

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILES 8672

2522 SCOMM 110: LONG TERM CARE TASK FORCE, 1998

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: Frances Purdy
Address: 3601 C. #260
Anchorage AK 99503

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.

Develop long term care ombudsman/advocate
for persons under 65 years of age who use or
need long term care services

Increase & consolidate advocacy/oversight and
ombudsman services (mental health advocate,
substance abuse services advocate, mental health
trust beneficiary complaint resolution, long term
care ombudsman, citizen's foster care review
Extend Medicaid to care services for Alzheimer's
care

Move assisted living home licensing out of Division of
Seniors and Division of Mental Health/Developmental
Disability to work with Nursing Home Licensing

Place stamp here.
The Post Office will
not deliver mail
without proper
postage.

Senator Gary Wilken, Co-chairman
Long-Term Care Task Force
State Capitol Building, Room 510
Juneau, AK 99801-1182

Thank you for participating in the review of Long-Term Care services.

Please fold on dotted line, tape the Comment Card closed and mail.

Certification of Hospice, Home Health - perhaps
moving this group out of Division of Medical
Assistance or leaving it there & just
consolidating the functions of licensing &
certification.

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Name: Pat Dooley
Address: 8011 Wistaria Street
Anchorage, Alaska 99502

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- projected future care demands and how to address the need;
- other issues relating to long-term care services.

- Identify gaps in services
(from senior point of view)
- partner with private sector
to provide services & "stretch"
dollars
- tailor services to the community
being served
- look at quality of life issues -
finding for Podiatry, glasses, hearing
aiders, glasses, respite care, mental
health services
- consider consolidated funding -
current process fragmented & confusing -

this fragmentation decreases access.

Fund senior centers and
mobile senior service vans or
programs - in a village for example
come 1x/month & podiatry, optometry,
audiologist, mental health services, education
& support groups, health screening such
as mammograms, PSA, immunizations

Fund multiple levels of dementia
care - Day care programs, respite care
support & education of caregivers

Regulation of all paid caregivers
Not just CNAs, but all PCTs, PCAs, NAs &

Please fold on dotted line, tape the Comment Card closed and mail. ^{care} coordinator

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Name: Sandy Murray
Address: PO Box 237
Seldovia AK, 99663

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- other issues relating to long-term care services.

- More qualified caregivers are needed. These are very special people.
- Make it available to all in need of it somehow.
- Fund with money from savings of phase out of longevity bonus. Also use these funds to fund insurance coverage for all Alaskans.
- Use preventive practice to hopefully decrease long term care clients.
- As Alaskans age more seniors will need long term care eventually
- need to plan ahead

The main thrust should be to keep Alaskans healthy longer thru preventing good mental attitudes, good nutrition, exercise and general well being. Education is important. Keep the minds and bodies alert & active. Good senior programs, funding and care givers are essential. Research into dementia and other illnesses. The money spent will pay off in the long term. I think.

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Name:

Sue Sanet

Address:

Providence Horizon House

4140 Father St A/A 99508 261-4140

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- other issues relating to long-term care services.

Review funding sources for assisted living - low-income via choice program have more access to assisted living.

Look at end of life services - not everyone can have hospice in home but don't need to be in an institution - nursing home/hospital sponsor hospice houses through public/private funding

Review how Balanced Budget Act is harming the fine home health services that are offered in Alaska

Review the four years the Medicaid waiver program has been in existence what's working - what's not -

What are the housing challenges for - chronic alcoholic, chronically mentally ill, middle & upper income elderly, middle age disabled who don't qualify for present senior housing funds

- Quality Assurance for all adult programs instead of reacting to complaints
Develop a 20 year Plan!! - Thank you

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Name: DANIEL K. KARMUN
Address: P.O. Box 819
NOME, AK 99762

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- other issues relating to long-term care services.

CONTINUED DELIBERATIONS FOR REMEDIES

PARTNERSHIP WITH FUNDING SOURCES

DELIBERATIONS ON FUTURE TO BE HEERED

KEEP ON TOP OF ISSUES

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Name: DON HOOVER
Address: 1029 Kodiak St. FAIRBANKS, AK 99709

Please provide your comments on:

- 1 • how to improve current long-term care services;
- 2 • possible funding options for long-term care;
- 3 • projected future care demands and how to address the need;
- other issues relating to long-term care services.

① Increased regulation standardization of nursing and assisted living facilities operation

② For those over age 60 - an automatic deduction from their Alaska State Dividend to help with their probable co-pay needs for Long Term Care insurance, or as seed money for coverage.

③ Promote general education on the rapid growth of senior needs + population. The older - the probable more need for long term care.

④ Make Alzheimer's eligible for Medicaid in Alaska

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Name: Anna Stull RN, Administrator
Address: Chugiak Assist. Living
22424th Birchwood Dr, Chugiak AK
99567

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Reduce the ratio of patient care givers - Quality
care cannot be given when c/was have
10-14 patients assigned to them & they
are responsible for their Total care during
their shift. More supervisory staff req.

I have no quick cure for funding. I
know the present costs are outrageous
and prohibitive. Many Conrad charges
10,000 monthly. Care costs & wages
do not reflect this amt.

One answer to future demands &
needs would be to encourage more
private LTC facilities & funding to maintain them

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Name: Judy Warren
Address: P.O. Box 164
Sterling, AK. 99672

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- other issues relating to long-term care services.

More \$ for disease research -
Put focus on prevention &
wellness through education
make Health Fair priorities -
especially in remote areas. -
Possibly a State HMO plan
to make insurance affordable -
Affordable Housing -

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Name: KATHERINE V Ferguson
Address: 1829 JACK ST
FAIRBANKS, AK 99709

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Do NOT Allow Seniors or anyone to become
impoverished to stay long time in LTC facility
in order to receive Medicare.

Funding - Find the means somehow from
STATE coffers - Permanent fund Dividends?

FUTURE CARE needs will increase -

Sometimes AKans need to go "outside"
to afford - try to prevent such from
happening -

Would be interested in what options
might be?

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Name: Peggy A. Burgin
Address: 1530 W. 11th Ave
Anchorage AK 99501

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Availability to all seniors.

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Name: CLIFFORD DARNELL

Address: P.O. Box 520955

Big Lake, AK 99652

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Keep long care services in
area that people already live in.
Put a cap on Dividend
at \$1,000 & designate part for
long term care, seniors, and
or Education on all levels.

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Name: _____

Address: _____

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- Change rate structure for
assisted living reimbursements.
- Fund capital costs for more homes,
then leverage of AHFC and other
monies. Provide more incentives
for Private Home.
- Don't rely on personal annuities from
a portion of the Perm Fund.
- Recognize that there is a role for the
State Govt. We have the financial
health in the State to make it more
possible for Seniors to continue to live
here.

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Name: Nenana Tortella Council on Aging
Address: PO Box 205
Nenana 99760

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- other issues relating to long-term care services.

Need more Care for
givers
More funding to
many Clinics

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Name: Beverli A. Thomas
Address: AHFC
PO Box 101020 99510-1020

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- other issues relating to long-term care services.

Recognize existing programs
and resources to include all
potential stakeholders.

State organizations are too
territorial.

SCOMM

110:4

LONG-TERM CARE TASK FORCE
November 17, 1998
10:00 a.m.

COMMITTEE CALENDAR

Work session

TAPE(S)

98-17, SIDE(S) A&B
98-18, SIDE A

NOTE:

The meeting was recorded and handwritten log notes were taken. A copy of the tape(s) and log notes may be obtained by contacting the House Records Office at 130 Seward Street, Suite 211, Juneau, Alaska 99801-1182, (907) 465-2214, and after adjournment of the second session of the Twentieth Alaska State Legislature, in the Legislative Reference Library.

Alaska State Legislature



Official Business

State Capitol
Juneau AK
99801 1182

Long-Term Care Task Force Meeting Via Teleconference

Tuesday, November 17, 1998

-
- 10:00 Welcome
 Review draft recommendations from the October 21 & 22 meeting
- 10:15 Overlooked Items
- Pioneer Home mission statement
 - Division of Senior Services missions & measures statements
 - Home Health Agency legislation and In-home & Community-based legislation (located in October 21-22 meeting packet)
 - Other items suggested by Task Force members
 -
 -
- 10:30 Follow-up Reports
- TRS/PERS Board action
 - Personal Care Attendant Summit
 - New York Life projections, if available
 - Other reports
- 11:00 Long-Term Care Insurance and Funding
- How do we want to address it?
- 11:30 LTC Task Force Final Report
- 1st draft available to Task Force members - 00/00/98
 - Public draft available - 00/00/98
 - Public hearing on draft - 00/00/98-99
 - Submit to legislature - 1/19/99
- 11:45 Adjournment
-



*Invitation
Only*

LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

SPONSOR: Long Term Care Task Force

SUBJECT: Work Session

START/END TIME: 10am DATE: 11-17

PLEASE PRINT

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	Bill No.
1.	Kay L Burrows	3601 C St Anch		269-3665			
2.	Maile K. Kline / Rep. Johnson			694-6683			
3.	Bill Palmer	600 3 rd St Unit - Fairbanks, AK	99701	452-7777		✓	
4.	BILL HERMAN	550 W 7 th #1820 Anch	99501	269-7962		✓	
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

11/17/98

LTCTF mtg

PAGE: 1

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
Bunde	004	Roll - see sheets Good morning
"	0023	Notion that first 2 weeks of Dec Draft for the committee + Public to take a look @.
	038	First item on agenda
Allison Elgee	041	Agree mission stmt that has been presented - - -
John Torjeson?	055	Mission stmt - - -
Kay Burrows	063	We have one change we'd like to make. add two words
Bunde	111	House Health Agency legislation
Elgee	120	We feel both bills are worthwhile - - -
Dennis Murray	162	3 bullet points @ - - - - (Ashna Rapt)

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
Bunde	201	I strongly support - - -
Gary	208	Thank Dennis for his referral
Joanna	215	Dennis I wonder if it would be appropriate
Bunde	230	Change empowers to encourage
"	238	one more comment from me - - -
Gary	300	Pull you back up to Sr missions and measures.
Bunde	344	Now, on the follow-up reports
Gary	400	Can we have what Allison just said to put in our report.
Bunde.	437	That brings us to the presentation from NYL
Bunde	456	Lets discuss - - - Kay?

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
Elmer Lindstrom	493	Mr Chairman, on a related subject --
John Sherwood	536	I want to bring up a point about --
Perdue	620	I was at the same mtg as Sen Steens -- Turntape over do not reset Counter
Maxine Coggins	648	A concern that I have related to this.
Shannon McCarthy Commerce	681	I have a question on the following bullet (request instead of require)
Walker ~~East~~ Fenton	696	if we could have a summary of where we've been and where we are
Cynthia Howard ~~Clara~~ Fenton	706	NYL Presentation -
"	720	An educational piece
"	728	3rd pg of Alaska offering
Joanna	757	So this is based solely on State Employees
Dennis	778	Am looking @ pg 8 of NYL info (Long term care policy should include)
John in Fbr	805	One thing. - - -

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
John in Fbx	813	encourage people to accept the NATC's acc's.
Allen	826	I don't think we are at a point where we could endorse a single product
Jennett ^{Page}	833	This is Jane Jennett The Commissioner on aging.
Marie Darling	876	All of a sudden we are seeing a great deal of interest from our Sr's - - -
Bunde	891	to summarize - - - John could I ask you to - - -
Bunde	947	Long term care insurance + funding has anybody come up w anything palatable
Wilken	004	We need some sort of Matrix in the report.
Allen Echee	019	Acknowledge what we have now - - -
John Sherwood Fbx.	034	I don't know who is going to work this up, but - - -
Bunde	129	It's 11:30 - we need to discuss LTCTF final report.

11/17/98
09:55:34

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
PARTICIPANT LIST (ALL PARTICIPANTS)
TCN:80962 SCHEDULED FOR:11/17/98 10:00 TO 12:00
WORK SESSION LONG TERM CARE TASK FORCE

LTN1150
BY:FBX
FOR:FBX

LOCATION:FAIRBANKS
LONG TERM CARE MS.
LONG TERM CARE SEN.

