SAGE Commission
Visioning & Planning Charrette

Data Book

June, 2009
Overview

Sage Commission Workplan
Key Strategic Questions
Current LTC Criticisms
SAGE Commission Workplan

**Phase I: Environmental & 9 County Assessment**
- Demographic & economic review of 65+ population
- Health care disparities analysis
- Use rates by level of care
- Caregiver ratios
- Inventory of current aging services
- Workforce issues/assessment of region
- Payer impact on aging services including health care reform
- Models of care & innovations in care delivery or services

**Phase II: Modeling Estimated Demand**
- Create an “As Is” Scenario
- Identify potential future aging services demand scenarios
- Develop & document the key assumptions for each scenario
- Develop additional scenarios with key assumptions
- Review scenarios with key constituents to obtain feedback
Phase III: Create a Person-Centered Vision & Plan

- Hold a one day retreat to discuss the vision, current barriers and gaps in vision and develop high level strategies
- Follow-up will include a summary report that includes a proposed Vision statement, identification of barriers and gaps in services, and high level strategies to achieve the vision.
- Based on the Commission’s June meeting we will discuss key strategies and scenarios with constituents and other interested parties as directed by the Commission.
Key Strategic Issues for Discussion and Consideration

1. What community or organizational characteristics will lead to a high performing aging services network in the FLHSA service area?
   - What services are critical to an aging services network?
   - How will you measure the success of the SAGE Vision?
   - How will reimbursement be designed to encourage the development of high performing aging services networks?

2. What strategies could be employed that would change consumer and provider management of chronic disease?
   - What strategies can the community develop for assisting individuals or providers to manage chronic diseases?
   - Are there structural or organizational mechanisms that can influence positive outcomes?
   - How could patients be targeted for intervention?
   - Are there conditions, such as obesity or diabetes that should have a stronger focus?

3. The 2020 Commission created two acute care scenarios for 2017. How will these scenarios impact aging services?
   - As inpatient use rates decline will older adults use post acute or other community based services more or less?
   - What impact will the Community Investment Recommendations of the 2020 Commission have on aging services?
4. What would be the impact on preference for the use of SNF if the facilities were newer and had a different model of care?

5. What changes are expected in care delivery such as Medical Homes, care coordination, clinical best practice implementation that might reduce the use of aging services?

6. What impact will the changing availability of caregivers have on the use of formal long term care services or the choices elders make in where to live?

7. What will be the impact of NY policies on funding aging services?
   - Will reimbursement encourage the use of H&CBS, assisted living, etc?

8. What impact will technology have on aging services?
   - Will technology allow older adults to stay in their homes longer?

9. Are there additional community individuals or providers that should be interviewed as a part of this process?

10. How will older adults & their caregivers experience the ideal aging services?
    - How will we include older adults in the design of service models or programs?
    - How will caregivers be supported in an ideal system?
Current Criticisms of Current Long Term Care Services

1. Biased toward institutional care
2. Service delivery is fragmented
3. Home and community based services are often too rigid or come with too many rules
4. Needs of informal caregivers are often ignored
5. Acute and long term care financing are fragmented and offer different incentives
6. Delivery and financing of long term care do not meet the needs of disabled
7. Current options available discourage participation even when eligible
8. Long term care services could be more culturally sensitive which may reduce existing health care inequities
Estimating Aging Services Demand
Demographic Information
Chronic Disease Information
Aging Services Utilization
Caregiver Data
Key Elements of Aging

Dying with Dignity

Social Participation

Successful Aging

Adequate Care and Good Quality

Staying Healthy

Adequate Income

Appropriate Housing
The Aging Services Field Is Evolving

Spectrum of Services

Want Driven

Preventative

Active Adult Communities

Continuing Care Retirement Communities/Multi-Level Campus

Need Driven

Long Term Care

Hospital

Source: Adapted from Greystone and used in previous LarsonAllen LLP presentations
Redefining Aging Services – The Conclusions

1. Demographic changes will reconfigure aging services
2. Greater market choices increases demand for all services
3. Chronic disease is a strong predictor of demand
4. Skilled care substitution is limited for complex residents
5. Caregiver availability influences choice and funding
6. Health care reform will change eligibility & provider incentives
7. Significant investments will be required to meet changing demand and upgrade existing facilities
8. Affordability of housing and health options will be more critical as older adults have limited financial resources
9. Workforce shortages will be challenging
Demand Predictors and Influencers

- Environmental Factors
- Public Policy Factors
- Lifestyle and Consumer Choice Factors
- Income and Wealth Factors

DEMAND
The population 65+ is growing more diverse with the largest non-white group being Black or African American. The numbers of elders of color are expected to continue growing over the next 25 year period.

We will discuss further the impact of the changing diversity of elders on the use of aging services.
The 65+ population is growing in the region, but the growth varies by county and age cohort. The growth in each category will impact aging services differently. Typically the growth in 65 to 75 will impact home care and short stay SNF utilization. Day care will be impacted by all age cohorts but particularly the 75+ population. The 85+ population growth will impact all aging services, but particularly SNF long stay and assisted living.

Source: University of Cornell Demographic Estimates provided by FLHSA and analyzed by LA.
The 65+ population is growing, but through 2015 the growth is primarily in the 65 to 74 age cohort.

The 85+ population in both counties remains flat throughout this time frame.

The 75 to 84 cohort declines or remains flat until 2015 when it begins to grow.

Source: PAD Population Estimates provided by FLHSA and analyzed by LA 4/09.
The 65+ population grows in these counties through 2030 and then begins to decline. The strongest growth is in the 65 to 74 cohort.

The 75 to 84 age group declines through 2015 and then increases each five year period.

The 85+ population sees slight growth over the time period.

Source: PAD Population Estimates provided by FLHSA and analyzed by LA 4/09.
The 65+ populations in these two counties grows through 2025 for all age cohorts although the rates of growth are not even.

The 65 to 74 age cohort will see strong growth over the next 15 years and then begin to decline.

The 75 to 84 year olds will remain flat or decline slightly through 2015 and then begin to grow.

The 85+ population will remain relatively flat throughout this time period.

Source: PAD Population Estimates provided by FLHSA and analyzed by LA 4/09.
The pattern of population growth for these two counties is similar to the remainder of the region. The 65 to 74 age group grows continuously until 2030 when they decline. The 75 to 84 age cohort declines through 2015 when they start to grow. The 85+ age group grows slightly over this time period.

Source: PAD Population Estimates provided by FLHSA and analyzed by LA 4/09.
Yates County will see growth in all three age cohorts over this time period. The 75 to 84 age cohort declines slightly until 2015 and then begins to grow. The 65 to 74 age group begins to decline in 2030, similar to other counties in the region.
## Demographic Population Growth

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CURRENT &amp; PROJECTED POPULATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 15-64</td>
<td>846,699</td>
<td>849,941</td>
<td>830,538</td>
<td>803,606</td>
<td>773,004</td>
</tr>
<tr>
<td>Females Age 45 - 64</td>
<td>B 170,720</td>
<td>177,893</td>
<td>175,827</td>
<td>165,625</td>
<td>153,100</td>
</tr>
<tr>
<td>Age 65+</td>
<td>170,143</td>
<td>174,300</td>
<td>192,255</td>
<td>213,350</td>
<td>234,979</td>
</tr>
<tr>
<td>Age 65-74</td>
<td>84,703</td>
<td>89,882</td>
<td>108,712</td>
<td>124,201</td>
<td>132,930</td>
</tr>
<tr>
<td>Age 75-84</td>
<td>59,567</td>
<td>57,138</td>
<td>55,470</td>
<td>61,708</td>
<td>74,579</td>
</tr>
<tr>
<td>Age 65-84</td>
<td>144,270</td>
<td>147,020</td>
<td>164,182</td>
<td>185,909</td>
<td>207,509</td>
</tr>
<tr>
<td>Age 85+</td>
<td>A 25,874</td>
<td>27,280</td>
<td>28,073</td>
<td>27,441</td>
<td>27,470</td>
</tr>
</tbody>
</table>

| **LIVING ALONE AND CAREGIVER RATIOS** |        |        |        |        |        |
| Caregiver Ratio       | B / A  | 6.6 to 1| 6.5 to 1| 6.3 to 1| 6.0 to 1| 5.6 to 1|

Caregiver Ratio is the total numbers of Women 45 to 64 divided by the total population 85+.

Source: Caregiver Ratio calculated by LA based on demographic data received from FLHSA. Cornell Demographic Center
Demographic Profile – 2008 Income & Home Ownership

The median household income and % home ownership declines for 85+ population, particularly as the number living alone grows.

It appears that older adults may have low incomes, but high home values…cash poor, but asset rich.

