

# Long Term Care Workshop: “Creating Solutions for New York State”

Monsignor Charles Fahey, Chairman

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October  
2008

Final Report

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## **EXECUTIVE SUMMARY**

The City University of New York (CUNY) engaged the services of the Vanderbilt Center for Better Health to assist in the research, facilitation, and reporting for the Long Term Care Workshop: “Creating Solutions for New York State.” The process involved approximately 100 providers, academics, policy experts, government officials, and advocates who gathered during a three-day workshop held at Baruch College in New York City to devise workable solutions to the challenges facing New York State’s long term care system.

The workshop was organized under the leadership of Monsignor Charles Fahey, who served as its chair. It consisted of multiple iterative work cycles facilitated by the Vanderbilt Center for Better Health. During the early stages of the three-day period, the workshop was highly structured to encourage participants to view the challenges of long term care in New York State from multiple perspectives. Building on this work, participants shared their own experiences, challenges, and concerns through facilitated group discussion. For the final workgroup discussion topics, the participants selected key areas of interest and were divided into working groups to devise the solutions presented in this paper.

The policy areas discussed during the workshop were framed by the current fiscal realities and aging demographics in New York State. Policy discussions were directed at devising action and reform for the outlying issues that burden not only consumers and providers, but also the state, federal, and local governments. The policy areas included:

- Financing long term care, including the integration of Medicare and Medicaid and the balancing of personal and public responsibilities.
- Streamlining and consolidation of administration and programs.
- Exploring a universal assessment model.
- Determining the future of home care and community-based services.
- Assuring the availability of high quality, affordable nursing homes.

- Developing and retaining a quality workforce.
- Utilizing information and information technology (IT).
- Providing enhanced access and guidance.

Throughout the workshop breakout groups and subsequent discussions, an array of policy options were generated and then presented to the entire group. This report details the policy options, but does not necessarily represent the full consensus of all of the participants. It follows that the recommended guidance offered by this report includes elements that are at times duplicative, or which may be rendered moot upon the adoption of other elements. Yet, taken as a whole, this report offers a consistent approach to reform, seeking to make more effective use of public resources to provide higher quality services that are responsive to the needs and interests of New York's growing older population.

Among the findings and policy options are the following:

- The State could use its regulatory and licensing authority to advance integrated models for care delivery and coordination. These models could focus on enrolling geriatric dual eligible beneficiaries requiring long term care and could be the building blocks of the New York State dual eligible program.
- The State could examine benefits accrued by consolidating New York State Department of Health (DOH) long term care programs. For example, consideration could be given to the consolidation, or more purposeful differentiation, of the Medicaid Personal Care Program (PCP), the Long Term Home Health Care Program (LTHHCP), and the Managed Long Term Care Program (MLTCP). The introduction of risk sharing opportunities and risk-adjusted reimbursement could be considered as a means of encouraging traditional provider organizations to assume responsibilities for risk management.
- The State could, over time, develop a comprehensive universal assessment instrument that adequately reflects the needs of the frail elderly. This

instrument could serve as the basis for care planning and target specific needs. Families and other concerned parties could be participants in these assessments and plans.

- The existing legal structure for the authorization, regulation, and funding of home care services in New York could be reevaluated and more effectively organized. Certified Home Health Agencies (CHHAs) and Licensed Home Care Service Agencies (LHCSAs) could be consolidated over time to simplify care delivery and financing.
- Through regulation and financing, the State DOH could incentivize a resident-centric model of nursing home operations. The State could also explore bed licensure and reimbursement flexibility to allow for aging-in-place, when it is appropriate and economical. For example, “swing beds” between assisted living programs (ALPs) and residential health care facilities (RHCFs) could enable providers to more easily adapt to changing community needs.
- Community health care workers could be given greater opportunities to advance their careers, to obtain health care coverage for their families, and to obtain wages commensurate with their skills.
- The State could continue its efforts to create an interoperable health care information infrastructure to better support the special needs of the frail elderly. The State could continue its policy efforts to assure that information can be made available to those who are entitled to receive such information and who are involved in patient care in a manner that does not violate the consent or privacy of a willing individual.
- The State could consider new innovative models that increase access to appropriate services. For example, the State could examine a model that includes a universal care assessment, the wide spread use of health IT, and the integration of funding streams.
- Reform should aim to ensure that consumers have a choice in the type of care they receive and who cares for them.

These policy options are offered in the spirit of cooperation and collaboration as the State government works to improve long term care services in New York State by providing consumers with better quality and more affordable care while laying the groundwork for future reforms. This report was authored by the workshop sponsor team under the leadership of Msgr. Charles Fahey, Chairman. We particularly want to thank Dr. Mark Frisse, Will Rice, Sarah Stewart, and the Vanderbilt Center for Better Health for their contribution to the final report.

## **INTRODUCTION**

In 1961, the National Council on Aging and the Ford Foundation convened a group of experts and concerned citizens at Arden House, a former Harriman mansion forty miles from New York City that has been the home to many events of national significance. Arguably, this group was the first statewide effort to address pressing health and social problems associated with aging. The findings of this group served as a basis for extraordinary state and federal changes in the ensuing two decades. A second Arden House conference in 1977, precipitated by the possible bankruptcy of New York City, re-examined the findings of the initial conference in light of increasing social needs and urgent fiscal crises.

