2020 Vision for Aging Services

Sage Commission, Final Report

Finger Lakes Health Systems Agency

May 4, 2011

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To the Community:

Finger Lakes Health Systems Agency (FLHSA) is dedicated to bringing together the entire community to make substantive changes to the local health care delivery system. Ultimately, FLHSA's goal is to create a health care system that delivers the right care in the right place at the right time.

The core of the agency's work centers on improving quality, reducing cost and ensuring access to care – particularly for those most vulnerable in our community. One of the most vulnerable populations in the Finger Lakes region is older adults, those people age 65 and over.

FLHSA convened the Sage Commission to develop a strategic vision and long-range plan to address the health and health-related services necessary for the aging population and their caregivers. We are delighted to be working side by side with more than 60 health and community leaders on this endeavor.

Together, we are taking a collaborative, multi-stakeholder approach to identify health system needs for older adults. This report sets forth the Sage Commission's vision for person-centered aging services for the year 2020 and beyond.

Sincerely,

Daan Braveman, Co-Chair
President
Nazareth College

Ann Marie Cook, Co-Chair
President and CEO
Lifespan of Greater Rochester, Inc.

Executive Summary

Future health care services for older adults in the Finger Lakes region will be dramatically affected by a projected aging population boom, a decline in the availability of caregivers, fragmented and unsustainable methods to pay for care, a workforce shortage, and health-care disparities that exist among elders.

To create a health system that addresses these factors and meets the needs of the region's elder population, FLHSA's Sage Commission has developed a long-range plan for aging health services. Central to the plan are a series of objectives aimed at creating a person-centered health system that accommodates older adults' preferences to live in the least-restrictive settings and that delays institutional care and allows older adults to remain in the community for as long as possible.

Another goal of the Sage Commission's objectives is to rebalance the long-term-care system. The Commission created detailed estimates of future demand for aging services, utilizing an interactive modeling tool developed by its consultant, LarsonAllen, LLP.

During its two years of extensive planning and analysis, the Sage Commission identified eight overall objectives and developed numerous recommendations to achieve them. This work was completed through continual collaboration with more than 100 stakeholders, including professionals, caregivers, and elders.

The Sage Commission's overall objectives are to:

1) Increase the array of home and community-based services, so older adults can receive care in the least-restrictive setting.
2) Promote expansion of housing options to ensure safe, accessible, and affordable housing is available to older adults.
3) Reduce skilled nursing capacity.
4) Improve access to care.
5) Propose changes to the current reimbursement and regulatory system to allow greater flexibility in paying for needs-based elder care at a cost that is sustainable.
6) Enhance support for family and other "informal" caregivers.
7) Enhance transportation services to help older adults maintain independence.
8) Increase the workforce dedicated to geriatric health and aging services.

This strategic report will be presented to the New York State Department of Health for review and comment. Recommendations will be prioritized as part of FLHSA's ongoing work.

Introduction

In 2008, FLHSA's Community Health System 2020 Commission completed a comprehensive, objective study of the acute care system and related needs for the six-county region's next generation of health care. During the 2020 Commission's work, it became apparent that any long-term view of the health care system must take into account the needs of the aging population.

FLHSA convened the Sage Commission in 2009 as a critical follow-up effort to the 2020 Commission. So named because the "Sage" Commission is identifying the future health care service needs of our community's older residents, the Commission and its work groups also feature the wise advice and talents of more than 100 people. These include experts in geriatric medical care, public health, inpatient and community-based long term care, housing, business, labor, human services, transportation, disability rights, health-care reimbursement, and caregiving and care management, along with older adults themselves.

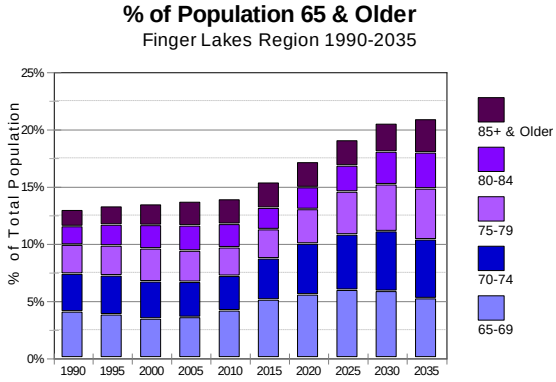
Specifically, the Sage Commission's mission is to set forth a comprehensive long-range plan to address the health service needs of the 65 and older population in the nine-county Finger Lakes region of Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates counties.

In fulfilling its mission, the Sage Commission set out to create a vision for a local system that makes health care more accessible for older adults, minimizes disparities, and is financially viable. This vision is being coordinated with FLHSA's 2020 Performance Commission, which is addressing inefficiencies in the local health system, including reducing potentially preventable hospitalizations and avoidable emergency department visits.

Funded by the New York State Department of Health, the Sage Commission's report summarizes its work to date and sets forth a series of objectives and concrete recommendations for improving care, from primary care to end-of-life care. It also provides a progress report on activities to achieve these objectives, along with next steps.

The Problem: A Perfect Storm is Brewing

A "perfect storm" of challenges threatens the viability of health care services for older adults: a burgeoning aging population, an expected decline in caregivers, the lack of a sustainable financing system, and a shortage of geriatric care workers.



Data Source: 1990-2005 U.S. Census Bureau, Population Estimates Program; 2010-2035 Cornell University, Program on Applied Demographics

1) The Aging Boom

The United States is on the verge of an aging population boom. The number of Americans age 65 or older is currently about 38.7 million and projected to increase to 40 million by 2010, to 55 million by 2020, and to 70 million by 2030.[1]

Baby Boomers, those born between 1946 and 1964 – the largest generation in American history – are aging. Boomers began reaching

retirement age and Social Security/Medicare-eligibility age in January 2011. In the Finger Lakes region, U.S. Census Bureau statistics show that the older adult population is expected to increase by 38 percent from 2007 to 2025 – and will then comprise 21% of the region's population. This aging boom will have a dramatic effect on the health care system.

2) Caregiver Decline

While the aging population is increasing, the availability of "informal" caregivers – family, friends, relatives and neighbors – in the region is projected to decline. Today, nearly 7 million people across the country and 2.2 million in New York State provide care to persons age 65 and older who need assistance with day-to-day activities – and 61% of these caregivers are women.[2] Informal caregivers provide at least 80% of community-based long-term care, which reduces public spending for support and services.[3]

Societal trends and demographics strongly influence the availability of informal caregivers. More women entering the work force, families having fewer children, and the needs for dual responsibility to care for aging parents and children will contribute to the stress of caregivers. Due to demographics, the informal caregiver ratio in this region is expected to decline from 6.6 caregivers to 1 older adult in 2007, to 5.6 caregivers to 1 older adult in 2025 – an overall decline of 15.2%.

3) Financial Instability

Health care costs represented about 16.2% of the Gross Domestic Product in 2008, and health care costs are expected to grow to more than 20% of the GDP by 2018.[4] The Finger Lakes region's aging services costs (including Medicaid costs of skilled nursing facility care and county-designated funds) amounted to more than $494 million in 2007. With no changes to current programs, these costs are expected to grow by more than $90 million, a more than 18% cost increase by the year 2025. When housing costs are taken into account, the increase approaches $110 million.

Service	2007	2025 Projection	Total Spending Increase
Medicaid Skilled Nursing Facility Care	$373,031,000	$416,013,000	$42,982,000
County-funded Aging Services	$121,336,000	$168,525,000	$47,189,000
Sub-total MA	$494,367,000	$584,538,000	$90,171,000 18.24%
Unlicensed Housing	$144,438,999	$163,889,000	$19,450,001
Total	**$638,805,999**	**$748,427,000**	**$109,621,001 17.16%**

4) Workforce Shortage

Following the national trend, the Finger Lakes area also will experience shortages in clinical professionals, geriatric-trained staff and other staff available to provide direct care for older adults.

