This is an ongoing project. This document reflects activity through June 30, 2009. Updates will be provided on the web-site at www.chfwcny.org

PROJECT CODA*:

A LOCALLY DRIVEN STRATEGY FOR **C**REATING **O**PTIONS FOR **D**IGNIFIED **A**GING IN ERIE & NIAGARA COUNTIES

*__Creating Options for Dignified Aging (CODA):__ In music, the coda is the last section performed and leaves a lasting impression of the performance in people's minds and hearts. In life, our coda should be just as memorable – full of respect, dignity and independence, with supportive family and community systems and high quality, appropriate health care.

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EXECUTIVE SUMMARY

The Community Health Foundation of Western and Central New York is dedicated to improving the quality of life of frail elders . The Foundation has assumed a vital leadership role to unite key stakeholders around the common goal of developing a person-centered approach to serving the needs of the elderly With its commitment to creating new service options for the elderly , the Foundation has invested significant financial and human resources to address the question: "Are we prepared to meet the evolving service and program demands of older adults in Erie and Niagara Counties?"

Henri Amiel once wrote, *"To know how to grow old is the master-work of wisdom, and one of the most difficult chapters in the great art of living."* The art of living requires planning and preparation. Just as there is no "one-size-fits-all" blueprint for individuals to grow older, there is no one solution for long-term care that "fits" every community.

Project CODA: *Creating Options for Dignified Aging in Erie and Niagara Counties* has developed a locally driven elderly-centered strategy that is based upon in-depth research on the demographics and specific needs and wants of elders, caregivers and service providers. The strategy lays the foundation for a framework that other communities can build upon to meet the changing expectations of elders.

To build a successful roadmap for the future it is important to know where you are and what path brought you to your present location. This document begins by providing an overview of the existing long-term care system in Erie and Niagara counties. It presents a snapshot of occupancy rates for skilled nursing facilities in the two county region and uncovers widespread fragmentation among levels of care.

Forecasting the future of long-term care was perhaps the most challenging aspect of the CODA project. It required developing models to project future economic and demographic trends, likely shifts in public policies and changes in consumer preferences.

The forecasts coupled with clinical and operational insights led to the development of a dashboard for projecting the future demand for aging services . Utilizing an interactive model, Project CODA steering committee members and long-term care stakeholders evaluated and compared the trade-offs of various approaches and came to an understanding about the impacts of changing reimbursement and revenue streams. Two distinct scenarios were developed to forecast the future of long-term care, including projecting the demand for skilled nursing facility care, assisted living programs, independent housing and community based supports.

The overall trends, which can be gleaned from the CODA Project's research, indicate that:

- If funding for home and community based serves and assisted living program units is available, the demand for skilled nursing home beds will decline in the Erie/Niagara region.
- The demand for community based services will increase, particularly if the current economic climate negatively impacts the resources of elders over the long term.
- If assisted living program beds (Medicaid eligible) are available, there will be increased usage of these services in both Erie and Niagara counties.
- Healthcare workforce shortages will continue to be a challenge for providers as they attempt to meet the demands of older adults. This issue will become particularly acute as the availability of informal caregivers declines.

- Public policy will encourage innovation to meeting increasing service demands and changing client preferences.

The CODA Project led to a shared mission statement, a set of guiding principles and a overarching vision statement to guide the development of an optimal long-term care service system for Erie and Niagara counties for 2027 and beyond. From this vision, a blueprint of community-based models and strategies to reinvent long-term supports for the elderly was formulated. These reinventions include initiatives to improve transitions of care, expand affordable and accessible housing, assure an adequate healthcare paraprofessional workforce, develop neighborhood-based care systems and shift policy to promote an elderly individual's right to prudent, informed self-determination.

The CODA Project has not only formed a roadmap for reshaping elderly services to address consumer demands and overcome existing service constraints, but it has also created a platform for educating and informing policymakers about evolving elderly services issues and the need for regulatory change. Equally important, the project provides guidance that may help influence investor decisions regarding appropriate financial investments in elderly services.

The Community Health Foundation of Western and Central New York encourages all interested parties…from elderly persons, service providers, policy makers to all other stakeholders…..to join us on the CODA journey.

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PREFACE: A PERFECT STORM

PROJECT CODA: **Creating Options for Dignified Aging in Erie & Niagara Counties**

Western New Yorkers are adept at dealing with storms and have gained national notoriety for being able to manage the "Lake Effect" phenomenon. Lake effect storms occur when a number of elements are present; they become more intense and eventually create instability. Weather, although not a perfect science is somewhat predictable. Unfortunately, another, less predictable storm-like event is rapidly forming in our region.

Erie & Niagara Counties are experiencing major demographic shifts in their populations. Declines in the middle aged population coupled with increases in the number of older adults (particularly the 85+ cohort, which will double by the year 2015) have significant implications for the regional economy, labor force and caregiver burden. Those demographic trends combined with other factors are creating "a perfect storm".

The Community Health Foundation of Western and Central New York is committed to supporting quality service options for the care of frail elders and to bridging identified service gaps. Given concerns over the immediate impact of facility closures and the future needs for long-term care in the area, the Board of Trustees of the Community Health Foundation approved significant funding to conduct a comprehensive study of long-term care in Erie and Niagara Counties. The Creating Options for Dignified Aging (CODA) project was designed with short, mid and long-term time horizons.

WHERE WE ARE AND HOW WE GOT HERE

Project Timeline:

A 12- month timeline for the project was initially established. The project was officially launched in January 2008. A clear set of deliverables was established for each project phase and procedures for routinely monitoring progress were put in place.

Project Overview:

Since 2004, The Community Health Foundation has had frail elders as one of the populations of interest. Due to the lack of a formal community plan for long term services for the elderly in WNY, this project was designed to examine long-term care needs in Erie and Niagara Counties and to generate critical data and information that can be used by multiple constituencies.

This effort was launched with three important aims:

- provide a guide for health system strategic planning
- help inform policy makers about the need for regulatory change
- promote sound decision making regarding programmatic and financial investments in elderly services.

The Foundation considered several possible obstacles when designing the project plan. First, since The Community Health Foundation had no "official authority", the buy-in of key constituencies to the tenets of the plan was considered a paramount objective. Secondly, given the 20-year time horizon for the project, it was important to maintain interest among the partners in long-term planning issues. Last but not least, the project had to confront the reality of high poverty levels among the elderly in Erie and Niagara Counties.

With the community as its primary client, project work began under the guidance of a Steering Committee. The Committee was comprised of key long-term care providers, community advocates for seniors, Department of Health representatives and other critical constituencies. Project tasks were conducted by consultants who have subject matter expertise in the areas outlined below. The Core Planning Committee consisted of the following:

- *Catholic Health System*
- *Kaleida Health*
- *Erie and Niagara County Offices of Aging*
- *Elderwood*
- *Weinberg Campus*
- *NYS Department of Health – Regional Office and State Office of Long Term Care*

The committee was eventually expanded to include representatives from:

- *Erie County Home Care Consortium*
- *Jewish Family Services (CASA coordinator)*
- *Center for Transportation Excellence*
- *Niagara County Long Term Care Advisory Board*
- *Niagara County PACE program*
- *AARP, WNY Regional Coordinator*

Project Phases and Key Research Questions:

The CODA project was officially launched in January 2008. A 12-month timeline was established for completing the first part of the project. Consensus was reached among the Steering Committee that the project should progress in phases as outlined below.

PHASE ONE: Define existing elderly demographics and forecast trends among this population.

PHASE TWO: Examine nursing home utilization patterns to avert a potential short-term crisis.

PHASE THREE: Project the demand for elderly services.

PHASE FOUR: Using two different sets of assumptions, forecast service delivery needs three to five years from now and twenty years from now.

PHASE FIVE: Engage in collective learning to ensure comprehensive planning.

PHASE SIX: Formulate mission and vision statements for the CODA project and determine principles to guide the effort.

PHASE SEVEN: Develop pilot projects.

A clear set of deliverables was identified for each project phase and procedures for routinely monitoring progress were put into place.

Several essential questions guided the development of the CODA project, to wit:

- What measures can be taken to improve the quality of life of the frail elderly?
- How can provider outcomes be improved?
- How can elderly services and outcomes be enhanced at an affordable cost (financial + effort) to sponsoring organizations (government, not-for-profit and for profit)?
- What person-centered best practices or new approaches can be implemented to permit frail elders and older adults to live in the community and remain independent as long as possible?

PROFILE OF THE ELDERLY POPULATION IN ERIE AND NIAGARA COUNTIES

-PHASE ONE-

The demographic profile of Erie and Niagara Counties is changing. Projected growth in the age 65 and over population will continue to increase as aging "Baby Boomers" join the ranks of the elderly.

With 3.4 million individuals aged 60 and older residing in New York State, New York has the third highest elderly population of any state in the nation. "By 2015, older people will constitute 20-24% of the county population in 35 counties and 25-29% of the county population in 17 counties. It is interesting to note that 8 percent of the female population (aged 60-79 years old) who reside in both Erie or Niagara Counties are living below the federal poverty level"[1]

As indicated in Figure One, by the year 2027, the age 65-84 population will increase by 16% in the City of Buffalo; 30% in Erie County outside of Buffalo and by 36% in Niagara County.

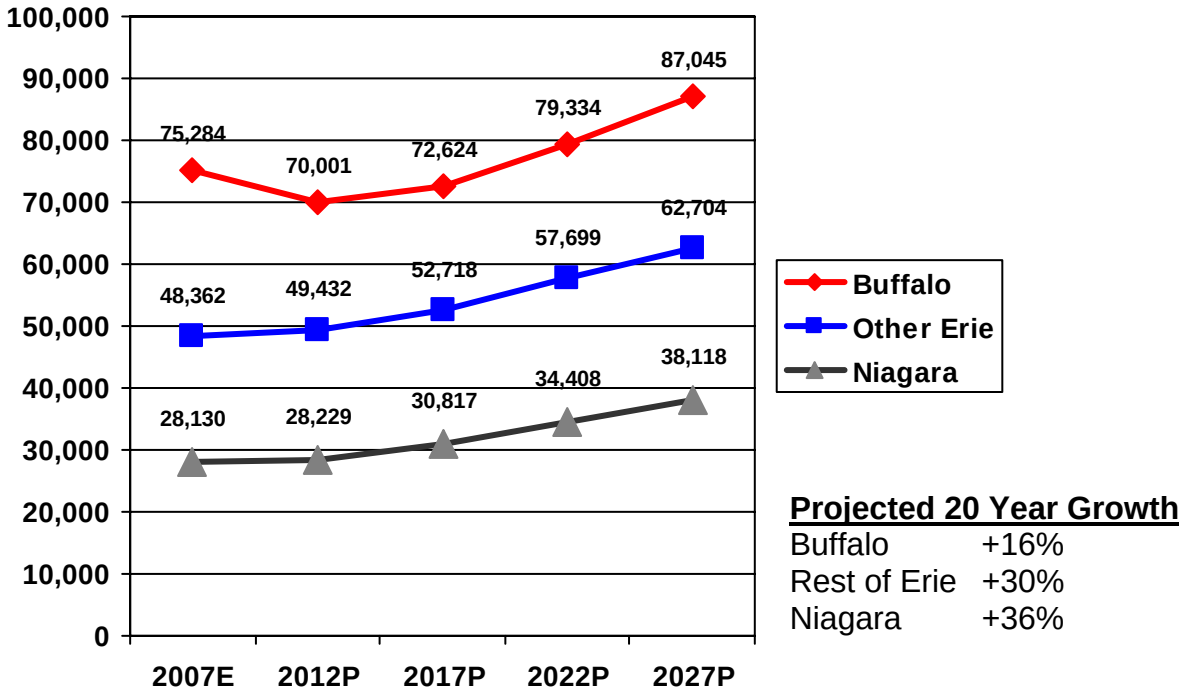

Figure 1: Erie and Niagara County Estimated 65-84 Population Changes
(*Source: KS&R Project CODA Report)*

[1] New York State Office for the Aging (NYSOFA) Four-Year Plan submitted to the Administration on Aging(AoA)