JOHN HANCHETT
GARY WILKEN

TESTIFY
TESTIFY

HOMER

JOYANNA GRESLER

11/17/98
10:15:42

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
PARTICIPANT LIST (ALL PARTICIPANTS)
TCN:80962 SCHEDULED FOR:11/17/98 10:00 TO 12:00
WORK SESSION LONG TERM CARE TASK FORCE

LTN1150
BY:JNU
FOR:JNU

LOCATION:JUNEAU

ALL ITEMS	LINDA	FINK	ASHNHA	OBSERVE
ALL ITEMS	LINDA	EGAN	NYL	OBSERVE
ALL ITEMS	JON	SHERWOOD	DMA	OBSERVE
ALL ITEMS	MARIE	DARLIN		OBSERVE
ALL ITEMS	ALISON	ELGEE	DOA	OBSERVE
ALL ITEMS	JANE	DEMMERT		OBSERVE
ALL ITEMS	ELMER	LINDSTROM	DHSS	OBSERVE
ALL ITEMS	COMM.	PERDUE		OBSERVE

SCOMM

110:5

LONG-TERM CARE TASK FORCE
January 6, 1999

COMMITTEE CALENDAR

Final Meeting

TAPE(S)

98-19, SIDES A&B
98-20, SIDE A

NOTE:

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LTC Task Force Mtg

1/6/99 Tape 1

PAGE: 1

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
GW	000	intro - review draft Before, intro to leg - introduced TF members
Allison	approx 45	concern about mission + measures - want to see them included in report
~~Brady~~ Tom Freeman	83	thanks for education reform - concern about state's retirement plan - concern about private pay costs
Emily DeVeaux	128	- '83-'95 pioneer home resident - concern about Arch Pioneer Home administrator (John Lowell) - ex of health concerns - attended adv meeting, but didn't get any response - appt a permanent cmte to study Pioneer Home
~~Elis~~ Katherine Ellis	175	- concerns about Pioneer Home - transfer of patients from API to Pioneer Home - empty rooms for mental patients
Lisa Ben		- expressed concerns re: Pioneer Home - gave example of abuse
Con Bunde	327	TF took prouder role than Pioneer Home - doesn't have power to appt a review board
Marty Bradley	370	- Care coordinator - CHOICE is working - Fully support recommendation #13 + 14 - want all support (Medicaid, Medicare, Veterans) coordinated
Sue Deadeam	424	- Wrangell - Bd of Nursing - standardized education of care givers
Kay Branch	454	Bristol Bay Native Assn #13 - HCBQ needs to be developed - esp rural area

missed TF discussion

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
		def of leg should be expanded to include Alzheimer
		#16 - will leg ^{be} intro to raise rate
		- supports Alzheimer under Medicaid - ^{wants to} highlighted
573 →		Dennis Murray - comment on rate study
Mary Ann Mills	584	June Senior Services
		#18 - make home delivery of meals + others
Second pg Side		more important
Leonard	0	- gave testimony on hchs leg +
Abel		proposed suggested changes
Alison Elgee	37	- LA's comments were agreed upon between Admin + HSS
L. Abel	51	responded to question from D. Murray
S. Larsen	90	talked about changes to proposed leg LS 0139
G. W + Con	183	- discuss - work with intro cmtc + make changes - include proposed changes into final report -
Marty Marchison	212	- leg should extend to institution
		- vulnerable adult leg
		- Pioneer home resident (father) -
		- wants a consumer protection unit for seniors
		- one activity a day - can't go to TV room - lack of staff
Charles McKe	301	re: pioneer home
??	??	
Rosemary Hagen	403	Catholic Cmty Services ex dir gave ex. of needs

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
Long Faye Lane	436	#2
		#5 assisted living - by level of care, not facility
		#16 - rate increase - most important for LTC
		one stop shopping is very important with 800 th
		delivered with longevity bonus
Theresa Lyons	540	explained how nurses interact with caregivers
		supported consumer protection unit su.
		quality indicator for nurse arrangement
Tape 2 - Side 1		
Theresa Lyons	0	CNA are trained very well
		- discussed role of a RN in Pioneer Home
		- the decision on who to hire depends on \$
		- confusion regarding AL. regs on requirement of a certified
		- the ed component of training must be tied to the financial end
Frances Purdy	045	- appoint a long-term cmte for LTC
		- want to see momentum continue
		- need to have an ombudsman for people under the age of 60
		- expand the #
Con Bunde	088	- LTC is a concern for all - AEA
John Handlett	91	- Pioneer Home problems? - progress
Frances Purdy	100	- responded to John
Dennis Murray	111	- case workers under adult protective services
	116	- Adult Protective Services are available, but busy
	122	Ombudsman has jurisdiction in institutions
B.W.	139	Admin + Leg continues effort as a formal recommendation - ~~Dennis Murray~~ extend or develop new one

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
Dennis Murray	150?	see prior pg
	167	
GW.	185	continue TF
Joyann	193	volunteered to draft rec. for ombudson ^{for} under 60 folks
Karen	194	wouldn't support recommendation
		- law disability; mental health folks
Con	208	- has been recommended ^{edit} + attach to report
Dolce. Nobe	219	- Alzheimer Assn
		- supports direction
		#14- dept of admin / h+s - tried to collect specific data - possibly
		LSO138- ~~pg~~ pg 3, line 12 - expand to include AD+RD
B. Jarvis	268	- takes a long time getting on to CHOICE
		- need to streamline accessing program
Laura Lamb	346	investigate elder - Adult Protective services
Bauman Margaret	366	PCA who she hired didn't work
		gave examples of poor help
GW	436	checking teleconf
Mary Weiss	445	sec. of Nursing Assn
		read ~~presidents~~ ^{co-chn of AL Nurses Assoc} - Judy Peterson response
		- only nurses should make the decisions ^{Professional Practice Committee}
		- consider other opinion
Ethel E.	515	explained history behind unlicensed assisted personal position paper
		- example of tying a Pioneer Home resident to chair

Tape 2
Side 2 - forgot to change counter

PAGE: 5

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
	614	nothing has changed at Pioneer Home
Linda Brown	617	addressed comments to Alison re: Pioneer Home
Alison	640	Good idea
	646	Linda gave address + e
Rick	660	Disability Law Center rep spoke in favor of #1 - national move from institution to community service - want to work with state
Charles	Dr. 680 (approx)	- volunteered to help - praised Frances Purdy
GLW	723	closing comment - include comments in draft
Con	732	- aware of high level of concern of pioneer home - should another body be created
John	740	- keep informed
Dennis	744	- adv bd should be involved
John	753	- the comfort level ^{with} ~~at~~ adv bd is questionable
GLW	760	#31 add - strongly worded letter } options
Alison	765	two sides of a story - will hold a public hearing before Feb 1 - concern about taking action based
Con	783	- constituents want to hear from govt - more communication - a better venue - to express

LTC Task Force
1/6/99

PAGE: 6

[illegible]



Alaska State Legislature

Long-Term Care Task Force

January 6, 1999 Meeting

NAME	MAILING ADDRESS (Please give full mailing address)			PHONE #	FAX #
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CoA Bea Shepard	12585 Glacier Hwy	Juneau	99801	789-7354	789-5231
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Dana Naugle	ACoA	" "	" "	465-4872	" "
Bill Sandhu	ACoA			465-4793	-4716
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David Price	DHSS / DAS / Facilities + Plan	Box 110650 Juneau, AK	99811-0650	465-3001	465-2499
Glenn B Anderson	3190 Foster Ave			586-1361	
Ritchie Sonner	Catholic Comm. Services / SE Senior Services			4103-6153	586-9018
Sandy Fleming	1617 Douglas Hwy.	Douglas, AK	99824	301-2319	

Please PRINT the above information. Thank you for participating in this task force meeting.



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2.	Patty Mandzoh	701 E Tudor Rd. Anchorage			NO
3.	Dee Craig	1416 Brickwood "	99508		"
4.	Mary Weiss	30 Box 221514	99522		yes
5.	Chris Kowalczewski	4420 Edinburgh Dr.	99515		NO
6.	Margaret Shannon	3310 Vassar Dr.	99508		NO
7.	Sarah Jane M. Keiser	1207 2nd St	99501		NO
8.	VR Kester	P.O. Box 253 Eagle River	99577		
9.	Patrick Cunningham	4770 Mills Drive	99508		NO
10.	Carolyn Tuohinen	5043 Mills Drive	99508	338-1573	
11.	MARVIE COGGINS	SEN. GREEN'S OFFICE			
12.	Virginia Carter	2260 Knoll Cir Anchorage	99501	277 1214	NO
13.	Shirley Anne Thrall	13643 Karen Circle	99515	345-8875	NO
14.	Robert E. M. M. M.	P.O. Box 20116	99521	670-2112	NO
15.	KEVIN CONRIGHT, M.D.	1942 BEAVER PLACE Anchorage	99514	333-9192	NO



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	Name/Representing	Address	Zip	Phone No.	Testify
1.	Finn Purdy OLTIC	3601 C #260 Anch ^{AK}	99503	563-6393	☒
2.	Jennifer Abbott / Alzheimer's Assoc.	240 E Tudor #110 AK	99503	561-3313	
3.	Della NOBRE / Alzheimer's Assoc.	240 E Tudor #110 AK	99503	561-3313	☒
4.	Barla Rathbun / SILC	1016 W. 6 th Ave Ste 205	99501-8968	269-3576	
5.	BILL HERMAN, AK Mental Health Trust	550 W 7 th Ave #1820 Anch	99501	269-7962	
6.	Kayla Burrows	3601 C Anch	99502	269-3666	
7.					
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B Juneau -



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2.	Lila Berry	3832 Apollo Drive Anch AK	99504	333-8148	NO
3.	Margaret Bauman	8100 Lamplighter Anch AK	99502	349-7917	Y
4.	Wendy Schade, M.D.	V. C. 1200 174th Lighter	99517	688-5530	NO
5.	Dr. Charles "CRUSH"				(yes)
6.					
7.					
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2.	CHARLES E. TRUSH M.D. - Self	610 MAYWOOD CIR. Anch.	99515	344-2084	
3.	LINDA Brown - (Elizabeth Warr)	2113 DUKE DR Anch	99508	276-2664	✓
4.	~~Redress~~				
5.					
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	Name/Representing	Address	Zip	Phone No.	Testify
1.	RICK Tessandore	615 E. 82ND #101	99518	344-1002	✓
2.					
3.					
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5 min time limit

LEGISLATIVE TELECONFERENCE N SIGN-IN SHEET

SPONSOR: Long Term Health Care Task Force

SUBJECT: Draft Report

START/END TIME: 1:30 DATE: 1-6

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	Name/Representing	Address	Zip	Phone No.	Testify
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2.	DARLENE FREEMAN	2211 TASHA DR ✓ 99532		344-1871	
3.	TOM FREEMAN	✓ ✓		✓	(X)
4.	RICK TESSANDORE	615 E. 92nd #101 99518		344-1002	(X)
5.	SUE MERRITT	2916 16th 99517		248-1280	
6.	Emily DuBois	9480 Morningside Sp. #202	99515	349-0315	(X)
7.	Kathryn Elmes ELMES	9480 Morningside Sp #305	99515	522-4774	(X)
8.	Lisa Wilson Bca B-U	2420 Cherokee Ave 99516	99516	345-0515	(X)
9.	Gayle Keller	Redesigns (idc)			
10.	ALBY LARSEN	4730 Business Bldg Suite 18	99503	561-8081	(X)
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12.	Dolly Swanson	3701 Eureka #48B	99503	562-1459	(X)
13.	Joe Spiller	9349 Center St. Juneau	99801	789-3780	
14.	Mary Magnuson	1401 West 13th Ave	99501	278-9275	(X)
15.	Charles E. McKee	P.O. #243053 Anch	99524	—	(X)

SCOMM

110:6

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

March 28, 1997

Honorable Gail Phillips, Speaker
Alaska State House of Representatives
State Capitol, Rm. 107
Juneau, AK 99801-1182

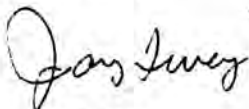
Dear Representative Phillips:

The Legislative Working Group on Long-Term Care that was established by Ch 84, SLA 96 has completed its work. A copy of the report has been delivered to the Governor's office as required.

Enclosed, please find additional copies for your use and review.

I hope you find this report useful and if we can be of any further assistance, please do not hesitate to contact me.

Sincerely,



Jay Livey
Deputy Commissioner

JL\bi

Enclosure

cc: Alaska State Representatives

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LEGISLATIVE WORKING GROUP
ON
LONG-TERM CARE



REPORT TO GOVERNOR TONY KNOWLES

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Executive Summary

CH84 SLA96 created the Legislative Working Group on Long Term Care to analyze issues relating to long term care and the certificate of need program. As mandated, this report describes the today's long term care system along with current and projected costs as well as projections for future long term care needs. It examines alternatives to nursing care and estimates the number of residents that could more appropriately be receiving home and community based care outside of nursing facilities. Finally, it recommends principles for guiding the development of the long term care system.

The long term care system in Alaska is heading for a crisis in its ability to provide services to a growing and increasingly aging population unless it can provide services in a more efficient manner. In 1996 Alaska spent \$120 million in long term care services to approximately 5,000 Alaskans. Approximately two thirds of these moneys, \$80 million, are State General Fund expenditures. Conservative assumptions about population and inflation would project costs for services at over \$215 million by the year 2015, moderate assumptions indicate a projection at \$545 million, and a robust projection would yield a demand for \$1 billion in 2015. It is, therefore, the conclusion of this report that this situation demands a shift from the current heavy reliance on costly institutional care to a more balanced, continuum of community based and home services.

The long term care system provides services to a broad range of individuals: children who suffer developmental disabilities, adults under the age of 65 with physical disabilities, and seniors age 65 and over. Individual needs range from assistance with routine activities of daily living to skilled nursing care. The expenses associated with meeting these needs can rapidly deplete even the most carefully planned financial resources of impacted individuals and their families. Public funding has been used to supplement personal resources to provide these services, primarily through Medicaid reimbursement for nursing home level of services and through grants to non-profit providers for assisted living services.