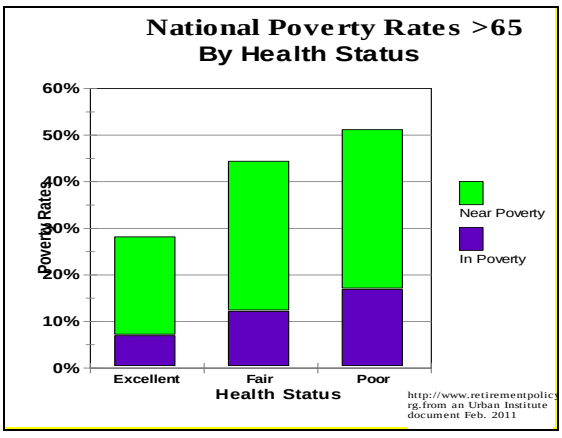
"We face an impending crisis as the growing number of older patients, who are living longer with more complex needs, increasingly outpaces the number of health care providers with the knowledge and skills to care for them capably."
– John W. Rowe, professor of health policy and management, Mailman School of Public Health, Columbia University

Physician supply is at great risk during the next decade due to expected retirement and aging, with nearly 20% of primary care physicians age 60 and older.[5] There are region-wide and ongoing concerns about the ability of providers to recruit and retain nurses' aides, a concern which will be exacerbated by growth in demand for home- and community-based services. In addition, a high proportion of health care workers who live in rural areas actually work in urban centers, making it harder for rural health care providers to staff their services.[6] Between workforce aging and migration, in many counties outside Monroe, nursing supply is projected to peak around 2015 and then decline,[7] although increasing numbers of nursing graduates may change that projection.

Disparities Among Elders

During its second year of work, the Sage Commission also focused on disparities in health care – the differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.[8]

Health status and health-care utilization data reveal that disproportionate burdens of chronic illnesses and premature death affect elders in the region who are poor, black or Hispanic, or who live in rural counties, particularly those living in the Southern Tier counties of the Finger Lakes region. Regional data show that being poor or near poor puts an elder at higher risk of having poor health status.[9] According to age-adjusted mortality rates in the region, black non-Hispanic elders have higher death rates for heart disease, stroke, diabetes, hypertension, and end-stage renal disease (*see Appendix for the full synopsis of disparities research*).



Key Tenets: A Person-Centered, Cost-Neutral (or Better) System

In addition to addressing the challenges facing older adult health services, the Sage Commission's primary goal is to develop a person-centered system that accommodates older adults' preferences to: 1) live in the least-restrictive, most-integrated settings; 2) delay institutional care and remain in the community for as long as possible; and 3) transition into institutional care when necessary. A secondary goal of the Sage Commission is to rebalance the system, to ensure that it is at least cost-neutral or better.

According to the Naturally Occurring Retirement Community (NORC) Aging in Place Initiative, nearly 75% of all Americans age 50 and older want to remain in their homes for as long as possible, and this desire increases with age.[10]

The Sage Commission's goal adheres to the philosophy of the federal Omnibus Reconciliation Act of 1987 (OBRA-87) and the 1999 Olmstead v. L.C. court decision.

Nearly 75% of all Americans age 50 and older want to remain in their homes for as long as possible.

- NORC Aging in Place Initiative

- Under OBRA-87, both an older adult's quality of life and quality of care must be considered when planning for long-term care.[11]
- In its landmark Olmstead decision (Olmstead v. L.C. 527 U.S. 581 (1999), the U.S. Supreme Court stated that persons with disabilities must be provided care "in the most integrated setting possible."[12]

In order to address the first three tenets adequately, the Commission identified two additional tenets:

4) Throughout the planning process, the Sage Commission will be mindful of addressing the unique challenges posed by meeting the needs of those who live in rural communities.

5) In cases of under-utilization of existing services, assess the reasons for under-utilization and build on current programs where efficacy has been demonstrated.

Vision and Values

During a daylong summit, Sage Commission members developed the following vision and values statement that laid the foundation for its work:

Older adults in the Finger Lakes Region are recognized as living healthier and longer lives with access to a full continuum of health and health related services. These services are culturally and geographically sensitive, person-directed, and family centered. The service systems make efficient use of the workforce and are financially sustainable.

The Sage Commission is committed to promoting cost effective, affordable, accessible quality health and aging services in the region. As such, it is vital that we meet both the challenges and opportunities of serving our region's elders through these values:

1. *The clinical care and operational delivery systems will be person-centered and dedicated to achieve optimal health status and health service delivery*.
2. *The regional health and aging services provided will be rational and financially sustainable*.
3. *Aging services will be provided in coordinated continuums of care that create integrated, seamless, and cost-effective care experiences for the patient and their support communities*.
4. *All services and programs will be designed to maximize independence, personal preferences and dignity*.
5. *Superior clinical and consumer satisfaction will be provided that focuses on quality and safety*.
6. *All information will be understandable for older adults, allowing them to be more accountable for their health and well-being*.
7. *A spirit of partnership will be fostered among older adults and their informal caregivers, who will be champions and advocates for the variety of needs of the diverse older adults living and working in the region*.
8. *The performance of aging services providers will be transparent and a system of care management and support will be available to enable older adults to select providers that best meet their preferences*.

Objectives / Recommendations

To achieve a person-centered health-care system, the Sage Commission's recommendations focus on five key areas: aging services and system design, informal caregiving, housing, workforce, and transportation. During the first year of planning, individual work groups developed strategies to address these specific areas of older adult services and quality of life. Within these work groups, issues of focus ranged from home- and community-based services, to skilled nursing facility capacity, access to care, payment reform, and technology. In the Commission's second year, work groups prioritized recommendations and demonstrated progress on at least one of their recommendations.

The Sage Commission's overall objectives and recommendations are as follows:

Objective #1: Increase the array of home and community-based services, so older adults can receive care in the least-restrictive setting.

As noted previously, older adults consistently express their preference to "age in place" and remain in their own homes. Based solely on the projected growth of the 65 and older population, home care need is projected to increase by approximately 20%[13]

While the Sage Commission grappled with ways to promote health and wellness so individuals can remain as healthy and, therefore, as independent as possible, the need for services increases as people age. Remaining in one's own home is not always possible. It requires

appropriate housing, a full array of services, and a way to pay for those services.

In developing recommendations to achieve this objective, the Sage Commission examined the current housing options, home- and community-based services, regulatory constraints, and delivery methods used by other states. The Commission also considered the Olmstead Supreme Court decision (which, as mentioned previously, mandates states to provide care in the least-restrictive setting and end unnecessary institutionalization).

Objective #1 Recommendations	Sage Commission Projections
Incrementally expand the capacity of home-and community-based services. *Rationale: Home care provides the opportunity to receive needed skilled and personal services that would otherwise require institutional care.*	• Home health services are expected to increase as follows by 2025: Medicare visits by 65,000; state and county-funded home health visits by 1,041,000; and personal care aide and other home health funded services by 785,000. • Compared to 2007, Medicare visits are expected to increase by 28.9%; state and county funded home care by 92.4%; county funded PCA and other services by 30.6%, by 2015. *(See Proposed Delivery Model for details)*
Incrementally expand the capacity of adult day health care. *Rationale: Adult day health care allows people to receive services that are comparable to a nursing home and then return to their own home. These programs provide socialization and a needed break for both the primary caregiver and the person being cared for.*	• Adult day health care expected to increase from 461 slots to 683 (48.2%) by 2015, to 817 slots (77.2%) by 2020, and to 961 slots (108.5%) by 2025. *(See Proposed Delivery Model for details)*
Incrementally expand hospice capacity. *Rationale: The percentage of seniors electing hospice care and the average duration of services are expected to increase due to the aging of the population, increased patient education, and regulation changes requiring primary care providers to advise patients of advance care planning's importance.*	• The region needs to expand hospice capacity for seniors by 22.6% to account for the increase in the senior census and double the number of patient days provided for seniors. • The population is expected to increase its use of hospice by 1% a year, and the length of stay is expected to increase from 48.5 days to 56.1 days by 2015. *(See Hospice Plan in Appendix)*

Objective #2: Promote expansion of housing options to ensure safe, accessible, and affordable housing is available to older adults.

Appropriate housing with access to needed services plays a critical role in the lives of older adults. However, high housing costs, especially for renters, remain a financial burden for many older persons, and low- income renters and persons living in rural areas face limited housing options.