**Source:** Senior Life Report, Claritas Inc. accessed 4/09 by LA
### Demographic Profile by Area - 2008

#### 65+ Living Alone

<table>
<thead>
<tr>
<th>County</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Livingston</td>
<td>23.3%</td>
<td>29.8%</td>
<td>27%</td>
</tr>
<tr>
<td>Ontario</td>
<td>17.6%</td>
<td>38.3%</td>
<td>29.3%</td>
</tr>
<tr>
<td>Schuyler</td>
<td>NOT AVAILABLE</td>
<td>NOT AVAILABLE</td>
<td>NOT AVAILABLE</td>
</tr>
<tr>
<td>Seneca</td>
<td>12.3%</td>
<td>27.8%</td>
<td>21%</td>
</tr>
<tr>
<td>Steuben</td>
<td>18.3%</td>
<td>39%</td>
<td>30%</td>
</tr>
<tr>
<td>Monroe</td>
<td>18.1%</td>
<td>37.2%</td>
<td>29.3%</td>
</tr>
<tr>
<td>Chemung</td>
<td>21.7%</td>
<td>42.5%</td>
<td>34.1%</td>
</tr>
<tr>
<td>Wayne</td>
<td>17.3%</td>
<td>37.4%</td>
<td>28.5%</td>
</tr>
<tr>
<td>Yates</td>
<td>15.9%</td>
<td>34.3%</td>
<td>26.1%</td>
</tr>
<tr>
<td>Total F.L.A.</td>
<td>18.1%</td>
<td>35.8%</td>
<td>28.2%</td>
</tr>
</tbody>
</table>

Source: Senior Life Report, Claritas Inc. accessed 4/09 by LA
## Demographic Profile by Area - 2008

### 75+ Population

<table>
<thead>
<tr>
<th>County</th>
<th>Poverty</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Livingston</td>
<td>7.06%</td>
<td>16.69%</td>
<td>30.19%</td>
<td>46%</td>
</tr>
<tr>
<td>Ontario</td>
<td>7.34%</td>
<td>17.65%</td>
<td>31.62%</td>
<td>49%</td>
</tr>
<tr>
<td>Schuyler</td>
<td>7.75%</td>
<td>16.10%</td>
<td>32.96%</td>
<td>49%</td>
</tr>
<tr>
<td>Seneca</td>
<td>8.82%</td>
<td>18.53%</td>
<td>33.68%</td>
<td>52%</td>
</tr>
<tr>
<td>Steuben</td>
<td>5.65%</td>
<td>20.13%</td>
<td>34.14%</td>
<td>54%</td>
</tr>
<tr>
<td>Monroe</td>
<td>8.58%</td>
<td>15.69%</td>
<td>32.01%</td>
<td>47%</td>
</tr>
<tr>
<td>Chemung</td>
<td>8.15%</td>
<td>17.67%</td>
<td>31.78%</td>
<td>49%</td>
</tr>
<tr>
<td>Wayne</td>
<td>11.15%</td>
<td>15.69%</td>
<td>32.24%</td>
<td>47%</td>
</tr>
<tr>
<td>Yates</td>
<td>7.52%</td>
<td>18.46%</td>
<td>29.14%</td>
<td>47%</td>
</tr>
<tr>
<td>Total F.L.A.</td>
<td>8.27%</td>
<td>45%</td>
<td>50%</td>
<td>48%</td>
</tr>
</tbody>
</table>

Source: Senior Life Report, Claritas Inc. accessed 4/09 by LA
Managing Chronic Disease is Critical

Data about individuals with chronic disease is plentiful, but key data is as follows:

1. People with 5 or more chronic conditions see 14 Physicians and fill 57 prescriptions per year
2. Seventy-five percent (75%) of Medicare spending funds beneficiaries with 5 or more chronic conditions
3. The number of 65+ people with chronic diseases & disabilities is expected to double between 2000 and 2030.
4. Annual Medicare expenditures for older adults with two or more ADL difficulty averages $14,775 compared to $4,289 for those with no problems with ADLs.
5. 36% of older adults with severe disabilities had incomes 125% below the federal poverty level compared to only 11% without a disability.

Source: *Long Term Care: Option in an Era of Health Care Reform*; Joshua Weiner, PhD., March 9, 2009; pgs 5-8.
Chronic Care Is Critical Issue

End of Life care was a cost reduction focus, but managing chronic care costs now receives greater scrutiny. The total costs of care per year vary little from 50 to 74, but then begin to increase significantly.

Two recent studies have begun to define Alzheimer’s and dementia as Diabetes Type III – potentially changing treatment options.

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Chart 6-4. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2005

Note: FFS (fee-for-service). Analysis includes FFS beneficiaries not living in institutions such as nursing homes. Direct spending is on Medicare cost sharing and noncovered services.

# Key Public Health Indicators for Finger Lakes Service Area

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Chemung</th>
<th>Livingston</th>
<th>Monroe</th>
<th>Ontario</th>
<th>Schuyler</th>
<th>Seneca</th>
<th>Steuben</th>
<th>Wayne</th>
<th>Yates</th>
<th>NY State</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Adults Overweight or Obese (BMI 25+)</td>
<td>63.3</td>
<td>60.5</td>
<td>59.3</td>
<td>60.5</td>
<td>63.3</td>
<td>59.2</td>
<td>58.7</td>
<td>59.2</td>
<td>58.7</td>
<td>56.7</td>
</tr>
<tr>
<td>Cardiovascular Disease Mortality Rate per 100,000 (ICD10 I00-I99) - Age-adjusted</td>
<td>271.2</td>
<td>233.3</td>
<td>240.9</td>
<td>253.2</td>
<td>283.5</td>
<td>284.0</td>
<td>281.8</td>
<td>261.3</td>
<td>256.5</td>
<td>285.5</td>
</tr>
<tr>
<td>Cardiovascular Disease Hospitalization Rate per 10,000 (ICD9 390-459) - Age-adjusted</td>
<td>157.5</td>
<td>190.2</td>
<td>159.8</td>
<td>166.4</td>
<td>158.2</td>
<td>187.7</td>
<td>165.8</td>
<td>179.8</td>
<td>183.2</td>
<td>184.2</td>
</tr>
<tr>
<td>Cerebrovascular Disease (Stroke) Mortality Rate per 100,000 (ICD10 I160-I69) - Age-adjusted</td>
<td>34.6</td>
<td>48.6</td>
<td>43.8</td>
<td>40.7</td>
<td>32.4</td>
<td>41.3</td>
<td>36.2</td>
<td>46.3</td>
<td>54.6</td>
<td>30.5</td>
</tr>
<tr>
<td>Cerebrovascular Disease (Stroke) Hospitalization Rate per 10,000 (ICD9 430-438) - Age-adjusted</td>
<td>25.7</td>
<td>26.4</td>
<td>23.9</td>
<td>23.2</td>
<td>26.2</td>
<td>26.2</td>
<td>22.0</td>
<td>23.6</td>
<td>28.1</td>
<td>26.7</td>
</tr>
<tr>
<td>Diabetes Mortality Rate per 100,000 (ICD10 E10-E14_) - Age-adjusted</td>
<td>21.0</td>
<td>14.4</td>
<td>14.9</td>
<td>20.9</td>
<td>18.1</td>
<td>18.9</td>
<td>23.5</td>
<td>28.2</td>
<td>16.1</td>
<td>18.8</td>
</tr>
<tr>
<td>Diabetes Hospitalization Rate per 10,000 (Primary Diagnosis ICD9 250) - Age-adjusted</td>
<td>17.2</td>
<td>9.3</td>
<td>13.1</td>
<td>11.3</td>
<td>12.6</td>
<td>8.8</td>
<td>15.8</td>
<td>8.7</td>
<td>14.9</td>
<td>19.7</td>
</tr>
<tr>
<td>COPD Hospitalizations among adults 18+ years (per 10,000)</td>
<td>60.1</td>
<td>29.5</td>
<td>19.0</td>
<td>34.7</td>
<td>28.8</td>
<td>28.0</td>
<td>51.6</td>
<td>34.8</td>
<td>45.7</td>
<td>39.7</td>
</tr>
</tbody>
</table>

The public health indicators monitored for each of the counties are listed above. There are significant variances between each of the counties which will impact the services older adults use.
### 2007 Acute Discharges/1000 – Finger Lakes Service Area

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Medical</th>
<th>Surgical</th>
<th>Psych</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 to 69</td>
<td>70.6</td>
<td>108.3</td>
<td>3.6</td>
<td>182.6</td>
</tr>
<tr>
<td>70 to 74</td>
<td>100.7</td>
<td>143.8</td>
<td>4.4</td>
<td>248.7</td>
</tr>
<tr>
<td>75 to 79</td>
<td>143.4</td>
<td>167.3</td>
<td>4.2</td>
<td>314.9</td>
</tr>
<tr>
<td>80 to 84</td>
<td>198.2</td>
<td>183.7</td>
<td>5.5</td>
<td>387.4</td>
</tr>
<tr>
<td>85+</td>
<td>281.8</td>
<td>170.3</td>
<td>6.6</td>
<td>458.7</td>
</tr>
</tbody>
</table>

Acute care utilization goes up significantly as we age, particularly for medical admissions. For many older adults this reflects multiple admissions per year.

An acute care admission can be the trigger that connects older adults to aging services particularly to a skilled nursing facility or a home care program.

These are the estimates used for hospitalization rates for FLHSA for 2017 and will be included in the aging services estimated demand analysis.