Population growth in Alaska, especially the rapid growth of the over 65 age group, has strained the existing capacity of the system throughout the state. Frequently, individuals needing long term care find themselves wait-listed for services, or go without until the need is so great that institutional care may be their only option.

Providing home and community based care is often a less costly and preferred option than providing institutional levels of care. Early intervention supports an individual in a home environment and fosters a less costly yet highly desirable level of independence for the individual. However, demand for these services exceeds current capacity, not to mention the future demands of our growing population. Without an increase in the proportion of home and community based services and without tighter controls on the approval of institutional expansion, public funding will continue to be channeled into development of institutional nursing home care with its associated costly Medicaid funding entitlements.

CHAPTER ONE: INTRODUCTION

Background

During the 1996 legislative session Committee Substitute for House Bill 528 (Rules) passed the legislature and was signed into law. The Bill thus became Chapter 84 of the Session Laws of Alaska 1996 (CH84 SLA96). CH84 SLA96 addresses issues related to the current mix of long-term care services in Alaska as well as a process to assess the future need for long-term care services. Specifically, CH84 SLA96:

- * Made legislative findings that Alaska has only recently begun to develop a system for providing long-term care for seniors through home and community based care; that the long-term care system is unbalanced at the current time because of a shortage of alternatives to nursing homes, and many nursing home residents would benefit from less intensive and less costly care such as assisted living, home health, and other home and community based services.
- * Placed a two year moratorium (until May 1, 1998) on the issuance of certificates of need or licenses for any new nursing home beds in Alaska; effectively preventing any nursing home beds from being added in Alaska until the moratorium expires.
- * Required the Department of Health and Social Services to accept and begin processing applications for certificates of need for new nursing home beds beginning September 1, 1997, although the certificates would not be effective until the moratorium ended on May 1, 1998. This would allow for nursing home certificates of need to be processed in time for the 1998 construction season.
- * Established a six-member working group to analyze issues relating to long-term care and the certificate of need program, and to deliver a report to the Governor.

Composition Of The Working Group

As a result of CH84 SLA96, the Legislative Working Group on Long-Term Care was established. According to CH84 SLA96 the membership of the group included:

- Two individuals appointed by the governor who are involved in providing long-term care services, one of whom is a licensed nursing home administrator who operates a community nursing home in this state;
- Two individuals appointed by the governor who are receiving long-term care services, at least one of whom must be at least 60 years of age;
- The commissioner of administration, or the commissioner's designee; and
- The commissioner of health and social services, or the commissioner's designee

The following individuals were then appointed to the Group by Governor Knowles:

Alison Elgee, Deputy Commissioner of Administration
Department of Administration
Commissioner's designee

Jay Livey, Deputy Commissioner of Health and Social Services
Department of Health and Social Services
Commissioner's designee

Jackie Ortelli, Assistant Administrator, Denali Center, Fairbanks
Licensed Nursing Home Administrator

Cyndi Nation-Cruikshank, Director Home Care Services
Tanana Chiefs Conference, Inc. Fairbanks
Long-Term Care Provider

Peggy Burgin, Anchorage (Group Chair)
Long-Term Care Recipient over 60

Thea Zumwalt, Soldotna
Long-Term Care Recipient

Duties Of The Working Group

CH84 SLA96 charged the working group to produce a report which contains the following:

- * A description of the current status and cost of the States system for long-term care services.
- * The projected number of state residents who will be needing long-term care services through the year 2000, the year 2005, the year 2010 and the year 2015.
- * The projected cost to the State, based on the projection of needs, if no changes are made to the State's present system of long-term care services.
- * An estimated number of state residents who are currently receiving care in nursing facilities that could more appropriately be receiving home and community based care outside of nursing facilities.
- * A description of the alternative methods available to provide nursing care for state residents and the relative cost to the state for these methods.
- * Recommendations for principles that should be used to guide the development of the states long-term care system, including principles that should guide the certificate of need process under AS 18.07.

List Of Meeting Dates

The Working Group on Long-Term Care held meetings on the following dates.

October 25, 1996
November 12, 1996
November 26, 1996
December 19, 1996
January 13, 1997
February 13, 1997
March 3, 1997

CHAPTER 2: STATEMENT OF LONG-TERM CARE PRINCIPLES

Primary Guiding Principle:

The long-term care system should be Alaskan centered and encourage the wise use of all resources.

1- The Encouragement of Individual Control: The long-term care system should encourage individuals to take control of both their personal health and the long-term care choices of provider, services and setting through:

- education and other prevention strategies that promote long-term , healthy lifestyle choices;
- consumer involvement in the design and development of services; and,
- a service system that is conceived as a part of, rather than an interruption to, living.

2 - Emphasis on a Meaningful Life: The long-term care system should be tailored to the individual's needs and strengths both as an individual and as a member of a family, a community, and a culture; and in doing so should work to preserve and encourage independence, usefulness, dignity and a meaningful life through:

- the development of balanced continuum of care;
- greater attention to home and community based services;
- quality care in the least restrictive setting whenever possible; and,
- providing a safety net when the need exceeds the ability of family, friends and volunteer resources.

3- Broad Based Collaboration: The long-term care system should encourage collaboration among providers, as well as among the individual, the service community, and the resources outside the formal system so that there is a high quality, flexible, seamless, and responsive continuum as a part of normal life through:

- incentives that encourage institutional providers to develop alternative, flexible services;
- participation of the family and the community in the design and delivery of services;
- CHOICE and similar strategies for keeping the individual as close to home as possible; and,
- service environments appropriate to age, cultural prerogatives and physical limitations.

4- Outcome Oriented Cost Effectiveness: The long-term care system should be outcome oriented to assure the proper monitoring of its quality and cost effectiveness through:

- a comprehensive planned approach that emphasizes quality;
- greater involvement of the consumer in articulating needs and assessing outcomes;
- encouraging greater participation of the family and local community in defining needs and designing and evaluating the quality of services;
- thorough consideration of alternative, less costly responses to long-term care needs through assessment tools and consumer input to determine the level of services required;
- standardization of data categories to better assess the cost effectiveness and quality of outcomes for clinical issues, risk factors, special needs populations, and legislative and regulatory changes.

5- A Stable High Quality Service Delivery System: The long-term care system should promote policies that encourage a stable, high quality service delivery system through:

- education and training to assure the desired skills among providers of services;
- maximizing the portion of health care dollars that go into services as opposed to administrative overhead or profits; and,
- holding providers, administrators, and the public sector accountable for the cost and quality of the service provided.

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CORRECTION

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CHAPTER 3: ALASKA'S PRESENT STATE-FUNDED LONG-TERM CARE SYSTEM.

Overview. This chapter describes Alaska's present state-funded long-term care services for three different populations: senior citizens (age 65+); Alaskans who are disabled due to developmental disabilities¹ and those Alaskans with physical disabilities which first occurred after the age of 21. As used in this report, "long-term care" is defined as personal care and assistance related to health and social services, given over a sustained time, to assist people of all ages and their families to achieve the highest level of functioning possible, regardless of the setting in which care is given. Long-term care consists of a range of services and informal supports. Long-term care services may be needed to assist with routine, chronic, and periodic needs, and may include service management, general medical services, in-home assistance, information and referral, community-based services (adult day, respite, and care coordination), and many other types of services.

Service systems for these three populations are at different stages of development. The contrasts are sharp. Long-term nursing facilities for the developmentally disabled such as Harborview in Valdez, and the six Pioneers' Homes which serve those 65 and over, have provided services for many years. However, the system of home and community-based long-term care for senior citizens and adults with physical disabilities is very new and remains incomplete. There are significant gaps in it: for example several regions lack even the most fundamental long-term care services for senior citizens. In contrast is the system of long-term care for the developmentally disabled: that system is recognized nationally for its comprehensiveness and responsiveness to the individualized needs of its consumers.

¹ AS 47.80.900 (7) defines a person with a developmental disability as one who experiences a severe, chronic disability that is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the person attains age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated. These are the criteria used to define eligibility for services from the Division of Mental Health and Developmental Disabilities, Alaska Department of Health and Social Services.

Long-Term Care for Alaskan Seniors, and Adults with Physical Disabilities

Many Alaskans approach their retirement years with the impression that their long-term care needs will be largely met through publicly funded services, should they need this type of care. There is the illusion that between Medicare, the Indian Health Service, Medicaid and private insurance, senior citizens will generally be able to cover long-term care expenses. This is generally **not** the case. In fact, most senior Alaskans **cannot** count on readily covering the costs of long-term care. Relatively few older Alaskans have the means to fully pay for long-term care, as is evidenced by data from the 1990 Alaska Census. 32.6% of those seniors age 65+ had annual incomes of less than \$15,000, while an additional 19.7% had incomes which fell between \$15,000 - \$24,999. Thus, collectively 52.3% of Alaskan seniors age 65+ had annual incomes of less than \$25,000. Yet in 1996, the average cost of nursing home care was \$75,000.

Funding: The purpose of this report is to define current patterns of state-funded expenditures that support long-term care. The State of Alaska supports long-term care service delivery in home and community-based settings, and in long-term care institutions. These services are provided through a variety of funding strategies. These include:

1. Comprehensive State underwriting of direct services, augmented through user fees as occurs in the Pioneers' Homes. Beginning in FY96, the Pioneers' Homes instituted annual resident rate increases. The intent is that by FY 2003, residents able to afford it will pay for the full cost of their care. Those unable to pay the full cost will pay according to their available resources.
2. State grants to local non-profit service providers who in turn contribute local matching funds and support to underwrite the costs of operating home and community-based services, and collect consumer payments for services based on their ability to pay. In FY96, the Alaska Commission on Aging found that local community contributions accounted for 45% of the funds necessary to operate local senior services, while 55% of the funds were from State and federal sources.²
3. Independently financed services which rely on Medicaid (funded on a 50-50 basis by the State of Alaska and federal funds) and Medicare (fully funded federally) payments, insurance billings, and payments by individual consumers.

Seniors with long-term care needs whose income levels and medical conditions qualify them for Medicaid, receive Medicaid-funded long-term care services funded through a match of federal and state dollars. Other seniors with long-term care needs and income levels excluded by Medicaid, pay for their long-term care services through insurance reimbursements, Medicare (when it applies), and payments on a sliding fee scale.

Since 1973, Medicaid funding has paid for long-term nursing home care for low-income Alaskan senior citizens age 65+ who experienced Medicaid-eligible medical conditions which required institutional levels of care. In 1994, Alaska established four Medicaid waiver programs. These waivers allow Alaska to use Medicaid funds to pay for the delivery of long-term care services outside of nursing homes, as long as the recipients: 1) are Medicaid eligible; 2) meet the criteria for needing nursing home care and 3) care in the community costs less than nursing home care.

² Alaska Commission on Aging. *Annual Report: FY96*. Juneau, 1997.

These waivers enable state and federal funding to be paid for many home and community-based services that are not funded through the traditional Medicaid program. These payments are critical to the successful development of assisted living homes, and a bolstering of Alaska's limited network of care coordination, adult day services, and respite care.

The senior citizen Medicaid waiver program is known as the CHOICE program. Through a combination of in-home care, and day-time attendance in programs available in other community locations, senior citizens are successfully receiving long-term care while maintaining their independence at an average annual cost of \$11,077, of which 50%, or \$5,538.50 was paid by the State of Alaska. In FY96, 218 seniors received long-term care in home and community-based settings through the CHOICE program. At this time, some 70 adults with physical disabilities receive care through the Medicaid waiver program.

In the late 1980's the Alaska Commission on Aging began making grants to community agencies to provide adult day services and respite care to seniors in regional hub communities throughout Alaska. This initiative established the foundations for home and community-based long-term care for senior Alaskans.

Home Care Program. Alaska has home health services and personal care services offered through the Medicaid program. Additionally homemaker services and chore services are offered through the CHOICE home and community-based Medicaid waiver program. This program, which has been administered by the Department of Health and Social Services' Division of Public Health is now being transferred to the Division of Senior Services within the Department of Administration.

Personal Care Attendant Services. Personal Care Attendant services enable functionally disabled handicapped and elderly Alaskans to live in their own home or community instead of being placed in a long-term care institution. PCA services are typically provided in a consumer's home by trained health care paraprofessionals under clinical supervision of a supervising PCA agency. Ideally, these services are part of a continuous and coordinated system of social and medical support.

Until 1992, PCA, Homemaker and Home Health Aide services were provided by multiple agencies. Functionally dependent individuals of any age could receive services in their home on a part-time basis. In early 1992, the state issued a request for proposals to expand delivery of PCA services and chore services in 10 regions within Alaska. This was done to expand the geographic availability of services and to expand the amount of services provided by shifting costs as much as possible to other shared fund sources, especially Medicaid. State general fund money is also used to support agency costs to develop a statewide service delivery system.

This program has greatly expanded. In FY96, 17,333 hours were served by state general fund dollars and 159,736 hours were served by Medicaid funding. 1,044 consumers were served by these programs in 128 communities in Alaska. This program is being transferred to the Division of Senior Services, to continue integration with other home and community-based services.