Federal housing programs, such as Section 202 public housing and Section 8 housing certificates, address the basic housing problems of only about one-third of eligible older persons because of limited federal budgets. Moreover, a shortage of viable residential options exists for frail older persons. It is possible for frail older persons to live in a variety of existing residential settings, including their own homes and apartments with the addition of services and home modifications. The last decade has seen a number of efforts to create additional service options by modifying homes and adding services.

The Sage Commission also reviewed New York State regulatory requirements and low reimbursement rates for assisted living and found that few providers are financially able to offer this service to low-income older adults. As a result, people with low income/assets and low-acuity needs often end up living in nursing homes (which Medicaid will pay for) instead of assisted living.

Objective #2 Recommendations	**Progress to Date (Housing Work Group)**	**Next Steps**
Promote the incremental expansion of licensed housing options for older adults by 907 units (22.8%) by 2015; by 1,103 units (27.7%) by 2020, and by 1,479 units (37.2%) by 2025.	• Reviewed Connecticut's Assisted Living Services Agency (ALSA) model (*see Appendix).* • Discovered that an advantage to Connecticut approach is that ALSA agencies can take this level of care to people who already live in congregate residential environments without the need for new capital (e.g. utilize existing senior apartment buildings, assistive living buildings, convert nursing-home wings). • Discussed the model with an ALSA program director in Connecticut and learned that it took two years to get agreement on legislative language to enable the program.	• Create pilot legislation based on Connecticut model. • Seek Senate and Assembly bill sponsors and Governor's support.
Promote the expansion of Naturally Occurring Retirement Communities (NORCs). *Rationale: NORC Supportive Services Programs (SSPs) may include case management, health care management and prevention activities, recreational activities, transportation, and volunteer opportunities for older residents.*	• Met with 2 NORC directors in the Finger Lakes region (Eldersource and Jewish Family Services). • Determined there is interest from an inner-city housing provider to Latinos (Ibero American Development Corporation), a suburban health system (Unity Health System), and a rural county (Steuben County Office on Aging) to develop NORCs. • Determined that NORCS are an important program, but there are regulatory aspects that undermine their continued existence and expansion in Upstate New York.	Convene parties interested in sustaining and expanding NORCs to: • Identify needed legal/regulatory changes. • Explore a local NORC business model to serve inner-city ethnic groups, suburban, and rural populations. Contact the New York Association of Homes and Services for the Aging (NYAHSA) and Area Agencies on Aging (AAA) for support in advocating for regulatory changes.

Objective #2 Recommendations	Progress to Date (Housing Work Group)	Next Steps
Promote the incremental expansion of un-licensed housing options for older adults by 4,967 units (28.4%) by 2015 and by 5,583 units (31.9%) by 2020; for a total increase of 7,127 units (40.7%) by 2025. (Note: Of these, 1,756 (24.6%) should be market-based and 5,373 (75.4%) should be subsidized housing)	• Identified barriers to developing rural-community housing, including capital availability and federal regulations requiring elevators regardless of structure size (don't account for the need for smaller, one story projects in rural areas or office space for case managers to assist residents) • Expanded work group membership to include major housing developers to gain expertise on private/public partnership opportunities. • The Steuben Senior Services Fund hosted a conference on universal design.	• Continue to utilize a group focused on elders' housing issues (FLHSA). • With community input, identify greatest need areas for additional subsidized housing. • Identify additional barriers to subsidized housing expansion. • Propose strategies for developing additional low-income housing in need areas. • Recommend necessary regulatory changes to encourage accessible, subsidized housing in the greatest need areas.

Notes:

- Licensed housing - Adult Care Facilities, Enriched Housing Units and Licensed Assisted Living Programs - provide room and board and supervision, as well as help with personal care. They do not provide services of licensed health care professionals, unless those services are provided under a care plan from a licensed provider.
- NORCs, authorized by New York State, differ from purpose-built housing for elders in that they were not designed with the provision of services to older persons in mind. As a result, seniors and community providers in some NORCs have sought opportunities to make recreational, health, and social services more widely available to older residents. Partnerships between providers and with housing managers have resulted in alternative models of health and social services delivery through NORC supportive services programs (SSPs) that meet both the needs and preferences of the older residents.

Objective #3: Reduce skilled nursing capacity.

The Sage Commission reviewed national and state data regarding nursing home bed numbers and compared that information to the licensed bed numbers in the Finger Lakes region. At the present time, this region has an excess dependence on nursing home care:

- The Finger Lakes region has slightly more than 50 beds per 1,000 people 65 and over.
- State and national averages are approximately 40 nursing home beds per 1,000 people 65 and over.
    - Oregon, the state with the current national best practice, has 17.4 beds per 1,000 people 65 and over.

The Commission reviewed in detail the State Department of Health 709.3 recommendations to reduce the number of nursing home beds in the region by 2016 (*attached in Appendix*) and

analyzed the financial viability of the current system. In the region, approximately 5%-6% of elders reside in nursing homes at any given time. Additionally, 75% of long-term Medicaid expenditures in this region go to institutional care.[14]

To meet the requirement to ensure people have opportunities for care in the most integrated and least-restrictive setting, the expectation is that 50% of the Medicaid long term care resources will be used for community-based care.

Despite steady increases in the older adult population over the last several decades, nursing home occupancy rates have actually decreased.[15] People are choosing alternative options first and staying in nursing homes for shorter periods.

The Sage Commission calls for rebalancing services for seniors by incrementally reducing the number of skilled nursing facilities by 636 beds by 2015, by 1,367 beds by 2020, and by 2,002 beds by 2025. These reductions in the nursing home bed numbers can *only* be achieved if housing and home- and community-based services resources are expanded as well. Any reduction in nursing home beds without additional housing, assisted living and home and community-based service options, could put elders at risk.

Objective #3 Recommendations	**Progress to Date**	**Next Steps**
Develop need estimates.	• Utilized modeling software to produce stated need estimates during the summer and fall of 2009 (*see Appendix for additional information*).	
Monitor increases in housing and home and community-based services.		• Conduct an annual assessment of housing, community-based service capacity, and SNF changes. • Adjust SNF need estimates if increases are not happening as expected.
Establish dedicated behavioral health units in nursing home facilities.	• In 2009, Excellus BlueCross BlueShield published a report, "Neurobehavioral Step Down Unit Program Proposal: The Community Need for a Centralized Neurobehavioral Step Down Unit." This report indentified the need for a specialized unit and program for older adults who require behavioral interventions and a treatment plan as well as long term care services (*see Appendix*).	• Recommend to NYSDOH that a neurobehavioral program and step down unit be developed based on community need.

Work in collaboration with nursing home owners, administrators, and community stakeholders to develop strategies and incentives for facilities to voluntarily reduce the number of skilled nursing beds in the region.	Nursing home owners, administrators, and community stakeholders met and developed a set of principles for rightsizing skilled nursing capacity. They are as follows: 1. The Sage Commission's need estimates should be used in place of NYS DOH's 709.3 need methodology. 2. Where bed reductions are needed, voluntary reductions in capacity are preferable. 3. NYS is encouraged to use tools it has available including, but not limited to, HEAL grants; the ability to forgive gross receipts assessments, interest, and penalties; the amount of capital required for down payments; and access to state dormitory authority funding to create incentives for facilities to reduce SNF bed compliments. 4. NYS DOH Bureau of Long Term Care and the Division of Finance are encouraged to define and apply objective quality and financial criteria that can be applied to initiate proceedings to close facilities in counties with excess capacity in those cases where facilities have a history of providing poor quality care based on a combination of objective indicators including but not limited to: a. A history of substandard quality of care or immediate jeopardy b. A history of consistently low occupancy rates that adversely impacts financial performance c. A history of ineffective financial management 5. Neither FLHSA nor DOH staff should recommend any Certificate of Need (CON) projects for approval if the facility has a history of substandard quality of care and a history of ineffective financial management (see point 4 above). However, CONs might be recommended for approval of renovation or replacement of the building when the reasons cited for substandard care are issues associated with building obsolescence and not quality of patient care. 6. FLHSA should give priority consideration to nursing home renovation/replacement projects that: a. Propose more home-like environments. b. Assure care access for those Medicaid-dependent at the time of admission. c. Address the programmatic need to care for specialty populations identified in Alternate Care Reports or other studies that document the patient types that face barriers to admission. d. Propose to reduce the SNF bed complement (and aren't affected by point 4 above). e. Propose to develop community-based alternative services. f. Provide high-quality, patient-centered care in a cost-effective, least-restrictive environment. g. Use LEED-certified construction to reduce energy costs	• Use need estimates from the software model to guide CON reviews for nursing home capacity changes. • Use strategies to right-size nursing home capacities in conducting CON reviews. • Recommend NYS DOH use the proposed set of principles as part of rightsizing in the Finger Lakes region.