Source: Community Health System 2020 Commission Final Report; August 18, 2008; page 15.
### Medicare Reimbursement for Selected Services

#### Medicare reimbursements for home health services per enrollee

**HRR Level Rates (2006)**

<table>
<thead>
<tr>
<th>Area</th>
<th>Population</th>
<th>Rates</th>
<th>Ratio to Benchmark</th>
<th>Surplus/Deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Average</td>
<td>25,935,924</td>
<td>434.46</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><em>State: New York</em></td>
<td>1,531,136</td>
<td>379.28</td>
<td>1.15</td>
<td>1,431,070,631</td>
</tr>
<tr>
<td><em>Rochester, NY</em></td>
<td>74,634</td>
<td>362.01</td>
<td>1.2</td>
<td>1,879,131,801</td>
</tr>
</tbody>
</table>

#### Medicare reimbursements for hospice services per enrollee

**HRR Level Rates (2006)**

<table>
<thead>
<tr>
<th>Area</th>
<th>Population</th>
<th>Rates</th>
<th>Ratio to Benchmark</th>
<th>Surplus/Deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Average</td>
<td>25,935,924</td>
<td>233.93</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><em>State: New York</em></td>
<td>1,531,136</td>
<td>126.31</td>
<td>1.85</td>
<td>2,791,394,141</td>
</tr>
<tr>
<td><em>Rochester, NY</em></td>
<td>74,634</td>
<td>106.55</td>
<td>2.2</td>
<td>3,303,717,674</td>
</tr>
</tbody>
</table>

#### Medicare reimbursements for skilled nursing facilities per enrollee

**HRR Level Rates (2006)**

<table>
<thead>
<tr>
<th>Area</th>
<th>Population</th>
<th>Rates</th>
<th>Ratio to Benchmark</th>
<th>Surplus/Deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Average</td>
<td>25,935,924</td>
<td>689.95</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><em>State: New York</em></td>
<td>1,531,136</td>
<td>703.4</td>
<td>0.98</td>
<td>-349,005,122</td>
</tr>
<tr>
<td><em>Rochester, NY</em></td>
<td>74,634</td>
<td>515.42</td>
<td>1.34</td>
<td>4,526,527,625</td>
</tr>
</tbody>
</table>

Medicare expenditures per enrollee for home care, hospice and SNF care in the Rochester area are all significantly lower than the national average and lower than New York averages.

Medicare Clients Readmitted w/in 30 Days

Rehospitalization rates are high for both medical and surgical discharges. These selected conditions represent some of the clinical care areas that see a higher than average readmission rate.

Source: Future of Care Management *Payment and Technology Innovations Driving New Care Models*; Health Care Advisory Board/Innovations Center Teleconference, 2009, pg 18
The skilled nursing facilities use rate for older adults has declined since 1974 for all age groups.

The decline in use rate has been most pronounced for men 85+.

One other factor to note is that Black elders are increasing their use of SNF services through 1999 when they started to decline for most age groups. Black elders 85+ use SNFs at a high rate similar to white females 85+.

<table>
<thead>
<tr>
<th>Facility</th>
<th># Beds</th>
<th>Medicaid Occupancy</th>
<th># Stars</th>
<th># Deficiencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Beds - Chemung County</td>
<td>738</td>
<td>70.77%</td>
<td>2 to 4</td>
<td>1 to 6</td>
</tr>
<tr>
<td>Total Beds - Livingston County</td>
<td>354</td>
<td>77.94%</td>
<td>1 to 4</td>
<td>2 to 5</td>
</tr>
<tr>
<td>Total Beds - Monroe County</td>
<td>5,334</td>
<td>67.39%</td>
<td>1 to 5</td>
<td>0 to 20</td>
</tr>
<tr>
<td>Total Beds - Ontario County</td>
<td>787</td>
<td>71.00%</td>
<td>2 to 5</td>
<td>1 to 5</td>
</tr>
<tr>
<td>Total Beds - Schuyler County</td>
<td>120</td>
<td>75.02%</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Total Beds - Seneca County</td>
<td>120</td>
<td>75.70%</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Total Beds - Steuben County</td>
<td>701</td>
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<td>1 to 4</td>
<td>4 to 8</td>
</tr>
<tr>
<td>Total Beds - Wayne County</td>
<td>564</td>
<td>68.84%</td>
<td>1 to 5</td>
<td>3 to 5</td>
</tr>
<tr>
<td>Total Beds Yates County</td>
<td>198</td>
<td>75.56%</td>
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<tr>
<td>Total Beds - FLHSA</td>
<td>8,916</td>
<td>1 to 5</td>
<td>0 to 20</td>
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</tr>
</tbody>
</table>

Source: Nursing Home Compare; NY DOH

Total beds by county, the Medicaid occupancy, CMS quality ranking and number of deficiencies are listed by county. Individual facility data is provided in the appendix. Additional information about the short stay and long stay mix of resident and their payer sources will be provided at the meeting. There are three facilities that did not have data about number of beds or CMS quality information. Further research on these facilities will need to be completed.
The use of short stay Medicare SNF services varies by county and is lower than national and New York state data. Nationally the average length of stay (ALOS) is about 31 days. This short stay data does not include enrollees in Medicare Advantage plans which if included might make the use rates comparable.
### Selected SNF Data by County and Facility - 2008

<table>
<thead>
<tr>
<th>Facility</th>
<th>Type</th>
<th>County</th>
<th>2008 MA Rate</th>
<th>CMI</th>
<th># Beds</th>
<th>Medicaid Occupancy</th>
<th># Stars</th>
<th># Deficiencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARNOT OGDEN MEDICAL CENTER</td>
<td>NF</td>
<td>CHEMUNG</td>
<td>$199.18</td>
<td>1.00</td>
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<td>58.90%</td>
<td>4</td>
<td>2</td>
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<tr>
<td>BETHANY NURSING HOME &amp; HE</td>
<td>NF</td>
<td>CHEMUNG</td>
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<td>1.28</td>
<td>122</td>
<td>51.36%</td>
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<td>NF</td>
<td>CHEMUNG</td>
<td>$180.53</td>
<td>1.20</td>
<td>200</td>
<td>67.53%</td>
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<td>NF</td>
<td>CHEMUNG</td>
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<tr>
<td>ST JOSEPHS HOSPITAL - SKI</td>
<td>NF</td>
<td>CHEMUNG</td>
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<td>1.07</td>
<td>71</td>
<td>64.10%</td>
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<td>5</td>
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<tr>
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<td>71.25%</td>
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<td>70.91%</td>
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<td>ONTARIO</td>
<td>$148.12</td>
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<td>46</td>
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<tr>
<td>LIVING CENTER AT GENEVA N</td>
<td>NF</td>
<td>ONTARIO</td>
<td>$171.31</td>
<td>1.12</td>
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<td>LIVING CENTER AT GENEVA S</td>
<td>NF</td>
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<td>$187.18</td>
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<td>2</td>
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<td>NF</td>
<td>ONTARIO</td>
<td>$166.22</td>
<td>1.06</td>
<td>98</td>
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<td>SCHUYLER HOSPITAL INC AND</td>
<td>NF</td>
<td>SCHUYLER</td>
<td>$177.44</td>
<td>1.15</td>
<td>120</td>
<td>75.02%</td>
<td>3</td>
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<td>HUNTINGTON LIVING CENTER</td>
<td>NF</td>
<td>SENECA</td>
<td>$174.13</td>
<td>1.10</td>
<td>120</td>
<td>72.81%</td>
<td>4</td>
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<td>NF</td>
<td>SENECA</td>
<td>$149.40</td>
<td>1.10</td>
<td>120</td>
<td>75.70%</td>
<td>4</td>
<td>3</td>
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<td>ABSOLUT CENTER FOR NURSING</td>
<td>NF</td>
<td>STEUBEN</td>
<td>$156.68</td>
<td>1.18</td>
<td>120</td>
<td>83.52%</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>FOUNDERS PAVILION</td>
<td>NF</td>
<td>STEUBEN</td>
<td>$193.59</td>
<td>1.26</td>
<td>120</td>
<td>70.66%</td>
<td>1</td>
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<tr>
<td>HORNELL GARDENS LLC</td>
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<td>STEUBEN</td>
<td>$155.87</td>
<td>1.17</td>
<td>114</td>
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<td>4</td>
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<tr>
<td>IRA DAVENPORT MEMORIAL HCC</td>
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<tr>
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<td>NF</td>
<td>STEUBEN</td>
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Source: Nursing Home Compare; NY DOH; 4/09
### Selected SNF Data by Facility – Monroe County 2008

<table>
<thead>
<tr>
<th>Facility</th>
<th>Type</th>
<th>CMI</th>
<th># Beds</th>
<th>Medicaid Occupancy</th>
<th># Stars</th>
<th># Deficiencies</th>
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</thead>
<tbody>
<tr>
<td>AARON MANOR REHABILITATIO</td>
<td>NF</td>
<td>1.15</td>
<td>140</td>
<td>65.91%</td>
<td>4</td>
<td>2</td>
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<tr>
<td>BAIRD NURSING HOME</td>
<td>NF</td>
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<td>28</td>
<td>49.05%</td>
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<tr>
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<td>NF</td>
<td>1.11</td>
<td>80</td>
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<td>120</td>
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<td>1</td>
<td>13</td>
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<td>161</td>
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<td>CHURCH HOME OF THE PROTEST</td>
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<td></td>
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<td>80</td>
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<td>3</td>
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<tr>
<td>EDNA TINA WILSON LIVING C</td>
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<td>1.10</td>
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<td>3</td>
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<td>196</td>
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<tr>
<td>HAMILTON MANOR NURSING HOME</td>
<td>NF</td>
<td>1.17</td>
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<td>HILL HAVEN NURSING HOME</td>
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<td>355</td>
<td>65.91%</td>
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<td>6</td>
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<tr>
<td>JEWISH HOME &amp; INFIRMARY O</td>
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<td>3</td>
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<td>KIRKHAVEN</td>
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<td>LATTA ROAD NURSING HOME</td>
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<td>40</td>
<td>51.88%</td>
<td>3</td>
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</tr>
<tr>
<td>LATTAD ROAD NURSING HOME A</td>
<td>NF</td>
<td>1.14</td>
<td>40</td>
<td>64.93%</td>
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<td>MAPLEWOOD NURSING HOME IN</td>
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<td>86.59%</td>
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<td>7</td>
</tr>
<tr>
<td>PARK RIDGE NURSING HOME</td>
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<td>1.19</td>
<td>120</td>
<td>38.86%</td>
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<tr>
<td>PENFIELD PLACE LLC</td>
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<td>48</td>
<td>65.14%</td>
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<tr>
<td>ST ANNS COMMUNITY</td>
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<td>17</td>
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<tr>
<td>ST ANNS COMMUNITY</td>
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<td>ST JOHNS HEALTH CARE CORP</td>
<td>NF</td>
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<tr>
<td>THE FRIENDLY HOME</td>
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<tr>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>THE HIGHLANDS LIVING CENT</td>
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<td>1.06</td>
<td>122</td>
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<td></td>
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<tr>
<td>THE HURLBUT</td>
<td>NF</td>
<td>1.17</td>
<td>160</td>
<td>79.52%</td>
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<td>THE SHORE WINDS LLC</td>
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<td>229</td>
<td>83.37%</td>
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<td>UNITY LIVING CENTER</td>
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<td>80.24%</td>
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<td>WEDGEWOOD NURSING HOME</td>
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<td>29</td>
<td>73.03%</td>
<td>5</td>
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<td>4</td>
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<td>124</td>
<td>78.60%</td>
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<td>4</td>
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<td>WOODSIDE MANOR NURSING HC</td>
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<td>1.31</td>
<td>44</td>
<td>37.74%</td>
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</tbody>
</table>