Once again, long term care is at the forefront of the challenges facing New York State. In 2000, the elderly, aged 65+, totaled 2,448,352 representing 12.9% of the population. Growth projections for the elderly population in New York State follow national trends; this population is estimated to reach 2,651,655 or 13.6% in 2010, and 3,916,891 or 20.1% in 2030<sup>1</sup>. The demand for long term care services will increase as the number and proportion of people over age 75 grows. According to estimates, there will be over 1.7 million New York State residents over age 75 by 2030; these residents will comprise 9% of the total population—a 53% increase over the year 2000<sup>1</sup>. The higher incidence of chronic illness and functional impairment among older adults will impact the intensity of long term care service demand, particularly in minority and low-income populations. New York State is facing this growing demand for long term care services and support at the same time that capacities are reaching their limits.

The demand for long term care may be attenuated by ongoing innovations in care, improved acute and chronic rehabilitation services, pharmaceutical innovation, and improvement in assistive devices. However, these expected mitigating factors – no matter how promising – will not offset the needs posed by the growing number of frail elderly both in absolute numbers and in proportion to the younger populace.

Growing demand spurred by population growth is not the only problem facing the State's long term care system; New York State also has the highest long term care expenditures by all payers of any state (\$19.3 billion), exceeding the second highest state – California – by 39%<sup>ii</sup>. An analysis of home care services across New York and California demonstrates that overall both states spent approximately the same amount on these services; however, New York State's per capita home health care expenditures are twice that of California. In New York City, hours spent in home care (per recipient) have increased across all categories and Medicaid costs per certified home health care aid recipient are increasing at an annual rate of 14%<sup>iii</sup>.

Our current approach to long term health care financing and service delivery is in need of reform. Since the returns on investments that seek to reduce total costs—such as prevention efforts or health IT—are uncertain and often associated with a long time-lag, it is difficult to include these returns into the resource balance. Defining how these costs are distributed among individuals, families, civic communities, and local, state, and federal government is the crux of this balance question.

The provision of care to the chronically-ill and frail population poses a constant challenge to our society while the responsibility to provide access to care falls at the crossroads of family and public obligations. As a result, fragmented resources have been cobbled together to form the current system of long term care. As we continue to shift care from institutional settings to home and community-based services, the formal system of care is strained by a variety of factors.

Any system of care addressing the needs of the elderly that is truly responsive to the variable and intermittent degrees of frailty suffered by these people must have several essential characteristics: the system must be applicable to all; it must be personalized; it must provide holistic services across a wide continuum of needs; it must be coherent and integrated; it must be adaptive and flexible to the ebb and flow of functional needs; it must be affordable to the individual and to the public; it must align financing incentives with expected and desired outcomes; it must be efficient, effective, and humane; it must be consistent in its efforts and



expectations; it must be centered around the directives of the individual being served; and finally, it must also recognize the essential role of families and other caregivers and support these individuals as they in turn support the elderly for whom the system is designed.

In August of 2008, nearly one hundred providers, academics, policy experts, government officials, and advocates met to perpetuate the spirit of the previous Arden House conferences. They discussed policy options that could provide guidance in a manner similar to the Arden House conferences. Although chronic illness and disabling conditions affect New Yorkers of all ages, the primary focus of the workshop and this report is the frail elderly. It is our hope that the report from the “Creating Solutions for New York State” workshop will provide an avenue for discussion and renewed focus on the critical tasks that lie ahead.

## **FINANCING LONG TERM CARE**

Two key issues that need to be considered in the financing of long term care are the integration of Medicare and Medicaid and the balancing of individual, family, and public responsibilities. The opportunity to integrate Medicare and Medicaid is vital and significant— in New York, individuals who are eligible for both programs (“dual eligibles”) accounted for 45% of Medicaid expenditures in 2003<sup>iv</sup>. However, Medicare and Medicaid incentives and payments are often misaligned, separated into silos, and based on financing variances. An array of models across the country have demonstrated that the integration of Medicare and Medicaid can help to realign payment incentives, maximize the resources available, and create greater flexibility to meet the numerous needs of dual eligible beneficiaries. To date, the scope of this strategy has been limited in New York State.

Financing long term care must also balance public and private responsibility. Currently, Medicaid serves as the “default” insurer for many families. While some families seek to divest themselves of assets in order to qualify for Medicaid, for most people, Medicaid often becomes a necessity after a period of financial and medical hardship, resulting in impoverishment. From the perspective of the individual and family, Medicaid and service eligibility is an “all or nothing” proposition, which poses many difficult questions for people as they age.

Moreover, the rate of acquiring long term care insurance in New York State, though consistent with national trends, remains quite low. The decision to purchase such insurance—even with the protections of the New York State Partnership Plan—is complicated. Consumers often do not understand the value of insurance or when to acquire it in order to make this forward looking investment.

## **POLICY OPTIONS**

There is a need to integrate Medicare and Medicaid and, in fact, New York State has some models in place. The workshop participants suggested that New York State could usefully enhance its commitment to integrated Medicare and

Medicaid models of care. This will create opportunities for consumers to benefit from the assured quality, flexibility, coordination, and accountability of carefully designed models of care that incorporate the seamless provision of services created by the integration of the two principal programs of governmental support. These models could be the building blocks of a more comprehensive New York State dual eligible program that serves people not yet requiring long term care.

