Mat-Su Regional Plan for Delivery of Senior Services

Prepared for a Collaboration of the Following Funders:

Alaska Mental Health Trust Authority

Denali Commission

Mat-Su Health Foundation

Rasmuson Foundation

United Way of Mat-Su

McDowell GROUP

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Executive Summary

The Alaska Mental Health Trust Authority, Denali Commission, Mat-Su Health Foundation (MSHF), Rasmuson Foundation and United Way of Mat-Su share a concern for the senior citizens of Alaska. The rate of population growth among the 65 and older demographic in Alaska is one of the highest in the nation. The increase in senior citizens is putting a strain on the senior services delivery system, particularly in Matanuska-Susitna Borough (Mat-Su). To better understand the needs of Mat-Su's senior population and to match those needs with an efficient and productive delivery system that can be implemented on a regional level, these organizations contracted with McDowell Group, in association with Health Dimensions Group (HDG), to prepare a regional plan for delivery of senior services in the Mat-Su. The funders offer this as one template for regional planning that can be used by the State and local communities to engage in proactive planning for their aging populations.

The study includes a demographic analysis of seniors in the Mat-Su and an assessment of senior services infrastructure, such as senior centers, senior housing, home and community-based services, senior transportation, and skilled nursing care. The team also conducted a demand analysis for senior services and analyzed the current gap in services and into the future. Taking all of these analyses into consideration, McDowell Group and HDG assessed regional plans and models found elsewhere in the United States for relevance to the Mat-Su condition. Four overarching regional strategies were developed for the Mat-Su and were analyzed for their financial feasibility.

Below is a summary of the key elements of the recommended regional strategies.

Challenges

Each of following challenges was considered in the development of a regional plan:

- **Lack of service coordination among providers**. There is a degree of perceived "territoriality" among providers but there are no specific "boundaries" with respect to service delivery. In effect, there is considerable duplication of service (and administration) in some areas. By way of contrast, there are areas in the borough that receive little to no service. The creation of a centralized resource to both provide information and refer seniors to service options will be essential in helping improve overall coordination of services.

- **The geography offers substantial challenges to service delivery.** The sheer distribution of seniors over a wide area is an omnipresent issue. Challenges imposed by distances, and the remote location of many communities with small concentrations of seniors impose considerable restrictions on the development of more services. Improved networking and communication among providers, the development of a chronic disease management model and the application of appropriate technology to support care monitoring will be critical in serving seniors throughout the Mat-Su effectively.

- **State governmental infrastructure is inefficient in identifying and qualifying seniors for service.** Alaska's current infrastructure to support and manage services for seniors needs to be improved. While Alaska directs more dollars to home and community based services than most states in the nation (51 percent of senior services funding vs. 25 percent nationally), external reviews of the state's long-term care system have identified fractured, fragmented and inefficient delivery of services.

- **Current service provisions are not sufficient to support future demand.** With the projected rate of senior growth in the Mat-Su and the increased need for services and programs accessed by seniors, program offerings and opportunities must grow or evolve to support increased demand. By 2030, total population for the borough will grow by 63.3 percent – a net increase of 53,354 persons. Senior population, including individuals age 65 and older, will expand at an even more dynamic rate. The age 65-to-74 cohort will more than double (159.2 percent), while the age 75 to 84 cohort will triple (247.0 percent). While this issue is not unique to the Mat-Su, the projected rate of senior population growth in the Mat-Su is roughly five times that of the nation as a whole.

Plan Management

Given the fragmented nature of current senior services in the Mat-Su, there is no dedicated, high-level organization available to lead, guide or champion a regional plan for senior service delivery. Thus, some method of plan management must be established as a foundational component.

The study group recommends a two-fold approach. First, overall responsibility for the evolution and daily management of the plan should be vested in a single individual or organization that can "own" and lead the process, coordinate community providers and participants, gain stakeholder participation, foster collaboration with the state and serve as a central voice for the process. Secondly, a senior service task force should be formed that encompasses participants from various organizations and providers in the Mat-Su. This task force should be mutually distinct from the current Coalition of Mat-Su Senior Centers (CMSSC) and should establish an appropriate scope to accomplish the recommended plan strategies, determine an appropriate meeting calendar, and elect officers.

