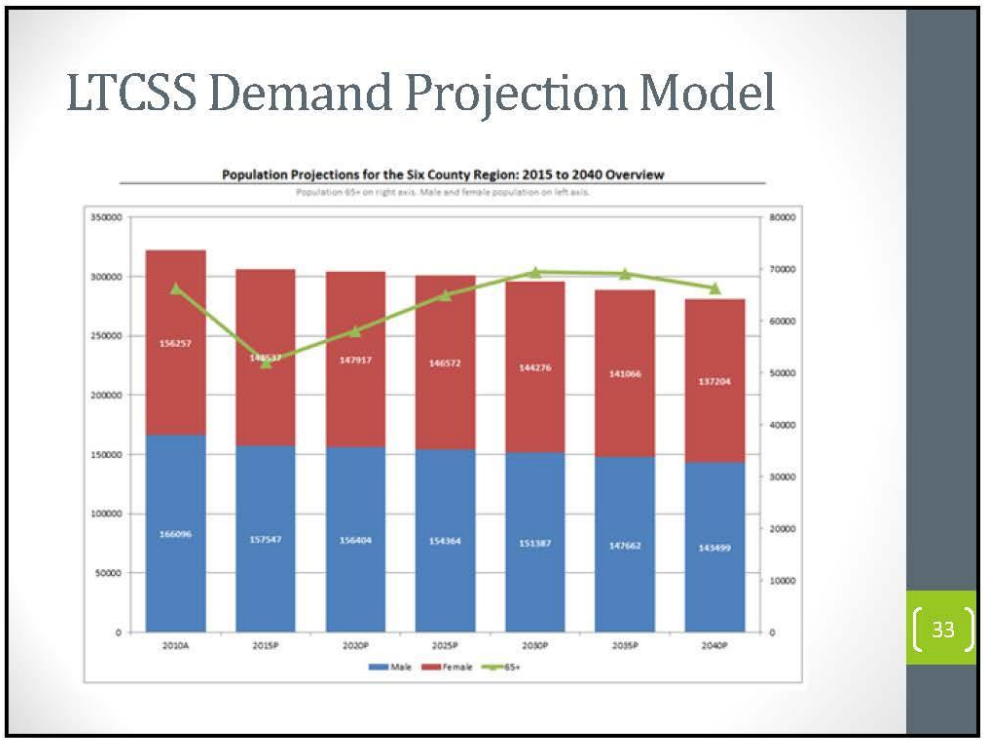
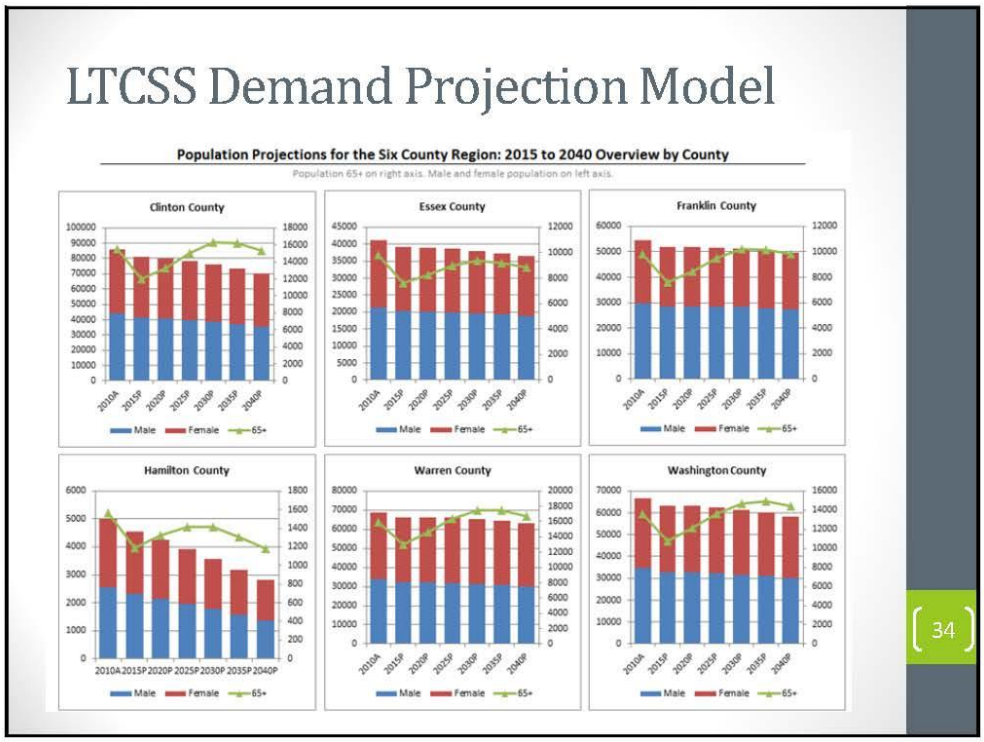
Appendix D: Symposium Presentation in Lake George on September 30, 2014