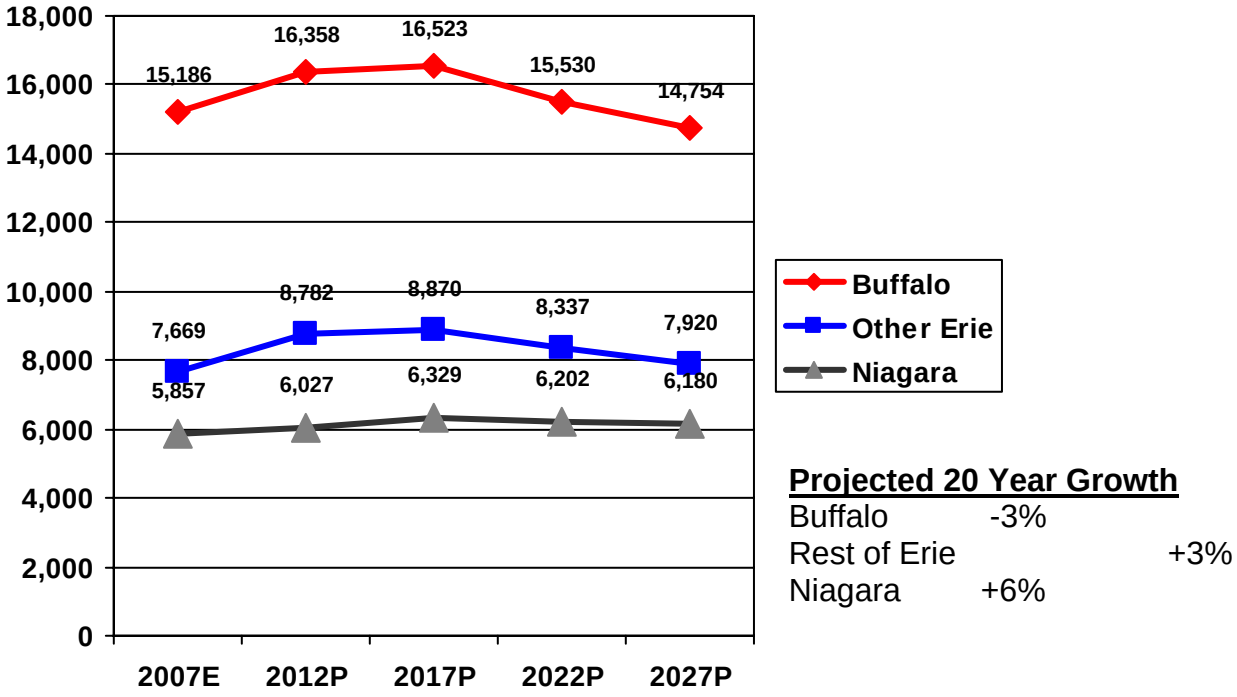

Figure 2: Growth in 85+ Population
(Source: KS&R Project CODA Report)

Figure Two illustrates that the age 85 plus population will reach its peak by the year 2017. During the ten-year period 2007 through 2017 this sector of the elderly population will grow by 8.8% in Buffalo; 15.7% in Erie County (exclusive of Buffalo); and by in Niagara County

The impact of this "graying population" will be felt at every level in our community. ***Community based services to support these elders will become increasingly important.*** Persons age 85 plus will require assistance with everyday activities. Elderly persons age 65 – 84 will need short term intermittent services such as rehabilitation. ***Assuring these elders can maintain their independence will require careful planning.***

IMMEDIATE / SHORT-TERM CONCERNS IMPACTING LONG-TERM CARE IN ERIE AND NIAGARA COUNTIES -PHASE TWO-

In December 2006 the New York State Commission on Health Care Facilities in the 21st Century, commonly known as the Berger Commission, recommended the closure of four Residential Health Care Facilities (RHCF) located in Erie and Niagara counties. The Commission also recommended the restructuring of two long-term care programs including the establishment of a second Program for All-Inclusive Care of the Elderly (PACE) at Our Lady of Victory in Lackawanna, N.Y, and the conversion of St. Elizabeth's of Lancaster from an adult nursing home to an assisted living facility. The Commission set June 30, 2008 as the deadline for downsizing the four Resident Health Care Facilities.

Work conducted in the initial project phase was driven by concerns that other nursing homes in the area, particularly those with a history of acute financial and quality of care issues, would close. These concerns were heightened by the knowledge that nursing home occupancy rates in both Erie and Niagara counties were approaching 100 percent of capacity and that the number of nursing home beds would be insufficient to meet nursing home care service needs.

Fortunately, the anticipated "crisis" did not occur. As facilities began to close and the number of available nursing home beds was reduced, there was sufficient capacity within the system to meet the ongoing demand for nursing home services. The availability of nursing home beds under these circumstances may be attributed to the decreasing lengths of nursing home stays among frail elders. Personal choice may be another significant factor. Given an option of home-based or facility based care, many individuals are following the trend and expressing their preference to remain in their home.

Snapshot:

This study objective sought to formulate information on the composition of long term care residents. The Western Regional Office of the New York State Health Department sponsored a survey that requested all nursing homes in Erie & Niagara Counties to report on occupancy rates at January 16, 2008. Area nursing homes were also requested to provide a snapshot of each resident (no resident names were used), describe the status of each resident and list potential barriers to discharging each resident to another level of care or to a home setting.

The response to the survey was excellent. In Erie County, 41 out of the 42 facilities responded and in Niagara County all 10 facilities provided data on their residents.

PERCENT OCCUPANCY AT SNF'S IN ERIE AND NIAGARA COUNTIES

County	Total Licensed Beds	%	Sub Acute Beds	%	General Acute/ SNF Beds	%
Erie	6572	96.18	876	90.07	5696	97.1%
Niagara	1430	97.76	171	95.32	1259	98.0%

At January 16, 2008, the overall nursing home occupancy rate in Erie County was 96.18 percent and in Niagara County it was 97.76 percent. The General Acute/Skilled Nursing Facility (SNF) bed occupancy rates and Sub-Acute occupancy rates generated by this survey of nursing homes in Erie and Niagara counties mirrored nursing home occupancy findings reported by the Western Regional Office in previous census reports. The high occupancy rates reported by this survey underscored the need to continue close monitoring of skilled nursing home occupancy in Erie and Niagara counties.

The survey also found that one-third of all SNF residents in Erie County were ranked as low acuity scoring[2]. In Niagara County, low acuity patients comprised 36 percent of the SNF population. The high number of low scoring patients revealed in the survey significantly exceeded previously assumed estimates on the prevalence of low scoring patients. These survey findings indicated that many low-scoring residents could be placed in a lower level of care if such alternative of care opportunities were available to them.

The top five "potential barriers" to placing a resident in community care that were most frequently cited by nursing home administrators were:

- Wheelchair bound
- Lack of outside support
- Homeless
- Difficult Behaviors
- Residents Won't Leave

Interestingly, the survey found that the Medicaid program funds the majority of these low-scoring patients (69% of such SNF residents in Erie County and 77% of low-scoring residents in Niagara County). It is estimated that the total cost of providing nursing home care to these low scoring Medicaid patients exceeds **$107.8 million** annually. New York State's share of these expenditures (projected at 40% of gross expense) exceeds $43 million.

This snapshot of nursing home residents in Erie and Niagara counties is limited in its predictability because it represents factors present at a single point in time. But, the resident census data generated by the project provided a glimpse of some of the key issues facing the long -term care system, including: the high cost of nursing home care; restricted placement options; and the need for service alternatives.

A Fragmented System of Long Term Care Options:

Another important element involved reviewing the long-term health care service environment in Erie & Niagara counties and determining the financial stability of each component. The Certified Public Accounting firm of Freed Maxick & Battaglia, PC was commissioned to prepare this portion of the study. In its report, Freed Maxick described a "fragmented system of long-term care options", beginning with the Skilled Nursing Facility (SNF) which offers a wide array of complex care, followed by a steep drop off in the continuum of care, "unless residents have funds to pay for services privately."

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[2] SNF's use the Minimum Data Set 2.0 (MDS 2.0) instrument to obtain a comprehensive assessment of each resident's functional capabilities. The evaluation determines whether and how frequently the patient needs assistance to engage in a given task, such as walking, ability to feed self, use the toilet or getting dressed, as well as the type of help involved (e.g., weight bearing or verbal encouragement). Low scoring individuals need less assistance with their activities of daily living

Figure 3 illustrates the board spectrum of services that often constitute Long Term Care services/supports. Eligibility for many of these options is dependent upon the source of payment (Medicare, Medicaid, and Private Pay).

The Freed Maxick report echoed survey findings by noting that a relatively high percentage of nursing home residents covered by Medicaid is classified at "lower acuity" levels. These residents would be able to reside in settings that are less costly and less "institutional" if other service options existed.

The firm's report pointed out that there is a limited number of licensed assisted living facility beds in Western New York that are eligible to receive Medicaid reimbursement. The Freed Maxick report noted that the Medicaid program in New York State has not adequately provided funding streams that would permit "right sizing" to occur, causing residents to remain at the skilled nursing level of care and resulting in higher costs to the system.

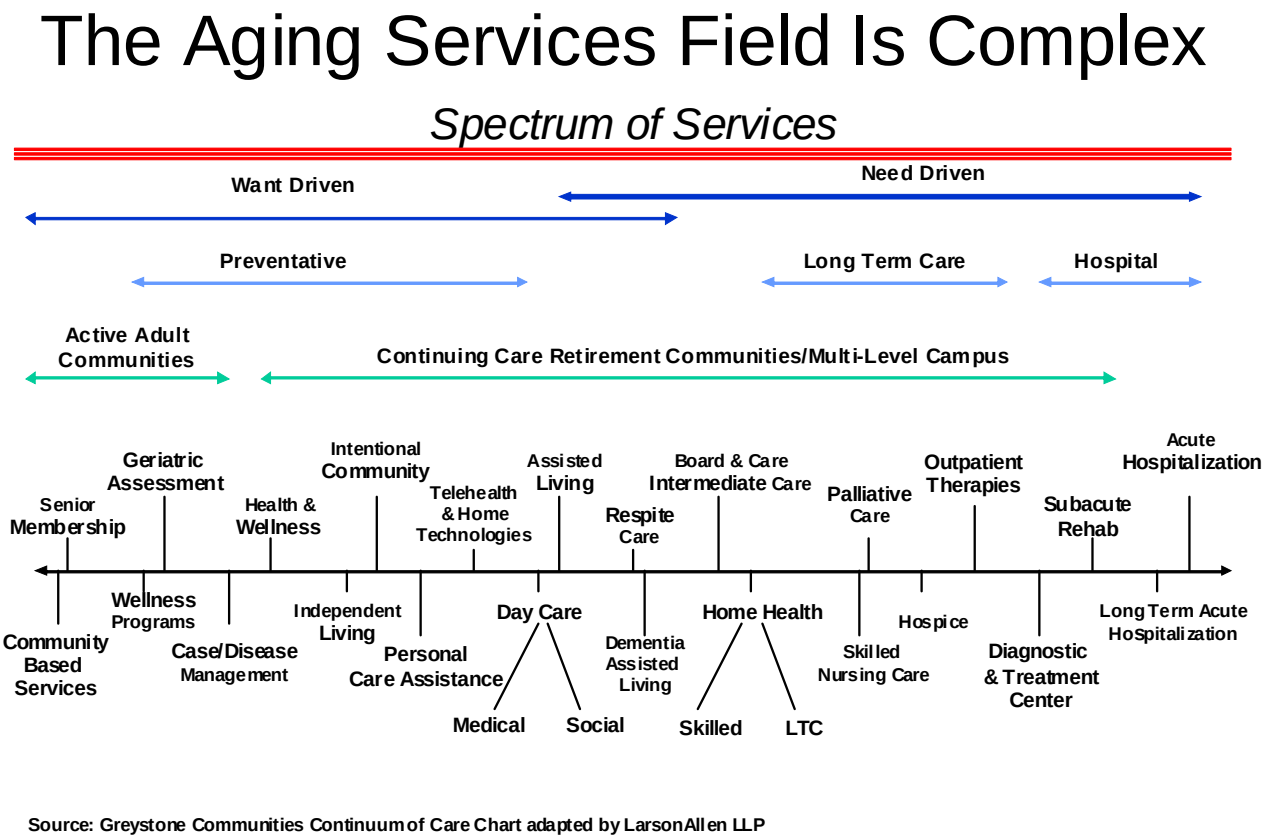


Figure 3: Illustration of the complexities of the broad spectrum of long term services and supports – there are limited connections between levels of support. Transitions between levels of care are not seamless.