Adults with Physical Disabilities Waiver. This program provides home and community based services to individuals between the ages of 21 and 64, who: 1) have been determined eligible for Supplemental Security Income (SSI), and 2) due to illness, injury, or other physical problems experience a severe and chronic disability that is likely to continue indefinitely and substantially limits the person's ability to obtain and maintain gainful employment. These individuals also would meet the nursing home level of care criteria and would, without the waiver, normally receive care in a facility for more than 30 days per year.

Approximately 70 individuals are currently utilizing this waiver in Alaska. The average proposed cost of care for each of these individuals for FY97 is \$28,769. These individuals may also use other services discussed in this chapter, and therefore may be a part of a duplicated count of Alaskans currently receiving home and community-based services.

Long-Term Care Services for Senior Citizens, and Adults with Physical Disabilities:

- **Adult Day Centers** provide supervised group care in a social setting which offers a wide range of services for seniors needing assistance with daily living tasks. Care is provided weekdays at a central site during normal working hours.
- **Respite Care** is a service through which trained caregivers provide intermittent in-home care to seniors. During this time, the family caregivers are able to take a break from their roles as full time caregivers. While this care is usually provided in the consumer's own home, it can also be provided in facilities such as assisted living homes and nursing homes, as well as in adult day centers.
- **Care Coordination** is a service through which a trained professional assesses a frail consumer's needs. Based on this assessment and in consultation with the consumer's family, appropriate services are identified and arranged. Care coordination incorporates outreach, intake screening, initial assessment, care planning, service arrangement, ongoing monitoring, and formalized reassessment. This approach assures appropriate use and coordination of long-term care resources.
- **Personal Care** is a service which provides in-home assistance with activities of daily living such as bathing, dressing, toileting, eating, and moving from one place to another. These services can enable a person with non-technical medical care needs to remain at home rather than live in an acute or long-term care facility. Without this service, many individuals would enter nursing homes or other institutions to receive needed care.
- **At-Home Skilled Nursing** care provides skilled nursing care by licensed professionals.
- **General Relief** is a form of payment with state General Fund moneys to meet the costs of room and board in assisted living facilities for low-income people at current or potential risk of neglect or self-neglect, abandonment, abuse, or exploitation. Individuals contribute what they can to meet this cost; the State pays the balance.
- **Nursing Home Care** is a service providing daily skilled nursing or skilled nursing rehabilitation services or both in a skilled nursing facility.
- **Pioneers' Homes Assisted Living** care includes room and board, and a range of levels of assistance with daily living, with an emphasis on the needs of seniors affected by cognitive impairments such as Alzheimer's Disease.

- **The CHOICE Long-Term Care for the Elderly Medicaid Waiver Program** is an individualized payment system which covers costs of medical care necessary for an individual to remain within the community. This is available to senior citizens whose medical conditions and limited incomes fall within Medicaid eligibility guidelines. CHOICE can provide payment for home care (personal care, homemaker and chore services), adult day center services and transportation to and from the center, respite care, at-home skilled nursing care, care coordination, home-delivered meals, or assisted living care above the room and board level.
- **Hot Meals** are generally provided weekdays by Alaska Commission on Aging grantees and Native agencies receiving Older Americans Act Title VI funding. Nutritious meals are offered at central locations, and are delivered to home-bound seniors.
- **Essential Transportation** services are provided by Alaska Commission on Aging and Title VI grantees, and made available to senior citizens to assist them with essential rides to attend adult day services, meal programs, doctors appointments, and to accomplish essential shopping.
- **Long-Term Care Ombudsman** is a service through which seniors are assured their basic rights for self-determination and respectful treatment while receiving long-term care.
- **Information and Referral (I&R)** is a statewide service through which seniors and their families receive telephone consultation on issues of concern (e.g. health insurance, community-based services and resources) and are referred to appropriate resources.
- **The Division of Mental Health and Developmental Disabilities** provides services for some adults with physical disabilities. A description of the services that might be provided are on pages 16 - 18.
- **In addition** to these program, supports senior citizens and disabled adults may also receive cash support through the Supplemental Security Income program (SSI), and Adult Public Assistance Programs and seniors may receive support from the Alaska Longevity Bonus Program

Access to the present long-term care system of direct services, payments for service, and grants to non-profits is very uneven across Alaska. In general, the range and quantity of available long-term care services increases with community size. Seniors in communities such as Kwethluk and Usibelli have no long-term services in their communities, while seniors in Fairbanks or Anchorage have limited access a full range of services. Appendix IV presents the geographic availability of these services.

Individual Profiles

The following profiles describe typical senior citizens and adults with physical disabilities who use Alaska's present services to receive long-term care.



Early Intervention to Delay the Need for Long-Term Care

SENIOR LIVING ALONE. Mrs. Jones was a 70 year old with multiple physical problems that were stable; however her endurance and strength were diminishing. Recently her husband and several friends had died. She had many changes to adapt to and was mildly depressed. Mrs. J. lives alone, and enjoys the *support and stimulation of services available to all seniors at the local senior center* she attends weekdays. There she has a *balanced hot lunch*, *receives tips on healthy foods and eating habits*, *is in an exercise group*, and *visits with other seniors*. She also *learns about other community services that may be helpful to her*. All of this helps her cope with her losses. Targeted interventions now delay or prevent need for more intensive services. *The services (in italics-above) Mrs. Jones uses are partially funded by Alaska Commission on Aging grants, and are available to seniors age 60+ at 103 locations across Alaska*

Home & Community Based Services for Alaskans with Moderate Impairments

Profile A. SENIOR WITH FAMILY

CAREGIVER: Mr. Smith was low income, age 75, and had Alzheimer's Disease. He and his wife lived at home; he required supervision and cueing to bathe, dress, and eat. Because he wandered away from home, he needed a caregiver 24 hours a day to ensure his safety. Alaska's



Medicaid law excludes Alzheimer's Disease as an allowable primary diagnosis for a nursing level of long-term care, so Mr. S. could not receive Medicaid assistance. A *care coordinator* has assessed his needs, and helped the Smiths develop a home and community based care plan. Mr. S. now *attends an adult day program* weekly. There he enjoys therapeutic recreational activities, a hot lunch, help with activities of daily living, and support adjusting to his limitations. Two week-end days a month, a *respite worker* relieves Mrs. S. from full time caregiving, so she can take a break herself. Since they don't drive, they use *senior center van rides* for essential shopping, doctors appointments, and Mr. S.'s travel to the adult day center. Mrs. S. *calls the Alzheimers' Association to learn about various aspects of dementia and attends caregiver support group meetings*. *The services (in italics - above) the Smiths use are partially funded by the Alaska Commission on Aging. The hot meal and transportation services are available to all seniors age 60+ at 103 locations across Alaska. The home and community-based services used by the Smiths are available based on care needs and available capacity: annual per consumer average General Fund costs for these services are: Care Coordination: \$1,262; Adult Day Services: \$4,020; Respite Care: \$1,457.*



Profile B: SENIOR LIVING ALONE: Mrs. Brown, age 83, was on a low income, and had Alzheimer's Disease. She lived on her own in a modified cabin until a year ago. However with the progression of Alzheimer's, she was seriously neglecting herself, and was in serious danger of accidentally harming herself. A niece who was

her guardian called the Division of Senior Services to figure out how to help her aunt. A care coordinator worked with Mrs. B. and her niece to fully assess Mrs. B.'s needs, and together they developed a plan of care. Mrs. B. is now living in an *assisted living home* with two other seniors where she is thriving on the *full time care* she now receives. Mrs. B.'s income doesn't fully meet the cost of her care. While she is not Medicaid eligible, her monthly income is being supplemented with General Relief assistance to pay for the costs of assisted living care. *The average annual General Relief long-term care General Fund payment is \$4,511.*

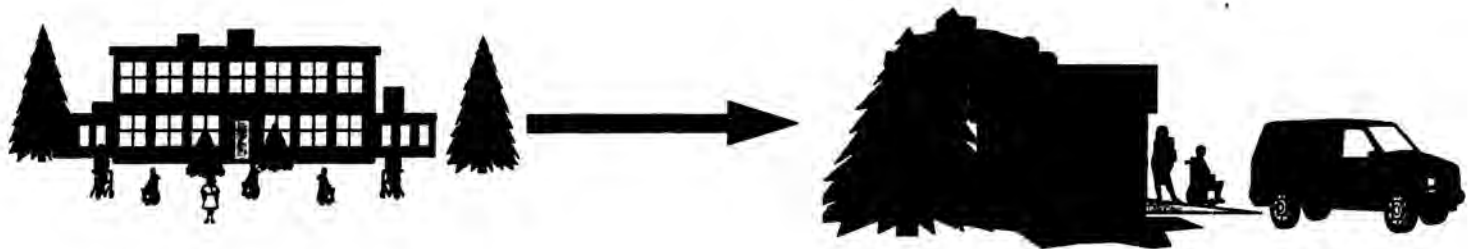
Home & Community Based Services for Alaskans with Severe Impairments



Profile A: SENIOR WITH FAMILY CAREGIVER: Mrs. Riley lived in her home of fifty years with her son who worked full time. She was 80, and lived on a low income. Last year complications from diabetes and hypertension resulted in amputation of her left leg. She was

now homebound, and needed assistance with activities of daily living and monitoring for her diabetes. Mrs. R. took multiple medications, and was somewhat malnourished. Fortunately, at this point she was referred to a *care coordinator* who assessed her needs and established that she was eligible for the CHOICE program. Now her care is funded through the Medicaid CHOICE home and community-based program which enables her to continue living at home. Her care plan included *adapting Mrs. R.'s home to add an entry ramp and bathroom grab bars* to increase access and safety. Mrs. R. uses *escorted rides* to doctors, and *receives daily home-delivered meals* from the local senior center. A *home health nurse* visits Mrs. Riley weekly to check on her condition and assist in medication management. A *senior companion* visits weekly to relieve social isolation. *The average General Fund annual cost for CHOICE Medicaid services in 1996 was \$5,538.50. Mrs. R's home health nurse payments are covered by Medicare. The hot meal and transportation services are available to all seniors age 60+ at 103 locations across Alaska.*

Long-Term Care Services for Consumers with a Medical Treatment Need



Profile A: Mrs. Clark had a stroke last year; she is 76. She received acute care in the hospital for a few days and then transferred to a nursing home for restorative and rehabilitative care. One side of her body is paralyzed and she has a speech impairment. In the nursing home, she began physical therapy to improve her mobility, occupational therapy to improve her ability to perform activities of daily living, and speech therapy to improve her communication. Her husband visited daily and learned to help with her rehabilitation. The nursing home social worker worked closely with a care coordinator and Mrs. C.'s family to develop a discharge plan. A wheelchair ramp, bathroom grab bars, and a shower chair were installed at the C's home prior to her return home after a four month nursing home stay. Mrs. C. uses the senior van to reach her weekly physical therapy sessions, and to attend an adult day program where she is in daily therapeutic activities tailored to her needs.

Institutional Long-Term Care Services for Alaskans with Severe Impairments



Profile A: SENIOR WITH FRAIL SPOUSE: Mr. Thomas was 83 years old. He had advanced Parkinson's Disease and needed 24 hour care. He had limited mobility, frequently had to use a wheelchair, and required assistance in eating, dressing and toileting. He also experienced moderate

dementia and was unable to clearly communicate his needs. While Mr. T.'s wife of 55 years cared for him for many years at home, she was now frail and unable to provide the physical assistance he needed. Because of many health-related expenses, the Thomas's lived on a low income. Mr. Thomas' low income and primary diagnosis enabled him to be eligible for Medicaid funded long-term care. As a result, he now lives in a nursing home which is paid for by Medicaid. Mrs. Thomas visits her husband daily. *The average annual General Fund cost for this service is \$37,500.*

Major Issues:

- The inadequacy of Alaska's present long-term care system for senior citizens is apparent in Appendix IV, which integrates data on present and projected regional senior populations, the prevalence of severe impairments among those seniors, and the present limitations of long-term care services available to seniors through State-funded services. At this time serious deficits exist across our State.
- Care coordination, the 'point of entry' to cohesive and cost-effective long-term care services, is presently unavailable to the general senior population on the North Slope, in Northwestern and Southwestern Alaska, on the Aleutian Chain, in the Copper River/Prince William Sound region. Other regions of the State have access to extremely limited services; e.g. 46 Interior villages have just begun to have access to care coordination through telephone-based service and one annual on-site care coordination visit through a new grant from the Alaska Commission on Aging. **In FY96, 615 seniors, of the estimated 3,933 with severe impairments, were served.**
- Adult day centers, one of the two basic home and community-based care services, now serve only 11 Alaskan communities. Sitka, Barrow, Cordova, Dillingham, Unalaska and Valdez completely lack this type of service. To date, due to funding constraints, centers are unable to provide services for the full work day; none are open weekends. This means that few caregivers are able to work full time, and yet a full time income is essential to providing the income relied upon by the caregiver and senior in care. **In FY96, 391 seniors, of the estimated 3,933 with severe impairments, were served.**
- Respite care, the second of the two basic home and community-based care services, is available on an average of 10 hours/month. **In FY96, 341 seniors, of the estimated 3,933 with severe impairments, were served.**
- At this time, long-term care residential capacity is extremely limited in many communities of our State. Recent planning grants from the Division of Senior Services are supporting the planning of the first assisted living capacity in Bethel, Dillingham, and Kodiak.
- There is a growing need to assure that long-term care consumers are aware of their rights and are able to effectively exercise them in regard to long-term care, senior housing, and other publicly funded services targeted to senior citizens.