- New York State could use its regulatory and licensure authority to advance its goal of more integrated care models. Examples of integrated programs that New York State could seek to expand or replicate include:
  - The Program for All-Inclusive Care for the Elderly (PACE), which includes Medicare and Medicaid services with monthly capitated payments.
  - The Massachusetts Senior Care Organization, which couples State Medicaid with Medicare Advantage Special Needs Plans (SNPs) for dual eligibles.
  - The Wisconsin Partnership Program, which is similar to the PACE model, but does not restrict the choice of primary care physicians or use adult day health care as the site of care.
  - The Minnesota Senior Health Options Program, which covers all Medicare and most Medicaid acute and long term care services and uses the PACE payment methodology.
  - The Montana Advanced Illness Care Coordination Program, a system of coordinated care for patients with advanced illnesses through Blue Cross & Blue Shield of Montana.
- When determining which models to utilize or expand, the workgroup suggested that New York State:
  - Focus on models that enroll geriatric dual eligible beneficiaries requiring long term care.

- Coordinate efforts and ensure that all available funds, including private resources, are integrated to support comprehensive and coordinated services.
  - Balance the interests of Medicaid, Medicare, providers, consumers, health plans, and the system as a whole.
  - Properly reallocate funds from duplicative programs to support services for an expanded number of consumers.
  - Incrementally expand the eligibility criteria to encourage enrollment of those at greatest risk of Medicaid financed long term care.
  - Encourage enrollment by utilizing appropriate incentives.
  - Collect and share data and promote accountability, transparency, and quality.
- The risks associated with the management of Medicaid covered services for the dually eligible are less than those associated with traditional health insurance plans. The regulatory and oversight role of the Department of Insurance (DOI) could be more limited than for more traditional plans, encompassing only the key issues of risk reserves and capitalization. The DOH should be the lead agency, guiding the development and regulation of these programs. This clarification could help expedite the expansion of integrated dually capitated programs.
  - The State could re-examine the viability of the LTHHCP in light of a trend toward integrated models of care. If the program does not appear necessary over the long term, consideration could be given to transitioning or limiting the program to individuals who may not have access to fully-integrated programs. If the program continues in any form, service authorization, reimbursement, and regulatory policies should be consistent with those of other programs providing similar services to similar people.

The issue of balancing personal and public responsibility will remain a difficult one, with significant moral and political implications. To begin to address it, the working group suggested the following options:

- Pooled trusts, a form of supplemental needs trust, can help bridge the gap between private resources and Medicaid support. They are commonly utilized by the families of younger people with disabilities to ensure access to the opportunities of community life without jeopardizing the availability of Medicaid reimbursement for essential services. With appropriate consumer protections in place, their utilization by older individuals could be encouraged as a means of helping assure access to market rate housing.
- Since the Partnership Plan and other long term care insurance policies are under-utilized, the State could gather additional information about consumer decision-making and then revise the Partnership Plan based on this knowledge. Some vehicles that can be utilized to determine appropriate revisions include statewide “listening tours,” telephone surveys, and soliciting long term care and State Office for the Aging (SOFA) provider commentary.

## **STREAMLINING AND CONSOLIDATION**

There are a large number of long term care programs and services throughout New York State and its counties. These programs differ in their availability and services across regions. Presently, state and local government share responsibility for Medicaid-funded services. At times, this leads to poor coordination, unnecessary duplication, and a waste of funds that could be used to provide additional care.

There are a variety of programs with overlapping eligibility and client profiles, yet with different payment methodologies, availability, and administrative oversight. The Medicaid PCP provides services such as housekeeping, meal preparation, bathing, and grooming. The LTHHCP offers a coordinated plan of medical, nursing, and rehabilitative care provided at home to disabled persons who are medically eligible for placement in a nursing home. Similarly, the MLTCP provides services that include nursing, medical equipment and supplies, transportation and social day care.

An excessive number of services and programs that cater to the same population do not so much increase choice as increase the likelihood of confusion. The clients of the Medicaid PCP are often nursing-home eligible, but do not receive the same care management or therapies as their counterparts in other programs. Additionally, the MTLCP and the LTHHCP are very similar in terms of scope and purpose, causing confusion for consumers and, sometimes, local social service districts.

Many of the experts who sustain this complex system learned as it evolved, but their expertise will vanish as an increasing number of them are expected to retire in the next few years. In addition, financially responsible reform cannot be achieved merely by adding new programs, nor can quality be assured in the face of continuing cost reduction while attempting to sustain the same program structure.

Counties have played an important historical role in the allocation of resources and controlling access to care. They should continue to play a vital role in

promoting access to needed care, as cost effective solutions require multiple levels of local and state services. However, the scope of control exercised by counties is a topic of debate. Careful and consistent coordination becomes vital, particularly as revenues to counties are decreasing and some administrative roles may be redundant.

Although the workshop's policy options broach the question of state and local government organization, they do so in a general way since the workgroup was aware of the complexity of this issue. Workshop participants did agree that this needs to be addressed within the context of long term care reform.