PROJECTED DEMAND FOR ELDERLY SERVICES
-PHASE THREE-

KS & R Market Study:

In an effort to forecast the demand for future services, the Community Health Foundation retained the Market Research firm of KS&R. Specifically, KS&R was requested to conduct an in-depth assessment of long term care needs in Erie and Niagara Counties. In addition, the firm was asked to provide information on demographic trends, project household incomes in Erie and Niagara Counties; identify non-nursing home facilities and programs in the two counties and conduct a demand analysis (need versus supply).

The results of this investigation demonstrated the need for affordable and accessible options in long term supportive services. This research assigned the highest priority need to the development of Assisted Living Program units (Medicaid eligible) to serve elderly persons requiring dementia care as well as those without cognitive impairments. Private pay Assisted Living units were ranked as the lowest priority.

KS&R combined secondary research and one-on-one executive-style interviews to obtain the needed information.

Tasks completed on behalf of the Community Health Foundation were the following:

- Completed one-on-one interviews with managers at senior living facilities (other than nursing homes and home care agencies)
- Conducted secondary research via the internet. The internet was used as a source for supplementing information received as a result of the interviews.
- Obtained demographic information. *Claritas, Inc., Woods & Poole Economics,* and *New York Statistical Information System (NYsis)*[3] data obtained.
- Performed a demand analysis to compile information about need versus supply, i.e., how many seniors in the two county area will require services and what services are available?

Priorities Established from KS & R Market Research

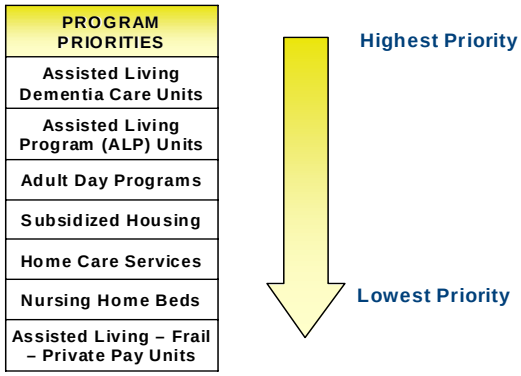


Figure 5: ***KS&R Market Research Study for CHF of W&CNY***

[3] Source: Cornell Institute for Social and Economic Research

The diagram shown in Figure Four depicts the program priorities identified in the KS&R market research. A summary of the key issues and priorities identified in the market research are summarized below.

Summary of Key Issues – Market Research Priorities:

- Assisted Living Dementia Care Units
  Both counties show an estimated under-supply of assisted living care units for individuals with memory problems. Using a conservative estimate of a 30-bed unit or 50-bed facilities, Erie County is in need of at least 8 to 10 more memory care units or facilities. Niagara County could use at least two more memory care units or facilities.
- Assisted Living Program (ALP) Units
  Projected need versus supply of subsidized assisted living units in both areas indicates that there is an under-supply of these types of units.
- Adult Day Programs
  There is a projected need for adult day programming by 1,800 to 2,000 individuals in Erie County over the next twenty years. This projection does not differentiate between social and medical model needs nor does it provide for projections of need for people with memory problems. The 13 programs currently providing adult day services in Erie County serve approximately 30 people per day.
  Niagara County has a projected need for adult programming by 400 to 550 people for this same time period. Currently, there are two adult day programs in Niagara County with two PACE programs expected to be open by 2010. People like to stay in their homes for as long as possible. Although there are some options available, there are not enough programs to meet the projected need in either Erie or Niagara Counties.
- Subsidized Housing
  The majority of housing authorities and other providers of subsidized housing for seniors indicated they have waiting lists of 6 to 12 months.
- Formal Home Care Services
  In Erie County, it is projected that at least 30,000 people age 65+ years for the current year as well as the next twenty years have a need for home care services. This is a projected need for formal care, i.e., paid services. In Niagara County, at least 7,500 individuals are estimated to need formal home care in the current year. This need will continue to increase in the next twenty years.
- Nursing Home Beds
  There is an over-supply of nursing care beds in Erie County. Niagara County has a projected need that may be fulfilled with the new PACE programs slated to open soon.
- Assisted Living – Frail – Private Pay Units
  There is an over-supply of assisted living – frail private pay units in both counties.

The executive interviews conducted by KS&R revealed other important observations that shed light on service demands and service availability. Key points concerning these findings are summarized below:

- The suggestions for needed community services for seniors that were made by individuals interviewed for this project are similar to those uncovered in the market research. These included more for more ALP units, additional assisted living dementia care for lower income people, more adult day care, and more affordable services.
- A suggestion that was frequently mentioned by these interviewees concerned transportation services for the elderly. Most agencies reported that they are not able to provide this service

due to lack of money to start-up such services, lack of reimbursement sources for providing the service, lack of staff, and concern for liability concerns.

- Related to this lack of transportation issue is the location of care options in Erie and Niagara Counties.
  - A review of the geographical locations of care options available for seniors in Erie County shows that the majority of offerings are in the suburbs within 10 to 15 miles of the city of Buffalo. These are areas that have higher concentrations of people and higher concentrations of higher household incomes. The exception to this is subsidized housing which is more concentrated within zip codes designated for the city of Buffalo.
  - Rural locations have sparse offerings with regard to senior services. Although these areas are aging at the same rate as other areas of Erie County, the choices available to seniors are limited.
  - In Niagara County, senior offerings are in the more populated areas of North Tonawanda, Lockport, and Niagara Falls. With the exception of a subsidized housing complex in Newfane, almost no senior services are in the more rural areas of Niagara County.
- Some individuals interviewed noted that current gasoline prices are affect the willingness of home care agency workers to travel to these remote areas. High gasoline prices also will influence whether transportation can be provided for adult day programs. In addition, family members in a rural area may not move a loved one to a care facility in the suburbs because of the distance to be traveled to visit.
- Another contributing factor to the decline in admissions at care facilities will be the change in the ethnic makeup of the region, especially Erie County. Most care facilities have historically had a high proportion of white residents.
  - Historically, African American cultures have been higher users of home care. Nationally, this trend has begun to change in that the proportion of white residents at care facilities has started to decline while the proportion of African Americans has increased. The percentage of African American residents in Erie County is expected to rise from 14% in 2007 to 25% by 2017.
  - Hispanic and Asian cultures tend to care for their elderly family members at home using informal care systems. Whether or not these families follow the trend of African American families and begin to use care facilities is yet to be seen. In the meantime, they may increase their use of formal home care and adult day programs. In Erie County, these ethnic groups represent about 7% of the population. They represent approximately 3% of the population in Niagara County.
  - Language issues, religious observance, and food preparation will all need to be considered when providing services for these ethnic groups.

Findings from the KS&R study underscored the need to allocate resources to serve the elderly population based on identified needs and careful planning. In planning for the future, not only do affordability issues need to be addressed but also the changing expectations of the consumers of these services need to be taken into account. The seniors of tomorrow will be very different from the seniors of today.

MID AND LONG TERM FORECASTS: YEAR 2012 TO THE YEAR 2027
-PHASE FOUR-

Mapping the Future:

The results of the CODA project's preliminary research prompted the project steering committee to ask: "What common vision can best guide planning for the future delivery of elderly care services in Erie and Niagara counties?

To address this challenge, it was necessary to conduct additional demographic-related work and to project service demands and service delivery needs. Larson Allen, LLP, a consulting group from Minnesota was retained to build upon the KS& R market study and tackle the next study phase. With input from the Steering Committee and the aid of various research studies, Larson Allen created an interactive a real-time model for projecting impact of policy, funding and program decisions on services and settings. This model is driven by the following predictors and influencers of demand:

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

The diagram to the right illustrates a sample "dashboard" which was generated by an Excel spreadsheet. The formulas calculate the interconnected impact of the above mentioned influencers. This screen shot is only one possible scenario for the City of Buffalo.[4]

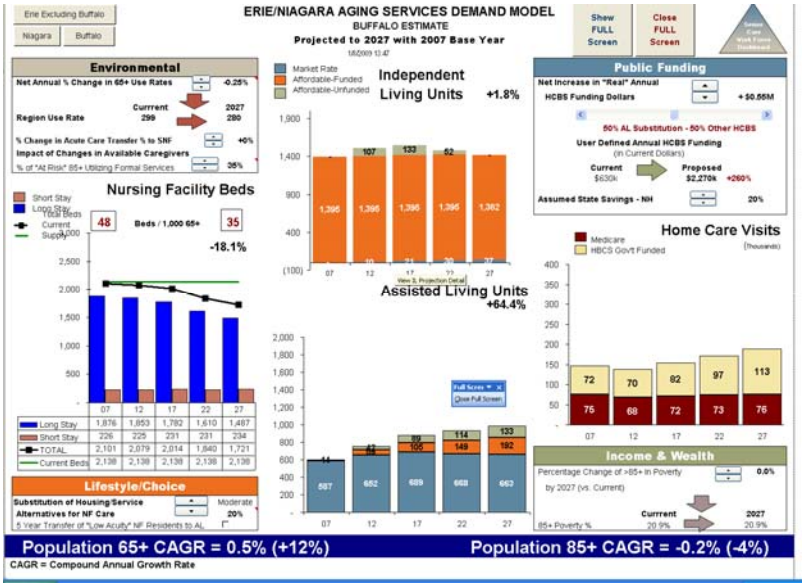


Figure 6: Larson Allen Real Time Demand Model Dashboard

Assumptions: A demand analysis was completed for the City of Buffalo, the remainder of Erie County (outside of Buffalo) and for Niagara County. The assumptions (*see Appendix #XVII*) used to forecast future demand in each of the three service areas were:

1. Growth in the 65+ population was based on KS&R estimates;
2. Hospital use rate would decline about .25% per year;
3. Substitution of Assisted Living and Home Health for Skilled Nursing care is estimated to be 20%;
4. Growth in poverty levels is assumed to match demographic estimates;
5. 35% of those who are age 85+ with no caregiver are assumed to seek "formal"[5] services;

[4] Please see the appendix for the dashboard of each of the three sub-regional areas

[5] Defined as services provide by someone other than a friend, relative or neighbor. Formal services could be paid through Medicare, Medicaid, LTC Insurance or private funds.

(footnote continued)

6. Home and Community Based Services if substituted for SNF services are estimated to save 20% of costs.

Projections of Impact on Services & Settings:

Two scenarios were analyzed. Scenario One is an "As Is" approach which assumes no changes in demands for services and maintenance of the status quo. The assumptions related to the second scenario maximize the use of alternative to skilled nursing. In this scenario, reductions in the number of skilled nursing home beds are presumed. Scenario Two invests a portion of the cost savings resulting from reduced nursing home utilization in Home and Community Based Supports while maintaining a 20% savings for the State.

Scenario One: "As Is" Aging Services Demand

This scenario assumes that older adults continue to utilize services as they have historically used services. This scenario assumes no changes to:

- Reimbursement that would change the current incentives or use patterns
- Medicaid or Medicare eligibility and coverage of services
- Hospital use rate
- Transfer to post-acute services
- Caregiver availability
- SNF use rates
- Availability of assisted living units or Home and Community Based Services funded publicly
- No increase in Medicaid funding for additional services that might substitute for SNF care
- Length of stay for long stay residents remains constant
-

This scenario demonstrates how many skilled nursing facility beds, assisted living units, skilled home care visits or independent living units will be required during the period 2007 through 2027.

The only variations reflected in this scenario are demographic related. They include projected growth or decline in the elderly population by age cohorts as well as variations in poverty levels by age cohorts (ages 65 to 84 and 85 plus population).