**Total Beds - Monroe County:**

- **5,334** beds with 67.39% Medicaid occupancy, ranging from 1 to 5 stars and 0 to 20 deficiencies.
There are 58 SNF facilities listed in the information available publicly in the nine county Finger Lakes region. There are five facilities for which we could not find CMS Nursing Home Compare data, but they were listed on the Department of Health listing of skilled nursing facilities.

Total estimated licensed beds in these facilities are 8,916 beds. Not all of these beds are set up and staffed.

Source: Nursing Home Compare; NY DOH; 4/09
2007 Licensed Residential Units Occupancy by County

<table>
<thead>
<tr>
<th>Total AL Units by County</th>
<th>Total Beds</th>
<th>Occupancy</th>
<th>Census</th>
</tr>
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<tbody>
<tr>
<td>CHEMUNG COUNTY</td>
<td>274</td>
<td>73.7%</td>
<td>202</td>
</tr>
<tr>
<td>LIVINGSTON COUNTY</td>
<td>173</td>
<td>71.7%</td>
<td>124</td>
</tr>
<tr>
<td>MONROE COUNTY</td>
<td>2463</td>
<td>78.4%</td>
<td>1,932</td>
</tr>
<tr>
<td>ONTARIO COUNTY</td>
<td>351</td>
<td>71.8%</td>
<td>252</td>
</tr>
<tr>
<td>SCHUYLER COUNTY¹</td>
<td>135</td>
<td>82.2%</td>
<td>111</td>
</tr>
<tr>
<td>SENECA COUNTY</td>
<td>24</td>
<td>87.5%</td>
<td>21</td>
</tr>
<tr>
<td>STEUBEN COUNTY</td>
<td>248</td>
<td>73.4%</td>
<td>182</td>
</tr>
<tr>
<td>WAYNE COUNTY</td>
<td>24</td>
<td>83.3%</td>
<td>20</td>
</tr>
<tr>
<td>YATES COUNTY</td>
<td>91</td>
<td>58.2%</td>
<td>53</td>
</tr>
<tr>
<td><strong>FLHSA Service Area</strong></td>
<td><strong>3,783</strong></td>
<td><strong>76.6%</strong></td>
<td><strong>2,897</strong></td>
</tr>
</tbody>
</table>

¹Include 24 beds w/ a census of 15 info for Bonnell Adult Home which closed.

There are 58 Adult Assisted Care Facilities in the nine county area of FLHSA. The total occupancy is under 80% and about 79.8% of residents pay privately. Approximately 5% are Assisted Living Program clients. The occupancy and payer mix data for 2006 is about the same. The occupancy at these facilities may be lower as the home sales and price have declined.

Source: FLHSA provided and analysis completed by LA.
## Estimated Demand and Availability of Adult Day Health

### Estimated Demand for Adult Day Health

<table>
<thead>
<tr>
<th>County</th>
<th>2015 Demand</th>
<th>2015 Available*</th>
<th>Unmet Need</th>
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<tbody>
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<td>Chemung</td>
<td>46</td>
<td>35</td>
<td>11</td>
</tr>
<tr>
<td>Livingston</td>
<td>28</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>Monroe</td>
<td>343</td>
<td>255</td>
<td>88</td>
</tr>
<tr>
<td>Ontario</td>
<td>60</td>
<td>55</td>
<td>5</td>
</tr>
<tr>
<td>Schuyler</td>
<td>12</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Seneca</td>
<td>19</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Steuben</td>
<td>58</td>
<td>38</td>
<td>20</td>
</tr>
<tr>
<td>Wayne</td>
<td>44</td>
<td>25</td>
<td>19</td>
</tr>
<tr>
<td>Yates</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Includes rightsizing proposals

The NY Department of Health has estimated the total demand for adult day health including both social and medical day health services.

Reimbursement is changing for these services which may impact the demand for services.

There is some variances between the counties in how older adults use these services.

*This demand will be recalculated for FLHSA and is being provided as a comparison.*

Source: 2015 Adult Day Health Care Program County Need Estimates; 1/2009; accessed via www.health.state.ny.us/nysdoh
Significant declines in caregiver availability projected in all counties and statewide.

Replacing informal care with formal care is very costly….in Minnesota each 1% decline in family care costs $30M in formal care.

Source: Calculated Caregiver ratio by LA using PAD population projections; Minnesota Department of Health.
Who Are the Caregivers in NY’s Aging Network System?

Based on the 2008 NY Statewide Caregiver Survey released March, 2009:

• Typical caregiver (NYS aging network services system):
  ➢ 64-year-old female
  ➢ High school or some college education
  ➢ Spends more than 40 hours a week providing care to her mother

• Majority (60%) of caregivers:
  ➢ Are older adults themselves
  ➢ Ages range from 32 to 94
  ➢ 30% are aged 75 or older

• The age of care receivers:
  ➢ Average age is 82.3 years old
  ➢ The majority (85%) of them are aged 75 or older
  ➢ 44% are aged 85 or older

• 54% co-reside with their care recipients

Source: 2008 Statewide Caregiver Survey Overview and Results, New York State Office for the Aging, March 2009
Caregivers in the NY’s aging network system provide intensive assistance to care receivers. Caregivers reported:

- They spent an average of 62.6 hours a week providing care to care receivers
  - This translates to 8.9 hours a day of care to the care receivers
- Many caregivers provided care at night, over weekends and on demand
  - 36% of the caregivers reported that their care receivers cannot be left alone at home.
    - 73% of these require 24 hour care or supervision
  - 42% reported that their care receivers can only be left alone for short periods or time or need to be checked in person several times a day

Source: 2008 Statewide Caregiver Survey Overview and Results, New York State Office for the Aging, March 2009
Without services, where would care receiver be living?

Out of those 52% of Caregivers reported:

- 50% Care receiver would live in a nursing home
- 24% Care receiver would live in an assisted living facility
- 11% Care receiver would live with him/her
- 7% Care receiver might have died without services
- 4% Care receiver would live with another family member or friend
- 4% Care receiver might be in a hospital, rehab center, or have around-the-clock help

Source: 2008 Statewide Caregiver Survey Overview and Results, New York State Office for the Aging, March 2009
Public Policy Factors
Regulatory Update – Fed & State
Innovations in Aging Services Public Policy
Workforce Issues
Health care reform, as much as three months ago, was not a certainty….today however, the conversation about reform runs to how much and how soon. The key elements of health care reform today are built around the:

- **Triple Aim**: Better Experience, Better Population Health & Lower Total Per Capita Costs

- **Design of Care**: Electronic Medical Records, Clinical Effectiveness, Transitions of Care, Care Coordination, etc.

- **Systems of Care**: Accountable Health Organizations, Providers sized to take risk, Monitor Quality, Payers engaged to encourage reforms, etc.

Source: Adapted from a NEJM article, *Perspectives* by Don Berwell, MD, et. Al., May, 2009
What we believe…..

Based on the reform discussions and the Obama Budget we believe the following:

1. The American Recovery & Reinvestment Act stimulus dollars are to be fully committed by December 2010.

2. Universal health insurance coverage will be accomplished, but it will required a reduction in other health care expenditures

3. Current goal is to reduce the rate of growth in health care spending by 1.5% or from 6.7% to 5.2%.

4. The Comparative Effectiveness Institute has announced their priorities and they follow current focus areas including the current reportable measures reflected in the Hospital Compare, Nursing Home Compare and Home Care Compare websites.
5. Health care providers, primarily physician practices & hospitals are scrambling to assure the electronic medical records they install will meet the anticipated standards for stimulus funding.

6. Widespread implementation of EMR that allows meaningful exchange and collection of critical information will take about five years.

7. Medicare and Medicaid reimbursement rates per unit of service are likely to see limited growth over the next few years. Payment for much of reform will come through reductions in current FFS rates & Medicare Advantage payments.

8. Reimbursement will likely shift to bundled payments for 30, 60 or 90 days of care following a hospitalization for those not in a managed care plan.