## **POLICY OPTIONS**

- The State could examine benefits accrued by consolidating New York State DOH long term care programs. For example, consideration could be given to the consolidation, or more purposeful differentiation, of the Medicaid PCP, the LTHHCP, and the MLTCP. The introduction of risk sharing opportunities and risk-adjusted reimbursement could be considered as a means of encouraging traditional provider organizations to assume responsibilities for risk management.
- Opportunities for administrative consolidation within the DOH could be examined, including the possibility of transferring oversight responsibility for the MLTCP to the Office of Long Term Care. At a minimum, the DOH and SOFA could work more closely at the state and local levels to assure the coordination of their services.
- Counties and municipalities represent the primary focus of care delivery, but their role in administering the complex array of local, state, and federal programs could be examined. Equitable access to services might be better assured if counties transfer responsibility for eligibility determination to the State. The State could then adopt a standard array of assessment and planning instruments whose development is proposed in this report.
- While program and administrative consolidation will contribute to easier reporting on providers, this issue could be addressed independently: efforts

must be made to identify data reporting overlap, waste, and duplication and a streamlining of those processes needs to occur.

- In order to create greater efficiencies, the State could coordinate long term care services for identifiable population groups more closely with hospitals and ambulatory care services.



## **ASSESSMENT**

Workshop participants discussed the desirability of a universal assessment tool, which would include medical, psycho/social, environmental, and financial elements. An ideal model would employ such an instrument in connection with an informational entry-point into the long term care system in order to assess health status and needs, and connect consumers to the best options for their circumstances.

Such an assessment could begin with a basic medical and social screening and expand as additional information is gathered about medical status, mental health, family and community supports, housing, demographics, and drug and alcohol use. This assessment would capture information necessary to help determine eligibility for medical, social, and community services paid for by the government or other sources.

Ideally, each assessment would generate a set of choices and care plans that serve as the basis for discussing choices with the individual, family members, care advocates, and caregivers. Although assessments could be separated from the management or financing of any specific long term care plan, these assessments would naturally lead to an exploration of community services, information resources, and coordinated care plans.

Assuring assessments of the right type at the right time will be a continuing challenge. For this reason, workshop participants favored a careful study of the existing assessment instruments and their use, which could lead to incremental progress, standardization, and tighter coordination among those who assess and those who act in response to assessments.

## **POLICY OPTIONS**

- The New York State DOH and SOFA could convene an inclusive expert and user panel to explore the range of required assessments and to develop a roadmap towards a more comprehensive, consistent, uniform, and actionable set of assessment instruments applicable to all life stages of the frail elderly. It could explore how these assessment instruments can be

linked to care management planning, quality measurement, resource allocation, and financing across the diverse set of communities and resources within the State. It could further define specific types of events that would trigger new assessments and modifications to care plans.

- The State could oversee rigorous, statistically valid evaluations of one or more recommended comprehensive assessment instruments across a limited number of sites, which would test the viability of these instruments in the diversity of settings encountered within the states. In particular, testing should be focused on the points of key transitions such as initial enrollment and hospital discharge to sub-acute or home care settings.
- The State could explore the creation of learning labs or pilot programs involving a select number of organizations that want to begin improving care management systems for the frail elderly. Participation in these programs could be managed through a competitive application process. Organizations participating in this initiative would have the responsibility of improving the means by which care management programs are developed, implemented, and measured. Care management models studied through these means would be assessed through a set of feasible quality measures with the expectation that such measures could be applied to the population as a whole at a future date.
- The effectiveness of care management models must be assessed through a set of available quality measures, which could be used to conduct evaluations across program silos and support care management planning. These measures are collected in the current service structures and are publicly reported to track current program performance.

## **HOME AND COMMUNITY-BASED SERVICES**

Home care is the fastest growing segment of New York's long term care system. Spending for non-institutional long term care and community rehabilitation services grew by 8.9% and 10.3%, respectively, from 2004 to 2006, while nursing home spending grew by only 1.2%<sup>v, vi</sup>. While this growth is consistent with the policy preference for providing appropriate non-institutional care, the provision of home care suffers from complexity, lack of coordination, and unnecessarily high expenses.

Estimates by the Urban Institute and the American Association of Retired Persons (AARP) show that over 90% of community-dwelling people with disabilities receive some informal assistance, and this is the only support two-thirds of this cohort receives<sup>vii</sup>. The shift from institutional care to home and community-based settings relies heavily on informal support that may not be available to the extent required. The ability of family and friends to provide care to the frail elderly may be reaching its limits. Providing informal care, however, is becoming more difficult and the burden of informal caregiving often adversely affects the caregiver's own health and financial circumstances.

In New York State, home care is delivered through a complex array of home health care organizations, including CHHAs and LHCSAs, as well as through other programs. This results in high overhead costs, redundancies, breakdowns of information sharing, and possible inappropriate levels of care. Moreover, payments to these entities are generally determined by care setting or program, rather than the individual's need.

However, home care has given thousands of medically needy individuals the ability to keep people living at home and in the community- a morally correct public policy goal. It is a vital service but it needs reform. In light of the Olmstead Decision, home care needs to be a part of any reform that seeks to achieve "the most integrated setting" for the frail and people with disabilities.