Scenario Two: Alternatives Maximized in Aging Services Demand

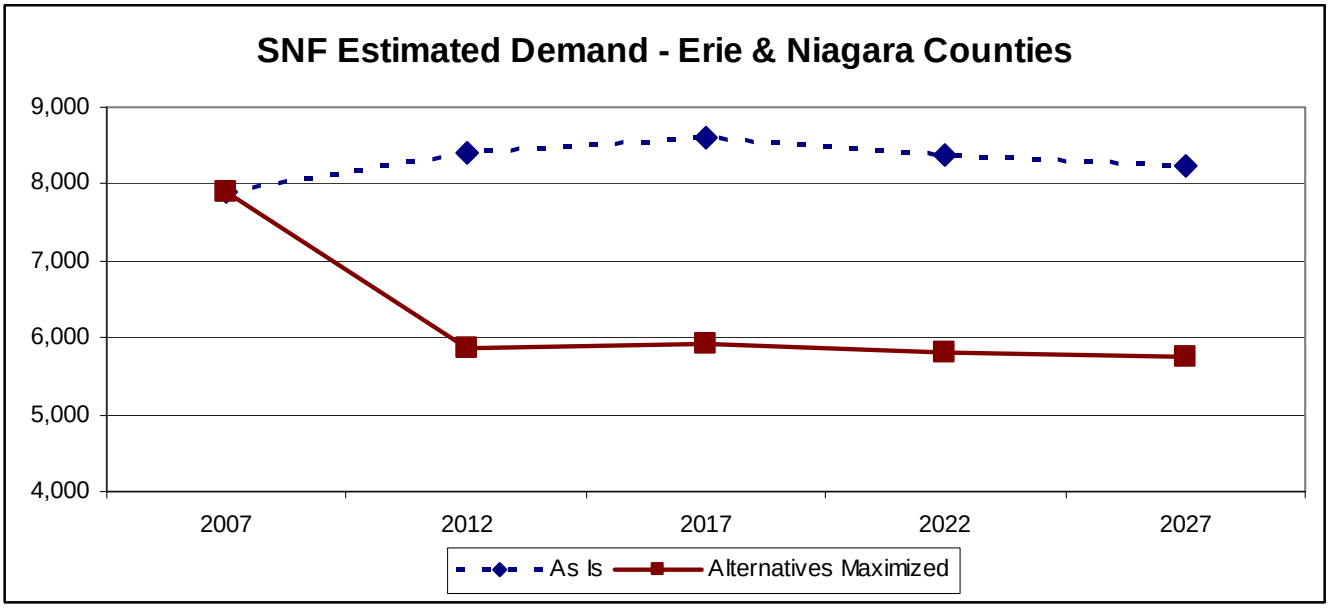
This scenario assumes that older adults will delay or avoid admissions to skilled nursing facilities if alternatives are available. The following assumptions apply to this scenario:

- Reimbursement will change the current skilled nursing facility use patterns resulting in a reduction in the number of low intensity nursing home residents;
- Assisted living and independent living units will be built to meet demand;
- Residents will substitute lower levels of care where possible or at least 35% of the time;
- Hospital use rate per 1000 for the age 65plus population will decline about .25% from 2007 to 2027

- Transfers from acute to post-acute services will remain constant;
- Reduced caregiver availability will result in 25% of those in the 85 plus age group to choosing formal services;
- SNF use rates will decline;
- Assisted living units or Home and Community Based Services will fund Medicaid residents;
- Medicaid funding for services that substitute for SNF care will increase;
- Medicaid funding for service alternatives will be about 20% less for Home and Community Based Services compared to SNF care.

The following charts and tables demonstrate how many skilled nursing beds, assisted living units, skilled home care visits or independent living units will be required from 2007 to 2027 under the Alternatives Maximized Scenario[6]

Skilled Nursing Facility:



The estimated demand for SNF beds in the "As Is" Scenario increases slightly until 2017 and then declines, but demand in 2027 is slightly higher than 2007.

The estimated demand for SNF beds declines by 2012 and remains relatively flat thereafter in the Alternatives Maximized Scenario.

[6] The full "dashboards" for these can be found in the Appendix

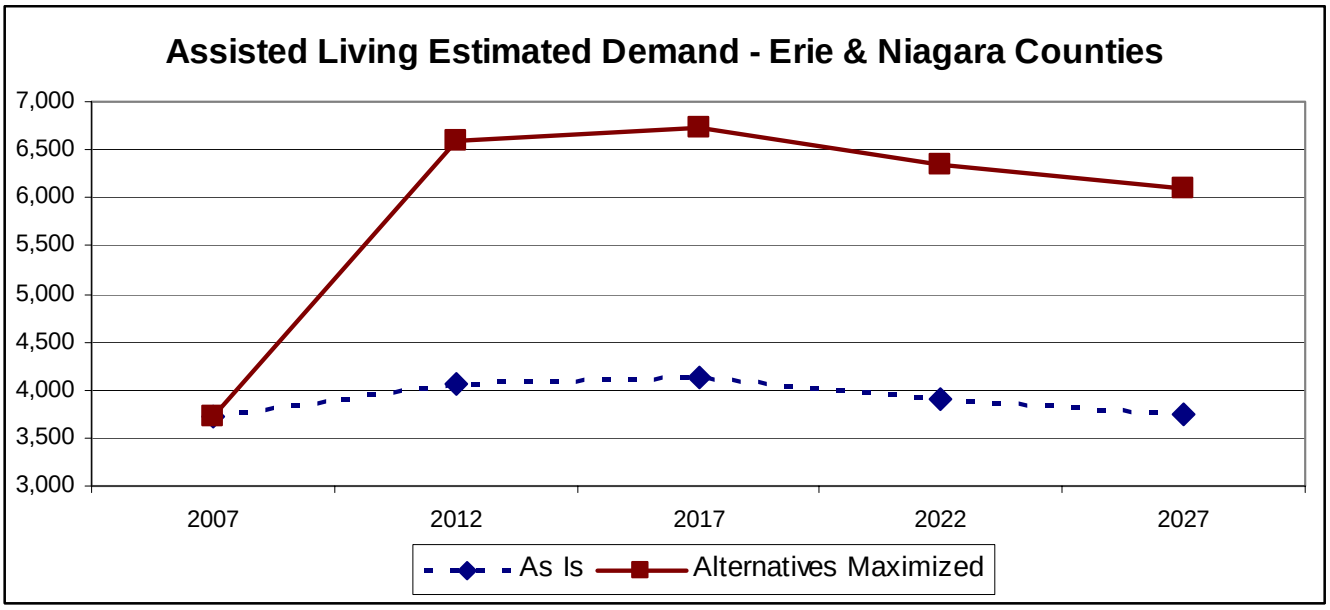
The SNF use rates are significantly different in each of the scenarios.

Skilled Nursing Facility Beds Per 1000 - Niagara & Erie Counties					
	2007	2012	2017	2022	2027
As Is					
65+	132	142	139	125	116
85+	818	803	808	830	851
Alternatives Maximized					
65+	132	100	97	90	85
85+	818	562	570	596	628

Assisted Living:

The estimated demand for Assisted Living increases dramatically under the Alternatives Maximized Scenario through the year 2017 and then declines slightly as the 65 plus population declines.

Assisted Living estimated demand under the As Is Scenario increases slightly through 2017 but by 2027 declines to the 2007 level.

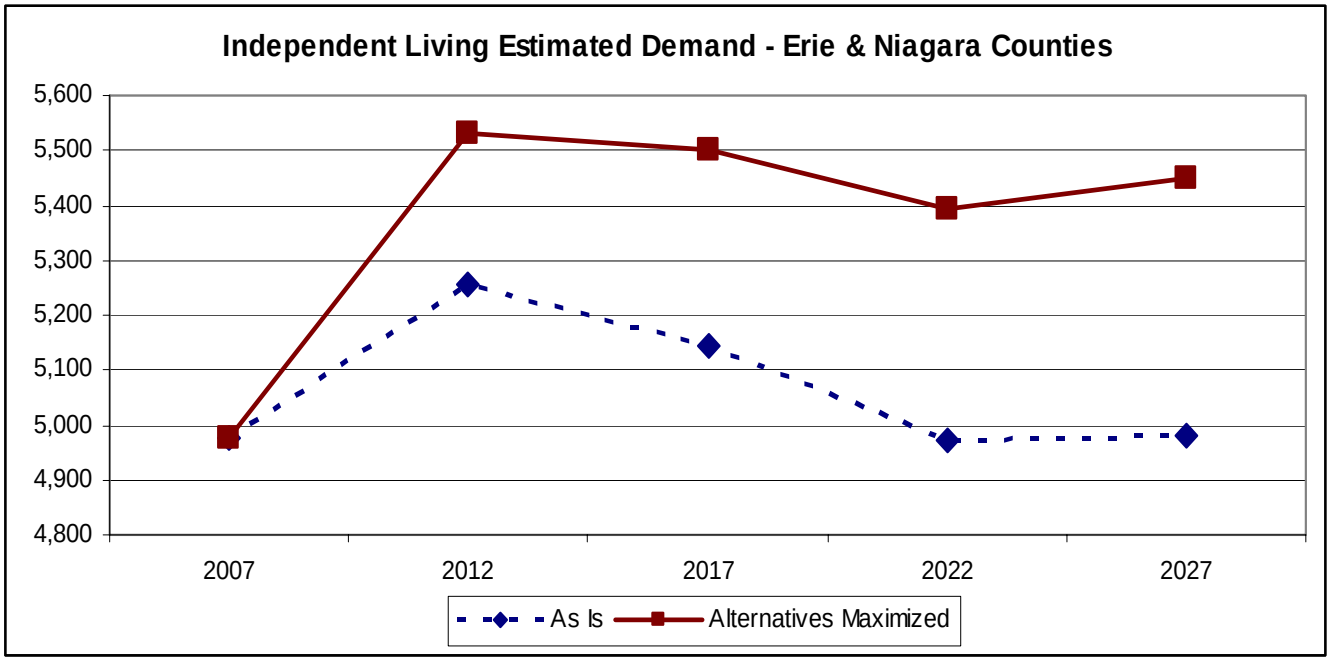


Assisted Living Units Per 1000 - Niagara & Erie Counties					
	2007	2012	2017	2022	2027
As Is					
65+	56	61	58	51	46
85+	343	343	343	343	343
Alternatives Maximized					
65+	56	102	101	91	82
85+	343	579	594	597	605

Independent Living:

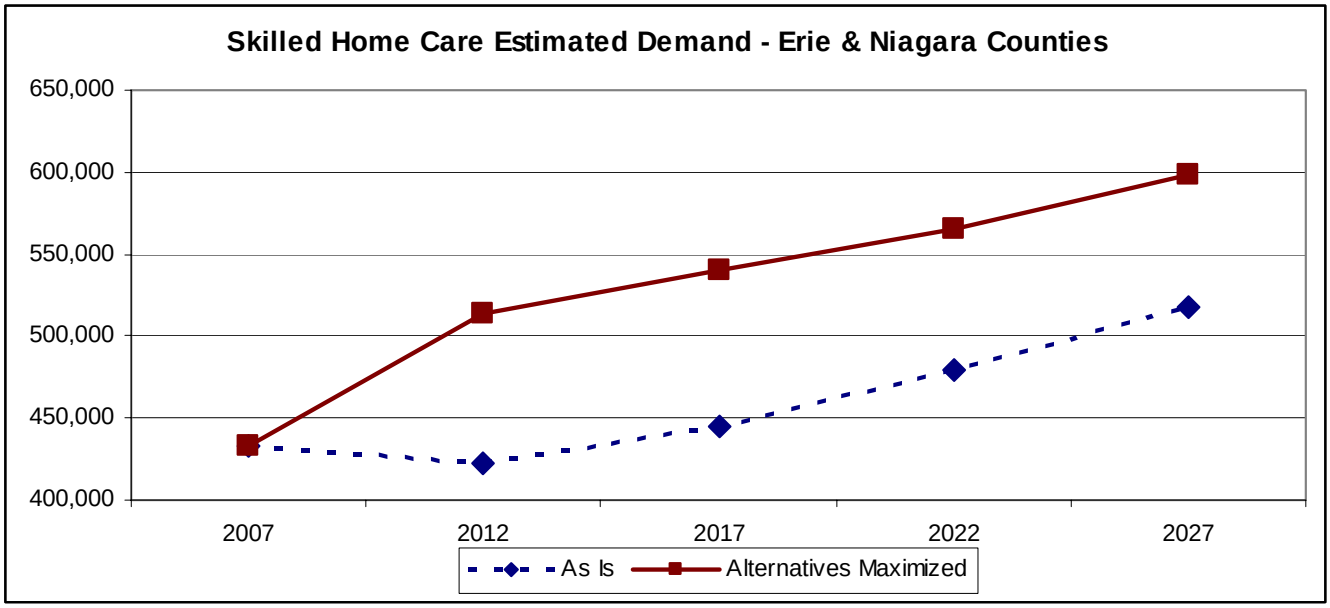
The estimated demand for Independent Living in Erie and Niagara counties increases through 2012 and then declines in both scenarios. The rate of decline is less under the Alternatives Maximized Scenario.