Regional Plan Steps

The study team envisions a senior service plan for the Mat-Su evolving over the next two to three years and encompassing four primary steps:

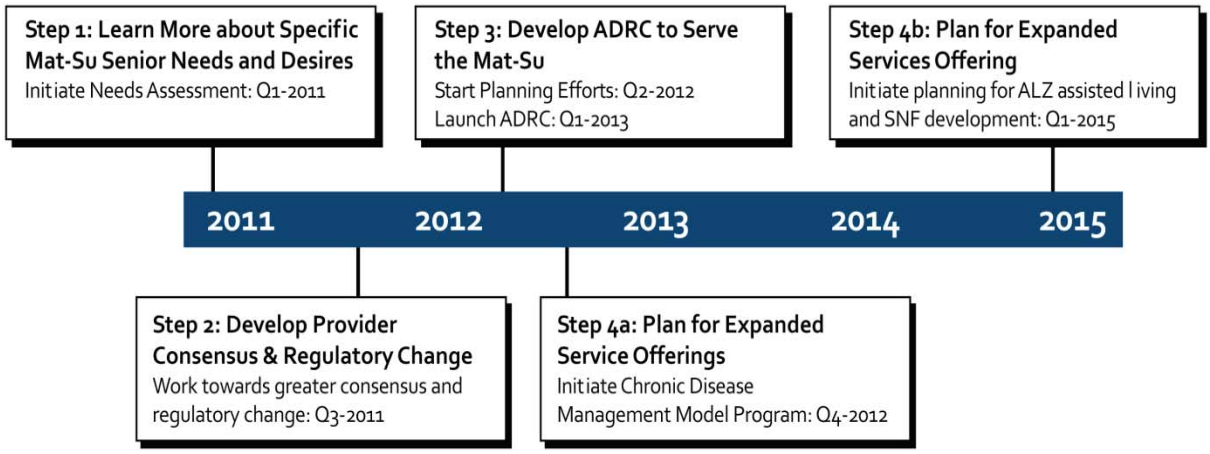
Step 1: Learn more about specific Mat-Su senior needs and desires

Step 2: Develop provider consensus about service areas and accomplish regulatory change

Step 3: Develop an Aging Disability and Resource Center (ADRC) to serve the Mat-Su

Step 4: Plan for expanded service offerings and new service development

Suggested Timeline For Mat-Su Regional Plan Next Steps, 2011 - 2015



Step 1: Learn More about Specific Mat-Su Senior Needs and Desires

To identify specific services, it will be critical to hear directly from consumers and seniors about their experiences in the Mat-Su area, opportunities for expansion or improvement of services, and general perceptions regarding living conditions, service availability, housing, transportation, and other areas.

Strategy 1a: Comprehensive Needs Assessment

A comprehensive needs assessment regarding senior care and services in the Mat-Su should be conducted. The needs assessment is foundational to the regional plan evolution and will provide both qualitative and quantitative information. The outcome of this assessment should serve to refine findings and issues identified by the regional plan and provide greater detail with respect to senior needs by location, age, gender, and other potential cross-tabulations.

The process should also both stimulate interest in senior services in the borough and provide "real world" senior experiences to help develop shared consensus and support a subsequent campaign for regulatory change at the state level.

Step 2: Develop Provider Consensus about Service Areas and Accomplish Regulatory Change

Step 2 will involve a sequential process that first requires shared consensus within the borough to, in turn, accomplish regulatory change.

Strategy 2a. Consensus about Service Areas

Providers, stakeholders, funders and the community at large must develop a shared consensus about how the coordination and delivery of senior services can be improved and what steps must be taken to achieve those improvements through better coordinated and consolidation at the local level. In addition, a collective effort must be set forth to help articulate and guide change at the state level. While establishing memoranda of understanding among the centers is an important first step, an inevitable future step may require or evolve into consolidation of all Mat-Su senior centers into one corporate entity with regional satellites or service sites in Palmer, Wasilla, Houston, and Talkeetna.

Strategy 2b. Regulatory Change

The goal of regulatory change will be to improve the overall quantity and quality of services delivered to seniors. To that end, three areas of action for change have been identified:

- **Create a distinct Mat-Su coverage area under the Alaska Department of Health and Social Services' senior service area assignments** – The Department's Coverage Area V currently encompasses the Mat-Su, Kenai Peninsula, and Valdez-Cordova. The state's current ADRC plan allows for one ADRC per administrative coverage area. Thus, the present regulatory structure precludes development of a new ADRC in the Mat-Su. Ungrouping Mat-Su from Region V is the first priority towards establishing an ADRC in the Mat-Su (*see Step 3*).

- **Secure an enhanced State commitment to evolve the ADRC model** – While some federal grant monies were secured to expand ADRC offerings for improved hospital coordination and Medicare beneficiary counseling, the state must dramatically increase ADRC funding to both achieve a fully-functioning model at the existing three sites and expand to other areas of need in Alaska. These efforts will likely require legislative support and planning efforts for FY2013 and should begin in late 2011.