Objective #3 Recommendations	Progress to Date	Next Steps
	St. John's Home and the Presbyterian Home in Rochester are in various stages of developing Green House Assisted Living SNF and residences. Other organizations have developed facilities with Green House model attributes, including Fairport Baptist Home, Livingston County Center for Nursing and Rehabilitation, and the Cottages at Unity.	• FLHSA will monitor evaluations of Green House, and Green House-like facilities for patient satisfaction and financial feasibility.

Objective #4: Improve access to care.

The Sage Commission believes that decreasing the incidence of preventable chronic disease is the optimal way to address the human and financial costs of future health-care needs. In practical terms, this means providing "the right care at the right time," not just for disease but also for risks of disease.

When looking at advanced medical care, the wisdom of the "right care at the right time" is highlighted by the following statistics:

- From 1997-2005, people 65 and older accounted for more than 10,000 preventable hospital admissions in the Finger Lakes region.
- Analysis of local ED visits identified more than 14,000 potentially avoidable ED visits in the elder population that might have been treated in a primary care setting.

Equally important to understand is that 40% of health status is the result of health behaviors which – when modified prior to development of disease and disabilities – have a tremendous impact on disability and cost. "A 2007 Milken Institute study projected a 42% increase in chronic-disease cases and $4.2 trillion in treatment costs and lost economic output by 2023. However, the study concluded, with modest improvements in disease prevention and treatment, 40 million cases of chronic disease could be avoided."[16]

The Sage Commission supports focusing prevention efforts for elders on cardio-vascular diseases, dementias, diabetes, respiratory diseases and falls.

In developing recommendations to improve access to care, Sage Commissioners reviewed the United Way of Greater Rochester's "Blueprint for Change: Aging," which developed a strategies to prevent disease and premature disability and support caregivers. The Sage Commission supports community agencies collaborating on wellness, prevention, and caregiver-support programs, such as the multi-purpose aging resource center that resulted from the United Way's Blueprint for Change.

The Commission also reviewed a care model developed by Commission member Dr. Patricia Bomba, Vice President and Medical Director, Geriatrics, Excellus BlueCross BlueShield, with input from two other physicians on the Sage Commission (Dr. Steven Rich and Dr. Steve Ryan) and geriatricians from the community. This care model, endorsed by the Sage Commission, provides compassionate and supportive care for older adults of all health statuses, including health and wellness care, disease management, palliative care, and end-of-life care.

In this model, compassion, support and education are provided with a goal of maintaining and/or maximizing health and independence and improving functional health literacy for all older adults. Health and wellness care are introduced early. Chronic disease management is effectively integrated with mental health and behavioral health for all older adults along the health-illness continuum from wellness until the end of life. Particular attention is paid to care transitions to ensure coordinated care. Palliative care is accessible to anyone who is given a potentially life threatening or life altering diagnosis. The three key pillars of palliative care include advance care planning, pain and symptom management, and caregiver support focused on patient-centered care goals.

Older adults' access to services is often limited by their knowledge of services, availability of services most appropriate to meet their needs, available financial resources and insurance coverage. Yet, best practice is to provide a person-centered approach that integrates health care and social services, which will result in coordinated and monitored comprehensive care plans.[17]

Objective #4 Recommendations	Progress to Date	Next Steps

Promote wellness, and prevent disease and premature disability - particularly among high-risk populations.
 	
Rationale: With the aging population and expected increases in people living with chronic diseases, we must manage cost and decrease morbidity and premature mortality.
	• United Way of Greater Rochester, Monroe County Office for Aging, Lifespan, and the Maplewood YMCA developed a new senior center model providing wellness and best-practice services for seniors and their caregivers (the Caroline "Lily" Lobozzo Aging Resource Center opened Feb. 17, 2011).
	  ○ Services include "It's a Matter of Balance," a chronic disease, self-care management program.
	• Chemung, Steuben, Ontario, Wayne, Livingston, and Seneca counties are providing peer-led workshops based on the Chronic Disease Self-Management Program, a best-practice model developed by Stanford University for people with conditions such as diabetes, arthritis, high blood pressure, heart disease, chronic pain, and anxiety.
	• Yates County Office for Aging has initiated "It's a Matter of Balance."
	• Eldersource and the Jewish Family Services, with funding from United Way of Greater Rochester, have initiated a Program to Encourage Active Rewarding Lives for Seniors (PEARLS), a mental health program for seniors.
	• FLHSA and the Rochester Business Alliance launched an initiative to improve high blood pressure control.
	• The Greater Rochester Health Foundation has funded the following programs:
	  ○ Implementation of a patient medical home at Anthony L. Jordan Health Center to provide comprehensive primary care to adults at risk for diabetes.
	  ○ Eldersource as the lead agency (in cooperation with Lifespan, Catholic Family Center, Peer Place and the University of Rochester's Geriatric Psychiatry Program) for an evidence-based program to address depression in older adults.
	  ○ Rochester General Health System for a program targeting hypertension patients.
	  ○ Unity Health System to fully implement the Patient Centered Medical Home model and apply the Chronic Care model to focus on people with hypertension.
	• The Patient Centered Medical Home pilot is supported with Excellus BCBS and MVP funding. The project has multi-year funding, includes both providers in Ontario and Monroe County, and includes a range of primary care practices.
	Note: The projects above are examples of activities in the FLHSA region, not an exhaustive list of all that is being done.
		• Encourage best-practice programs to share results.
		• Continue to promote collaborative programs that provide best-practice wellness programs.
		• Focus primary prevention activities on smoking cessation, healthier eating, exercise; focus secondary prevention efforts on early identification and treatment; and focus tertiary prevention activities on timely access to the right care.
		• Develop strategies to begin dementia treatment at its earliest stages.
		• Develop strategies to address health disparities.
		• Support the work of the United Way of Greater Rochester as a model for urban communities.
		• Support the activities of the FLHSA-RBA High Blood Pressure Collaborative.
		• Identify opportunities to coordinate with the Greater Rochester Health Foundation to address programmatic needs identified in the Sage Commission plan.
		• Support expansion of advance care planning as a wellness/ prevention activity.

Objective #4 Recommendations	Progress to Date	Next Steps

Promote innovative models of primary care that provide compassionate and supportive care for older adults of all health statuses.
 	
Rationale: Helps achieve a more "person- centered" approach to elder care in which the patient and family have a voice in – and participate in – the development of a treatment plan that supports the patient's life and goals.
	• Three physicians on the Sage Commission developed a vision for an integrated model of health services and medical care to address patient needs through various stages of health.
	• Key elements include:
	  ○ Care is provided in the least-restrictive environment that is culturally sensitive and aligns with patient-centered goals for care, including financial goals.
	  ○ Focus is on providing the right care for the right person in the right location by the right provider at the right price; services are based on functional need and not age or diagnosis.
	  ○ Financial models allow flexible funding for needs-based care (e.g. preventive services, physician home visits, appropriate reimbursement for cognitive vs. procedural-based services) and is based on patient-choice.
	• Program of All Inclusive Care for the Elderly (PACE), a primary managed care model for people 55 or older at skilled-care level, has demonstrated its ability to maintain people in the community using an inter-disciplinary team model of flexible services focused on social day centers that help maintain wellness and minimize the use of hospital and emergency department care.
	• Long Term Home Health Care Programs have demonstrated that home- and community-based waivers provide community-based care as an alternative to nursing home placement, at costs at or below 75% of the average cost of nursing home care.	