Long-Term Care for Alaskans with Developmental Disabilities

Individuals with developmental disabilities require lifelong services. Although the type and intensity of services varies over the lifespan, the availability of ongoing support services is essential for people with developmental disabilities to assume the same roles in the community as people without disabilities.

In the last five years, service delivery for Alaskans with developmental disabilities and their families has been redirected from emphasis on facilities and programs to emphasis on consumers and families. This has reshaped the way services are provided, and altered the roles of consumers, families, service providers and funding agencies. Service providers assist consumers and/or their families to establish connections with the vast array of natural supports in local communities: friends, extended families, neighbors, churches, employers, generic community resources such as libraries and social organizations, for example. Services are brought to consumers and families in the community; they no longer have to leave their home communities to receive services. In some instances, consumers and/or their families use vouchers to purchase services, placing consumers fully in control over how they spend resources allocated to meet their needs.

Funding: Most State-funded services individuals with developmental disabilities receive are home and community-based. Institutional services have been provided by the Harborview Developmental Center and Hope Cottages' Intermediate Care facilities. Harborview will close by December 31, 1997 and the Intermediate Care Facilities will close by June 30, 1998.

These services are provided through a mix of direct services from the State, payments for individualized services and grants to non-profit agencies. Payment for these services is covered by state and federal funding. Individuals with developmental disabilities whose income and medical conditions qualify them for Medicaid, receive Medicaid-funded long-term care services funded through a match of federal and state dollars. Other individuals with long-term care needs and income levels excluded by Medicaid are funded with state dollars.

Many individuals receive multiple services. An analysis of the costs associated with one, two and three or more services as well as the percent of persons receiving one, two, or three or more services is presented in Table 1 of Appendix I.

Long-Term Care Services for Alaskans with Developmental Disabilities: Most communities are served by small local providers, local one-person branches, itinerant providers or contract employees. The one exception is Anchorage which has developed large specialty providers. Most direct services are provided by local non-profit agencies. As a result of growth over the last five years, 197 communities are now served by 32 DD providers.

The DD regions are broken out according to these Alaska Borough and Census areas:

Northern Region: North Slope, Northwest Arctic, Nome, Yukon-Koyukuk, Fairbanks North Star, Denali and Southeast Fairbanks.

Southcentral Region: Wade Hampton, Bethel, Dillingham, Bristol Bay, Lake and Peninsula, Aleutians East, Aleutians West, Kodiak, Kenai Peninsula, Matanuska-Susitna and Valdez-Cordova.

Anchorage Region: Metro area.

Southeast Region: Skagway-Yakutat-Angoon, Haines, Juneau, Sitka, Wrangell-Petersburg, Ketchikan Gateway, Prince of Wales and Outer Ketchikan.

The percent of total persons served by region is fairly consistent with state census data. (See Table 2 of Appendix I).

Services: Depending on individual need, long-term care for Alaskans with developmental disabilities may include any of the services described below. An individualized plan is developed with the person and/or his family (depending upon age, guardianship status and the desires of adults with developmental disabilities). This defines services to be used. Many persons with developmental disabilities require more than one service to achieve maximum independence in their chosen life styles. In Anchorage or Fairbanks consumers may use services from more than one provider. It is noteworthy that consumers may design their own services to meet unique needs, interests and desires.

These services are available to both children and adults:

Case Management: This service assists the individual to access medical, social, education and other services supported by various funding sources. This can include specialized services such as professionally administered medication necessary for medical stability.

Personal Assistance Services: These services include in-home health care, chore services and assistance with activities of daily living, including but not limited to bathing, grooming and feeding assistance.

Respite: This service provides relief from the everyday stress of caring for a family member who experiences a developmental disability. It is not be used to replace the services provided by regular child care or adult day care except for short-term emergency situations. Respite care for youth and adults differs from that provided for children in that is not primarily intended to give relief to families; instead, it is used as an opportunity for consumers to participate in social and recreational activities.

The following services are primarily provided to children and youth and/or their families:

Family Resource Consultants: There are five Family Resource Consultants (FRCs) serving five regions of the state who currently work with 200+ families. Parents of children with developmental disabilities serve as FRCs, and in this role, help families learn to independently navigate the provider system to build community and natural supports around individuals and families.

Foster Care: Foster care provides full-time out-of-home care, with a qualified adult or family member. Foster care is only provided in State-licensed foster homes; however, this approach

does *not* require the natural family to give up custodial or parental rights. The natural and foster families jointly agree to a written service plan and visitation schedules.

In-Home Training: This service help parents develop skills in coping and managing individual behaviors. The purpose of this service, which may be time-limited or ongoing, is to prevent or forestall out-of-home placements.

Natural Family Supports: This service assists youth and children living at home to secure assistive technology services and devices, respite care, adaptive equipment, in-home training, ramps, lifts, etc. The capacity to respond to individuals and families in this manner is one of the most cost-efficient services the State offers.

Services for Children Who Experience Special Health Care and Developmental Needs: These services are provided to children who require external supports which may include medication administered by staff to maintain their medical stability. All services are highly individualized to prevent the institutionalization of young children and to support them in family-centered, community-based environments. This service is primarily offered to children, although similar support plans may be developed for adults.

Shared Care: Two families, one of whom is usually the natural family, share the responsibility of caring for the child with a developmental disability. Arrangements are made for the second "family" to care for the child approximately 50% of the time.

The following services are primarily offered to adults and youth transitioning from school to adult life:

Group Homes: This full-time, out-of-home residential care in a group setting assists consumers in developing relationships and skills to increase their independence. Group homes have a maximum number of 6 residents and are licensed by the State.

Supported Living: Based on individual service plans, training and supervision is provided to assist individual consumers to live successfully in settings which maximize their independence.

Vocational Supports: Based upon an individually tailored plan, individuals receive training in an income-producing or subsistence setting. Ongoing support is regularly provided to maintain successful employment.

Respite is the most frequent service consumers use, although no one service is used by a majority of service recipients. (See Table 5 in Appendix I.)

A snapshot of the costs and range of costs associated with specific services in Alaska is provided in Table 6 of Appendix I. For the most part, those services which are low cost also tend to be the services that consumers most frequently receive (e.g. respite, case management, natural family supports, individualized services, supported living and vocational supports).

Individual Profiles: *A service provider helped a mother who was at risk of losing her children to the custody of the Division of Family and Youth Services. Supports were secured from three local agencies. Services provided included case management, family counseling, daily life skills training and parenting supports at an initial cost of \$21,000. Long term, ongoing support is now being provided to her at an annual cost of less than \$8,000.*

A family with two children with developmental disabilities needed to make their home and vehicle accessible. The family was virtually home bound since both children weighed in excess of 50 pounds and the mother could no longer physically lift the children. A family resource consultant helped the family secure funding for a platform lift, home modifications and a van lift at a cost of \$7,600; the family contributed \$1,000. No additional services are needed at this point in time; therefore, there are no ongoing cost to serve this family.

A 31-year old woman who lived in a nursing home for 14 years was able to move into the community after a service provider advocated for her to receive Personal Assistance Services in her own home. She is now gainfully employed and is working in the community of her choice at an annual cost of \$9,000; she also pays \$3,000 per year.

Major Issues: The wait list for DD services continues to grow. For example, it grew by 15% (632 to 725 individuals) from May 1996 to December 1996. (See Tables 7-10 in Appendix I.) It takes almost two years for persons on the wait list to receive services. Even then the individual may not receive all services at the intensity needed; for example, the individual may receive vocational supports but not supported living services, or the family may be offered 10 hours of respite per month when 15 hours is needed.

A huge waiting list perpetuates a crisis-driven system, in which individuals in crisis get priority for services and almost always at a high cost. This, in turn, deprives other individuals of supports and may force them into crisis. A system of lower cost early intervention and community supports reduces the frequency of crises which are expensive to resolve. The Division of Mental Health and Developmental Disabilities (DMHDD) has funded early intervention and community support services for the past five years. This has resulted in real cost savings and increased consumer satisfaction.

Funding is not available to provide full services to everyone on the wait list or even to a majority of those wait listed. Therefore, the Division (DMHDD) is exploring the potential of offering "Core Services" to wait listed persons. The "Core Services" approach will build upon proven early intervention and community strategies that reduce costs and increase consumer satisfaction. Although discussions are still in the preliminary stages, at a minimum this approach will include strategies which empower consumers to successfully negotiate service delivery systems: peer support (consumer-to-consumer and family-to-family), information and referral, natural family supports and advocacy.

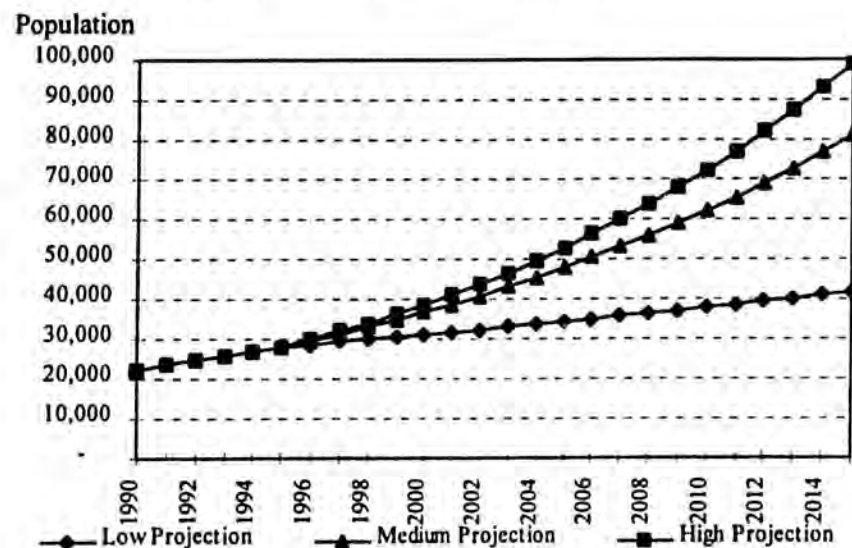
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CHAPTER 4 - LONG-TERM CARE PROGRAM USAGE IN ALASKA TO 2015

Assumptions

Alaska's population has been growing, but at a decelerating rate, for the past six years. The average rate of increase for the most recent five year period was 1.75%. There is no indication that a change in this slow growth for the Alaska population will occur. A reasonable range of population growth possibilities would be 1% (low), 2.5% (medium) and 5% (high). It is assumed that the under 65 population of those needing long-term care services could grow at these rates. These rates are used here to make simple projections of Alaska's under 65 population in need of long-term care services, to the year 2015. For Alaska's population aged 65 and above, a higher growth rate appears likely. The most recently published population data for Alaskans 65 and over shows an average yearly growth rate of 5.432% for the past five years. Information from waiting lists for Pioneers' Homes and other programs for Alaska's seniors also indicates that the population group aged 65 and above will continue to grow at a higher rate than the Alaska population as a whole. Therefore, yearly growth rates of 2%(low), 5.432%(medium) and 6.5%(high) are assumed for the population aged 65 and above. These rates will be used here to project growth of costs and service demands to the year 2015. The State Demographer uses a much more sophisticated model to generate population projections. At this time no official population projections are available. The State Demographer concurred that ours is one simple and reasonable method for projecting future population growth. He warned that there are large numbers of Alaskans who will turn 65 during the next twenty years. It should be noted that the growth recently experienced by the senior population is caused by an increase in the number of Alaska seniors remaining in Alaska.

Figure 1
Alaska's Population Aged 65 and Over, Projections to 2015



Note: 1990 is actual U.S. Bureau of Census Count, 1991-1995 are Alaska Department of Labor Estimates, 1996 - 2015 are the high, medium and low growth projections.

Figure 1 graphs three projected growth rates for Alaska's senior population to the year 2015. Figure 1 illustrates that a medium to high growth rate for Alaska's senior population will mean a dramatic increase in the number of Alaskan seniors needing long-term care services.

Analysis

Tables 1 and 2 show the long-term care service programs, number of cases, either consumer days or hours of service delivered, total expenditures and state general fund expenditures for the two age groups; ages 65 and over, and under 65 years of age. These expenditures are for Fiscal Year 1996. Every effort has been made to provide an accurate count of service delivered and funds expended for these programs. However, some individual consumers are probably double counted due to the nature of the way services are provided and the different systems used to account for services delivered.

Service Units are used in the Tables to show the amount of service delivered. Some programs measure the number of **hours** of service delivered to individuals in a program. Other programs measure the number of **days** of service an individual receives in a program. Please note the type of service units (days or hours) listed in the Source/Comments columns of Tables 1 and 2.