## POLICY OPTIONS

- New York State could create a PACE-like model that introduces greater flexibility of service design and phases in full risk sharing for Medicaid and Medicare. The development of acuity based rates would help realize the potential of this type of service structure.
- The State could seek to learn the lessons of existing home and community-based demonstrations and apply those lessons in order to move from demonstration to implementation.
- The Visiting Doctor Model could be expanded. This model provides medical care to participants with complex and serious illnesses who have difficulty leaving their homes. The program provides preventive care, diagnostic evaluation, and treatment to help patients maximize their health and independence.
- For individuals who possess the requisite capacity for self-directed care, the State could consider creating a consumer-directed social model with targeted cash and counseling, similar to the models used in New York City. This will give eligible consumers more control over their own care and caregivers and could lead to greater cost-effectiveness.
- The State could target training for consumers transitioning to home and community-based services.
- In order to promote better service coordination, the State could consider the consolidation of LHCSAs into CHHAs. LHCSAs provide hourly nursing care, homemaker, housekeeper, and personal-care attendants and other health and social services. In some cases, LHCSAs contract with local social services departments, or CHHAs to provide services to persons with Medicaid coverage. CHHAs provide part-time, intermittent health care and support to individuals who need intermediate and skilled health care as well as long term and home health aide services. These two programs could be consolidated by phasing out LHCSAs over a multi-year period. All

existing LHCSAs would be converted or merged into CHHAs. In addition, utilization could be decreased.

- The New York State Consumer-Directed Personal Assistance Program (CDPAP) provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services. Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse. The State could incorporate CDPAP features into all long term care programs.
- Recipients of home care may receive other Medicaid benefits or supportive services funded by SOFA services and benefits. A single provider needs to be vested with the responsibility of developing a comprehensive care plan for an individual receiving services. The State could encourage family participation in the development of an individual's comprehensive care plan, which would require on-going family responsibilities.

## **NURSING HOMES**

In both New York State and the broader United States, nursing home demand by individuals with access to alternative services is steadily declining, undermining the financial stability of many providers who are caring for an increasingly complex population. The needs of long stay residents are growing more intense compared to even just five years ago. Across this population, levels of functional disability have significantly increased, a greater number of diagnoses and medications are involved, and behavioral issues are now the norm. In the next decade, the absolute number of persons with advanced progressive intermittent frailty will grow, straining the system.

At the same time, there are some nursing homes residents who are in nursing homes not because of their care needs, but for other reasons that must be addressed. These reasons may include: overburdened or absent informal caregivers; housing that can no longer suit the needs of the frailer seniors; and the necessity of prompts and supervision to make it through their daily activities.

Nursing homes play a vital role in society's response to the needs of people with serious functional declines. However, for those needing post-acute rehabilitation services or for those at the end of life, the model must be brought into the 21<sup>st</sup> Century where quality outcomes, person-centered care, and efficient use of technology are integrated.

## **POLICY OPTIONS**

- The State could more vigorously encourage a resident-centric view of nursing homes within the New York State DOH to encourage flexibility and reform. This departmental culture change would encourage policies that allow individuals to age-in-place. The DOH's role could be transitioned from one that emphasizes the regulation of nursing homes to one that more fully embraces a responsibility to inform and support their operations.
- The State could explore bed licensure and reimbursement flexibility to allow for aging-in-place, when it is an option. For example, "swing beds"

between ALPs and RHCs would enable providers to more easily adapt to changing community needs.

- The State could implement a pay-for-performance program based on outcome and quality. These programs, which could utilize IT and quality metrics, would lead to higher quality services.
- Wherever possible, state and federal government could establish multi-year budget guidance so that providers could anticipate reimbursement levels and make appropriate long term investments. Furthermore, to avoid the need for nursing homes to borrow funds to manage cash demands (and increase overall costs in the system), the State could try to reduce delays in payments for appropriate services.
- The State could find means of ensuring nursing home placement by a uniform assessment applied in conjunction with personal preference when the individual or family has the capacity to participate. The same assessments could be applied on a periodic basis to ensure that more effective and personal alternatives to nursing home placement are found for those whose need for such care is no longer acute.
- The State could reconsider staffing requirements to increase flexibility, reduce costs, and still accommodate needs of residents.
- Survey reform could be considered on the state and federal levels. The existing system evaluates “point-in-time” resident status and compliance with regulatory standards. Greater attention should be paid to resident outcomes and satisfaction over time. Also, nursing homes should have greater flexibility and accountability to assure that nursing home beds are reserved for those that truly need that level of care.
- The State could bring together housing and nursing home providers in order to seek solutions for those not requiring nursing home placement, but still needing a high level of care or for those residents who no longer require nursing home placement. The expansion of assisted living models

would give individuals an alternative to nursing home placement, ensuring that individuals placed in nursing homes really need to be there.

- The Medicare Advantage SNPs provide an opportunity for nursing homes to benefit from reductions in the unnecessary utilization of high cost medical services. Nursing homes should be incentivized to strengthen their programs and services in order to minimize the necessity for resident transfers to hospitals and other medical service providers.



## **WORKFORCE**

The workforce crisis in the long term care field has been well documented. Strengthening this field will require a comprehensive approach that encompasses wages, health insurance, educational benefits, and career ladder opportunities for both direct care workers and professional-level personnel.

Workforce research shows that access to affordable employer provided health insurance is an important factor in recruiting and retaining a quality frontline staff. Too many low-wage health care workers employed in publicly funded jobs by private agencies do not have adequate health coverage for themselves or their families.