Objective #4 Recommendations	Progress to Date	Next Steps
Partner with other groups to develop, implement models of simplified, better coordinated care between providers, caregivers, patients, and families. *Rationale: Services are currently fragmented across multiple providers and organizations.*	FLHSA's 2020 Performance Commission has set a community goal to decrease PQI admissions by 25% and decrease avoidable ED use by 15% by 2014. Their work is actively under way: • Worked with discharge planners from hospitals in six counties who have identified best-practice standards for discharge planning; focused on ensuring physician follow-up visits for high-risk patients within five days after discharge. • Developed an embedded care manager program for nine community physician practices. • Trained 15 coaches in the Coleman model to improve transitions of care. • The three certified home health agencies in Rochester have all had staff trained as Coleman coaches. • Lifetime Care Certified Home Health Agency has added a fifth "pillar" of advance-care directives for all its transition coaching. • The coaches have developed a learning collaborative that meets regularly. Livingston County has developed a care transitions program using EMTs that: • Identifies people at risk while transporting patients to the hospitals. • Seeks approval to refer the individual to a team of a community health nurse and social worker. • Makes follow-up contacts with the patient after discharge to assess the need for community services. • Coaches patients on how to use services to prevent re-hospitalization. The Jewish Senior Life Physician House Calls Program consists of experts in geriatrics and palliative care who are committed to providing patient-focused care, and can manage the complex needs of the aging, in the comfort of their own home. A pilot demonstration has been going on for more than five years, and the data demonstrate that this is a PCP model that keeps people out of costly medical settings and effectively transitions to hospice and end-of-life care.	• Continue the community work under the auspices of FLHSA's 2020 Performance Commission.

	The Department of Health has approved a Medical Orders for Life-Sustaining Treatment (MOLST) form and process, to help physicians and other health-care providers discuss and convey a patient's wishes regarding cardiopulmonary resuscitation and other life-sustaining treatment. MOLST is intended for patients with serious health conditions: who want to avoid or receive any or all life-sustaining treatment; who reside in a long-term care facility or require long-term care services; and who might die within the next year. • Excellus has spearheaded getting legislative approval and patient information about the importance of family conversations regarding patient wishes. • Trainings have been conducted from Rochester to Elmira. NY CONNECTS programs in eight counties are helping people understand service options, and helping them navigate through "siloed" programs, eligibility, payers, and paperwork necessary to connect people with services that address their needs thus helping to improve their functional health literacy. Chemung County has created the Community Partnership Program - consisting of a recently merged hospital, five long-term-care facilities, two home-care providers and a hospice – to construct a framework to improve coordination among the organizations. This work includes a reference guide of procedures for admissions, discharges, and transfer guidelines to not only these organizations, but also to adult homes, assisted living facilities, services for people with intellectual and developmental disabilities, Elmira Psychiatric Center, prison, and VA facilities.	

Objective #4 Recommendations	Progress to Date	Next Steps
Promote technologies that support innovations in care, enhance communication, provide timely access to care, and help assure continuity of care. *Rationale: Electronic access to health records, information and community support services allows timely communication between professionals involved with the individual, and a more comprehensive assessment of the patient's circumstances and health history.*	The Rochester Regional Health Information Organization (RHIO), which facilitates more timely communication of patient information, is operating in 11 counties in the Rochester and Finger Lakes region. • A number of major medical practices, health systems, hospitals, home care, and nursing home providers are linked to the RHIO. • As of March 2011, more than 200,000 people over age 65 have consented to have their information submitted to the RHIO. • Approximately 13.6% of the patients in Monroe County who are being taken care of by Rochester RHIO physicians are over the age of 65. • Peer Place, an electronic platform for communicating information from community-based agencies, now links to the RHIO. • eMOLST and the electronic registry for advance directives are examples of cutting-edge technologies. The Sage Commission's Technology work group developed a paper that articulates: • How technology can be used to support elders and their caregivers. • How technology can enhance communication. • How technology can improve productivity of the workforce, and patients' access to personnel. • The need to develop a local clearinghouse to help consumers and providers stay abreast of technology (*see Appendix*). Rochester General Health System has developed a geriatric telehealth consultation service demonstration for rural counties, and FLHSA is contracted to evaluate that program.	• Identify a clearinghouse for consumers and health providers with information on the availability, effective-ness of emerging technologies. • Encourage AAA and other major aging services providers to link to Peer Place (make providers aware of critical social-support information and community services patients are receiving if information is allowed to be shared). • Increase RHIO participation (the 2020 Performance Commission will leverage relationships with hospitals, physicians; to encourage links by nursing homes and certified home health agencies). • Continue support of eMOLST.
Improve functional health literacy among patients, family caregivers, and professionals.		

Objective #5: Propose changes to the current reimbursement and regulatory system to allow greater flexibility in paying for needs-based elder care at a cost that is sustainable.

The current health system for elders is financially unsustainable. New York State Medicaid pays almost twice what other states pay for long-term care services.[18] If the existing pattern of service delivery for elders in this region does not change, Medicaid spending for key services is expected to increase approximately 1% per year (18.4%) from 2007-2025.[19]

Many complicating factors influence the financing discussion. From a consumer's perspective:

- The funding source often defines the type and the amount of services they receive. There is an institutional bias in New York State, which limits the possibilities for less-restrictive and less-costly options for care for some people. Despite the amount of the Medicaid expenditures, there is inadequate flexibility to pay for services based on elders' needs.
- Frustration and confusion often arises due to multiple sources of funding, which generally operate independently and have varying ways of defining eligibility, scope of services, and the amount and duration of payments. In some cases, actions taken by payers to minimize exposure to costs result in patients receiving care in inappropriate sites.

From a provider's perspective:

- Medicaid rates often do not justly compensate providers for the cost of care.
- Retroactive adjustments and changes in reimbursement methods frustrate providers' abilities to do budget planning and service development.
- Payers (including but not limited to Medicaid and Medicare) do not pay enough for some essential services for older adults (including primary care physicians, geriatricians, home health care, nursing facility care), contributing to shortages of essential personnel.
- They frequently are expected to provide services that are reimbursed below cost.

No single source tracks all of the resources older adults receive from various organizations, so there is no mechanism to monitor total resource utilization, total costs, average costs by people with comparable needs, or average costs by providers for units of comparable services. Since there is no comprehensive monitoring of costs, there can be no easy analysis of inefficiencies.

As a result, the Sage Commission believes that payment reform must be a cornerstone in the redesign of elder care. Such reform, however, should not be isolated to issues that affect the elderly, but must be pursued across the reimbursement systems that affect the entire community to prevent fragmentation of efforts. Sage recommends that the community develop a payment system that would integrate existing resources from all current payers of health and health-related services. This goal is to pay for resources that span the breadth of patient needs and that are flexible to cover care in a timely way and at the most appropriate location. Such a system ideally would be operated by a local body that would define the benefit package and be held accountable for both patient outcomes and cost.

Objective #5 Recommendations	Progress to Date (Payment Reform Work Group)	Next Steps
Define the current payment policies that result in discordance between the way services are reimbursed and the desired Sage Commission vision of elder care.	• Reviewed the full Sage Commission's findings of situations where the current payment structure works against the commission's desired goals. • Presented a report to the Sage Commission that outlines the recommendations to be incorporated in a community payment reform effort; identifies the most urgent areas of payment reform to address. • Two overarching imperatives identified: 1. Resources are finite and the current way of paying for services is not sustainable. 2. There are major inefficiencies in the current siloed systems and constraints imposed by payers and regulations. Greater flexibility is needed to redistribute the existing money to allow resources to match persons' needs. • Recommendations: • The payment system should support care at the most cost effective site of care to meet patient needs. • Regulatory barriers to patient-centered care at the most cost-effective site (consistent with patient needs and choices) need to be eliminated. • Coordinated care management needs to become the standard for dual eligible patients. • There needs to be a standardized, electronic assessment tool with a corresponding standardized care-planning tool. • Patient incentives need to encourage individual responsibility. ○ The current system discourages individual responsibility for long term care expenses. ○ There is little or no advantage for individuals to save or have long term care insurance as public benefits provide the same services. ○ Current laws allow people to shield assets which promote wealth transfer to access public programs. • Increased patient involvement in decision making will help limit expenditures, thus freeing funds to broaden the population that can be served • The work group cautioned: there is the potential "woodwork effect" as people who previously went without services come into paid services; there are onetime costs of transitioning to a front-loaded wellness- and prevention-based payment focus.	• Establish a payment reform commission to build on this region's best practices, including but not limited to: Program of All Inclusive Care for the Elderly (PACE); long term home health care programs and other home- and community-based waiver programs for managing long-term home care needs; Evercare; the Community Coalition for Long Term Care demonstration project; and the capital cap and hospital reimbursement experiences of Rochester Area Hospitals Corporation and Finger Lakes Area Hospitals Corporation. • Incorporate the Sage Commission's recommendations into FLHSA's community payment reform effort.