9. Developing robust and easy to manage quality measurement systems will be critical.
Proposed LTC Changes

The Obama Budget, the American Recovery & Reinvestment Act and current health care reform discussions will have a significant impact on LTC providers. Some of the anticipated impacts include the following:

1. Primary physicians will receive a bonus if 60%+ of total care provided is in SNF, office & patient homes

2. Establishment of a Chronic Care Management Innovation Center

3. Proposal to assign Medicare patients to Accountable Healthcare Organizations(2012) which are organizations of affiliated doctors and hospitals. This allows physicians & hospitals to share in cost savings.

4. Increased SNF reporting of ownership will be required

5. The Federal Medicaid Program allocation percentage increase received in 2009 & 2010 is reduced to original levels by FY2011.
Proposed LTC Changes

6. Health Information Technology connectivity to post-acute provider will be required and will grow.

7. New reimbursement methodologies will evolve:
   - Value Based Purchasing
   - Pay for Reporting/Pay for Performance
   - Payment for Care Transition for chronically ill
   - Medicare Advantage revenues are being reduced and moved to national rates focused on P4P.
   - Bundled payment for acute discharges with 8 conditions (2010); All diagnoses bundling is proposed to begin 2015.
     - 20% withhold for lowest performing 25%

8. The reduction in growth of 1.5% will impact LTC providers particularly with anticipated the population growth of elders.
Implications for LTC Providers

The array of changes being proposed will provide a number of opportunities and create new requirements to remain competitive.

1. Post-acute providers will need to develop strong referral relationships with physicians and hospitals.

2. Development of robust quality measurement systems are essential & should start now. This data will help distinguish post-acute providers and help position them for inclusion in Accountable Health Organizations.

3. Establishing methodologies for estimating actual costs by diagnosis or chronic condition will be critical for negotiating bundled pricing.

4. Developing systems for implementing best clinical practices is critical. Demonstrated compliance with clinical guidelines will determine some reimbursement in the future.

5. Determine whether participating in Medicare/Medicaid/Foundation demonstration projects would provide opportunities.
6. Continued focus on cost-cutting and revenue enhancement are paramount as revenues remain flat to small growth.

7. The increased focus on reducing readmissions and hospital quality improvement will impact post acute care provider volumes. The growth in the 65+ population may offset expected quality improvement declines.

8. Key proposed workforce strategies could improve the staff availability, but competition will grow stronger, possibly increasing wages.

It is anticipated that all segments of the long term care continuum will experience operating issues over the next three years. The proposed health care reforms combined with the impact of recent economic downturns are sure to challenge providers to reinvent themselves. *Research has shown that during times of turmoil and crisis we can tolerate greater change.....and it looks like we are going to see if this adage still holds true.*
Quality is a Cornerstone of Reform

A focus on patient transitions and clinical quality has become a priority for CMS.

SNFs, Home Care and other providers that are able to demonstrate high clinical capabilities and outcomes should be well positioned.

Sources: V. Mor; Brown University; Commonwealth Fund study “High Performance Health Systems; 2006; Agency for Healthcare Research & Quality, 2007 State Snapshots, accessed via the web 2/09.
NY Aging Services Health Care Reform Principles – 2009+

- Support and enhance family care giving resources
- Increased consumer choice and control for older individuals, persons with disabilities, and chronic illness.
- Ensure access to an appropriate array of home and community based long term care supports and institutional care when necessary.
- **Reduce costs** and promote payment mechanisms that support and reward better performance.
- Encourage personal planning for long term support needs – including greater awareness of private sources of funding.
- Reverse the institutional bias in Medicaid eligibility.
- Enhance quality measurement to enable care in the setting most appropriate for an individual’s needs.
- Improve coordination of long term care and post acute care services.
- Utilize enhanced health information technology to better inform beneficiary choices, clinical decisions, payment, and care coordinate functions.

Source: Adapted from a Mark Kissinger’s presentation to the NY Home Care Association, 2008 Annual Conference, 6/3/08; pg 17
Proposed NY Medicaid Changes and Updates

Currently Medicaid is being re-evaluated and reviewed to include the following:

- Medical Home standards
- Addressing financially distressed SNF
- Home care reimbursement study group to address home based services
- Identifying and quantifying additional SNF beds to close
- Estimating additional demand for assisted living units
- Development of long term care assessment centers – “no wrong door” approach
- Further development of Consumer Directed Personal Care Programs

NYSOFA Recommendations for Client Assessments

Assessment of clients for service needs should:

1. Permit the person to easily articulate his or her preferences and ideas.
2. Include a person’s preferences & needs rather than eligibility alone.
3. Identify community support needs and preferences for how these needs are met.
4. Include available “natural supports” or assistance, that can be provided.
5. Recognize skills and competencies already have in place. These competencies must be recognized, worked with, and incorporated as future services/supports are developed.
6. Not require specialized knowledge, services or funding streams, but creatively match a person’s daily needs to community resources.
7. Address community supports & service needs in all areas of a person’s life, e.g., medical and psychological needs, health and safety, housing, personal assistance, transportation, relationships, social outlets, and employment.
8. Consider cost effectiveness.

# The New Vision - Patient-Centered Medical Home

<table>
<thead>
<tr>
<th>Principal</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Physician</td>
<td>Each patient has ongoing relationship with personal physician trained to provide, continuous, comprehensive care</td>
</tr>
<tr>
<td>Physician-Directed Medical Practice</td>
<td>Personal physician leads team of individuals who take responsibility for ongoing care of patients</td>
</tr>
<tr>
<td>Whole Person Orientation</td>
<td>Personal physician responsible for providing all patient’s health care needs, appropriately arranging care with other qualified professionals; Includes care for all stages of life: acute care, chronic care, preventive services, end of life care</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>Care is coordinated, integrated across health care system, patient's community</td>
</tr>
<tr>
<td>Quality and Safety</td>
<td>Evidence-based medicine, clinical decision-support tools guide decision making; patients actively participate in decision-making; Information technology is utilized appropriately; patients, families, staff participate in quality improvement activities</td>
</tr>
<tr>
<td>Enhanced Access to Care</td>
<td>Enhanced access to care available through systems such as open scheduling, expanded hours</td>
</tr>
<tr>
<td>Payment</td>
<td>Payment appropriately recognizes added value provided to patients who have a patient-centered medical home through combination of PMPM payment, FFS visits, P4P incentives, gainsharing on cost savings</td>
</tr>
</tbody>
</table>
“One little-tested assumption is that safety – defined vaguely or not at all – is the be-all and end-all of long term care. Embedded in most of our rules & regulations is the idea that long term care should aspire to the best quality of life as is consistent with health and safety. But ordinary people may prefer the best health and safety outcomes possible that are consistent with a meaningful quality of life.”

Rosalie Kane, PhD.
University of Minnesota, 2001

Source: Long Term Care: Options in an Era of Reform; Wiener, Joshua M., PhD., RTI International, March 9, 2009
Innovative Examples of LTC Public Policy

1. Wisconsin Family Care
2. Vermont BluePrint for Health Care
3. Florida’s Cash and Counseling Demonstration
4. Arizona Long Term Care System (ALTCS)
5. Minnesota Senior Health Options
6. Texas STAR +Plus Program
7. Social HMOs
8. Program for All Inclusive Care of Elderly (PACE)
9. The NY United Health Fund Grants Focus
10. Personal Health Records
11. Comprehensive Assessment and Record Evaluation (CARES Tool) Demonstration
12. California Work & Family Coalition
13. City of Louisville – Center for Health Equity
14. Wisconsin Hospital Association partnership with the Univ. of Wisconsin System of Higher Education to expand health professionals education
RE-AIM Framework for Evaluating Services

- **Reach**
  - How do we reach the targeted population?

- **Effectiveness**
  - How do we know the program is effective?

- **Implementation**
  - How do we ensure that the program is delivered consistently?

- **Adoption**
  - How effective is the program in different settings?

- **Maintenance**
  - How do we incorporate the program so it is delivered over the long term?

How do we reach the targeted population?

How do we know the program is effective?

How effective is the program in different settings?

How do we incorporate the program so it is delivered over the long term?

How do we ensure that the program is delivered consistently?

Source: Assuring Healthy Caregivers; A Public Health Approach to Translating Research into Practice: The RE-AIM Framework; Kimberly-Clark; 2008, page 23; accessed on-line at Kimberly-Clark Foundation or CDC.
National Action Plan for Reducing Falls in the Elderly

The key dimensions of the National Action Plan include a focus on:

1. Physical mobility
2. Medications management
3. Home safety
   - Floor coverings
   - Adaptive equipment
   - Personal safety
   - Cooking and food storage
4. Community safety
   - Sidewalks
   - Public transportation
   - Lighting

Source: State of Aging & Health in America 2007; CDC & Merck Company Foundation; 2007; page 32; www.cdc.gov/aging
Falls among the elderly are a significant issue that results in increased costs and utilization of health related services.

The fall hospitalization rate for women 65+ is almost twice the rate for men.

Additionally, in almost all counties the fall hospitalization rate has been increasing each of the last 5 years.

Source: SPARKS data provided by FLHSA staff and analyzed by LA for years 2000 – 2004.
The falls that result in a hospitalization for men are about half of women’s experience, but like women’s the rate of hospitalizations has been increasing in most counties over each of the five years.
The RN Workforce is Aging

- The RN shortage is estimated to be 1,000,000 by 2020 even assuming a 2% per year decline in hospitalizations.
- RNs are growing older and are not being replaced by new graduates.
- RNs typically leave the nursing profession in mid-50s for other fields or retirement.