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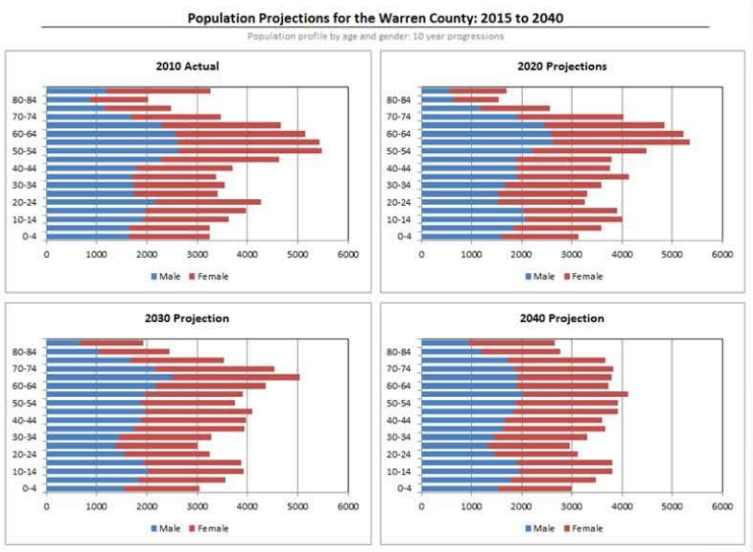
LTCSS Demand Projection Model



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LTCSS Demand Projection Model

County	Gender	Age Group (Salient)	Age Group (Population)	Y2010	Adult Day Health	Assisted Living
Clinton County	Male	00-05	0-4	2088		
Clinton County	Male	06-11	5-9	2088		
Clinton County	Male	12-17	10-19	4471		
Clinton County	Male	18-44	20-44	15649	0.6	
Clinton County	Male	45-64	45-64	12746	2	
Clinton County	Male	65+	65+	7143	3.2	1.4
Clinton County	Female	00-05	0-4	1981		
Clinton County	Female	06-11	5-9	1981		
Clinton County	Female	12-17	10-19	4223		
Clinton County	Female	18-44	20-44	13693	0.4	
Clinton County	Female	45-64	45-64	11725	2.6	0.4
Clinton County	Female	65+	65+	8409	8.8	4.4
Essex County	Male	00-05	0-4	925		
Essex County	Male	06-11	5-9	925		
Essex County	Male	12-17	10-19	2105		
Essex County	Male	18-44	20-44	6458		0.2
Essex County	Male	45-64	45-64	6259		0.4
Essex County	Male	65+	65+	4564		0.6
Essex County	Female	00-05	0-4	927		
Essex County	Female	06-11	5-9	927		
Essex County	Female	12-17	10-19	2004		
Essex County	Female	18-44	20-44	4905		
Essex County	Female	45-64	45-64	5872		1.2
Essex County	Female	65+	65+	5271		1.8
Franklin County	Male	00-05	0-4	1463		
Franklin County	Male	06-11	5-9	1463		

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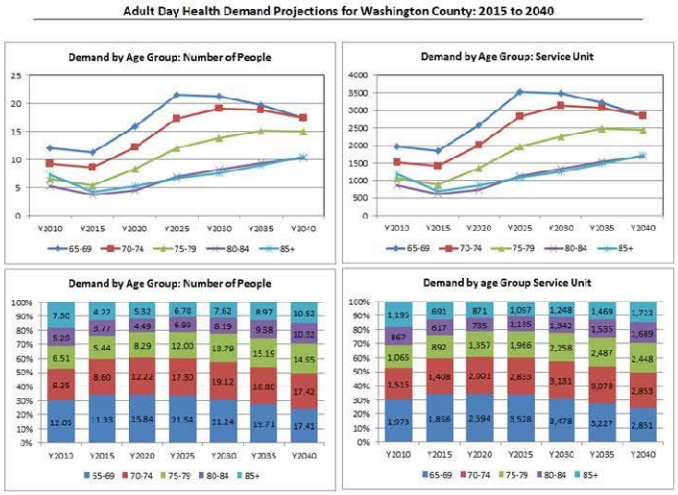
LTCSS Demand Projection Model



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Key Demand Assumptions

Key Assumption #1: With the exception of a decline between 2010 and 2015, the projected growth in the 65+ population between 2015 and 2035 will increase the demand for most health care services including acute care, skilled nursing facility, home care, home and community based services and other long term care services.

Key Assumption #2: The implementation of mandatory Medicaid managed care for the community-based and nursing home long term care populations will change the utilization of long term care services moving recipients to the least expensive and restrictive setting funding some services not previously covered.

Key Assumption #3: Growing penetration of Medicare Advantage plans and other care management programs (e.g. ACOs, PCMHs) will reduce hospitalizations and the use of post-acute services and delay the need for long term care services.

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Key Demand Assumptions

Key Assumption #4: The decrease in the number of available informal caregivers will increase the demand for some health care services including home care, adult day health care, assisted living, and other home and community based services (e.g. home-delivered meals, housekeeping, transportation) .