Objective #5 Recommendations	Progress to Date (Payment Reform Work Group)	Next Steps
Address the regulatory burden in order to make the systems of health and health related services more cost effective and more flexible.	• Identified regulatory burdens and the examples of the need for regulatory relief (*see Appendix for details*). • Sent proposed regulatory changes to the NYS DOH Director of the Bureau of Long Term Care, for consideration by the Medicaid Redesign Team (at the Director's request).	Develop a Policy and Advocacy work group. • To identify strategies and potential partners to address priorities. • To review and prioritize suggested policy and regulatory changes.

Objective #6: Enhance support for family and other "informal" caregivers.

Informal caregivers are the backbone of the long-term care system, providing an estimated 80% of all community-based, long-term care[20] with an annual economic value of $25 billion in New York State. Without informal caregivers, the system simply could not afford to pay for all of the services that caregivers provide without charge, and the quality of life and the health status of many who need care would decline. Despite the caregivers' extraordinary contributions, caregiving takes a toll on them as individuals — economically, physically and mentally.

Economic toll:

- A 2006 MetLife Study found that caregivers cost businesses in the US $357 billion annually due to caregivers' responsibilities
- 37% of caregivers have quit their jobs or reduced work hours due to caregiving responsibilities[21]
- Caregivers are often challenged to find services offered outside of 9 a.m. to 5 p.m. during the workweek

Physical and emotional toll:[22]

- The longer a caregiver has been providing care, the more likely she or he is to report *fair* or *poor* health. Specifically, 23% of those who have been providing care for five years or more report their health is *fair* or *poor.*
- 17% of caregivers feel their health has gotten worse because of caregiving
- Those who have been providing care for five years or more are nearly twice as likely as shorter-term caregivers to report this decline in their health (24% vs. 14%)
- 73% of caregivers report having been diagnosed with high blood pressure[23]
- 90% of caregivers report emotional strain[24]

Profile and needs:

- According to the 2009 NYS Family Caregiver Council Report, one of the biggest issues caregivers face is that they are unaware of available services until faced with a crisis.
  - There is scarce funding for caregiver services
  - Care recipients often need extensive care or supervision.

- On average, they are 82 years old, and 79% of them have limitations performing three or more activities of daily living
- 77% of caregivers provide all or nearly all care to the care recipient
- Caregivers identified transportation, availability of staff, and resource limitations as major barriers

- The typical caregiver in the New York aging service network is a 64-year-old-female, who has either high school or some college education, and spends more than 40 hours a week providing care to her mother.[25]
- The majority (60%) of caregivers are older adults themselves. Their ages range from 32 to 94, with an average of 64, and 30% are aged 75 or older.[26]
- Caregivers report that the most prevalent reasons their care recipient needs care are old age, Alzheimer's or dementia, mental/emotional illness, cancer, heart disease, or stroke.[27]
- Caregivers are also critical in assisting with Instrumental Activities of Daily Living, including transportation (83%), housework (75%), grocery shopping (75%), meal preparation (65%), managing finances (64%), and arranging or supervising outside services (34%).[28]

Objective #6 Recommendations	**Progress to Date (Caregivers Work Group)**	**Next Steps**
Streamline access to information about community support through New York Connects and/or County Offices for the Aging.	Developed a "caregivers' toolkit" in partnership with the Alzheimer's Association and Monroe County Office for the Aging. • Toolkit is based[29] on the Alzheimer's Association Resource Guide platform; expanded to address caregiver needs. • Now available online at http://www.alz.org/rochesterny/documents/Caregiver_Resource_Guide_2011.pdf	• Invite region's Office for the Aging directors to include toolkit on their Web sites. • Request permission to include the OFA URLs in the toolkit to provide each county's most up-to-date resources. • Support continued state funding of NY Connects for reliable information on long-term care services.
Support consumer-directed care.	• Identified fact sheets that can be used to educate people who are hiring care (e.g., legal and tax problems that can arise when hiring, directing care themselves). • Identified the potential value of having a "backroom" service provider to coach consumers on how to advertise for, hire, direct, and supervise aides, and how to file taxes and insurance.	• Review and vet fact sheets and information. • Add information to the caregiver toolkit; distribute to POEs and Area Agencies on Aging. • Request a Center for Disability Rights presentation on the "backroom" services it provides; and explore possible expansion.

Objective #6 Recommendations	Progress to Date (Caregivers Work Group)	Next Steps
Create a list of non-medical resources available to patients and families during the discharge planning process. *Rationale: Knowledge of these services could potentially make patient discharge timelier, and provide in-home supports to prevent caregiver burnout.*	• Compiling the list of resources that families have found to be helpful after discharge. • Information being collected through such organizations as Eldersource, the Alzheimer's Association, physicians, care managers, and Offices for the Aging.	• Evaluate the list with area AAA and Point of Entry directors. • Finalize the list, add to caregivers' toolkit, and provide to the 2020 Performance Commission's Discharge Planning work group.

Objective #7: Enhance transportation services to help older adults maintain independence.
The lack of affordable non-emergency transportation services continues to be a significant issue for older adults, preventing access to adequate health care and affecting their quality of life. This reality has gained increased recognition as evidenced by:

- A strategic plan developed by the Genesee Transportation Council in 2004, "Access to Non-Emergency Medical Services," recommended an "increase in coordination and sharing of resources among not for profit agencies," as well as that the community "apply new technologies to improve efficiency" in routing and scheduling.
- The resolution adopted by the 2005 White House Conference on Aging, which stated that we must ensure that older adults have transportation options to retain their mobility and independence.
- A Monroe County Office for the Aging public hearing (2007) cited transportation as one of the top three issues facing the elderly.
- The recently completed "Coordinated Public Transit/Human Services Transportation Plan for the Genesee/Finger Lakes Region" that concluded there is a need to "support specialized transportation services and volunteer transportation services in areas where public transit is not sufficient or appropriate."[30]
- A national study under the auspices of the National Academies of Science Transportation Research Board, which concluded, "net healthcare benefits of increased access to medical care for the transportation-disadvantaged exceed the additional costs of transportation."[31]

Objective #7 Recommendations	Progress to Date (Transportation Work Group)	Next Steps
Create a regional transportation alliance to expand quality transportation services, make them more accessible, affordable, and share best practices.	• Developed a vision statement and an approach to create an alliance of mobility managers. • Achieved buy-in from 18 organizations, including representatives from eight of the nine counties in the region (Medical Motors, Genesee Transportation Council, Elmira-Chemung Transportation Council, Allegany/Western Steuben Rural Health Network, Catholic Family Center, CP Rochester, AARP, Rochester Genesee Regional Transportation Authority, Livingston County DSS, Lifespan, Steuben County Institute for Human Services, Inc., Monroe County Department of Human Services, ARC of Steuben, ARC of Yates, Monroe County DHS, ARC of Livingston, Ontario County Transit, and the Center for Disability Rights). • Participated in the planning of, and testified at, Rochester Genesee Regional Transportation Authority (RGRTA) hearings related to a mobility managers alliance, safe streets, mixed use zoning, and walkable communities. • Genesee Transportation Council issued its Long Range Transportation Plan for the Genesee Finger-Lakes Region 2035, which includes a recommendation to design and implement a mobility management program that coordinates existing and future services of public, not-for-profit, and private transportation providers to meet individual customer needs.	• Develop a business plan for a regional alliance of mobility managers. • Create a mechanism to develop the transportation alliance's policies, procedures. • Recommend an organizational sponsor. • Seek funding for a regional alliance.