- **Revise the State's Medicaid requirements to support individuals with Alzheimer's Disease and Related Disorders (ADRD)** – At present, participants in the Older Alaskans state waiver program must meet a requirement for nursing home level of care to qualify for Medicaid support. Most individuals who have been diagnosed with ADRD do not meet or require this level of care, and as such, they do not qualify for this support. This magnifies an already challenging issue, which is lack of service statewide (and in the Mat-Su) to manage people with ADRD. The state's current Medicaid plan can be revised to accomplish this change, which could result in increased Medicaid matching funds for the state. This change would benefit the development of an assisted living facility in the Mat-Su to support those patients with Alzheimer's disease, dementia and cognitive impairment. Absent some sort of change, current challenges with this population will persist and the state will face an increasing challenge to serve individuals with ADRD.

Beyond these three specifics, the study team also recommends that senior service stakeholders in the Mat-Su consider efforts in the following four areas:

- Support the consolidation of payment mechanisms in Division of Senior and Disability Services (DSDS) into a unified payment structure. At present, the DSDS manages 10 different funding authorities for long-term care services. This lack of integration requires that DSDS manage each program as a separate effort and creates a maze for consumers to navigate.
- Encourage the Division of Senior and Disability Services to seek more federal grant dollars through participation in new programs resulting from the Patient Protection and Affordable Care Act, including increased appropriations for ADRCs, service delivery models to be tested under the Center for Medicare and Medicaid Innovation, the Independence at Home demonstration program and grants for the creation of community health teams to develop medical homes by increasing access to comprehensive, community-based coordinated care.
- Create a financial incentive at either the state or borough level to support development of long-term care/skilled nursing facility in the Mat-Su. An incentive might take the form of tax-increment financing, property tax rebates or labor incentives for a developing organization.
- Revise the state funding formula for senior services accordingly to reflect population growth in the Mat-Su. At present, the Mat-Su is grouped with Kenai and Valdez Cordova as an administrative region with the DSDS. The state's funding formula for Older Americans Act Title III dollars is based on a series of factors, including the total number of seniors age 60+ in a given area, seniors age 80+, minority population 60+, 65+ seniors in poverty, and the number of rural seniors age 60+. Of these factors, poverty and rural account for half of the total formula. While Mat-Su accounts for only 49 percent of the total age 60+ senior population in the Area V administrative region, 58 percent of the rural component is vested in the Mat-Su. As such, the formula skews additional dollars for the region overall because of Mat-Su's rural contribution. Revisions to the state formula should reflect the Mat-Su as its own region.

Step 3: Develop an Aging Disability and Resource Center (ADRC) to Serve the Mat-Su

The third step of the regional plan would be focused on improving the overall coordination of services provided to seniors in the borough by both tribal and non-tribal providers, and offer expanded information about services. These tasks would be accomplished through two primary strategies:

1. Development of a fully functional ADRC to serve aging and disabled clients in the Mat-Su.
2. Creation of an on-line, senior navigator resource tool.

Strategy 3a: ADRC

An ADRC is an evolving model of service coordination, sponsored by both the US Administration on Aging (AOA) and the Centers for Medicare and Medicaid Services (CMS). ADRCs serve as single points of entry into the long-term supports and services system for older adults and people with disabilities. The primary goals of a Mat-Su ADRC would be to simplify and streamline access to long-term living services and supports; assist consumers who are seeking services and making long-term living decisions; and increase awareness of and provide access to reliable information.

Other specific outcomes would include:

- Creation of "One Stop Shop" where consumers can access long-term living and related services.
- Development of a seamless system that would eventually include eligibility screening, counseling, a single application, quicker functional and financial eligibility determinations, and personalized referrals.
- Make available comprehensive and consumer friendly information on long-term living services and benefits so that consumers can make informed decisions.
- Identify and intervene with individuals at risk of entering an institution with the goal of providing them with information and counseling that will allow them to make informed choices about the long term supports they receive.
- Link consumers who are not eligible for waiver or Medicaid-supported home and community based services with other community resources or opportunities.

The ADRC financial analysis presented in this report assumes a range of different funding supports for a Mat-Su ADRC, including federal grant monies, Older Americans Act funds, Medicaid support, an Alaska self-funded initiative for ADRCs, a one-time legislative allocation for the Mat-Su, and potential third-party grant support.

Strategy 3b: Senior Navigator Program

As a concurrent development with the ADRC, a web-based "Senior Navigator" or similar program is recommended that offers a centralized, on-line information portal regarding aging and disability resources in the Mat-Su. This portal would be publicly accessible from any computer and offer a searchable database of information, including health and aging, financial concerns, legal questions, health facilities, assisted living and housing, exercise programs, support groups and more. Information would be usable for seniors, adult children, caregivers, and providers alike. An on-line portal would serve as an adjunct to "211" services currently deployed in Alaska.