Independent Living Units Per 1000 - Niagara & Erie Counties					
	2007	2012	2017	2022	2027
As Is					
65+	86	92	87	78	72
85+	528	520	509	515	528
Alternatives Maximized					
65+	86	97	93	85	79
85+	528	547	543	558	578



Home Care:

Throughout the twenty year forecast, Skilled Home Care utilization increases significantly. The projected growth rate in the use of home care is even greater in the Alternatives Maximized Scenario.



Skilled Home Care Visits Per 1000 - Niagara & Erie Counties					
	2007	2012	2017	2022	2027
As Is					
65+	6,206	6,198	6,312	6,694	6,474
85+	39,158	34,968	36,713	42,154	48,054
Alternatives Maximized					
65+	6,206	7,765	7,868	7,759	7,694
85+	39,158	43,835	45,785	51,134	56,988

The overall trends, which can be gleaned from the Larson Allen Models, are summarized as follows:

1. If funding for home and community based services and assisted living program units is available, the demand for skilled nursing home beds will decline in the Erie/Niagara region.
2. The demand for home and community based services will increase, particularly if the current economic climate negatively impact the resources of elders over the long term.
3. If Assisted Living Program Beds (Medicaid eligible) are available, there will be increased usage of these services in both Erie and Niagara Counties.
4. Healthcare workforce shortages will continue to be a challenge for providers as they attempt to meet the demands of older adults. This issue will become particularly acute as the availability of informal caregivers declines.
5. Public policy will encourage innovation to meet increasing service demands and changing client preferences.

The findings from the demand model along with the previously mentioned reports and surveys provided important guidance during a comprehensive planning session that was held on May 15, 2008.

BUILDING COLLECTIVE LEARNING:
PROBLEMS, NEEDS & COMMUNITY RESPONSES
– PHASE FIVE-

Organization of Process:

Following the planning session, the CODA Project Steering Committee came together and set the course for the next phase of the project. Membership on the steering committee was expanded to include representation from the Home and Community-Based Services sector.

A total of ten (10) learning sessions were held to educate the Steering Committee members on an array of long-term care topics. These sessions focused on home care / home and community-based services; housing alternatives (assisted living/adult homes/group homes); transportation (older adult and workforce related); consumer education; financial security; and direct care workforce shortages. At each learning session, a subject matter expert presented on a specific topic conveyed their views on how the system would evolve over the next 10 years and discussed challenges and barriers to progress, including limitations due to policies and regulations. The information presented at these sessions helped to prioritize critical areas of need and develop a strategy for involving Federal, State and local government leaders in long-term care planning issues.

Prior to launching the learning sessions, the Steering Committee catalogued the essential components of long-term care planning. The group also conducted an assessment of what consumer and provider driven initiatives were currently underway in Erie and Niagara counties to address existing and future elderly service issues.

Figure Six is a chart which identifies the various aspects of the existing system of long-term care (center column) and the boxes to the right and left of the center column list the organizations, coalitions and agencies which are currently involved in working towards improving the system. This chart was designed as a conceptual map of how the various initiatives and processes underway locally can fit into a plan for long-term care in Western New York.

Consumer initiatives are those aimed at understanding people's current and future needs and their changing behaviors. Consumer initiatives seek to improve health status, increase access to services and enhance quality of life.

Provider initiatives are geared to improving the availability, quality, access, systems and services that are delivered to people living in the community.

Interestingly, there are several initiatives that are being pursued by both provider and consumer sectors. The common aims of consumers and providers helped to build a framework for the learning sessions. Representatives from more than 25 various groups and organizations participated in the learning phase of the CODA project.

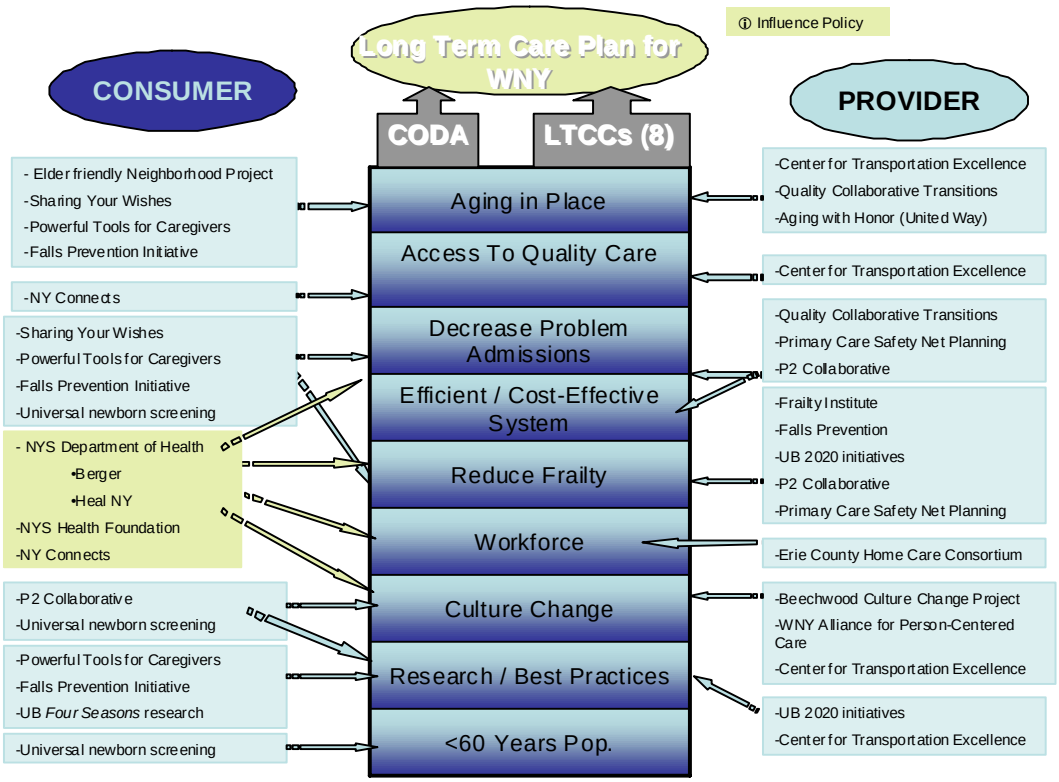


Figure 7: Community Partners Working on the Components of a Complex Multifaceted Long Term Care System

The learning sessions helped Steering Committee members gain a clearer understanding of elderly service planning issues and allowed them to gain new insights into the challenges that lie ahead. A summary of discussions that took place at these sessions is presented here.

Federal Government's Focus on Rebalancing the Long-Term Care System:

Members of the committee invited a National Health Policy expert, Mr. Richard Browdie, to discuss several initiatives that the Center for Medicare & Medicaid Services (CMS) would be examining regarding the provision of long term care to low income elders. CMS is seeking to rebalance the long-term care system by *"Reaching a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services and those used for community-based supports. A balanced LTC system offers individuals a reasonable array of … options, particularly adequate choices of community and institutional options."*[7]

Since the direction of CMS is aligned with Project 2020: *Building on the Promise of Home and Community Based Services,* it was suggested that CODA project planning follow a similar path. Project 2020 is a joint effort between the National Association of State Units on Aging and the National Association of Area Agencies on Aging. This effort focuses on three areas:

1. Person-Centered Access to Information;
2. Evidence-based Disease Prevention and Health Promotion;

[7] A Guide to Long-Term Care for State Policy Makers: Recent State Initiatives in Rebalancing Long-Term Care. The National Conference of State Legislatures.
http://www.ncsl.org/programs/health/forum/LTC/guidereblance.htm

3. Home and Community Based Services.

The first two areas of focus are being pursued by other collaborative efforts in the region. In Erie and Niagara Counties, the New York State Initiative, *NY Connects: Choices for Long Term Care* is responsible and accountable for providing person-centered access to information. Further, evidenced-based disease prevention and health promotion initiatives are being coordinated across the eight counties of Western New York through the work of the P2 Collaborative [8]

It became apparent, however, that no other entity was providing leadership for the development of a locally driven strategic plan for providing a coordinated and comprehensive approach for home and community based long term supports. With this knowledge in hand, the Project CODA team placed a special emphasis on ways to enhance home and community based services.

What are Long-Term Supports, Who Needs Them and How are These Services Accessed?

These were underlying questions that were discussed at several of the learning sessions. The project team became increasingly aware that if the existing system is to be rebalanced, it is essential that drivers for change fully understand how the long-term care system works or does not work.

Long- term supports and services, or long-term care, consist of the following services:

- Institutionally-based services (e.g., nursing homes and intermediate care facilities),
- Services in alternative residential and community settings (e.g., assisted living)
- Personal supports and services provided to people in their homes.

An aging population, the burgeoning costs of nursing home care and a stressed Medicaid system are factors that are encouraging federal and state governments to rethink the way that long-term care systems have traditionally worked.

Like other states and the federal government, New York had begun efforts to "rebalance" the state's long-term care systems to provide greater access to non-institutional, home and community-based alternatives. The state's overall objective is to help the elderly remain a part of their communities.

The New York State Office for the Aging (NYSOFA) and Department of Health (DOH) have worked collaboratively to create a restructured and accessible long term care system that supports the consumer's choice to live independently while offering affordable services that meet individual needs. NY Connects: *Choices for Long Term Care* is an important first step toward achieving that vision. This State-funded program, established at the county level, provides for a consumer-centered access point for information and assistance. This resource is available to all individuals and caregivers in need of long term care services, regardless of age, income, or payment source.

Each participating county is charged with establishing a Long Term Care Council (LTCC), which is representative of consumers, providers and local government. Its mission is to assist in the evaluation of the local long term care system on an on-going basis, identify gaps and duplication in the system and make recommendations to address identified needs.

[8] P2 (Pursuing Perfection) Collaborative of Western New York is a not-for-profit organization dedicated to improving the health of people in Western New York.

The councils from both Erie and Niagara Counties were engaged in the planning process for Project CODA. Their input helped to assure that long term care consumers and persons with disabilities under the age of 65 were represented in planning discussions.

Opportunities and Impediments in Housing, Transportation, and Support Service Delivery:

The concerns and issues identified in each of these areas centered on four common themes: access, choice, quality and economics.

- **Access** – Whether it a ride to the doctor, a home delivered meal, or care at home, individuals cannot always get what they need when they need it. Home and Community Based Services (HCBS) are not able to keep pace with the rate of hospital discharges. This may be due to staff shortages, eligibility criteria, long waiting lists (limited funding) and/or the lack of services. An identified goal was to improve people's access to services. Whether it is education, transportation, health care, or other essential needs, these services should be available to individuals regardless of payor source.
- **Choice**– Individuals who need long-term support do not always have a choice, in many instances they are "slotted in" to what services are available in the community. Due to the lack of affordable housing alternatives or Assisted Living Programs in a neighborhood, individuals have few options. A "bias" towards institutional care was identified as a barrier/limitation. If people meet the financial and functional criteria for Medicaid-funded nursing home care, they have an "entitlement" to that care. There is no such entitlement to Medicaid-funded Home and Community-Based Services (HCBS). States maintain slots for HCBS waiver programs, however once those slots are filled, eligible people must be placed on waiting lists or enter a nursing home whose services are guaranteed under Medicaid.[9] For example, The Long Term Home Health Care Program (LTHHCP) only utilizes 65% of capacity locally. This is a trend which is mirrored across the state.
- **Quality** – Some long-term care services do not always support "quality of life". Many programs are solely based upon the medical model. As a result, they fail to promote wellness and may lead to frailty. As David Rodgers writes "the territory of care of the elderly does not belong to the health professions alone" [10] Therefore a multidisciplinary approach is essential. Many social models however, may not be viewed as vital services and, as a result, do not receive the same levels of funding. The goal here is to improve the overall quality of the long-term care system by focusing on achieving people's health and social outcomes through programs such as PACE and Person Centered Care. These initiatives promote the right of the elderly to live in the most integrated settings/least restrictive environments, and they aim to reduce frailty and achieve wellness and independence.
- **Economics**– Another essential question was posed ***"Are we spending more money than necessary?"*** While significant funds are expended for services, often the outcomes are not indicative of an improved quality of life. This is illustrated by the fact that approximately 30% of nursing home patients in the Erie and Niagara region could be served more appropriately in a less intense, less expensive level of care. There needs to be incentives for

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[9] A Guide to Long-Term Care for State Policy Makers: Recent State Initiatives in Rebalancing Long-Term Care. The National Conference of State Legislatures.
http://www.ncsl.org/programs/health/forum/LTC/guidereblance.htm

[10] Care of the Elderly Patient: Policy Issues and Research Opportunities (1989)
Institute of Medicine (IOM)

providing and purchasing cost-effective long-term care alternatives. Steps should also be taken to advocate to the New York State Department of Health for the expansion of the Assisted Living Program in both Erie and Niagara Counties.