A quality workforce requires the dynamism provided by a career ladder. A certified, statewide “direct care generalist” job title could be a step up on a career ladder for dedicated and motivated direct care workers. This new job title is needed to build a more individualized and consumer directed model of service delivery.

Educational benefits including tuition assistance and paid release time to attend public colleges are part of the dynamic of any quality workforce. The entire long term care workforce, especially direct care workers, clinicians, and frontline supervisors, needs access to undergraduate and graduate certificate and degree programs in gerontology and related disciplines.

Institutions of higher education need resources to expand their capacity to graduate health and human services professionals with a specialization in the fields of aging and disability, including more nurses and social workers.

Creative collaborations involving public colleges, state government, private providers, and organized labor can leverage existing resources to support the professional development, higher education, and career advancement of personnel in long term care.

## POLICY OPTIONS

- The State could consider a group purchasing arrangement, or other innovative mechanism, to support the design of a standardized, affordable, state-sponsored health benefit for direct care workers that can be purchased at a discount through their private employers.
- The State could develop a “direct care generalist” job title as a rung on a career ladder for home health aides, certified nursing assistants, patient care associates, personal care aides, and other entry level direct care workers. Such a certification could provide a salary increment for a cadre of experienced staff that possesses: core competencies that cut across job functions and service delivery settings; specialized knowledge in geriatrics and disability; cultural sensitivity; and critical thinking and communication skills. A high school diploma or GED could be required for promotion to the generalist position. Generalists could also have a broader, more flexible, and integrated scope of work, with more autonomy and responsibility. They could, for example, administer medications across a range of service environments. A “master level” rung could include training in mentoring, leadership, and supervision, and could require some college.
- The State could provide tuition vouchers and paid release time for direct care workers and frontline supervisors who enroll in public colleges in certificate and degree programs in personnel shortage areas including nursing and social work. To participate in a state-sponsored tuition voucher program, private employers and/or unions should contribute a matching tuition benefit.
- Through the Healthcare Workforce Retraining Initiative or other sources, the State could provide funding to CUNY and the State University of New York (SUNY) to expand their capacity to graduate health and human services professionals with a specialization in the fields of aging and disability.

- Funding could also be provided to develop a new Master's program in geriatric case management for Bachelor's in Social Work graduates and Bachelor's in Science of Nursing graduates and interdisciplinary certificate programs in aging and disability at the undergraduate and graduate level.
- The State could expand training and support programs for informal and family caregivers and facilitate collaborations with paid staff.
- The impact of immigration policies on staff shortages could be studied and used to develop approaches to expand the pool of potential workers.
- NYS DOH and State Education Department (SED) policies could be coordinated in relation to licensure and other certifications.

## **INFORMATION AND INFORMATION TECHNOLOGY**

New York State has demonstrated leadership and commitment towards spearheading initiatives that develop interoperable health IT infrastructures that will improve health care quality and coordination, reduce health care costs, and improve health outcomes. The State is addressing critical obstacles such as providing capital financing, initiating discussions regarding the interoperability of state-based data sources, and adopting a statewide policy on consent to ensure personal control, privacy, and confidentiality of patient health data.

However, stakeholders of long term health care and social services could be further integrated into these discussions and action could be taken to address critical issues such as patient education, financing, and workforce capability. These initiatives must also continue to define privacy and control. The State could also utilize existing data sources, such as the Minimum Data Set (MDS), and work alongside long term care providers to forecast future demands to align appropriate resources.

The increased use of technology in the spectrum of long term care services will improve care in all settings. Furthermore, health IT is an important part of systemic improvement and cost-effectiveness. There is widespread agreement and evidence that better health information would dramatically improve quality, affordability, and outcomes. Ultimately, the information stored in health IT infrastructures must be portable and transferable to caregivers and consumers to empower consumers in health care decision and connect them with services based on their individual data.

### **POLICY OPTIONS**

- The State could expand its broad capabilities in health IT to assure that effective use is made of medical information and personal health records in every setting by every qualified individual. This information could be made available in a secure and reliable way to everyone involved in assuring safer care within the home and transitions among various care services and settings.

- The State could continue its efforts to create an interoperable health care infrastructure and emphasize enabling care to the frail elderly. Similarly, the State could continue its policy efforts to assure that information can be made available to those who are entitled to receive such information and who are involved in patient care in a manner that does not violate the consent or privacy of a willing individual.
- The State could provide non-profit and other small or underserved long term care service organizations access to capital financing by tying capital costs to reimbursements, grants, subsidized loans, or bonuses for the advancement of technology.
- IT financing and budget planning could be integrated across state agencies to help identify joint projects that can be used by multiple groups instead of duplicating efforts with double the cost. Core functions such as identification, eligibility determination, care authorization, financing, capacity, and assessment information could be emphasized in these efforts.
- A “market analysis” and inventory of existing databases, including the MDS could be performed by the State. Existing information can then be mined for quality analysis and forecasting service demands.
- The State could work with long term care service organizations to promote a research agenda to evaluate the quality of care being delivered, as well as the quality of data being reported.
- The State could convene a task force with the DOH and SOFA to inventory existing data resources to identify overlap and duplication. This task force could also examine various ways in which information necessary for consumer choice can be made available efficiently.
- Over time, existing quality metrics work within the State could be extended more systematically to the elderly population to improve health assessment, care planning, and care quality measurements.