TABLE 1. - Long-Term Care Services - 65 and Over Age Group - FY96

Program	Service Units	Expenditures	GF Expenditures	Source/Comments
'Nursing Homes	151,933	\$34,737,440	\$ 17,368,720	MMIS-STARS/Units are consumer days
Pioneers' Homes	214,237	\$30,016,400	\$ 24,683,900	'see note below/ Units are consumer days
'Personal Care Services	160,965	\$ 1,316,564	\$ 658,282	DMA MMIS-STARS/Units = consumer days
'CHOICE	47,677	\$ 2,946,295	\$ 1,473,148	Older Alaskan Waivers/Units =consumer days
Personal Care Services	12,600	\$ 1,059,100	\$1,059,100	Div. Public Health/Units: hours of service ¹
DD Grant Funded	8,760	\$ 235,000	\$235,000	DMHDD/Units are consumer days
Commission on Aging Grants ⁴	139,065	\$ 115,443	\$115,443	ADRD ⁵ Support/Units are consumer days
Commission on Aging Grants ⁴	253,587	\$ 2,493,949	\$2,493,949	Respite Care/Adult Day Care/Care Coordination/Units are Hours of Service ¹

¹Some payments had not been made at the time these figures were compiled. There is a possible small increase for these figures. Does not include payments to Nursing Homes by third parties or consumers (so-called co-payments).

²Pioneers' Homes FY96 actual expenditures, Units = estimated consumer days from a monthly snapshot count, -not actual.

³Based on number of seniors receiving PCS who are not funded by Medicaid

⁴Commission on Aging defines seniors as 60 years of age and over and report data by this age category

⁵ADRD is Alzheimer's Disease & Related Disorder

Please note that there are no ICF/MR costs for the 65 and over age group. All ICF/MR consumers were under 65 years of age in FY96.

TABLE 1A. Long-Term Care Services - 65 and Over Age Group - FY96 (Condensed)

Programs	Service Units	Expenditures	GF Expenditures	Cost per unit	GF Cost per unit
Nursing Homes	151,933	\$34,737,440	\$17,368,720	\$ 228.64	\$114.32
Pioneers' Homes	214,237	\$30,016,400	\$24,683,900	\$ 140.11	\$115.22
Home Based Service - Days	376,907	\$ 4,613,302	\$ 2,481,873	\$ 12.24	\$6.58
Home Based Services - Hours	266,187	\$ 3,553,049	\$ 3,553,049	\$ 13.35	\$13.35

In Table 1A, Home Based Services are reported in the two categories discussed above: consumer hours and consumer days. The lower cost and the higher number of people served in these two categories makes a strong argument for increased investment in the home based services.

It is not easy to relate hours of service to days of service. A nursing home may be reimbursed on a per diem (per day) rate for its cost of care. A personal care service may charge a per hour fee for services to an individual. It is not possible to determine an average number of hours of home and community based services that will delay or avoid an individual's need for more expensive nursing home care. However home and community based services can be a lower cost alternative to institutional care in many cases.

A few hours a week of home based services may allow an individual to remain in his or her home and deter or delay the need for institutional care. Another individual may need more hours of home based services to remain independent and in their own home. Often, the individual will also utilize other community based services provided by various agencies within the community. This process of accessing different agencies, as well as informal resources, such as family, to cover all the needs of the individual makes it difficult to determine what amount of home and community based services and other community resources are needed to help maintain an 'average' consumer's independence. Each case is unique, as each consumer's needs are unique. Due to the relatively low cost of home and community based services and the relatively high cost of nursing home care the provision of ample home and community based services will often be a cost effective option for the State of Alaska. The population of those in need of services will increase over time as will the cost of services. The information in this Chapter illustrates that home and community based services, because of the relatively low cost, must become an even larger part of the mix of long-term care services available to consumers in Alaska.

The following Tables, 2 and 2A, present information for long-term care services to those under 65 years of age.

TABLE 2.- Long-Term Care Services for Under 65 Age Group - FY96

Program	Service Units	Expenditures	GF Expenditures	Source/Comments
Nursing Homes*	50,233	\$ 11,139,258	\$5,569,629	DMA MMIS-STARS/Units are consumer days
ICF/MR - Hope*	13,843	\$ 4,936,809	\$2,468,405	DMA MMIS-STARS/Units are consumer days
ICF/MR - Harborview*	8,302	\$ 3,453,031	\$1,726,516	DMA MMIS-STARS/Units are consumer days
D.D. Grant Funded	636,925	\$ 17,035,000	\$7,035,000	DMHDD-units are estimated consumer days
TEFRA *	65,078	\$ 1,328,422	\$ 664,211	DMA MMIS-STARS/Units are consumer days
Waiver Program-ADP*	16,902	\$ 1,006,778	\$ 503,389	HCFA 372 Form DMA/Units are consumer days
Waiver Program-CCMC*	17,365	\$ 1,181,823	\$ 590,912	HCFA 372 Form DMA/Units are consumer days
Waiver Program- D.D.	44,238	\$ 4,268,157	\$2,134,078	HCFA 372 Form DMA/Units are consumer days
Personal Care Services(no TEFRA/Waiver)*	90,520	\$ 1,639,965	\$ 819,983	DMA MMIS-STARS/Units are consumer days
Commission on Aging Grants	13,989	\$ 101,575	\$ 101,575	Age under 60 / Units are hours of service
Personal Care Services	5,400	\$ 453,900	\$ 453,900	Div. Public Health/Units: hours of service**

* These numbers do not capture all expenditures since some payments for services have not been recorded and some payments have not been made.

** Estimate based on number of seniors in the program and number of Personal Care Services recipients funded under Medicaid

TABLE 2A Long-Term Care Services for Under 65 Age Group - FY96 (Condensed)

Program	Service Units	Expenditures	GF Expenditures	Cost Per Unit	GF Cost Per Unit
Nursing Homes	50,233	\$11,139,258	\$5,569,629	\$ 221.32	\$110.65
ICF/MR	22,145	\$8,389,840	\$4,194,920	\$ 378.86	\$189.43
Home Based Service - Days	871,028	\$ 26,460,145	\$21,747,573	\$ 30.38	\$24.97
Home Based Services - Hours	19,389	\$ 555,475	\$555,475	\$ 28.65	\$28.65

In Table 2A the Home Based Services are consolidated into two categories; one for Home Based Services measured by consumer hours served and the other for Home Based Services measured by consumer days.

Tables 3 and 4, (pages 25 and 27), show projections of low, medium, and high growth rates for the services and costs of the long-term care system in Alaska to 2015. The population growth and inflation rates used to make these projections are described in the text. It should be noted that ICF/MR institutions are being eliminated and these consumers needs are being addressed using home based services. This results in one time transfers of consumers and costs from ICF/MR to Home Based Services in the projections for the Under 65 age group.

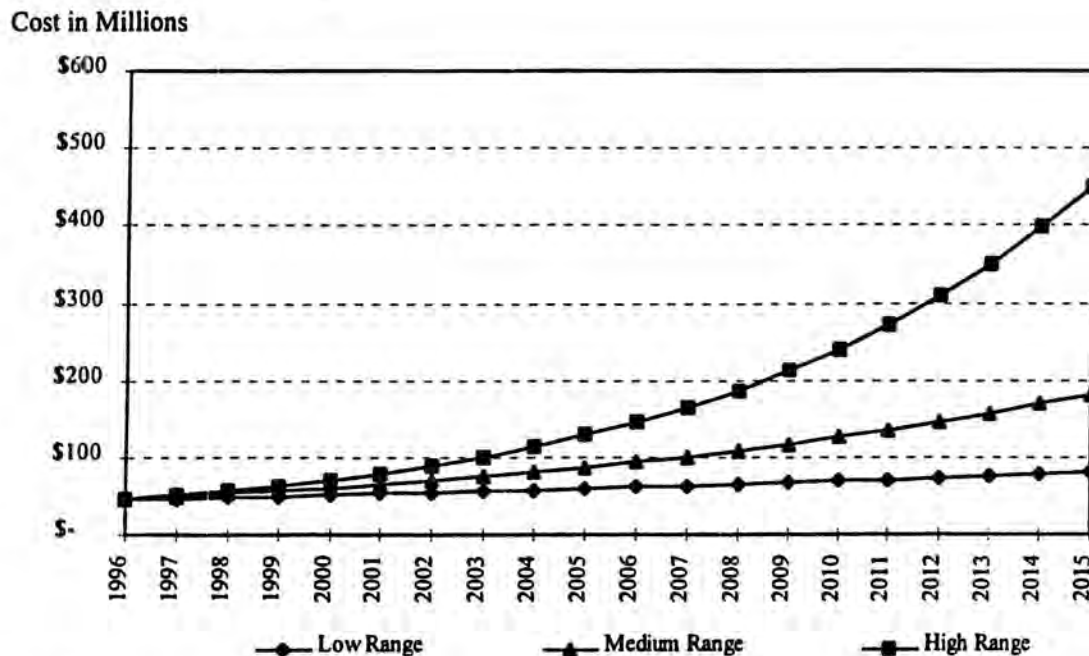
The tables and charts on the following pages show that the public costs of care for Alaska's senior population could grow by substantial amounts in the next twenty years. When planning for the future provision of services each consumer must be provided the most efficient and cost effective mix of services to meet their

needs. One strategy to do this will be to use lower cost services such as home and community based services whenever practical and try to keep the use of the higher cost services such as nursing home beds at a reasonable level. Judicious use of institutional alternatives must be considered as one strategy for keeping costs down. The State is charged with keeping costs at a minimum while providing the necessary services to all who have a need.

...the public costs of care for Alaska's senior population could grow by substantial amounts in the next twenty years...

The Anchorage Consumer Price Index, which is the closest proxy for inflation in Alaska, has recorded increases ranging from 2.1% to 6.2% per year since 1990. Anchorage Consumer Price Index increases as high as 13.7% and as low as 0.4% have occurred in the past 20 years. The Alaska Department of Labor, Division of Administrative Services, Research and Analysis Unit is the source of this Consumer Price Index information. Inflation factors of 2% for low, 5% for medium and 8% for a high range are used in this report to project cost increases to 2015.

Figure 2
Long Term Care Costs - Under 65 Years - 1996 - 2015



The future costs for the long-term care programs for those under 65 have been lessened somewhat by the planned closure of the ICF/MR facility at the Harborview Development Center and the conversion of the ICF/MR facilities of Hope Cottages. The growth of the long-term care programs for the population under 65 will still be significant over time if costs or population grow at even a moderate rate. The projections made for this

The growth of the long-term care programs for the population under 65 will still be significant over time if costs or population grow at even a moderate rate. ...A serious effort to use more home and community based services while maintaining a viable nursing home option must be made.

age group and for the 65 and over age group assume that the mix of services will not change (excepting the closure of the ICF/MR facilities and holding the number of available Pioneers' Home Beds constant). Thus one of the strategies for reducing future costs will be to change the mix of long-term care services used by the consumer. Nursing home care is one long-term care option that must be used efficiently by the consumer. A serious effort to use more home and community based services while maintaining a viable nursing home option must be made.

Table 3, on page 25, shows that for the low range projected increase of 1% population growth and 2% inflation growth, the cost of the long-term care service programs, for those under 65 years of age, would increase from \$46.5 million to \$79.7 million in 20 years. For the medium range projected increase of 2.5% population growth and 5% inflation the cost of the programs would nearly quadruple to \$181.3 million in 20 years. For the high growth projected scenario, an increase of 5% population growth and 8% inflation, the cost of the programs would increase from \$46.5 million to \$456.1 million, nearly a ten fold increase. The higher the growth of population and cost inflation the more pressure there will be to find the most efficient and cost effective program services for those Alaskans with long-term care needs.