Home-Care Personnel Issues: Hidden Challenge in Providing Long Term Care Support:

Direct care workers are found at every level and in every setting of the long-term care service continuum (hospital, nursing home, assisted living, Hospice, Home and Community Based agencies). The range of classifications, certifications, educational requirements and non-standardized training across these settings results in a long list of job titles. The list includes, Home Health Aides, Certified Nursing Assistant, Personal Care Aide, Hospice Aide, Medical Assistant, Medication Aide, Rehabilitation Aide, etc.

There are a myriad of titles, training requirements and certification regulations which ultimately place limitations on the pool of qualified workers who are able to provide care. This system creates obstacles that make it difficult to utilize this workforce in an effective and efficient manner, both across and within the organizations that employ these workers. During the learning session on workforce issues, the Steering Committee discussed state laws and regulations that govern the direct care workforce including requirements for criminal background checks and training requirements. Recruitment and retention of staff was discussed.

The need to recruit workers is well documented, but of greater importance is the retention of those individuals. A recent study by the Institute of Medicine (IOM)[11] estimates the cost of staff turnover in homecare to be $1.4 billion annually. In addition, 40-60% of all home health aides leave within their first year of employment and 80-90% leave within the first two years. This data emphasizes the importance of this study. Direct care workers have articulated the key elements necessary for them to continue to serve the most vulnerable persons in our communities. The high cost associated with turnover is passed on to the consumers as well as to the payors – Medicare and Medicaid.

Reduction in turnover would result in significant savings to employers, the payors and ultimately to the taxpayers. This is a critical need. If we do not act in a timely manner, we will lack the capacity (in both size and ability) to meet the needs of older patients.

This session reaffirmed the demand analysis conducted by Larson Allen, LLP which indicated that in the coming years, healthcare workforce shortages will continue to challenge providers to meet the demand of older adults, particularly as caregiver availability declines.

In Erie and Niagara Counties and the City of Buffalo, where a direct care workforce shortage currently exists, Larson Allen, LLP estimates the need will increase by more than 586 FTE's by the year 2017. Caregiver shortages are being confronted across New York State.

The learning sessions provided an opportunity for the Steering Committee to gain a "satellite view" of the storm that was rapidly approaching and to learn first hand from those "on the ground" how they are feeling the effects of the rising storm.

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[11] Retooling for an Aging America: Building the Healthcare Workforce (April 2008) http://www.iom.edu/Object.File/Master/54/320/Workforce05-01-2008.pdf

BUILDING A BLUEPRINT FOR THE FUTURE

-PHASE SIX-

Introduction:

To assure that CODA strategies are built on a strong platform, it was deemed essential that key stakeholders and community be engaged in the development of a long-term care plan. The objective was to gain consensus for the CODA mission, vision and the principles that would guide further development of this plan.

A major objective of the planning session held on October 3, 2008 was to develop a CODA mission statement that would guide current and future endeavors. The mission statement that was developed at the planning session appears below.

The CODA Mission:

Ensure an improved quality of life for the frail elderly in Erie and Niagara Counties and enhanced service outcomes at an affordable cost (financial + effort) to sponsoring organizations (government, not-for-profit, for profit). Stimulate the use of person-centered best practices and new approaches to increase the availability and flexibility of innovative programs that can be easily accessed by frail elders and older adults and allow them to remain independent as long as possible.

Guiding Principles:

Along with developing a mission statement, the October 2008 planning session set forth guiding principles for attaining project goals. A summary of these principles is as follows.

- Long term care supports should promote well-being, health, physical comfort and emotional support and be designed to postpone frailty and reinforce continued activities of daily living.
- Individuals' care needs should determine what long-term supports they receive. In publicly funded programs, their preferences should be honored within the limitation of reasonable cost constraints.
- Elders and their families should always be included in the decision-making process, except in rare circumstances where such involvement would be detrimental to the person needing care.
- People should have adequate, appropriate, and accessible options as to where they receive services and by whom. These options should be person-centered and be sensitive to cultural backgrounds and lifestyles.
- People needing long term supports and wishing to remain in the community should have available alternative housing options and supports as near to their neighborhoods as possible.
- Informal caregivers are vital to the quality of health and life of the people for whom they care. These caregivers should be respected, have their contributions acknowledged and have a voice in the planning process when possible.
- Providers of services should coordinate and integrate their activities across settings in support of the person needing care and their families.

- An informed, educated, well-trained, person-centered workforce that demonstrates understanding of and compassion for persons in their care is essential to maintaining an effective, high quality care system.

- The transition from current service options to a new model of care and services needs to be thoughtfully managed: potential new roles for current providers should be identified; and a timely plan to maintain high quality care while moving toward a new service configuration should be assured.

- Government regulation and financing strategies must support and reinforce a person-centered, flexible system of care, through streamlined effective oversight and incentives which are designed to achieve the long-term person-centered goals of CODA.

- Providers should meet individuals' personal needs (physical and emotional); accommodate their preferences within appropriate cost constraints and tailor supports to these individuals' abilities, goals and hopes to maximize their independence and dignity.

- To the extent possible, each competent individual should have the final say in determining their life and circumstances. This includes knowingly evaluating the degree of risk created by their choices and making their own decisions about recommended services, programs, settings and treatments. Assuming the person is competent in making these decisions, they are also accountable for the consequences of their decision. Service providers, physicians and/or governmental agencies should not be held accountable for the consequences of informed risk accepted by an individual.

Vision of the Optimal Long Term Care Service System in 2027:

To help achieve strategic goals and objectives, participants at the October 2008 planning session formulated a *Vision of the Optimal Long Term Care Service System in 2027*. Elements of the vision statement, which was prepared by the planning group, are outlined below.

CODA Vision Statement

- Respects, supports, encourages, and promotes **individual self-determination** and **family/community empowerment and involvement**.
- Creates an **efficient and dynamic continuum of long term care** including in-home services, assisted living of various kinds, care management services, respite care services, nursing home care, hospice care, primary care, chronic care management, and acute hospital care services.
- Provides **accessibility through a single point of information, assessment, care planning and entry into the system** for those seeking long term care services ensuring that each individual is supported to make fully informed decisions regarding his/her services with the participation of chosen family and friends.
- Uses **consumer-centered processes and tools** to assess and match the individual's needs and desires across a continuum of LTC services based upon demonstrated need, effective individualized management and care planning.
- Promotes **efficient and appropriate movement across the continuum of LTC services** by developing innovative financial policies that allow resources to follow the individual.
- Assures the **quality and cost effectiveness of the nursing facility care system.**

- **Supports home and community based service system** by assuring that all those who need high levels of care have a range of options that allow them to live in the community, if that is their choice.
- **Builds and sustains an adequate, well-trained, highly motivated, and appropriately compensated workforce** across the long term care continuum.
- Is **supported by a regulatory model** that assures safety and quality while removing unnecessary barriers that prevent us from moving toward an efficient and dynamic continuum of care.
- Have a significant number of citizens who have **financial plans in place (including but not limited to long term care insurance**) to support individual needs and desires across a continuum of long term care services.
- Actively **supports and promotes community health, caregiver support, injury control (e.g. falls prevention) and chronic disease prevention and management programs** that reduce the need for long term services.
- Includes **planning and oversight** of efforts and includes a central, meaningful role for participants and families and other stakeholders.
- Has **capacity to involve and educate the general population** by increasing awareness about the continuum of long term care, insurance options, and helping consumers make informed choices.

MODELS & STRATEGIES FOR REINVENTING LONG-TERM SERVICES – PHASE SEVEN-

The CODA planning group utilized the results of the Project's extensive research as well as their own knowledge of long-term care services to develop strategic community solutions.

Developing Community Solutions:

Several ***action oriented*** strategies were recommended by the CODA Steering Committee to address findings from the project's study phases. The top five priorities of the overall strategy pertain to:

a) Care Transitions
b) Workforce
c) Housing
d) Neighborhood-Based Care System
e) Individual Risk /Self-Determination – Shift public policy philosophy to one of allowing prudent, informed self-determination

In January, 2009 workgroups were launched and asked to develop a work-plan for each of the pilot projects listed along with estimated budgets for preliminary work phases. Listed below, are the identified problem statements, followed by a table which outlines the intended outcomes and the components of each project.

Care Transitions Problem Statement: Fragmentation of supportive care in the home and community, particularly an elderly person's hospital discharge and transition back to home and community, often has a negative impact on the person's health and well-being, resulting in a return to hospital or a higher level of care.

This issue was identified as a key area of need in both Erie and Niagara counties. It was recommended that a home care and/or a community based provider function as the coordinator of care for those individuals transitioning from acute care to a SNF or to other community settings. This strategy would help to assure that discharge issues and essential care requirements are coordinated to meet the needs of the individual and the caregiver.

The Community Health Foundation is continuing to sponsor its care transitions collaborative initiative. April 2009 marked the kick-off of the third quality improvement initiative. Several members of the steering committee from Project CODA participated in this learning session. The workgroup then asked for feedback from both current and prior year grantees about "next steps". The Foundation's work will be linked where appropriate, and will be shared with policy makers and providers in the field.

Care Transitions	
Outcome of the Project	• Elders will receive the support and services needed for independent living and experience continuity of care and sense of security. • Specific transition improvements that result from this work such as models of care which exhibit improved coordination of service providers • Measurable results and costs/benefits from a reduction in recidivism rates.

Components of the Project	• Use a home care and/or a community based provider as the care coordinator for those individuals transitioning from acute care to an SNF or to other community setting. Assure that the discharge and essential care are coordinated and meet the needs of the individual / caregiver • Work plan and budget

Workforce Problem Statement: The myriad of titles, training requirements and certification regulations place limitations on the pool of qualified workers who are able to provide care and creates obstacles that make it difficult to utilize this workforce in an effective and efficient manner, both across and within the organizations that employ these workers.

Workforce was also identified as an important priority for each county. Although there is a shortage of workers in a variety of areas in the health care arena, the specific need identified concerned the use of Direct Care Workers. It was suggested that the numerous categories of direct care workers be collapsed into a structured career ladder. A coordinated and standardized training capacity (centralized of decentralized) should also be created in order to effectively train all direct care workers and reduce costs to providers.

A demonstration grant proposal was submitted to the NYSDOH in October, 2008. The scope of the project includes exploring current efforts in New York State and nationally to identify best practices and develop partnerships (i.e. Paraprofessional Healthcare Institute (PHI); State of Iowa Direct Care Worker Task Force.)

During the CODA process, providers expressed significant concerns regarding the lack of a centralized registry that could process updated background checks, health screenings, immunization records, licensing, and training. There was a strong consensus that measures need to be taken toward meeting the central registry goal. (Note: In June, 2008, The New York Certified Aide Registry and Employment Search Act (NY-CARES), was introduced by legislative health committee chairs in the Senate and Assembly. The legislation would create added protections for care-dependent New Yorkers by establishing a central registry for processing background and training information for home health and personal care aides. It is anticipated that this registry will be developed in 2009 and will address the concerns expressed by provides in Erie and Niagara Counties).

Workforce	
Outcome of the Project	• Increased recruitment and improved retention of Direct Care Workforce • Sufficient qualified staff to meet the growing demand for services • Reduced wait list for clients in need of home care • Measurable results and costs/benefits to employers
Components of the Project	• Collapse current categories of direct care workers into a structured career ladder • Create a coordinated and standardized training capacity (centralized or decentralized) which would effectively train all direct care workers and reduce costs to homecare providers • Create a centralized registry of direct care workers which can be updated with background checks, health screenings, immunization records, licensing, training, etc. • Develop long range work plan and budget

Housing Problem Statement: There are inadequate, unsafe and limited options for affordable, accessible housing for older adults to age in place.

The research studies completed by KS&R and Larson Allen LLP identified the need for housing options which are affordable, accessible and meet the special needs of frail elders.