Key Assumption #5: An increase in the percentage of individuals 65+ living alone will increase the demand for the services listed under Key Assumption #4 above and will bolster the demand for residential care that nursing homes and assisted living programs provide.

Key Assumption #6: An increase in the percentage of 65+ in poverty will result in increased enrollment in Medicaid among seniors in the region and increased demand for Medicaid-funded services, and greater demand for affordable senior housing.

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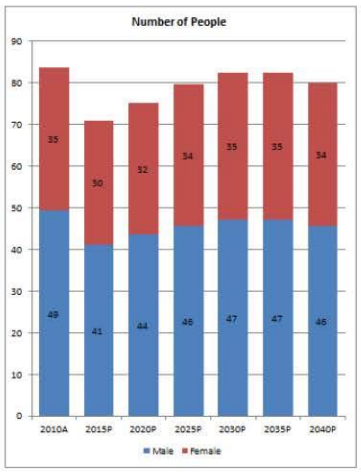
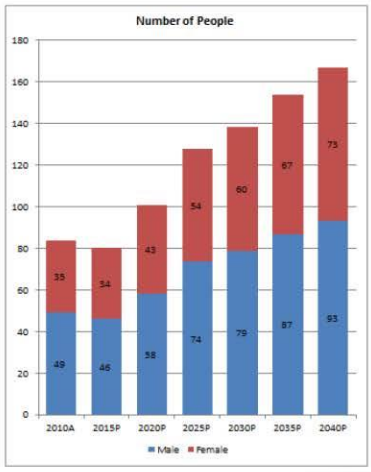
Demand Model - ADHC

Population change



Population change with scenario variables



DIFFERENCE BETWEEN DEMOGRAPHICS ALONE AND SCENARIO

	2010	2015	2020	2025	2030	2035	2040
ADHC	0	9	25	48	56	71	87

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Major Findings

- Demand for nursing home services will increase between 2010 and 2015 and then begin to decrease between 2015 and 2040.
- There will be an increase in demand for all other types of services in the model between 2015 and 2040: ALP, home health care, personal care and ADHC.

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Draft Recommendations

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Draft Recommendations

1. ***Increase alternatives to nursing home services*** by promoting the expansion of assisted living for Medicaid-eligible and low-income seniors and expanding adult day care and home care access and capacity. The projected population growth for adults 80+ in the region is expected to decline by about 3% between 2010 and 2020 and then grow by more than 25% each of the following two decades. Current estimates show that there are already shortages of nursing home beds, assisted living units and adult day health slots in some or all counties in the region. This recommendation includes creating the array of services and facilities to ensure adequate access to and funding for affordable senior housing and community medical and non-medical based services allowing individuals to age in place, engage in the community and lead purposeful lives.

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Draft Recommendations

2. ***Address health care workforce availability and preparation for realigned service delivery.*** The current availability of home health staff is one reason this region sees about 40% fewer patients referred to home health following acute care than the state average. The caregiver ratio is also declining by about 35% from 2010 to 2030 and then remains flat through 2040. This recommendation proposes interventions that enhance the ability to serve older adults in their homes by expanding the consumer directed personal assistance program, creating regional coalitions to address worker recruitment and retention, facilitating better use of professional and paraprofessional skills, and enhancing workforce education and training in care management, technology and other areas.

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Draft Recommendations

3. ***Address other service infrastructure issues.*** Currently some areas of the North Country are not able to maximize the use of telehealth or technology due to limited internet and broadband access limiting opportunities to increase efficiencies through technology. This recommendation includes improving telehealth and telemedicine capacity, expanding hospice and palliative care awareness and access, and pursuing regulatory reforms that will be needed to reconfigure and sustain LTCSS in rural areas.

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Draft Recommendations

4. ***More fully develop the concept of Villages for Successful Aging/Medical Villages*** with the goal of efficiently utilizing existing resources and consolidating the essential health, wellness, prevention, care coordination and social programs required for successful aging. Based on the population growth and an estimated 30 miles or 45 minute maximum drive time for area elders we believe there is a need for four to five Villages which would be co-located with existing senior living campuses. These Villages would have a wide array of both medical and non-medical services that are easily accessible.

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Draft Recommendations

5. ***Promote adoption of health information technology and exchange among long term care service providers*** and other providers and practitioners to create efficient and effective care delivery programs and services across all sites of care and in the community. Currently, long term care providers have limited access to health information prior to transfer and in the community on clients they serve; the acute care providers and community physicians also do not have access to ongoing services provided by long term care providers. This recommendation focuses on innovative ways to provide an elder with a personal health record that is comprehensive and easily accessible by all care team members.

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Draft Recommendations

6. ***Increase the Medicaid funding available to rural, essential services*** to assure that nursing home, home health care, adult day care and other services are available within a reasonable driving distance (within 30 miles). Providers who meet the essential services definition or have XX% (TBD) of total services provided to Medicaid participants would be provided a supplemental payment to compensate them for the higher costs per unit associated with small size and/or geographically dispersed patient volume.

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Next Steps

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