Table 3. Long-Term Care System - Total Expenditures for those Under 65 - Projected to the year 2015

Low Range Projection 1% Population Growth and 2% Inflation Rate					
Year	Service Units-Hours	Cost per Unit-Hour	Service Units-Days	Cost per Unit-Day	Total Expenditures
1996	19,389	\$28.65	943,406	\$48.75	\$46,544,718
1997	19,583	\$29.22	972,074	\$47.79*	\$47,028,347
1998	19,779	\$29.81	981,794	\$48.75	\$48,448,603
1999	19,977	\$30.40	991,612	\$49.35	\$49,544,175
2000	20,176	\$31.01	1,001,528	\$50.34	\$51,040,409
2001	20,378	\$31.63	1,011,544	\$51.34	\$52,581,829
2002	20,582	\$32.26	1,021,659	\$52.37	\$54,169,800
2003	20,788	\$32.91	1,031,876	\$53.42	\$55,805,728
2004	20,996	\$33.57	1,042,195	\$54.49	\$57,491,061
2005	21,205	\$34.24	1,052,616	\$55.58	\$59,227,291
2006	21,418	\$34.92	1,063,143	\$56.69	\$61,015,955
2007	21,632	\$35.62	1,073,774	\$57.82	\$62,858,637
2008	21,848	\$36.33	1,084,512	\$58.98	\$64,756,968
2009	22,066	\$37.06	1,095,357	\$60.16	\$66,712,629
2010	22,287	\$37.80	1,106,310	\$61.36	\$68,727,350
2011	22,510	\$38.56	1,117,374	\$62.59	\$70,802,916
2012	22,735	\$39.33	1,128,547	\$63.84	\$72,941,164
2013	22,962	\$40.12	1,139,833	\$65.12	\$75,143,987
2014	23,192	\$40.92	1,151,231	\$66.42	\$77,413,336
2015	23,424	\$41.74	1,162,743	\$67.75	\$79,751,218

* Decrease due to the closure of ICF/MR facility (Hope Cottages)

Medium Range Projection 2.5% Population Growth and 5% Inflation Rate					
Year	Service Units-Hours	Cost per Unit-Hour	Service Units-Days	Cost per Unit-Day	Total Expenditures
1996	19,389	\$28.65	943,406	\$48.75	\$46,544,718
1997	19,874	\$30.08	985,893	\$49.61	\$49,506,515
1998	20,371	\$31.59	1,010,414	\$51.95	\$53,136,274
1999	20,880	\$33.16	1,035,675	\$53.37	\$55,965,468
2000	21,402	\$34.82	1,061,566	\$56.04	\$60,232,835
2001	21,937	\$36.56	1,088,106	\$58.84	\$64,825,589
2002	22,485	\$38.39	1,115,308	\$61.78	\$69,768,540
2003	23,047	\$40.31	1,143,191	\$64.87	\$75,088,391
2004	23,624	\$42.33	1,171,771	\$68.11	\$80,813,881
2005	24,214	\$44.44	1,201,065	\$71.52	\$86,975,940
2006	24,820	\$46.67	1,231,092	\$75.10	\$93,607,855
2007	25,440	\$49.00	1,261,869	\$78.85	\$100,745,454
2008	26,076	\$51.45	1,293,416	\$82.79	\$108,427,295
2009	26,728	\$54.02	1,325,751	\$86.93	\$116,694,876
2010	27,396	\$56.72	1,358,895	\$91.28	\$125,592,860
2011	28,081	\$59.56	1,392,867	\$95.84	\$135,169,316
2012	28,783	\$62.54	1,427,689	\$100.64	\$145,475,976
2013	29,503	\$65.66	1,463,381	\$105.67	\$156,568,520
2014	30,240	\$68.95	1,499,966	\$110.95	\$168,506,869
2015	30,996	\$72.39	1,537,465	\$116.50	\$181,355,518

For more detailed expenditure projection see Appendix II

High Range Projection 5% Population Growth and 8% Inflation Rate					
Year	Service Units-Hours	Cost per Unit-Hour	Service Units-Days	Cost per Unit-Day	Total Expenditures
1996	19,389	\$28.65	943,406	\$48.75	\$46,544,718
1997	20,358	\$30.94	975,800	\$51.22	\$50,609,333
1998	21,376	\$33.42	1,024,590	\$55.32	\$57,390,990
1999	22,445	\$36.09	1,066,575	\$53.38	\$57,745,711
2000	23,567	\$38.98	1,119,904	\$58.17	\$66,062,858
2001	24,746	\$42.09	1,175,899	\$65.82	\$78,444,651
2002	25,983	\$45.46	1,234,694	\$71.09	\$88,956,234
2003	27,282	\$49.10	1,296,429	\$76.78	\$100,876,370
2004	28,646	\$53.03	1,361,250	\$82.92	\$114,393,803
2005	30,079	\$57.27	1,429,313	\$89.55	\$129,722,573
2006	31,583	\$61.85	1,500,778	\$96.72	\$147,105,397
2007	33,162	\$66.80	1,575,817	\$104.46	\$166,817,521
2008	34,820	\$72.14	1,654,608	\$112.81	\$189,171,068
2009	36,561	\$77.91	1,737,338	\$121.84	\$214,519,992
2010	38,389	\$84.15	1,824,205	\$131.58	\$243,265,670
2011	40,308	\$90.88	1,915,416	\$142.11	\$275,863,270
2012	42,324	\$98.15	2,011,186	\$153.48	\$312,828,949
2013	44,440	\$106.00	2,111,746	\$165.76	\$354,748,028
2014	46,662	\$114.48	2,217,333	\$179.02	\$402,284,263
2015	48,995	\$123.64	2,328,200	\$193.34	\$456,190,355

Figure 3
Long Term Care Program Costs - Age 65 and Over
1996 to 2015

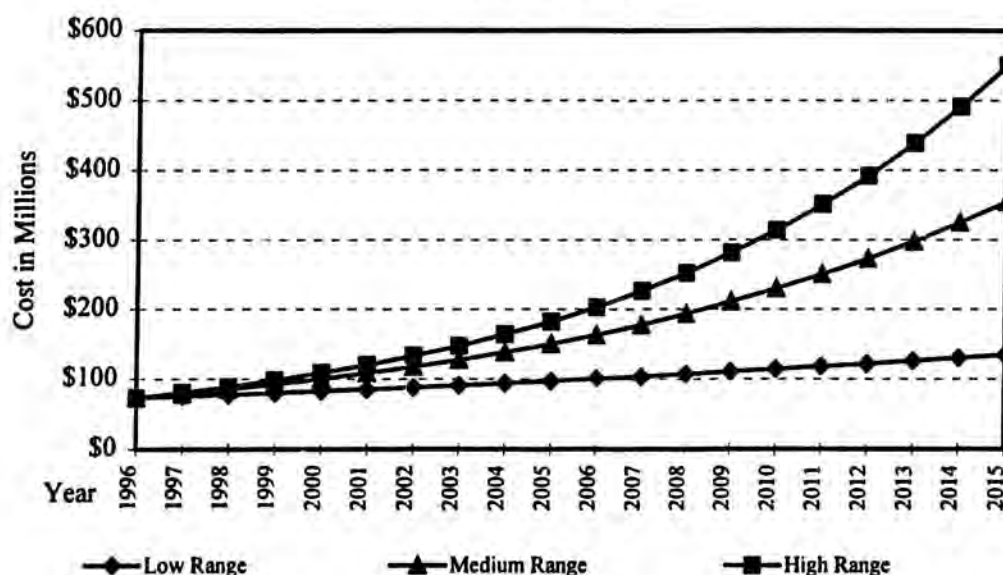


Figure 3 shows that for the population aged 65 and over the costs of long-term care services will continue to increase greatly in the future. The most optimistic projection scenario for low cost and population growth presented in Table 4, on the previous page, projects nearly a doubling in costs over 20 years. The cost projection for the high

growth scenario is \$550 million a year by 2015, this would cause such a demand for scarce funds for long-term care programs that many consumers could be denied needed services. This scenario must be avoided. Lower cost home and community based services could be used to reduce the demand for higher cost institutional based services when it is practical.

... for the population aged 65 and over the costs of long-term care services will continue to increase greatly in the future. ...Lower cost home and community based services could be used to reduce the demand for higher cost institutional based services...

The mix of services used to fulfill consumer needs is important. With resources becoming relatively finite, the 65 and above age group population growing and costs increasing, those who deliver long-term care services to this age group must insure an adequate supply of services to the greatest number of consumers while keeping costs at a sustainable level.

**Table 4. Long-Term Care System -Total Expenditures for those 65 and Over -
Projected to the year 2015**

Low Range Projection 2% Population Growth and 2% Inflation Rate					
Year	Service Units- Hours	Cost per Unit- Hour	Service Units- Days	Cost per Unit-Day	Total Expenditures
1996	266,187	\$13.35	743,077	\$ 93.35	\$72,920,191
1997	271,511	\$13.61	753,654	\$ 94.95	\$75,253,868
1998	276,941	\$13.89	764,442	\$ 96.57	\$77,669,543
1999	282,480	\$14.16	775,446	\$ 98.23	\$80,170,319
2000	288,129	\$14.45	786,670	\$ 99.91	\$82,759,384
2001	293,892	\$14.74	798,119	\$101.63	\$85,440,052
2002	299,770	\$15.03	809,797	\$103.37	\$88,215,763
2003	305,765	\$15.33	821,708	\$105.15	\$91,090,090
2004	311,880	\$15.64	833,857	\$106.96	\$94,066,749
2005	318,118	\$15.95	846,250	\$108.80	\$97,149,598
2006	324,480	\$16.27	858,890	\$110.68	\$100,342,644
2007	330,970	\$16.60	871,783	\$112.59	\$103,650,053
2008	337,589	\$16.93	884,934	\$114.54	\$107,076,154
2009	344,341	\$17.27	898,348	\$116.52	\$110,625,441
2010	351,228	\$17.61	912,030	\$118.55	\$114,302,588
2011	358,253	\$17.96	925,986	\$120.60	\$118,112,449
2012	365,418	\$18.32	940,221	\$122.70	\$122,060,069
2013	372,726	\$18.69	954,741	\$124.83	\$126,150,691
2014	380,181	\$19.06	969,551	\$127.01	\$130,389,762
2015	387,784	\$19.45	984,657	\$129.23	\$134,782,943

Medium Range Projection 5.432% Population Growth and 5% Inflation Rate					
Year	Service Units- Hours	Cost per Unit Hour	Service Units- Days	Cost per Unit-Day	Total Expenditures
1996	266,187	\$13.35	743,077	\$ 93.35	\$ 72,920,191
1997	280,646	\$14.02	771,804	\$ 97.28	\$ 79,013,298
1998	295,891	\$14.72	802,091	\$101.38	\$ 85,672,948
1999	311,964	\$15.45	834,023	\$105.67	\$ 92,955,538
2000	328,910	\$16.22	867,690	\$110.16	\$100,923,253
2001	346,776	\$17.04	903,185	\$114.86	\$109,644,706
2002	365,613	\$17.89	940,609	\$119.77	\$119,195,621
2003	385,473	\$18.78	980,065	\$124.91	\$129,659,576
2004	406,412	\$19.72	1,021,665	\$130.29	\$141,128,838
2005	428,488	\$20.71	1,065,525	\$135.93	\$153,705,275
2006	451,764	\$21.74	1,111,767	\$141.83	\$167,501,372
2007	476,303	\$22.83	1,160,520	\$148.01	\$182,641,353
2008	502,176	\$23.97	1,211,922	\$154.49	\$199,262,422
2009	529,454	\$25.17	1,266,117	\$161.27	\$217,516,138
2010	558,214	\$26.43	1,323,255	\$168.39	\$237,569,931
2011	588,537	\$27.75	1,383,497	\$175.84	\$259,608,789
2012	620,506	\$29.14	1,447,011	\$183.66	\$283,837,114
2013	654,212	\$30.59	1,513,975	\$191.86	\$310,480,784
2014	689,749	\$32.12	1,584,577	\$200.45	\$339,789,430
2015	727,216	\$33.73	1,659,014	\$209.47	\$372,038,957

High Range Projection 6.5% Population Growth and 8% Inflation Rate					
Year	Service Units- Hours	Cost per Unit- Hour	Service Units-Days	Cost per Unit- Day	Total Expenditures
1996	266,187	\$13.35	743,077	\$ 93.35	\$ 72,920,191
1997	283,489	\$14.42	777,452	\$98.21	\$ 80,436,622
1998	301,916	\$15.57	814,061	\$103.33	\$88,815,397
1999	321,540	\$16.81	853,049	\$108.74	\$98,163,163
2000	342,441	\$18.16	894,572	\$114.45	\$108,600,378
2001	364,699	\$19.61	938,794	\$120.48	\$120,263,142
2002	388,405	\$21.18	985,890	\$126.87	\$133,305,281
2003	413,651	\$22.88	1,036,047	\$133.62	\$147,900,712
2004	440,538	\$24.71	1,089,465	\$140.77	\$164,246,122
2005	469,173	\$26.68	1,146,355	\$148.34	\$182,564,016
2006	499,670	\$28.82	1,206,942	\$156.35	\$203,106,176
2007	532,148	\$31.12	1,271,468	\$164.85	\$226,157,582
2008	566,738	\$33.61	1,340,188	\$173.85	\$252,040,878
2009	603,576	\$36.30	1,413,375	\$183.40	\$281,121,425
2010	642,808	\$39.21	1,491,319	\$193.53	\$313,813,061
2011	684,591	\$42.34	1,574,329	\$204.28	\$350,584,625
2012	729,089	\$45.73	1,662,735	\$215.68	\$391,967,384
2013	776,480	\$49.39	1,756,888	\$227.80	\$438,563,453
2014	826,951	\$53.34	1,857,160	\$240.66	\$491,055,379
2015	880,703	\$57.61	1,963,950	\$254.33	\$550,217,019

For more detailed expenditure projections see Appendix II

CHAPTER 5: ALTERNATIVES TO THE PRESENT SYSTEM

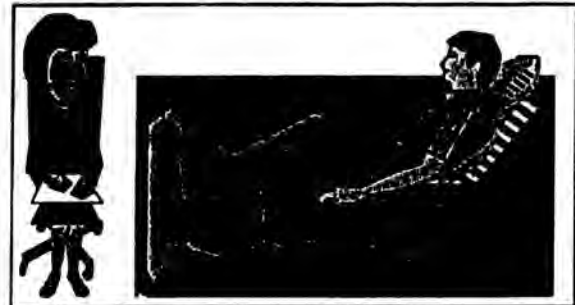
Senior Alaskans And Alaskans With Physical Disabilities. By 2015, Alaska's population of senior citizens age 65+ will increase by a projected 180% from the 1995 figure of 28,096 to 80,927, based on the medium growth projection data in this report. This will in turn propel growth in long-term health care and supportive service needs. Whereas it is estimated that 3,933 seniors now have severe impairments, by 2015 those with severe impairments will have grown to 11,225³.