Currently, an established "Housing Workgroup" representing various sectors of the housing development community has been meeting to discuss possible alternatives to address the diverse needs of a "graying community". The group has expressed an interest in and willingness to partner with the Community Health Foundation on priority initiatives identified by Project CODA.

The feasibility of several "best practice" options which include shared housing, supportive housing, independent housing, age-in-place models and accessory dwelling units (ADU's) will be reviewed by the Foundation. Specifically, the State of New York Mortgage Association (SONYMA) will be contacted about developing an urban and/or rural "best practice" model in Buffalo and Niagara Counties respectively.

Due to Mayor Byron Brown's "5 in 5" initiative, a plan to demolish 5000 homes in five years, a significant number of vacant parcels will become available for development in the City of Buffalo. In many areas of the City of Buffalo, entire blocks have been leveled. Discussions with the SUNYAB School of Architecture and City leadership around a possible student design initiative will begin. Students will be asked to design an affordable elder friendly housing development in the City of Buffalo using universal design standards.

HOUSING	
Outcome of the Project	• Elders will receive the support and services they need for independent living • Elders will live where they choose for as long as they have the capacity to do so • Creates a livable community for every generation • Individuals have a say in where and how they choose to live
Components of the Project	• Utilize existing housing in the City of Buffalo and/or other sites – develop a plan to bring community supports and resources on site. • Develop affordable Assisted Living using low income tax credits • Contact SONYMA to discuss possibility of a project in which the state housing fund could invest with private developers in transforming housing in the inner city / rural community • Creatively design a community which facilitates aging in place using universal design

Neighborhood-Based Care Problem Statement: There are limited options for Assisted Living and Nursing Home facilities in the City of Buffalo due to the large percentage of individuals on Medicaid. Therefore a viable alternative is the creation of a comprehensive care system lead by a designated organization or cluster of providers would be responsible and accountable for "wrapping" services around elders in a specific/targeted geographic region.

The "neighborhood" approach associated withnaturally occurring retirement communities (NORC's) has been utilized by The Jewish Federation. In New York State, the criteria for funding

a NORC project require that 40 percent or more of the designated community's households be headed by a person 65 years of age or older, as long as there are a minimum of 200 such individuals.

One community organization in Buffalo has begun a planning initiative around their elder residents as well as special need populations under the age of 60. Their design incorporates a fee-based menu of services, a low-income sliding fee scale and collaborative partnerships with community based services. A partnership project with the Department of Senior Services in Erie County is also being sought to provide a safety net for those without resources.

Neighborhood-Based Care	
Outcome of the Project	• Elders will utilize supportive care programs • Elders will manage chronic health conditions • Elders will benefit from improved health, mental health, economic well being and community involvement • Measurable results and costs/benefits will be estimated to inform public policy.
Components of the Project	• Create a comprehensive care system using an organization or coalition of service providers(group services, social services & health care services) who would be responsible & accountable to address the health and care needs of elders in a specific/targeted geographic region. (e.g. This could be those 75+ with 2 or more compromised ADL's in a 4 zip-code region) • Connect individuals with the supportive care needed for independent living and participate in the life of the community

Risk vs. Safety Problem Statement: A question that needs to be asked is "Are we assuming too much risk for those receiving services?" And "Are we doing more harm than good – disrupting their lives?" The current system of long term care is premised on risk management. Risk management is defined as the identification, assessment, and prioritization of risks followed by coordinated and economical application of resources to minimize, monitor, and control the probability and/or impact of unfortunate events.[12] The strategies to manage risk include transferring the risk to another party, avoiding the risk, reducing the negative effect of the risk, and accepting some or all of the consequences of a particular risk.

If we wish to pursue a person-centered, community-based model, there needs to be a philosophical shift. We need to move away from the "minimize all possible risk to an individual" paradigm and transition toward a policy that should "allow informed, prudent self-determination".

[12] Douglas Hubbard "The Failure of Risk Management: Why It's Broken and How to Fix It" pg. 46, John Wiley & Sons, 2009

Rosalie Kane and Carrie Levin[13] write that Home and Community Based Services are more popular alternatives to nursing homes because they are more home-like and less restrictive. Individuals choose home and community based service options because they give them a sense of independence, continuity of lifestyle preferences and opportunities to direct their own care. Unfortunately, many providers of home and community care are refusing to provide care due to the perception that the environment does not allow for a safe care plan. Focusing on physical safety alone, without considering social well-being, often does more harm than good.

At the present time, the SUNYAB School of Law in concert with Legal Services for the Elderly, Disabled and Disadvantaged of WNY are conducting further research on the subject of Risk vs. Safety. They will be exploring the legal implications and the feasibility of a risk waiver policy in New York State. A white paper should be completed by September 2009.

RISK WAIVER	
Outcome of the Project	• Elders maintain personal dignity by choosing the services they need and their daily routine • Individual choices are respected • Evolution of a "true" person-centered system of home & community based support. • Educate and inform public policy
Components of the Project	• Shift philosophy underpinning NYS Public Policy from "minimizing all possible risk to an individual" to a philosophy based on "allowing informed, prudent self-determination."

[13] Holstein, MB & Mitzen, PB (eds) (2001). Ethics in Community-Based Elder Care New York: Springer Publishing

CONCLUSION

Making the vision of the CODA Project a reality will be challenging. It will require additionalresearch, a high level of commitment by the community and creative leadership. The Erie/Niagara region has a limited window of opportunity to make the necessary changes to address the physical, economic, environmental and psychosocial needs of our elders before the anticipated wave of persons needing long term supports arrives at our doorstep. Realization of the CODA vision will require collaboration across a broad base of disciplines.

As this work is conducted, there will be a need to reexamine our beliefs about moving through the phases of life – planning for our futures, personal responsibility, respecting an individual's right to choose, quality of life, and community/family supports in an aging community. Robert Butler once stated that "the contemporary prolongation of life and aging touches everything – family and community life, productivity, public resource allocation, health and quality of life", and indeed it does.

It is the hope of the Foundation that changes to the existing long- term support system will be more efficient and more sustainable than existing care models. Providing a cost effective, reliable and efficient array of supports for long-term care is sound public policy that will allow Medicare and Medicaid to more effectively serve those individuals who have the greatest need and who are at the greatest risk for more costly care.

Transforming the current system should lead to a long-term care support system, which optimizes choice and independence; encourages personal responsibility; provides seamless, coordinated and flexible supports; and promotes physical and mental health wellness and functioning. The CODA vision for long-term supports broadens the scope of what is traditionally viewed as the long-term care system to encompass elements such as housing, workforce and transportation. The Community Health Foundation of Western and Central New York will continue to partner with other agencies and groups aligned with its mission to achieve change and realize our vision for long-term care.

APPENDIX TO PROJECT CODA* REPORT

CREATING OPTIONS FOR DIGNIFIED AGING

APPENDIX

GLOSSARY OF LONG TERM CARE TERMINOLOGY

ADL's Activities of Daily Living (ADL's)

People who are healthy tend to take most of the simple activities that they perform each day for granted. But for a disabled and/or older person, performing these activities may present a real challenge. Bathing, dressing, getting in and out of bed or chair, walking, going to the toilet and even eating can all become a problem. Many seniors who require help with such activities are largely independent, requiring help with one or two ADL's. In such cases, intermittent help from a family member or friend may be all that is needed. However, in many cases, particularly when needs are more extensive and/or the importance of scheduling these activities is critical, informal care arrangements may not be adequate.

Adult and Social Day Care Facilities

Adult Day Care facilities are designed for adults who have a need for significant medical attention and supervision but who do not require institutionalization in a nursing home. There are a limited number of such facilities in New York City. Where available, Adult Day Care centers are typically utilized for between 3 and 12 hours per day, up to 7 days per week. Social Day Care facilities are meant for adults who have no significant medical needs, but who may benefit from socialization opportunities and need supervision throughout the day. By visiting a social day care facility, the senior has companionship and supervision during the day.

ALP Assisted Living Program Serves persons who are medically eligible for nursing home placement but serves them in a less medically intensive, lower cost setting

ALP provides personal care, room, board, housekeeping, supervision, home health aides, personal emergency response services, nursing, physical therapy, occupational therapy, speech therapy, medical supplies and equipment, adult day health care, a range of home health services, and the case management services of a registered professional nurse.

Who is eligible? To be eligible, both Medicaid recipients and private-payers must be medically eligible for, and would otherwise require, placement in a nursing home due to the lack of a home or suitable home environment. However, eligible ALP residents must **not** require continual nursing care, be chronically bedfast or chairfast, or be impaired to the degree that they endanger the safety of other ALP residents. The ALP program is limited to 4,200 residents*(approximately 85% are Medicaid recipients).

Private-payers and Medicaid recipients may contact the ALP directly. However, Medicaid recipients must have their ALP services approved in advance by the Local Social Services District (LSSD). ALPS are regulated by the State Department of Health. The regulations require that the appropriateness of ALP services be determined by initial and periodic reassessments provided by the ALP. ALP operators are required to provide sufficient staff to perform case management functions for assisted living residents and to ensure their health, safety and well-being. ALPS are required to provide a staffing plan for review by the Department. ALPS also must meet prescribed environmental standards, which include standards for the installation of fire prevention systems and the space provided for administrative activities. * Increased by 40%(1584) in June 2008

ALR Assisted Living Residence

CASA Community Alternative System Agency

CASA's primary function is to determine the appropriateness and necessity for Medicaid long-term care services and develop suitable care plans for community based elderly and/or disabled individuals to remain as independent as possible.

After assessing the client's needs CASA arranges for home care services for its clients. CASA clients may receive:

a) Personal care aide services, which provide assistance with meal preparation, personal hygiene, dressing, etc.
b) Environmental aide services, which cover assistance with household chores, meal preparation, shopping, laundry, and similar activities.
c) Private duty nursing services, if continuous skilled nursing assistance is warranted.

HOSPICE Program for the Terminally Ill

Hospice is a special concept of care designed to provide comfort and support to patients and their families. Patients are referred to hospice when life expectancy is approximately six months or less. A patient can remain in hospice care beyond six months if a physician re-certifies that the patient is terminally ill.

Hospice care is a covered benefit under Medicare. Approximately 45 states and the District of Columbia offer hospice coverage under Medicaid. Many private health insurance policies and HMO's offer hospice coverage and benefits.

This benefit covers all services, medications and equipment related to the illness. These include: physician & nursing services; home health aides; medical appliances, medication, and supplies; spiritual, dietary, and other counseling; continuous home-care or inpatient care during crisis periods; trained volunteers; bereavement services; social work services; inpatient respite; and 24/7 on-call support

There is no mandatory nationwide accreditation for hospices. Many programs are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Community Health Accreditation Program (CHAP).

HOSPICE RESIDENCE State Program for HOSPICE patients. A facility of 8 -10 beds. Patient must physically move to the residence and establish new address

HOSPICE INPATIENT UNIT Free standing or hospital space for HOSPICE patient

IADL's Instrumental Activities of Daily Living (IADL's)

Instrumental activities of daily living are considered those which are less basic than ADL's. They need to be performed, but scheduling may not be as critical. IADL's include such activities as shopping, paying bills, cleaning, doing the laundry and snow removal. Many more seniors require, or simply prefer, assistance with IADL's than with ADL's. Some seniors may merely want someone to escort them when they are shopping and help them avoid any situations that might cause them to fall. Other seniors may have become forgetful and welcome assistance with their bill paying and medical appointments. Still others who have become weakened by illness may require assistance with many IADL's as well as one or more ADL's. The good news is that whatever the need, there are workers and programs to provide appropriate support.

LDSS Local Department of Social Services

APPENDIX: GLOSSARY OF LONG TERM CARE TERMINOLOGY
(CONTINUED)

LHSCA Licensed Home Care Service Agency (no CON required)

- LHCSAs provide hourly nursing care and homemaker, housekeeper, personal-care attendants and other health and social services.

Who is eligible?

Services are available to clients who have private insurance and those who pay privately. In some cases licensed agencies contract with local social services departments, or certified home health agencies, to provide services to persons with Medicaid & Medicare coverage.

Referrals to LHCSAs can come from a variety of sources, including physicians and hospital discharge planners.

Note: There is a moratorium on PCA contracts in Erie County.

LLHCSA Limited Licensed Home Care Services Agency

LTHHCP Long Term Home Health Care Program also known as "The Lombardi Program" or the "Nursing Home Without Walls" program, was designed to provide care in the home for those who are qualified to enter a nursing home but who have lesser care needs and prefer to remain in their homes. In addition to receiving home nursing care, Lombardi participants receive assistance from home health aides and are often provided with social day care, home delivered meals and transportation to and from medical appointments.