Source: Florida Dept. of Health, 2008; Nurse Workforce Demand Report 2000 – 2020, HRSA, US Department of Health & Human Services,
The demand for health care workers has increased over the last five years, particularly for nursing facilities and personal care providers, where the growth has been about 8.3%. The reimbursement changed for Medicare home care during this time changing the types of personnel and amount of home care visits provided reducing the numbers employed in home care agencies.
## Skilled Nursing Facility Recruitment Survey Results

### Nursing Home Recruitment and Retention Difficulties for Selected Occupations, 2007

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Average Assessment of Difficulty</th>
<th>Percent of Respondents who Indicated Reasons for Difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Recruitment</td>
<td>Retention</td>
</tr>
<tr>
<td>Certified Nurse Aides</td>
<td>3.1</td>
<td>3.5</td>
</tr>
<tr>
<td>Clerical</td>
<td>2.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Dietitians/Nutritionists</td>
<td>3.3</td>
<td>2.5</td>
</tr>
<tr>
<td>LPN</td>
<td>3.9</td>
<td>3.5</td>
</tr>
<tr>
<td>Physical Therapists</td>
<td>3.7</td>
<td>2.8</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>3.7</td>
<td>2.7</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- experienced</td>
<td>4.3</td>
<td>3.7</td>
</tr>
<tr>
<td>- newly trained</td>
<td>3.8</td>
<td>3.6</td>
</tr>
<tr>
<td>Respiratory Therapists</td>
<td>3.2</td>
<td>2.8</td>
</tr>
<tr>
<td>Social Workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- MSWs</td>
<td>3.2</td>
<td>2.5</td>
</tr>
<tr>
<td>- BSWs</td>
<td>2.9</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Source: Exhibit 29, *The Health Care Workforce in New York, 2006*; published 1/8/09, School of Public Health, University of Albany

Note: The Finger Lakes Region for this report does not include all 9 counties in the FLHSA service area. The shortages experienced in these counties are assumed to be similar to shortages experienced throughout the nine counties.
Estimated Workforce Projections – Finger Lakes Region

### Exhibit 65

**Employment Projections for the Top Eleven Health Care Growth Professions in the Finger Lakes Region, 2004-2014**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurses</td>
<td>10,810</td>
<td>12,610</td>
<td>1,800</td>
<td>16.7%</td>
</tr>
<tr>
<td>Home Health Aides</td>
<td>6,100</td>
<td>7,980</td>
<td>1,880</td>
<td>30.8%</td>
</tr>
<tr>
<td>Nursing Aides, Orderlies, and Attendants</td>
<td>6,990</td>
<td>7,910</td>
<td>920</td>
<td>13.2%</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>4,220</td>
<td>4,460</td>
<td>240</td>
<td>5.7%</td>
</tr>
<tr>
<td>Social Workers</td>
<td>3,670</td>
<td>4,000</td>
<td>330</td>
<td>9.0%</td>
</tr>
<tr>
<td>Dental Assistants</td>
<td>1,280</td>
<td>1,520</td>
<td>240</td>
<td>18.8%</td>
</tr>
<tr>
<td>Medical and Health Services Managers</td>
<td>1,400</td>
<td>1,530</td>
<td>130</td>
<td>9.3%</td>
</tr>
<tr>
<td>Medical Assistants</td>
<td>740</td>
<td>930</td>
<td>190</td>
<td>25.7%</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>830</td>
<td>980</td>
<td>150</td>
<td>18.1%</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>800</td>
<td>900</td>
<td>100</td>
<td>12.5%</td>
</tr>
<tr>
<td>Speech-Language Pathologists</td>
<td>1,140</td>
<td>1,180</td>
<td>40</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

Source: NYS Department of Labor, Labor Market Information, Occupational Outlook, 2004-2014

Note: The Finger Lakes Region for this report does not include all 9 counties in the FLHSA service area. This information is provided for your information and may be similar to the experiences of providers in the nine counties.

Source: Exhibit 65 from Health Care Workforce in New York 2006; 1/08; University of Albany School of Public Health; page 75.
Income & Wealth Factors
The numbers of men entering old age unmarried are expected to be similar to women within 15 years due to changes in marital patterns.

About 28% of women 65+ are poor or near poor, in part because they retire earlier, hold lower paying jobs, are not married and are less likely to have a pension.

Source: Boston College, Center for Retirement Research, *Why are Widows so Poor?*, July 2007, Number 7-9, accessed via the web, 1/09
The Changing Customer – Study is Prior to 2008 Declines

### Portrait of a generation

Average annual financial data per household in 2006, by segment of US baby boom generation (born from 1946 to 1964)

<table>
<thead>
<tr>
<th>High Confidence in the future</th>
<th>Unprepared but envisioning retirement</th>
<th>Affluent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unaware of lack of preparation</td>
<td>10 million households</td>
</tr>
<tr>
<td></td>
<td>• 11 million households</td>
<td>• Income = $110,000</td>
</tr>
<tr>
<td></td>
<td>• Income = $73,000</td>
<td>• Net worth = $1,273,000</td>
</tr>
<tr>
<td></td>
<td>• Net worth = $183,000</td>
<td>• Consumption = $82,000</td>
</tr>
<tr>
<td></td>
<td>• Consumption = $84,000</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Aware of lack of preparation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 13 million households</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Income = $68,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Net worth = $260,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consumption = $68,000</td>
<td></td>
</tr>
</tbody>
</table>

In 2015 60% of all consumption by boomers will come from those who are unprepared for but envision retirement.

Source: The McKinsey Quarterly, Nov/Dec 2007; Serving the Aging Baby Boomers; McKinsey Global Institute
Changing Boomer Wealth Estimates – 2004 to 1st Q 2009

45 to 54 Age Cohort
- Median household net worth declined 45% from 2004 to Q1 2009
- Net worth declined from $150,500 to $82,200 in 2009 dollars
- An estimated 30% have lost all the equity in their homes

55 to 64 Age Cohort
- Median household net worth declined by almost 38% from 2004 to Q1 2009
- Total net worth declined from $229,600 to $142,700 in 2009 dollars
- An estimated 15% have lost all the equity in their homes

Most individuals 55+ will have difficulty recovering from the downturn in the economy unless they continue to work well beyond age 65 years. The impact for this age group was not only on the home values but in their retirement portfolios, if they did not have a defined benefit pension plan.
### 2008 Household Income for 65+ Population

<table>
<thead>
<tr>
<th>Income Range</th>
<th>65 to 74</th>
<th>75 to 84</th>
<th>85+</th>
<th>65 to 74</th>
<th>75 to 84</th>
<th>85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 to $14,999</td>
<td>7,624</td>
<td>8,624</td>
<td>4,387</td>
<td>14.3%</td>
<td>21.9%</td>
<td>27.8%</td>
</tr>
<tr>
<td>$15k to $29,999</td>
<td>13,065</td>
<td>12,605</td>
<td>5,277</td>
<td>24.4%</td>
<td>32.0%</td>
<td>33.4%</td>
</tr>
<tr>
<td>$30k to $49,999</td>
<td>13,772</td>
<td>9,345</td>
<td>3,358</td>
<td>25.8%</td>
<td>23.7%</td>
<td>21.3%</td>
</tr>
<tr>
<td>$50k to $74,9999</td>
<td>9,495</td>
<td>4,566</td>
<td>1,468</td>
<td>17.8%</td>
<td>11.6%</td>
<td>9.3%</td>
</tr>
<tr>
<td>$75,000 +</td>
<td>9,482</td>
<td>4,270</td>
<td>1,304</td>
<td>17.7%</td>
<td>10.8%</td>
<td>8.3%</td>
</tr>
<tr>
<td><strong>Total Households</strong></td>
<td><strong>53,438</strong></td>
<td><strong>39,410</strong></td>
<td><strong>15,794</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

- Households with incomes $75,000+ is slightly higher than some markets.
- Median homes values owned by those 55+ is $117,898 in 2008.
- About 69% of 65+ non-institutionalized are estimated to own their own home in 2000.
- About 10.97% of those 65+ have incomes at or below poverty levels.

Source: Claritas Senior Life Report, accessed and analyzed 4/09 by LA.
### Table 1: Asset Transfer Cases Denied Medicaid SNF Services in NY (1998 - 2008)

<table>
<thead>
<tr>
<th>NYS Medicaid Districts</th>
<th>% of Elderly Medicaid Enrollees Denied Nursing Facility Services Due To Asset Transfers (1998-2008)</th>
<th>Average % of County Residents Below Poverty (1998-2005)</th>
<th>% OF Spend-Down Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemung</td>
<td>4.0</td>
<td>13.2</td>
<td>9.7%</td>
</tr>
<tr>
<td>Livingston</td>
<td>9.6</td>
<td>10.7</td>
<td>3.4%</td>
</tr>
<tr>
<td>Monroe</td>
<td>6.3</td>
<td>12.0</td>
<td>1.2%</td>
</tr>
<tr>
<td>Ontario</td>
<td>14.0</td>
<td>8.1</td>
<td>39.4%</td>
</tr>
<tr>
<td>Schuyler</td>
<td>2.0</td>
<td>12.0</td>
<td>0.6%</td>
</tr>
<tr>
<td>Seneca</td>
<td>2.1</td>
<td>11.6</td>
<td>1.9%</td>
</tr>
<tr>
<td>Steuben</td>
<td>1.1</td>
<td>13.0</td>
<td>19.4%</td>
</tr>
<tr>
<td>Wayne</td>
<td>5.3</td>
<td>9.6</td>
<td>0.7%</td>
</tr>
<tr>
<td>Yates</td>
<td>1.1</td>
<td>13.0</td>
<td>0.2%</td>
</tr>
<tr>
<td>NY State</td>
<td>7.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Assessing Asset Transfer for Medicaid Eligibility in New York State; Prepared by: The New York Health Policy Research Center; for The New York State Department of Health; March 2009