Objective #7 Recommendations	Progress to Date (Transportation Work Group)	Next Steps
Locally promote "Livable Communities" and "Complete Streets" that encourage accessible home design, multiple transportation options, walkability assessments, appropriate signage, sidewalk maintenance, and traffic flow (taking into account older adults as drivers and pedestrians).	• Participated in AARP actions related to raising awareness about the importance of safe streets. • AARP assembled a list of communities that have walkability and safe streets audits for their region (*see Appendix*). • Sage disparities data demonstrate racial disparities in access to personal transportation across each of the subareas within the Finger Lakes region (*see Appendix*). • The Village of Pittsford in Monroe County has completed Complete Streets legislation, which AARP will help to promote as a model for other towns and villages. • An AARP consultant and AARP staff have introduced the AARP Universal Design project to the Rural Association of Mayors and Supervisors. Its objective is to create, within the building permit process, a requirement that home builders educate buyers about universal design concepts that could be incorporated into their homes. AARP staff have met with the towns in the southern tier and Monroe County and provided sample ordinances.	• Encourage stakeholder support of AARP livable communities' strategies. • Encourage stakeholder support of local transportation plans that address mixed use zoning, safe streets, and walkable communities. • Continue to support efforts of AARP, Center for Disability Rights, and Area Agencies on Aging to encourage localities to modify codes in support of universal design, complete streets, and walkable communities.
Encourage the expansion of volunteer-based programs and services.	• Best-practice volunteer transportation programs in this region have been developed by churches in the Rochester suburb of Irondequoit and by Steuben County. In Steuben County, the Institute for Human Services secured federal grant funding to re-energize the work of the Steuben Coordinated Transportation Committee, to bring volunteer, public and private transportation providers together to streamline access, increase ridership, and resolve gaps in service. • Lifespan coordinates a consortium of transportation providers to consolidate the volunteer recruitment and training efforts for Monroe County.	• Identify best-practice, volunteer-based transportation models. • Share these models with AAA directors and other appropriate parties. • Continue to support the collaborative work of the regional mobility managers to enhance the seamless interface of transportation networks.

Objective #8: Increase the workforce dedicated to geriatric health and aging services.

An effective service delivery system for older adults depends upon a well-prepared and adequately sized workforce. Many communities do not yet have the health and long-term care workforce in place to meet current — let alone future — demands. This situation is occurring precisely at a time when the population most reliant upon these systems, those aged 85 and over, is growing at an accelerated rate.[32]

"The lack of a well-trained, well-qualified workforce for long-term care—professional and paraprofessional—is a graver problem than financing and delivery problems."
– Robyn I. Stone, Dr.P.H., "Long-Term Care Workforce Shortages: Impact on Families"

New York also lacks enough people trained as geriatric specialists in health and human service disciplines to meet the needs of the growing cohort of older adults. In 1998, there were about 9,000 geriatricians nationally; today there are just 6,700.[33]

Furthermore, there remains a need for well-qualified paraprofessional and professional front-line workers, including home care workers, certified nursing assistants, personal care aides, and case managers, including individuals trained in geriatric care management.[34] Finding ways to recruit and retain frontline long-term care workers must be a priority. Major issues include pay and benefits, transportation costs, childcare resources, the work environment, training and preparation, career ladder opportunities, and "competition" from other employers, such as fast-food restaurants, malls, and the like.[35]

To address the need for aide level personnel, the Sage Commission recommends that first priority be given to creating an alliance of stakeholders to design, fund, and implement regional training centers that will adopt best practices for recruiting, training, and supporting aides. It is expected that these centers will seek waivers to allow them to prepare dually certified personnel (certified nursing assistants, home health aides); use technology to enable instructors to provide lessons to remote locations; and learn from best practices of agencies that have an outstanding record of filling staff positions and minimizing staff turnover, such as Heritage Christian Services.

To expand the potential pool of aides, to improve the respect aides receive from health professionals, and to expand the numbers of family caregivers who have been trained to provide care for loved ones, the Sage Commission suggests offering allied health professionals an opportunity to reduce their college debt.

- By enabling future health professionals to be trained and to work as aides in college.
- By considering aide work hours as part of work-study hours or by offering student loan forgiveness (using a federal demonstration of loan forgiveness modeled after physician shortage areas).

Objective #8 Recommendations	Progress to Date (Workforce Work Group)	Next Steps
Increase the number of trained aides.	• Expanded work group membership to include additional stakeholders with workforce expertise. • Interviewed leaders of large organizations that employ aide-level personnel. • Developed a series of strategies to: 1) expand the availability of aide related personnel; 2) reduce turnover; 3) improve recruitment, training, and support for the aides; 4) foster greater respect for aides as an essential, trusted partner in long-term care. • Finger Lakes Community College and Livingston County collaborated on a pilot project that can serve as a model. FLCC has obtained approval from the NYS Department of Education to grant dual certification to aide level personnel in nine counties. To date students from Livingston and Monroe have participated, and 95% of the graduates have been employed (cost per enrollee is approximately $2,500).	• Create a partnership of regional stakeholders to design, fund, and implement a regional training center for aide personnel. • Identify a lead agency or management mechanism for the training center. • Seek waivers or regulatory relief to permit single certification processes for aide-level personnel. • Utilize technology to enhance access to classroom training in rural counties.
Develop a pilot program to expand the potential pool of aides using loan forgiveness.	• Identified a model used in Elmira to recruit college students. The Student Certified Nurse Aide Employment Program is collaboration among the Chemung County Nursing Facility, St. Joseph's Hospital, Bethany Manor, GST-BOCES, Steuben County facilities and the Chemung Valley Rural Health Network. • Developed a concept that would include student-loan forgiveness for time worked as an aide while in college. • Presented this concept to the NYS Department of Labor's Assistant Administrator, who encouraged working with a community college to develop a pilot program.	• Design a prototype work-study program for medical schools, nursing schools, and allied fields where students are required to become certified as aide-level workers. • Identify a community college to serve as a lead organization to receive grant funding. • Develop an "aide shortage area" model to recruit students; submit the proposal to the NYS Department of Labor for funding.

Objective #8 Recommendations	Progress to Date (Workforce Work Group)	Next Steps
Enhance geriatric medical education to ensure: 1) a systemic approach to standardize curriculum for fellows; 2) require a rotation in geriatrics for medical students; and 3) develop a program for all physicians on practical approaches to caring for geriatric patients.	The Sage Commission is aware of numerous educational programs to address the needs of elders. Some examples include: • The Division of Geriatrics and Aging at the University of Rochester offers education, research and practice opportunities. • The Geriatric Medicine Fellowship, based at Monroe Community Hospital. • Enhanced training opportunities are provided by the Finger Lakes Geriatric Education Center, University of Rochester John A. Hartford Center of Excellence, the Rochester-Canandaigua VA Medical Center, and the Center for Healthy Aging. • The Division of Geriatrics and Aging provides a variety of educational offerings targeting medical students, residents and fellows as well as community-based health care professionals. • RIT and Rochester General Health System will open the Institute of Health Sciences and Technology in September 2011. The Institute will train future health-care professionals, while advancing technology-based research. • Nazareth College offers Rehabilitation and Wellness Clinics, including physical and occupational therapy; music and art therapy. • The Greater Rochester Collaborative MSW program is a public-private partnership between Nazareth College and the SUNY College at Brockport, which provides field placement and training opportunities in geriatric health and social service settings.	Sage Commission stakeholders will support geriatric education of the highest quality.

Proposed Delivery Model: Less Institutional Care without Higher Cost

Significant discussion and research went into developing a long-term vision that could be financially sustainable. The Sage Commission held monthly meetings and gathered community input from elders and providers during a one-day summit and from a web-based survey. The Sage Commission also coordinated its work with that of FLHSA's 2020 Performance Commission.

The result is an estimate of future demand for aging services to create a more balanced, person-centered approach to services. Estimates were created using an interactive, demand-modeling tool developed by the Commission's consultant from LarsonAllen, LLP. This tool was designed to simultaneously forecast needs for many of the major elements of the long term care system.

Below is the Sage Commission's proposed preferred scenario for a "rebalancing" of services, beds and/or units (the change in skilled nursing beds, housing units, home care visits or other units of service is listed in the final column).