- The State could consider expanding NY Connects as a means of aggregating program and service information into a consolidated resource with multiple access and assistance channels.

## **ACCESS AND GUIDANCE**

At present, the frail elderly and their families are often confronted with a confusing array of programs and financial challenges with little guidance. In New York State, the availability of professional advice differs from county to county. Individuals with significant impairments, supported only by inexperienced family, seem unlikely to access the appropriate resources without assistance. The workgroup identified a possible model that would allow individuals to easily access appropriate long term care services based on a universal assessment and personal preferences.

## **POLICY OPTIONS**

- The model would create an organization that could provide a one-stop information source for entry into the long term care system. The organization would connect patients to a comprehensive array of services and have the ability to pool funding streams. This organization would need to be flexible and be able to evolve with the individual, yet highly regulated to ensure that there is no incentive for under-service.
- An individualized set of services would be provided based on a comprehensive care assessment. This assessment would be triggered by a major event, such as a hospitalization, or by information on an electronic health record; additional triggers could be identified. The assessment would be done without regard to payer and would generate a budget constraint based on a patient's determined impairments. Care assessments would also regularly reoccur so that services could change with the individual.
- After the assessment, the patient would be connected to a complete array of services, including medical, psychosocial, behavioral health, ADLs/instrumental ADLs, substance abuse and care management services. Services would be based on consumer and family preference. However, when public payers are involved, services would most likely be provided

based on need. Geography, community, and phase of life would also impact the array of appropriate services.

- The State could develop a learning lab to: investigate existing models, such as NY Connects and federal demonstration projects that share some characteristics of the ideal model; identify the data needed to assess and evaluate the model; and identify the information needed to oversee payment regulation.
- In order to move this idea forward, the State could create a timeline to identify standards and specifications for how to proceed in the implementation of this model.



## **CONCLUSION**

New York State's long term care system requires systemic reforms in order to meet the needs of the frail elderly and the many others who require assistance due to chronic disabling conditions. The policy options presented here are intended primarily as a means of meeting the current and future needs of these individuals. However, the workshop participants also recognized the financial limitations of consumers and providers and the constraints of the state, federal, and local governments.

Current fiscal realities and our aging demographics require New York State to act expeditiously to reform and consolidate existing service delivery models while improving care. New York State faces both the challenge and opportunity to build a technologically up-to-date long term care system that offers access, quality, and financial sustainability while respecting the rights and independence of the individuals it seeks to help.

The needed systemic reforms will, in some cases, be extremely hard to implement and may force all of us to take some difficult positions. However, the status quo is not a viable alternative. We must recognize our individual and collective obligations to those who need assistance or who cannot care for themselves.

If we do not act soon, New York's health care system will not be able to support the unsustainable and quickly spiraling financial burden of the current paradigm. The greatest burden, however, will be on New Yorkers who depend on these services to live.

# APPENDIX

## PARTICIPANTS

<b>Priscilla Almodovar</b>	President and CEO, NYS Housing Finance Agency
<b>Cora Alsante</b>	Partner, Hancock and Estabrook, LLP
<b>John Baackes</b>	CEO, Senior Whole Health
<b>Deborah Bachrach</b>	Deputy Commissioner, Office of Health Insurance Programs and State Medicaid Director, New York State Department of Health
<b>Joseph Baker</b>	Acting Deputy Secretary of Health and Human Services, Office of the Governor
<b>Howard Bedlin</b>	Vice President, National Council on Aging
<b>Mark Benton</b>	Program Officer, Milbank Memorial Fund
<b>Sally Berry</b>	Senior Vice President, Policy and Program Development, Loretto
<b>Rachel Block</b>	Executive Director, NY eHealth Collaborative
<b>Charles Brecher</b>	Executive Vice President and Director of Research, Citizens Budget Committee
<b>Pamela Brier</b>	CEO, Maimonides Medical Center
<b>Richard Bringewatt</b>	Co-Founder and President, National Health Policy Group
<b>Greg Burke</b>	Vice President of Planning, Montefiore Medical Center
<b>Kathleen Caggiano-Siino</b>	Executive Deputy Commissioner, New York State Office of Alcoholism and Substance Abuse Services
<b>Maria Casteneda</b>	Secretary-Treasurer, 1199 SEIU
<b>Myra Christopher</b>	CEO, Center for Practical Bioethics
<b>David Cohen</b>	Senior Vice President, Clinical Integration, Maimonides Medical Center
<b>Jonathan Cooper</b>	Sachs Consulting