This chart demonstrates the variances between counties is the frequency that applicants are required to spend their assets to receive Medicaid coverage of SNF services. Some of the variances between counties is believed to be differences in administration of the program.
Lifestyle & Consumer Choice Factors
Older Women Are More Likely to Live Alone

Marital status of the population age 65 and over, by age group and sex, 2007

Note: Married includes married, spouse present; married, spouse absent; and separated.
Reference population: These data refer to the civilian noninstitutionalized population.
**65+ Population**

<table>
<thead>
<tr>
<th></th>
<th>Living Alone</th>
<th>W/ Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>7.4%</td>
<td>35.40%</td>
</tr>
<tr>
<td>Female</td>
<td>22.6%</td>
<td>38.90%</td>
</tr>
</tbody>
</table>

The numbers of elders living alone goes up significantly with age. The 65+ living alone percentages are low for most areas of the country. In many markets 65%+ of women over 85 live alone. Disability rates are slightly higher than other markets.
Technology Applications in Aging Services
**In-home Sensor Technology**

- Assesses normal patterns of behavior and physical activity, and monitors changes.
- Identify changes early to prompt health care interventions to delay or prevent serious health events.
- The technology may include:
  - tilt sensors on medicine boxes
  - motion detectors on walls detecting movement within rooms
  - contact sensors on kitchen cupboards and refrigerator doors to monitor eating patterns
  - toilet sensors to monitor usage
  - pressure sensors on beds detecting when a resident gets in or out of bed
  - home-or-away sensors detecting when the resident comes and goes from home
- Additional reading:
  - QuietCare: [http://www.quietcaresystems.com/index_fl.htm](http://www.quietcaresystems.com/index_fl.htm)
MyCommunity Connection: Mississippi

• Encourages residents to get out, socialize, exercise, eat regularly and maintain health awareness.
• Provides an additional layer of safety with simple, automated daily check-ins.
• Features an in-depth medication management regimen
• Tracks progress trends in wellness programs.

• **Site includes:**
  – My Service Requests
  – My Schedule
  – My Menus
  – My Buddies
  – My Wellness
  – My Directories
  – My Opinion
  – Family & Friends Portal

For more information:
http://www.mycommunityconnection.com/contact.asp
South Carolina Personal Health Record: MyPHRSC

- Voluntary Electronic Personal Health Record Medicare demo project for Medicare recipients
- Stores Medicare claims history for the past 24 months.
- Updated daily and can be accessed anywhere, anytime

For more information: https://myphrsc.com/
Google Health Personal Health Record

For more information: https://www.google.com/health
Telemedicine Services and Devices


• General resource for latest news on telemedicine:  

• Federal legislation has been introduced by Congressman Mike Thompson (D-California) to provide $30 million in grants to help health facilities pay for telehealth equipment and expand telehealth support services. The Medicare Telehealth Enhancement Act (House Resolution 2068) would expand Medicare reimbursement to urban and suburban areas and include more facilities. It will also allow doctors to monitor patients remotely. Currently about 80% of Americans do not have access to telemedicine because of restrictions that limit funding for these types of facilities to rural areas.

  The Obama Administration has indicated that telemedicine will be an important part of their health care reform agenda.

  Last July, Thompson’s provisions to expand the types of facilities authorized to provide telehealth care were passed into law as part of the Medicare Improvement for Patients and Providers Act (MIPPA). This bill will further expand the type of facilities that are eligible.

(Source: Eureka Times Standard, April 27, 2009)
Bluetooth-enabled chair scale

• Product Name: Ideal Life Body Manager Plus
• Web site: www.ideallifeonline.com
• Designed for individuals who are too frail or obese to use conventional weighing scales
  – Works with any mode of communication: cell phones, telephone lines, and the Internet.
  – Wireless, real-time capture, store, and share health information.
  – Survey shows 57% reduction in hospital re-admission rates for congestive heart failure patients when they used the wireless IDEAL LIFE Body Manager™ scale to monitor their weight--Business Wire 2009
  – Company offers other products to wirelessly monitor blood pressure, glucose, etc.
Elder Care Robots

Researchers at the University of Massachusetts Amherst have developed a robotic assistant that can dial 911 in case of emergencies, remind clients to take their medication, help with grocery shopping and allow a client to talk to loved ones and health care providers.

For more information:

• http://www.sciencedaily.com/releases/2008/04/080416212725.htm
• http://marc.med.virginia.edu/projects_eldercarerob.html
Intelligent toilet

• Company: Toto's
• Starting cost: $3500
• The Intelligence Toilet system daily measures:
  – urine sugar
  – blood pressure
  – body fat
  – weight
• Data transferred over a home network and then analyzed/viewed on PC.
• Advice on exercise and diet are dispensed
Sleep Monitoring Shirt and Bed Sheet

• Sleep Monitoring Shirt
  – Monitors the user’s heart rate and blood pressure continuously
  – Data can be displayed on a watch or a mobile phone
  – If blood pressure reaches certain high level, a built-in MP3 player automatically plays appropriate therapeutic music to lower the pressure.

• Bed Sheet
  – No wires attach to the person
  – Vitals are monitored and if reach dangerous level an alarm is triggered or phone call made for help.

For more information: http://www.cuhk.edu.hk/cpr/pressrelease/090209e.htm
Implantable Blood Pressure Monitor & Smart Pill Box

• Implantable Blood Pressure Monitor
  • [Link](http://www.iom3.org/news/implantable-blood-pressure-sensor)

• Smart Pill Box
  • [Link](http://web.mit.edu/newsoffice/2008/itw-india-tt0206.html)
  • [Link](http://www.uwm.edu/News/Features/06.05/Smart_Pillbox.html)
Cell Phone Technologies

• Medication Reminders via cell phone or PDA:

• Mobile Health Information applications:
  – http://www.mayoclinic.com/health/intouch/AM00070

For additional technology applications & information see:
CAST State of Technology in Aging Services Reports:
Estimated Demand in “As Is” Scenario
“As Is” Scenario of Demand for Aging Services

Estimating the use and demand for aging services requires making assumptions about what will change in the future such as medical breakthroughs or technology that would reduce the use of certain services. For example, if Alzheimer’s is cured many who currently live in assisted living and skilled nursing facilities might be able to remain independent longer.

The “As Is” scenario was developed assuming the future use of aging services will be the same as the past. The only change we anticipate in this scenario is the population growth of the 65+ age cohort and the continued growth in life expectancy as estimated by Cornell University.

Potential categories of variables that could be changed in other scenarios include:

– Workforce availability (all positions)
– Availability of alternatives – capital access for construction, funding for alternatives, models of care/service, etc.
– Impact of payer changes and pay for performance incentives
– Impact of cultural norms, disparities, etc.
– Changes in age at admission
– Impact of technology on levels of care & independence
– Others
**Demand Influencer:**
Translation of Substitution and HCBS Funding Assumptions

**Example**
Tracking the Impacts of Substitution and HCBS Funding

### Substitution from NF

#### Substitution Metrics

(Increment $$ Only)

**% of Substitution Attributed...**

- **AL**
  - 30.0%  
  - *Per above metric*

- **IL (Housing)**
  - 12.0%  
  - *Per above metric*

- **Adult Day Care**
  - 10.0%  
  - *Per above metric*

- **HCBS Home Care (Services)**
  - 48.0%  
  - *Per above metric*

### HCBS Funding

#### HCBS Funding Metrics

(Increment $$ Only)

**% of Future HCBS $$ to...**

- **Home Care**  
  - 37.5%  
  - *see above HCBS funding matrix*

- **Personal Care**  
  - 37.5%  
  - *see above HCBS funding matrix*

- **Assisted Living (Housing Component)**  
  - 6.3%  
  - *see above HCBS funding matrix*

- **Adult Day Care**  
  - 18.8%  
  - *see above HCBS funding matrix*
“As Is” Scenario – Regional Estimates

FINGER LAKES REGION AGING SERVICES DEMAND MODEL

FINGER LAKES REGION ESTIMATE
Projected to 2025 with 2007 Base Year
4/26/2011 23:03

Environmental
Net Annual % Change in 65+ Use Rates
- 0.00%

Finger Lakes Use Rate
Current 297
291

%Change in Acute Care Transfer % to SNF
Current = 17%
2025 = 17%

Annual Change in Short Stay Length of Stay SNF
0.00%

Impact of Changes in Available Caregivers
% of "At Risk" 65+ Utilizing Formal Services
0.00%

Unlicensed Units

Licensed Units (ALP/ACF)
+6.2%

Population 65+ CAGR = 1.4% (+38%)
Population 85+ CAGR = 0.3% (+6%)

CAGR = Compound Annual Growth Rate

NOTICEABLY DIFFERENT
“As Is” Scenario Findings

The “As Is” Scenario estimates of service use demonstrate:

1. Growth in SNF beds required in both short stay post-acute recovery and long stay residential beds to meet population growth.
2. A growth of 13.5% in the number of independent living units required for the region.
3. A growth of 6.2% growth in assisted living and enhanced living funding for elders.
4. Medicare skilled home care services will grow about 30% over the period.
5. All other home and community based services will grow about 31%.
The “As Is” Scenario