Proposed Scenario: Needed Capacities, Finger Lakes Region					
Equipment	**As Is**	**Proposed Model**			
	2007	2015	2020	2025	
Skilled Nursing Facility (SNF) Beds	Occupied	Need	Need		Need/Surplus
Short Stay	979	1,080	1,136	1,206	227
Long Stay	7,824	7,288	6,538	5,880	-1,944
Total	8,803	8,368	7,674	7,086	-1,717
Licensed by Year	9,077	9,040	9,040	9,040	
Need/Surplus based on Licensed		-672	-1,366	-1,954	
Note: -1,954 represents the difference between beds expected to be licensed in that year; and -1,717 represents how beds were occupied with short- and long-stay patients in 2007.					
Licensed Housing Units (Adult Care Facilities and Assisted Living)	2007	2015	2020	2025	Need/Surplus
Market Rate	2,881	3,308	3,355	3,512	631
Affordable-Funded	926	997	1,009	1,030	104
Affordable-Unfunded	160	579	716	914	754
Unlicensed Housing Units	2007	2015	2020	2025	Need/Surplus
Market Rate	9,633	10,377	10,661	11,389	1,756
Affordable-Funded	7,867	7,867	7,867	7,867	0
Affordable-Unfunded		4,223	4,555	5,373	5,373
Home- and Community-Based Services (H&CBS)	2007	2015	2020	2025	Need/Surplus
Medicare Visits	225,000	247,000	268,000	290,000	65,000
State- and County-Funded Home Health Visits	541,000	972,000	1,264,000	1,582,000	1,041,000
Units of County-Funded PCA and other Services (including PCA, EISEP and transportation services)	2,558,000	2,786,000	3,014,000	3,343,000	785,000
Adult Day Health Care	2007	2015	2020	2025	Need/Surplus
Existing Slots	457	491	491	491	491
Need	462	688	825	973	973
Unmet Need	5	198	334	482	482
Note: Change in capacity represents increased slots at DeMay (19) and the Jewish Home (15).					

Following an analysis of the New York State Department of Health's 709.3 recommendation to reduce Skilled Nursing Facility (nursing home) beds by 1,186 beds by the year 2016, the Sage Commission suggests a more gradual approach to achieving the state's proposed reduction (a reduction of 599 beds by 2016).

Comparison: Sage Commission Proposed Need Estimates to NYS DOH Estimates

County	2015 Bed Capacity	2015 Need (Sage estimate)	Need/Surplus (Sage)	2016 Need (NYS)	Need/Surplus (NYS)	2025 (Sage estimate)	Need/Surplus (Sage)
Chemung	736	560	-176	551	-185	395	-341
Livingston	354	310	-44	475	121	313	-41
Monroe	5,473	5,067	-406	4,167	-1,306	4,060	-1,413
Ontario	623	720	97	533	-90	719	96
Schuyler	120	137	17	139	19	145	25
Seneca	280	199	-81	389	109	158	-122
Steuben	699	677	-22	691	-8	631	-68
Wayne	559	505	-54	635	76	480	-79
Yates	196	193	-3	208	12	185	-11
Total	**9,040**	**8,368**	**-672**	**7,788**	**-1,252**	**7,086**	**-1,954**

Note: There is a discrepancy between NYS DOH estimates for Ontario and Seneca counties because DOH estimates have recorded Seneca beds in Ontario because they are on Finger Lakes Health's license.

The Sage Commission's proposed delivery model provides a greater shift from institutional (nursing home) care to home- and community-based services, without resulting in higher total costs.

- In the "as is" scenario, total costs increase 17.2%; in the proposed model, total costs increase only 10.1%
- In the proposed model, the per capita cost increases 9.9%, about half the growth rate of the "as is" scenario (18.4%)

Cost Comparison: Proposed Model vs. "As Is"

	Medicaid spending on institutional care compared to home-and community-based services	**2025 Projection (per capita)**	**2025 Projection (total cost)**
2008	75% to 25%		
"As is" scenario (no changes to current system)	71% to 29%	$586 per capita	$748,427,000
Proposed model	**56% to 44%**	**$544 per capita**	**$703,006,000**

Key Assumptions

The proposed delivery model is based on several key assumptions:

1) The number of skilled nursing facility beds declines from 52 beds/1,000 (age 65+) to 30 beds/1000 (65+) by 2025. This decline will occur gradually over the 15 years.
2) The transfer rate from acute to skilled nursing care and home care will remain constant at 2008 levels.
3) The numbers of individuals living alone over age 85 who received informal caregiving support will grow by 25%.
4) The county and state support of community based service use rate and dollars will remain constant at 2007 levels.
5) Substituting home- and community-based services for clients who would otherwise have received SNF care results in Medicaid paying 20% less per day of services.
6) Any savings in the model are assumed to be used to provide care for more individuals.
7) Substitution of SNF days into other sites of care will occur as financing and eligibility change and needed alternatives are developed. This will result in admissions to SNF being delayed and/or avoided altogether.
8) The distribution of the savings from a reduction in the use of skilled nursing facilities are assumed to be spent 60% on subsidized housing and 40% on services.
9) The rate of poverty for older adults over age 65 will remain constant.

Limits of Analysis

1) The “as is model” is based on reallocation of people assuming no changes in the current use rate.
2) Payments of home- and community-based services will be limited to 80% of a person’s reimbursement for an equivalent level of nursing home care.
3) Cost analysis assumes the use of long-term home health care and assisted living to be limited to projected capacity needs shown in the model.
4) This is a study of the health needs of the 65 and older population in the Finger Lakes region. While the service-use rates of the under-65 population are included in the need projections, there has been no attempt in this report to adjust utilization of the under-65 population.

Below are expected changes in key metrics between 2007 and 2025:

Key Assumptions by County **(To achieve 30 SNF beds/1,000 age 65+ by 2025 and keep H&CBS dollars/beneficiary about the same – at county level)**					
County	**Beds per 1,000 Population 65+**		**Substitution Rate**	**H&CBS $ / Person**	
	2007	**2025**		**2007**	**2025**
Chemung	55	30	40%	$3,813	$3,888
Livingston	44	30	10%	$3,143	$3,225
Monroe	55	30	42.5%	$5,099	$5,157
Ontario	44	30	12.5%	$5,555	$5,677
Schuyler	40	30	5%	$7,176	$7,269
Seneca	54	30	32.5%	$3,737	$3,828
Steuben	45	30	20%	$2,510	$2,509
Wayne	47	30	25%	$4,305	$4,336
Yates	45	30	22.5%	$3,403	$3,542
Total	**52**	**30**	**37.5%**	**$4,690**	**$4,638**

The Sage Commission's proposed delivery model estimates an approximate 21.5% reduction in the use of skilled nursing beds to care for elders, with an associated increase in licensed and unlicensed housing units, home health, adult day care, and other community support services. This expected reduction will result in substantial changes in staffing needed. Generally, as more home and community-based services are required, the need for registered nurses (RN) and licensed practicing nurses (LPN) declines, and the need for nurse aides, home health aides (HHA) and personal care aides (PCA) increases. The proposed scenario results in the following staff need estimates:

Nursing Staffing Needs – Finger Lakes Region					
	2007	**2015**	**2020**	**2025**	**Add'l Staff**
RN/LPN	2,252	2,243	2,135	2,061	-191
Aides/HHA/PCA	9,412	11,136	11,547	12,264	2,852

Conclusion

The planning process and analysis completed by FLHSA's Sage Commission has been extensive and inclusive of a broad spectrum of professionals, caregivers, and elders. However, some issues considered but not incorporated into the planning process include:

- Changes that will result from the 2010 passage of the Patient Protection and Affordable Care Act and other health care reform legislation.
- New technology, procedures or pharmaceuticals that might significantly change the care for elders, such as breakthroughs in dementia prevention or management.
- Behavioral changes that reduce the incidence and severity of selected chronic diseases such as obesity, heart disease, etc.
- The long-term impact of the recent economic downturn on the elders' economic position and their ability to pay for services.
- The potential "woodwork effect" as people who previously went without services come into paid services; there are onetime costs of transitioning to a front-loaded, wellness- and prevention-based payment focus.

The Sage Commission recognizes that changes in regulation and administrative rules, new thinking and innovative services are required to achieve its vision. Implementation of this report will require additional discussion, engagement of the community, and the ongoing commitment of key stakeholders.

Commission members remain committed to collaborating with all stakeholders — including aging services providers, funding sources, the State Department of Health, and, most importantly, the region's older adults and caregivers — to assure this plan's success. In two years, the Sage Commission has created a comprehensive plan for a person-centered, health system for elders that provides them the right care (from primary care to end-of-life care), at the right time, and at the right place.

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