<b>Kenyon Craig</b>	President, Housing Vision
<b>Bruce Darling</b>	Organizer, New York State Assembly's Task Force on People with Disabilities
<b>Tom Dowling</b>	Former Chair of the New York State Governor's Health Advisory Committee
<b>William Ebenstein</b>	University Dean for Health and Human Services, CUNY
<b>Brian Ellsworth</b>	President and CEO, Connecticut Association of Home Care & Hospice
<b>Charles Fahey</b>	Program Officer, Milbank Memorial Fund
<b>Bruce Feig</b>	Executive Deputy Commissioner, Office of Mental Health, New York State Department of Health
<b>Eli Feldman</b>	President and CEO, Metropolitan Jewish Health System
<b>Daniel Fox</b>	President Emeritus, Milbank Memorial Fund
<b>Keville Frederickson</b>	Professor, Graduate Center, CUNY
<b>Mark Frisse</b>	Accenture Professor of Biomedical Informatics, Vanderbilt Center for Better Health
<b>Howard Gold</b>	Senior Vice President of Managed Care and Business Development, North Shore Long Island Jewish Health System
<b>David Gould</b>	Senior Vice President for Program, United Hospital Fund
<b>Dona Green</b>	Assistant Vice President of Corporate Planning and HIV Services, New York City Health and Hospitals Corporation
<b>Michael Gusmano</b>	Assistant Professor of Health Policy and Management, Mailman School of Public Health, Columbia University
<b>Jennifer Hajj</b>	Sachs Consulting
<b>Kathryn Haslanger</b>	Vice President of Community Benefit and External Affairs, United Hospital Fund
<b>Michael Hogan</b>	Commissioner, New York State Office of Mental Health

<b>Alene Hokenstad</b>	Project Director, Division of Policy Analysis, United Hospital Fund
<b>James Introne</b>	President and CEO, Catholic Health Care System
<b>Harold Iselin</b>	Managing Shareholder, Greenberg & Traurig, LLP
<b>Thomas Jung</b>	Assistant Director, Division of Health Facility Planning, New York State Department of Health
<b>Mark Kator</b>	President, Isabella
<b>Susan Kelly</b>	New York State Captain, CMS Regional Office
<b>Deborah King</b>	Executive Director, Training and Education Fund (1199)
<b>Mark Kissinger</b>	Deputy Commissioner, Office of Long Term Care, New York State Department of Health
<b>Dennis Kodner</b>	Director, Center for Gerontology & Geriatrics, New York College of Osteopathic Medicine of New York Institute of Technology
<b>Kathryn Kuhmerker</b>	Vice President, The Lewin Group
<b>Anthony Lechich</b>	Senior Vice President for Medical Affairs, Terrance Cardinal Cooke Health Care Center
<b>Philip Levy</b>	President and CEO, YAI/National Institute for People with Disabilities Network
<b>James Lytle</b>	Partner, Healthcare Industry, Manatt, Phelps & Phillips, LLP
<b>Virginia Maar</b>	Principal, Loeb & Troper
<b>Brian McLane</b>	Executive Director, Burton Blatt Institute
<b>Hope Miller</b>	Vice President of Care Services, Isabella
<b>Ann Monroe</b>	President, Community Health Foundation of Western and Central New York
<b>Kirstin Mooney</b>	Sachs Consulting
<b>Elizabeth Mullin Diprosa</b>	President, St. Ann's Community of Rochester

<b>Carmen Odom</b>	President, Milbank Memorial Fund
<b>Greg Olsen</b>	Deputy Director, Division of Policy, Management and Public Information, New York State Office for the Aging
<b>Morin Oluwole</b>	Sachs Consulting
<b>Laurie Pferr</b>	Executive Deputy, New York State Office for the Aging
<b>Bruce Pyenson</b>	Principal, Milliman Inc.
<b>Carol Raphael</b>	President and CEO, Visiting Nurse Service of New York
<b>William Rice</b>	Senior Consultant, Vanderbilt Center for Better Health
<b>Carol Rodat</b>	New York Policy Director, Paraprofessional Healthcare Institute
<b>Stuart Rosenblatt</b>	Director, Division of Planning and Policy, Office of Long Term Care, New York State Department of Health
<b>Steve Rosenthal</b>	Chief Operating Officer, The Care Management Company
<b>Kathryn Ruscitto</b>	Vice President, St. Josephs Hospital Health Center Syracuse
<b>Jeffrey Sachs</b>	President, Sachs Consulting
<b>Jay Sackman</b>	President, Jay M. Sackman Consulting Services
<b>David Sandman</b>	Senior Vice President, New York State Health Foundation
<b>Doug Sanstead</b>	General Counsel, Catholic Health Care System
<b>Wendy Saunders</b>	Chief of Staff, New York State Department of Health
<b>John Sheridan</b>	President, E-Health Data Solutions
<b>Allison Silvers</b>	Director, Strategic Grants and Contracts, Village Care of NY
<b>Sarah Stewart</b>	Coordinator, Vanderbilt Center for Better Health
<b>Rick Surpin</b>	President, Independence Care Systems
<b>John Turongian</b>	CEO, United Helpers Management Company
<b>Bruce Vladeck</b>	Executive Director, Health Sciences Advisory Services, Ernst & Young

<b>Fredda Vladeck</b>	Project Director, Aging In Place Initiative, United Hospital Fund of New York
<b>Patricia Wang</b>	President and CEO, Health First
<b>Arthur Webb</b>	President and CEO, Village Care of New York
<b>Dana Beth Weinberg</b>	Assistant Professor, Department of Sociology, Queens College
<b>Audrey Weiner</b>	President and CEO, The Jewish Home and Hospital LifeCare System
<b>Carla Williams</b>	Deputy Director, Office of Long Term Care, New York State Department of Health
<b>Ann Wyatt</b>	Consultant
<b>Robert Zorowitz</b>	Medical Director, Village Care of New York

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