“As Is” Scenario by County
### FINGER LAKES REGION AGING SERVICES DEMAND MODEL

**CHEMUNG COUNTY ESTIMATE**

Projected to 2025 with 2007 Base Year

4/28/2011 5:45

#### Environmental

<table>
<thead>
<tr>
<th>Metric</th>
<th>Current</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Change in Acute Care Transfer</td>
<td>+0%</td>
<td>+0%</td>
</tr>
<tr>
<td>Annual Change in Short Stay Length of Stay SNF</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>% of &quot;At Risk&quot; 65+ Utilizing Formal Services</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

#### Public Funding

- **Net Increase in "Real" Annual HCBS Funding Dollars**
  - $0.0M

- **60% AL Substitution - 40% Other HCBS**
  - User Defined Annual HCBS Funding (per Capita 85+)
    - Current: $3,813
    - Proposed: $4,330 (13.6%)

- **Assumed State Savings - NH**
  - 20%

#### Home Care Visits

- **(Thousands)**
  - 2007: 87
  - 2010: 85
  - 2015: 84
  - 2020: 85
  - 2025: 89

#### Income & Wealth

- **Percentage Change of >65+ Dual Eligible**
  - by 2025 (vs. Current)
  - Current: 26.4%
  - 2025: 26.4%

#### Nursing Facility Beds

- **-6.1%**

#### Lifestyle/Choice

| Substitution of Housing/Service | User | 0.0% |

---

**Population 65+ CAGR = 0.6% (+16%)**

**Population 85+ CAGR = -0.6% (-12%)**
"As Is" Scenario – Changes Based on Population Changes Livingston County

FINGER LAKES REGION AGING SERVICES DEMAND MODEL
LIVINGSTON COUNTY ESTIMATE
Projected to 2025 with 2007 Base Year
4/26/2011 5:48

Environmental
Net Annual % Change in 65+ Use Rates
County Use Rate
%Change in Acute Care Transfer % to SNF
%Annual Change in Short Stay Length of Stay SNF
Impact of Changes in Available Caregivers

Nursing Facility Beds +7.7%

Home Care Visits

Population 65+ CAGR = 1.7% (+47%)
Population 85+ CAGR = -0.1% (-3%)
“As Is” Scenario – Changes Based on Population Changes

Monroe County

FINGER LAKES REGION AGING SERVICES DEMAND MODEL
MONROE COUNTY ESTIMATE
Projected to 2025 with 2007 Base Year

Environmental

Net Annual % Change in 65+ Use Rates
0.00%

County Use Rate
Current 275 → 2025 285

% Change in Acute Care Transfer % to SNF
Current = 20%
2025 = 20%

Annual Change in Short Stay Length of Stay SNF
0.00%

Impact of Changes in Available Caregivers
% of “At Risk” 85+ Utilizing Formal Services
0%

Nursing Facility Beds +14.3%

Unlicensed Units

Licensed Units (ALP/ACF) +8.7%

Public Funding

Net Increase in "Real" Annual
HCBS Funding Dollars + $0.0M

User Defined Annual HCBS Funding (per Capita 85+)
(in Current Dollars)

Current $5,099 → Proposed $4,716 -7.5%

Assumed State Savings - NH 20%

Home Care Visits (Thousands)

Income & Wealth

Percentage Change of 65+ Dual Eligible
by 2025 (vs. Current) 0.0%

65+ Dual Eligible %
Current 20.5%
2025 20.5%

Population 65+ CAGR = 1.4% (+37%)
Population 85+ CAGR = 0.3% (+8%)
“As Is” Scenario – Changes Based on Population Changes
Ontario County

FINGER LAKES REGION AGING SERVICES DEMAND MODEL
ONTARIO COUNTY ESTIMATE
Projected to 2025 with 2007 Base Year

4/28/2011 5:51

Environmental
Net Annual % Change in 65+ Use Rates
-0.00%

County Use Rate
Current 2025
303 293

% Change in Acute Care Transfer to SNF
Current 10% 2025 = 10%

Annual Change in Short Stay Length of Stay SNF
-0.00%

Impact of Changes in Available Caregivers
% of "At Risk" 85+ Utilizing Formal Services
-0.0%

Nursing Facility Beds
-0.0%

Home Care Visits (Thousands)
+42.8%

Public Funding
Net Increase in "Real" Annual
HCBS Funding Dollars
+ $0.0M

60% AL Substitution - 40% Other HCBS
User Defined Annual HCBS Funding (per Capita 85+)
(in Current Dollars)
Current $5,555 Proposed $5,014 -8.7%

Assumed State Savings - NH
20%

Income & Wealth
Percentage Change of >65+ Dual Eligible
by 2025 (vs. Current)
65+ Dual Eligible %
Current 18.1% 2025 18.1%

Population 65+ CAGR = 1.9% (+53%)
Population 85+ CAGR = 0.4% (+11%)
“As Is” Scenario – Changes Based on Population Changes

Schuyler County

Currently there are no enriched Living/AL units in the county and the assumption is that residents will go elsewhere if they require services…this needs to be re-evaluated.
“As Is” Scenario – Changes Based on Population Changes  
Seneca County

FINGER LAKES REGION AGING SERVICES DEMAND MODEL  
SENeca COUNTY ESTIMATE  
Projected to 2025 with 2007 Base Year  
4/29/2011 5:56

Environmental

<table>
<thead>
<tr>
<th>Net Annual % Change in 65+ Use Rates</th>
<th>Current 296</th>
<th>2025 286</th>
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</thead>
<tbody>
<tr>
<td>County Use Rate</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>% Change in Acute Care Transfer % to SNF</td>
<td>+0%</td>
<td></td>
</tr>
<tr>
<td>Current = 14%</td>
<td>2025 = 14%</td>
<td></td>
</tr>
<tr>
<td>% Annual Change in Short Stay Length of Stay SNF</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Impact of Changes in Available Caregivers</td>
<td>% of At Risk 85+ Utilizing Formal Services</td>
<td>0%</td>
</tr>
</tbody>
</table>

Nursing Facility Beds +11.5%

Licensed Units (ALP/ACF) +29.5%

Unlicensed Units +47.8%

Public Funding

Net Increase in "Real" Annual

HCBS Funding Dollars

60% AL Substitution - 40% Other HCBS

User Defined Annual HCBS Funding (per Capita 85+)

Current $3,737 Proposed $3,687 -3.5%

Assumed State Savings - NH 29%

Income & Wealth

Percentage Change of 65+ Dual Eligible by 2025 (vs. Current) 0.0%

65+ Dual Eligible %

Current 18.1% 2025 18.1%

Population 65+ CAGR = 1.6% (+45%)

Population 85+ CAGR = 0.2% (+4%)
“As Is” Scenario – Changes Based on Population Changes
Wayne County

FINGER LAKES REGION AGING SERVICES DEMAND MODEL
WAYNE COUNTY ESTIMATE
Projected to 2025 with 2007 Base Year

Market Rate
Affordable-Funded
Affordable-Unfunded

Unlicensed Units
+41.9%

Licensed Units (ALP/ACF)
+35.6%

Population 65+ CAGR = 1.7% (+47%)
Population 85+ CAGR = 0.4% (+11%)

NOTICEABLY DIFFERENT
## As Is Scenario – Changes Based on Population Changes

Yates County

### FINGER LAKES REGION AGING SERVICES DEMAND MODEL

#### ONTARIO COUNTY ESTIMATE

Projected to 2025 with 2007 Base Year

4/20/2011 6:00

#### Environmental

<table>
<thead>
<tr>
<th>Net Annual % Change in 65+ Use Rates</th>
<th>0.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Use Rate</td>
<td>Current 303, 2025 293</td>
</tr>
<tr>
<td>% Change in Acute Care Transfer % to SNF</td>
<td>+0%</td>
</tr>
<tr>
<td>Annual Change in Short Stay Length of Stay SNF</td>
<td>0.00%</td>
</tr>
<tr>
<td>Impact of Changes in Available Caregivers: % of &quot;At Risk&quot; 85+ Utilizing Formal Services</td>
<td>0%</td>
</tr>
</tbody>
</table>

#### Nursing Facility Beds

- 0.0%
- Short Stay: 615, 647, 674, 683, 711
- Long Stay: 79, 82, 89, 94, 102
- Total Beds: 694, 729, 762, 778, 813

#### Unlicensed Units

<table>
<thead>
<tr>
<th>Year</th>
<th>Market Rate</th>
<th>Affordable-Funded</th>
<th>Affordable-Unfunded</th>
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<tr>
<td>07</td>
<td>655</td>
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<td>15</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>655</td>
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</tbody>
</table>

#### Licensed Units (ALP/ACF)

<table>
<thead>
<tr>
<th>Year</th>
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<th>Affordable-Funded</th>
<th>Affordable-Unfunded</th>
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<tr>
<td>07</td>
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<tr>
<td>25</td>
<td>102</td>
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</table>

#### Public Funding

- Net Increase in "Real" Annual HCBS Funding Dollars: + $0.0M
- 60% AL Substitution - 40% Other HCBS
- User Defined Annual HCBS Funding (per Capita 85+)
  - Current: $5,555
  - Proposed: $5,014 (-4.7%)
- Assumed State Savings - NH: 20%

#### Home Care Visits

- (Thousands) +42.8%
  - County Funded HH: 85%
  - County Funded-Other: 52.6%
  - Medicare: 30.6%

#### Income & Wealth

- Percentage Change of >65+ Dual Eligible by 2025 (vs. Current): 0.0%
- Current 65+ Dual Eligible %: 18.1%
- 2025 65+ Dual Eligible %: 18.1%

### Population

- Population 65+ CAGR = 1.9% (+53%)
- Population 85+ CAGR = 0.4% (+11%)