The Working Group's goal is to advocate for long-term care that is responsive to the individual circumstances of Alaska's senior citizens and those with physical disabilities. To best meet growing long-term needs, our intent is to make **fullest use of Alaska's long-term care resources through a more flexible use of current resources, provide choice** in the types of available care, provide access to services as close to home as is feasible, assure that all options provide **quality services**, and expand the basic **long-term care capacity**. Our long-term care resources exist in terms of state and federal funding; families and community members who voluntarily commit their time, expertise and love to care for family and community members; non-profit agencies that meld locally-raised funding and in-kind contributions with state grants to provide home and community-based long-term care services; professional knowledge; and long-term care facilities such as assisted living homes and nursing homes.

Alaska will always need institutional care for severely medically needy individuals, and for people without families or social supports necessary to stay at home. As the community based long-term care system evolves, however, the focus of nursing homes is also changing. When people enter nursing homes now, they tend to have been discharged from a hospital and need rehabilitation services or short-term placements. Many people leave nursing homes to live at home with support from their families and home and community services.

Desired Entry Into The Long-Term Care System

Standardized Assessment and Care Coordination precedes all hospital discharges to long-term care placements.



What should be the features of a long-term care system that is responsive to the individual circumstances of Alaska senior citizens and those adults with physical disabilities?

- Home and Community-Based Care capacity is increased. Additionally, nursing homes will provide more flexible rehabilitative resources which maximize functioning and help return people to their homes, in addition to providing long-term skilled nursing care.
- They begin with a **standardized assessment of long-term care needs** used to establish the plan of care when a senior is discharged from a hospital, and when a senior living in the community develops a need for long-term care.

³ Based on the rate of occurrence of severe impairments for the population age 65+, as established by the *Forecast of Service Needs of Older Persons*, Savant, Inc. & Older Alaskans Commission, Juneau, 1991.

- Linked to the adoption of a standardized assessment is the **universal availability of consistent care coordination services**. These services, offered by trained providers, will ensure that long-term care resources are used strategically. This will promote best use of limited public funding, and assure an appropriate crafting and match of services for seniors' individual circumstances. Over time, our long-term care system should be poised to provide long-term care support to seniors earlier in the progression of a chronic condition or disease than is now provided for. This will reduce crises which require more intensive and expensive interventions.
- Basic long-term care services should be available **as near to home as is economically feasible**. This will take the shape of rurally-based care coordination in all regions of the State; the development of flexible strategies and funding for adult day services and respite care to support home caregivers; and the development of regional and sub-regional assisted living homes.

Alaskans With Developmental Disabilities.

The mix of long-term care services available to Alaskans with developmental disabilities should not change much over the next twenty years, although the language used describe specific services may change. No change to the eligibility definition is anticipated.

Services will continue to be provided on an individualized basis according to each consumer's desires, interests and needs and may include any of the following services: case management; family resource specialist; foster care; group home; in-home training; natural family supports and other assistive technologies; personal assistance services; respite; services for children who experience special health care and developmental needs; shared care; supported living; and vocational supports. However, the consumer is in no way limited to these services and, in fact, may design his or her own services to meet unique desires, needs and interests.

All services will continue to be provided in home and community-based settings in the consumer's community of choice. It is anticipated that current trends impacting service delivery will be operationalized across the state as follows:

- continued transition from funding services through grants to agencies to funding services according to individualized plans with money following consumers as they re-locate or negotiate service delivery with alternative providers;
- continued emphasis on funding low-cost early intervention services which help avert high-cost crisis situations;
- continued emphasis on developing natural supports in the community and assisting individuals with developmental disabilities to be full participants and contributors in local community life;
- continued collaboration with generic and specialized community resources (e.g. with local recreation agencies or with senior centers as individuals with developmental disabilities retire from the work force;
- gradual closure of group homes as additional supported living arrangements which more closely approximate those used by persons without disabilities are developed;
- implementation and evaluation of a core services approach for persons on the wait list which at a minimum includes the following: peer counseling (consumer-to-consumer and family-to-family), information and referral, and advocacy;
- increased emphasis on supporting communities and ordinary citizens to see themselves as competent and willing to become involved in the lives of people with developmental disabilities; and
- expansion of voucher programs which give funding control to consumers and/or their families.

CHAPTER 6: CERTIFICATE OF NEED PROGRAM

How The Program Works

Alaska, like most other states, has a certificate of need review process for health facilities planning to spend \$1,000,000 (one million dollars) or more for construction, expansion, or remodeling projects. Facilities that must comply with the process include hospitals and nursing homes and other facilities such as psychiatric or tuberculosis hospitals, kidney disease treatment centers, intermediate care facilities and ambulatory surgical centers.

The certificate of need review imposes a planning process to help control health care costs by requiring that a proposed project be of good quality and meet the public need, while preventing excessive, unnecessary or duplicative facilities or services. In the case of nursing homes, the certificate of need review seeks to ensure that, based on future projections, only the number of beds that are necessary be built, because of the high cost to Medicaid and the State general fund dollars that are associated with new beds.

The certificate of need review is initiated through a letter of intent sent to the Department of Health and Social Services. The letter of intent provides a project description, estimated cost and estimated starting and completion dates of a project. Based on the letter of intent, the Department of Health and Social Services determines if the proposed project requires a certificate of need review. If a certificate is required, a detailed application must be submitted. Once the application is received and declared complete, the Department of Health and Social Services provides an analysis and makes recommendations to the Commissioner of Health and Social Services who decides to approve or deny a certificate of need. Time frames for each step in the review process are provided for in law and regulation, and extensions may be granted as required. The decision to grant or deny a certificate of need may be appealed.

Current Standard Of Review

AS 18.07.041 requires the Department of Health and Social Services to grant a certificate of need if "the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services to maintain the good health of citizens of this State."

A certificate of need must be granted if the service is not available or not sufficiently accessible, and if the applicant demonstrates that the proposed services will be provided in a quality manner. Quality, for example, can be demonstrated if the applicant provides for an adequate level of staffing to operate the new services or if the applicant shows sufficient usage of the proposed service to obtain a high level of proficiency with appropriate staff training.

Limitations Of Current Standard Of Review

While availability, accessibility and quality are important, they are insufficient for assessing "a current or projected requirement for health services..." Meeting a current requirement does not mean that there is a long term need for the service or facility or that there will be the resources necessary to sustain the service or facility throughout its life cycle. Similarly, meeting a current or projected need does not mean that it is the most cost effective method for doing so; nor does it mean that the State, facing declining resources, should encourage and support a low priority service in the face of more pressing priorities. The certificate of need program requires more explicit statutory and regulatory definition in these areas to better control costs and better target the health care priorities of Alaskans.

Recommendations For Principles To Guide The Certificate Of Need Process

The Working Group believes that basing certificate of need reviews only on matters of availability, accessibility and quality, as is now required by statute, is insufficient. Other important principles should be used, including: appropriate planning, demonstration of need, and cost effectiveness when reviewing applications which impact the State's long-term care system. Therefore, the Working Group believes that the Department of Health and Social Services should seek legislative approval to strengthen the certificate of need program by adding these important principles to the certificate of need statute (AS 18.07). This will allow long-term care projects to be reviewed under the following principles:

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Appropriate Planning The Working Group believes that all certificate of need projects should be planned in the context of statewide as well as regional and community needs.

Of primary importance is the development of a State long-term care plan which outlines the existing and desired long-term care system in a comprehensive manner. Proposed projects should integrate well with the existing long-term care system. Certificate of need applicants would be required to demonstrate how well their proposal would fit with other plans, including community, agency and statewide plans, and ongoing services.

Proposed projects must reflect public participation and support. This can be demonstrated by a high level of participation in a public hearing or written support for a proposed service. In addition, for proposed community projects, support may be demonstrated by a local municipality or borough providing matching funds through local tax levies or bond referendums. The applicant must also discuss the approaches used to involve affected groups (e.g. potential recipients and family members, community service providers) in the planning process; a summary of their input; and a description of how the proposal is responsive to their input.

Finally, a proposed project should help balance out the long-term care system by ensuring a mix of services consistent with community needs and desires to have alternative choices.

Quality: As is the case with the current certificate of need statute, (AS 18.07.041) the quality of a proposed project must also be demonstrated. As mentioned above, quality can be demonstrated if the applicant provides for an adequate level of staffing to operate the new services or if the applicant shows sufficient utilization of the proposed service to obtain a high level of proficiency with appropriate staff training.

Demonstration of Need: The Working Group believes that proposed projects should convincingly demonstrate need through sufficiently high projected utilization rates to justify the expenditures. For example, projected population growth rates should be sufficient to support a proposed project. Nursing homes seeking to replace old or worn out infrastructure should have to demonstrate facility deficiencies and ongoing need. Specific review standards should be used to determine this need. These standards should include methodologies and criteria for determining bed capacities as well as thresholds for approving the expansion of the health care system. As is the case with the current certificate of need statute, (AS 18.07.041) availability and accessibility to health care services also need to be considered in demonstrating need.

Cost Effectiveness: The Working Group believes that cost effectiveness of a proposed project should be demonstrated before it is approved. Proposed projects need to be compared against feasible alternatives to determine if the proposal is the most cost effective way of achieving comparable results. The assessment of financial feasibility should address the full life of the project or at least a significant part of the life of the project and include such items as the availability of funds to pay for the project, the likelihood of private or governmental financing, and the passage of a bond referendum by a community.

The Working Group believes that it is critical to recognize the financial impact of nursing home bed expansion on the Medicaid program. Approximately 90 percent of nursing home expenditures in the State are made by Medicaid. To maintain an individual in a nursing home costs approximately \$75,000 per year, consequently, expansion of nursing home beds has significant policy implications for the State. Therefore, the Working Group believes that the potential financial impact, to the consumer and the State, of expanding the number of nursing home beds warrants approval by the legislature for larger projects.

Recommendations: The Working Group recommends that in the case of a certificate of need application related to long-term care services the following actions be taken;

- if subject to the certificate of need process the application is reviewed by the Department to assure that it complies with all criteria,
- if the proposed expansion of service (through the addition of new or replacement nursing beds) is projected to cost the State more than \$3,000,000 in Medicaid reimbursement for operating and capital costs⁴ over the first ten years of the project, the certificate of need issued by the Department of Health and Social Services will be considered approved upon adoption of a legislative resolution approving the project and recognizing the cost impact on the Medicaid budget,
- if the proposed expansion of services (through the addition of new or replacement nursing beds) is projected to cost the State less than \$3,000,000 in Medicaid reimbursement for operating and capital costs over the first ten years of the project, cost effectiveness should be considered by the department as a review criteria but a legislative resolution is not required.

The working group recognizes that there are differences in construction and operating costs between urban and rural areas. The Department should take geographical cost differences into consideration when evaluating certificate of need applications.

The following page contains a summary of the recommended Guiding Principles/Criteria to be used for reviewing certificate of need applications.

⁴ The estimated per diem rate for the facility will be used to determine whether proposed facility costs will be over the \$3,000,000 threshold which require legislative approval for funding. Per diem rates may be estimated by the facility, by the Medicaid Rate Advisory Commission, or using a per diem rate of a similar size facility located in Alaska.

RECOMMENDED GUIDING PRINCIPLES/CRITERIA FOR CERTIFICATE OF NEED

Criteria and Standards are used in each Certificate of Need application review to determine findings of need or no need for a project and to make recommendations as to whether a project should be approved or not.

CURRENT LAW	PROPOSED ADDITIONS	
Current State Certificate of Need law only allows consideration of availability, accessibility, and quality Availability • Services not available Accessibility • Services not sufficiently accessible Quality • Adequate staffing • Adequate resources • Adequate training • Adequate no. of procedures	Appropriate Planning • Relationship to existing plans • Public participation - including local financing of the project • Relationship to existing health care system • Consensus of community • Balanced system Quality (in current law) • Adequate staffing • Adequate resources • Adequate training • Adequate no. of procedures	Demonstration of Need • Utilization • Population growth • Deficiencies in existing facilities • Adopt specific standards of review • Availability (in current law) • Accessibility (in current law) Cost Effectiveness • Availability of less costly/more effective <u>alternatives</u> • Financial feasibility • Cost of similar service in area • The cost impact to the consumer and the state, and • Legislative resolution supporting new costs based on a financial threshold

STATE HEALTH POLICY PLAN

There is a need to develop a state health policy plan which outlines statewide, regional and community needs. Also, if allowable, the CON law needs to include language that requires federal facilities competing for state dollars to be reviewed.