Initial funding for development of the portal could be secured through third-party grant support or contributions from commercial insurance organizations and Alaska corporations.

Step 4: Plan for Expanded Service Offerings and New Service Development

The evolution of new and currently unavailable services to meet future need should be anticipated. The volume of home and community-based providers currently present may be sufficient to serve seniors in the five to seven year timeframe. Into the future, however, these organizations must inevitably expand their capacity. Given that they are already operating in the Mat-Su and will likely continue into the future, the study team focused its discussion to new service offerings:

1. Implementing a model for Chronic Disease Management (CDM)

2. Developing facility-based services for Alzheimer's or dementia care and/or a long-term care nursing facility.

Strategy 4a: Chronic Disease Management

CDM is focused on the senior, not the venue. Thus, it is not tied to a building and is not necessarily limited by geography. In this sense, it is ideal for the Mat-Su. (It is important to note that the study team considered the Program for All-Inclusive Care for the Elderly – PACE – as a potential model for Mat-Su but determined that it would not be feasible, given the limited number of qualified dual-eligible persons in the area and the transportation challenges imposed by the geography.) An alternative model (GRACE) was considered instead that is highly similar to the Nuka Model currently deployed and in use by the Southcentral Foundation.

A CDM program for the Mat-Su would be grounded in first identifying potential candidates who might benefit from the program. This will require the development of specific characteristics for participation and might include individuals living independently at home who are "at risk" for institutionalization of expanded care management services, or it might include patients already enrolled in some degree of home and community-based service.

An initial assessment process would identify both the social and medical needs of a potential program participant and serve as the springboard for the development of an individualized service plan. Those individuals requiring specific medical or primary care services could be enrolled in an enhanced clinically-based component that includes nurse practitioner support, which might offer in-home visits to support seniors with multiple medical issues, medications, or compliance with doctor's orders.

The interdisciplinary team would meet on a regular basis to monitor and review program participants, identify opportunities for improvement or revision and guide participant care appropriately. Non-invasive, electronic (wireless) monitoring technology could be integrated into the program, thereby enabling the monitoring of a client's daily living activities and detection of possible deviations in behavior.

Beyond the funding opportunity found in the Independence at Home Demonstration Program (set forth in Patient Protection and Affordable Care Act), primary care services, including the physician and nurse extender, are covered by a participant's Medicare Part B benefit. Funding to support the interdisciplinary team component and wireless monitoring option could be potentially secured from commercial insurance and/or managed care organizations. Preventative models of senior care that encourage senior independence and quality of life are also of particular interest to major gifting organizations.

Strategy 4b: Facility-Based Services

The study team projected two areas of greatest demand: Alzheimer's or dementia care in a secure setting and long-term skilled nursing care.

MEMORY CARE (ALZHEIMER'S) ASSISTED LIVING

Dementia-care assisted living is a highly specialized supportive living environment for individuals with cognitive impairment or Alzheimer's disease. Servicing seniors and other disabled adults with these disorders in the Mat-Su already presents significant challenges. Placement for individuals who require this service typically involves admission to mental health facility via an acute hospital emergency room admission. Hospitals are, in turn, additionally challenged to find an appropriate placement.

The determination of need/demand for memory-care assisted living is not only based on affordability/income levels but also by need as measured by age and physical capabilities. Financial analysis was performed for the potential development of a 32-unit memory care assisted living facility, located ideally in the core Palmer-Wasilla area.

Development of a memory-care assisted living involving a private development effort is anticipated.

LONG-TERM/SKILLED NURSING CARE

While the State of Alaska has been historically adverse to the development of institutional-based skilled nursing care, the sheer volume of seniors requiring some form of institutional long-term care in the Mat-Su in the future cannot be ignored. A local service option will be essential in supporting Mat-Su seniors and should lessen the impact to providers in Anchorage and elsewhere.

Development of a Mat-Su long-term/skilled nursing care facility will require compliance with the State of Alaska's certificate of need (CON) process. A review of recent CON approvals in Alaska indicates favorable outcomes for additional long-term care bed development across the state. It is important to note, however, that these approvals have been for small bed additions to existing operations. A new facility CON has not transpired for long-term/skilled nursing care in recent history.

The development of a long-term/skilled nursing care facility will likely involve a private development effort, most likely by a proprietary operator of such facilities. Despite national trends strongly favoring home and community-based services, nursing home development nationwide continues at a steady pace.

The study team performed a financial analysis regarding the potential development of a 76-bed long-term/skilled nursing care facility. As with a memory-care assisted living facility, a long-term/skilled nursing care development would be ideally situated in the core Palmer-Wasilla area.

Detailed financial analyses assumptions and findings for each of the regional plan steps are presented in the financial analysis section of the report.