This program is available to individuals who are medically eligible for placement in a nursing home and choose to receive services at home. These individuals must have care costs which are less than the nursing home cost in the county.

Individuals can access this program through a hospital discharge planner, the local Department of Social Services (LDSS), or a Long Term Home Health Care Provider. The county determines eligibility for the program, and the LDSS authorizes all services that are provided.

All regular Medicaid services are provided and the following may be available:

- Case management by RNs
- Home delivered or congregate meals
- Housing improvements and moving assistance
- Respiratory therapy
- Medical social services, nutrition and dietary services
- Respite care, social day care, and social transportation

-The LDSS is responsible for participating in the periodic reassessment of the services provided.

-The providers are responsible for obtaining physician orders and administering the assessment tools.

-The NYS Department of Health periodically surveys the providers to determine the quality and scope of the medical, nursing and rehabilitative care they deliver

-The capacity is based on # of slots in County. Approximately 60% of LTHHC Beds are filled in Erie & Niagara Counties.

NHTW Nursing Home Transition Waiver

Home and Community-Based Services

Medicaid Waiver for Nursing Home Transition and Diversion

The Home and Community-Based Services (**HCBS**) Medicaid Waiver for Nursing Home Transition and Diversion (**NHTD**) is one of the options available to New Yorkers with disabilities and seniors so they may receive services in the most appropriate, least restrictive setting. This summary provides a general overview of the **NHTD** waiver.

The **NHTD** Medicaid waiver was developed based on the philosophy that individuals with disabilities and/or seniors have the same rights as others to:

- Be in control of their lives.
- Encounter and manage risks and learn from their experiences.

A waiver:

- Is an opportunity for comprehensive services to be available in the community rather than in an institution.
- Allows states to assemble a package of carefully tailored services to meet the needs of a targeted group in a community-based setting.
- Maintains the waiver participant's health and welfare through an individualized service plan.
- Assures the overall cost of serving waiver participants in the community is less than the cost of serving a similar group in an institution.

Why did New York State Develop the NHTD Medicaid Waiver?

- State legislation authorized a new HCBS Medicaid waiver to provide a cost-effective community-based alternative to nursing facility care, reflecting the State's commitment to serve all persons in the least restrictive setting, appropriate to their needs.
- Individuals with disabilities and seniors, their families and other interested persons advocated for additional options for community-based services and supports.
- Otherwise existing Medicaid services and other supports may not be sufficient or most efficient to meet the needs of some individuals with disabilities and seniors to transition into or remain in the community.

What are the Expected Outcomes?

- Participants will have an additional community-based choice.
- Participants will have opportunities to live meaningful and productive lives in their communities.
- Families and other informal caregivers will have access to additional supports to assist them in their caregiver roles.

To be Eligible for the NHTD Medicaid Waiver an Individual Must:

- Be capable of living in the community with needed assistance from available informal supports, non-Medicaid supports and/or Medicaid State Plan services and be in need of one or more waiver service;
- Be eligible for nursing home level of care;
- Be authorized to receive Medicaid Community Based Long Term Care;
- Be at least 18 years of age or older;
- Be considered part of an aggregate group that can be cared for at less cost in the community than a similar group in a nursing home;
- Choose to live in the community as a participant in this waiver rather than in a nursing home; and
- Not participate in another HCBS waiver

OASIS Outcome and Assessment Information Set

Medicare-certified home health agencies are required to use a standard set of data items, known as OASIS (Outcome and Assessment Information Set) as part of a comprehensive assessment for all patients who are receiving skilled care that is reimbursed by Medicare or Medicaid. OASIS data are submitted by home health agencies to the States, and subsequently transmitted to the Centers for Medicare & Medicaid Services. These data form the basis for patient case mix profile reports and patient outcome reports that are used by home health agencies for quality improvement and quality

monitoring purposes and by state survey staff in the certification process. Home health agency quality measures that appear on the CMS Home Health Compare website are also based on OASIS data, and the data are used for case-mix adjustment of per-episode payment.

PACE The Program of All-Inclusive Care for the Elderly
(PACE) features a comprehensive and seamless service delivery system and integrated Medicare and Medicaid financing. Eligible individuals are age 55 years or older and meet the clinical criteria to be admitted to a nursing home but choose to remain in the community. An array of coordinated services is provided to support PACE participants to prevent the need for nursing home admission. An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs; develops care plans; and delivers or arranges for all services (including acute care and, when necessary, nursing facility services), either directly or through contracts. PACE programs provide social and medical services, primarily in an adult day health center setting referred to as the "PACE center," and supplement this care with in-home and referral services in accordance with the participants' needs. Each participant can receive all Medicare- and Medicaid-covered services, as well as other care determined necessary by the interdisciplinary team.
For a health care organization to be approved as a PACE program, the State must elect PACE as a voluntary State option under its Medicaid plan. In addition, the prospective PACE organization and the State must work together in the development of the PACE provider application. On behalf of the prospective provider, the State submits the application to the Centers for Medicare and Medicaid Services (CMS) with assurance of the State's support of the application and its contents. Each approved PACE program receives a fixed amount of money per PACE participant regardless of the services the participant utilizes.

PCA Personal care workers (called home attendants in New York City) are specially certified under New York State law. The scope of their services is essentially limited to providing assistance with ADL's and IADL's, but they cannot perform the health care functions that a home health aide can (such as taking a patient's temperature). However, for people who simply need general (rather than medical) assistance, home attendants perform a valuable service.

PSA Protective Service for Adults

PERS Personal Emergency Response System is a device that's worn as either a bracelet or necklace. If you need help, you simply press a button on the PERS device and a central emergency station is instantly signaled by phone. The emergency station promptly communicates with you via a special wide area speaker-phone that is usually included with the PERS device. After the emergency station learns the nature of the emergency, a call is made (in accordance with pre-arranged instructions) to the appropriate person or persons 911, for instance, or a neighbor or family member.

SOFA State Office for the Aging

SPECIAL NEEDS CHHA Special Needs Certified Home Health Agency

TBI Traumatic Brain Injury - Waivered Service 64 yrs. & under Monthly cap of $5,000

APPENDIX

SUPPORTING DOCUMENTS ON TRENDS AND DEMOGRAPHICS

TOPIC	APPENDIX #
As is Scenario-Buffalo, New York	I
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As Is Scenario - Buffalo

Erie Excluding Buffalo | Niagara | Buffalo

ERIE/NIAGARA AGING SERVICES DEMAND MODEL
BUFFALO ESTIMATE
Projected to 2027 with 2007 Base Year

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Show FULL Screen | Close FULL Screen

Senior Care Work Force Dashboard

Environmental

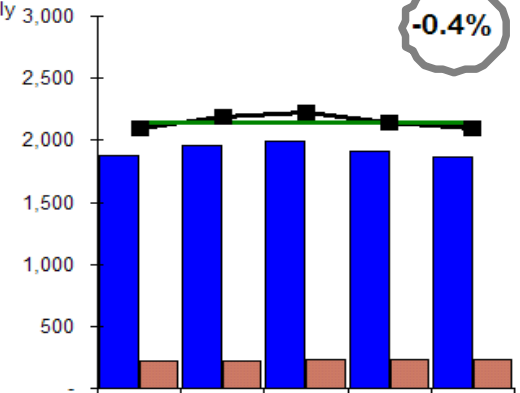
Net Annual % Change in 65+ Use Rates		0.00%
	Currrent	2027
Region Use Rate	299	295
% Change in Acute Care Transfer % to SNF		+0%
Current = 13%	2027 = 13%	
Impact of Changes in Available Caregivers % of "At Risk" 85+ Utilizing Formal Services		0%

Nursing Facility Beds

Short Stay / Long Stay / Total Beds Current Supply

48 Beds / 1,000 65+ 43

-0.4%



	07	12	17	22	27
Long Stay	1,876	1,963	1,992	1,913	1,860
Short Stay	226	225	230	230	233
TOTAL	2,101	2,188	2,222	2,144	2,093
Current Beds	2,138	2,138	2,138	2,138	2,138

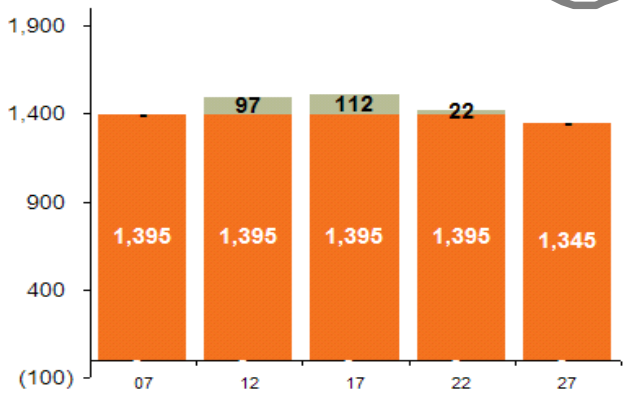
Lifestyle/Choice

Substitution of Housing/Service Alternatives for NF Care	None 0%
5 Year Transfer of "Low Acuity" NF Residents to AL	☑

Market Rate / Affordable-Funded / Affordable-Unfunded

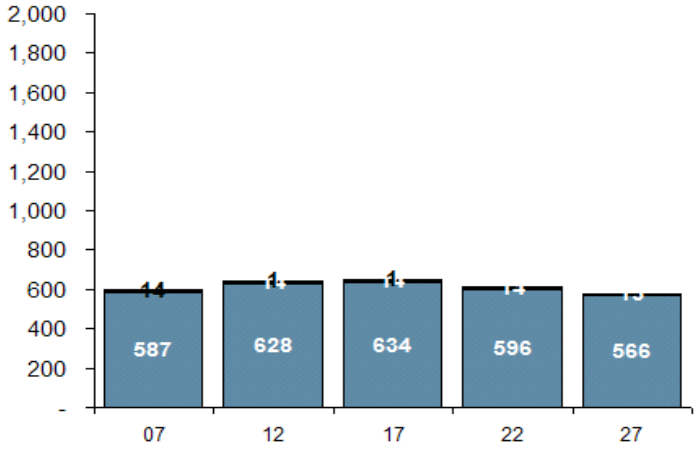
Independent Living Units

-3.5%



Assisted Living Units

-3.5%



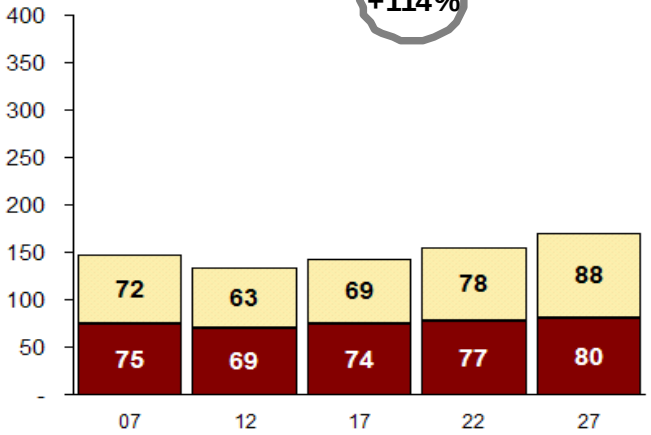
Public Funding

Net Increase in "Real" Annual HCBS Funding Dollars	+ $0.00M
50% AL Substitution - 50% Other HCBS	
User Defined Annual HCBS Funding (in Current Dollars)	
Current $630k → Proposed $653k	+4%
Assumed State Savings - NH	0%

Home Care Visits

Medicare / HBCS Gov't Funded (Thousands)

+114%



Income & Wealth

Percentage Change of >85+ In Poverty by 2027 (vs. Current)		0.0%
	Currrent	2027
85+ Poverty %	20.9%	20.9%

Population 65+ CAGR = 0.5% (+12%) **Population 85+ CAGR = -0.2% (-4%)**

As Is Scenario – Erie County w/o Buffalo

Erie Excluding Buffalo | Niagara | Buffalo

ERIE/NIAGARA AGING SERVICES DEMAND MODEL
ERIE EXCEPT BUFFALO ESTIMATE
Projected to 2027 with 2007 Base Year
4/13/2009 16:57

Show FULL Screen | Close FULL Screen | Senior Care Work Force Dashboard

Environmental

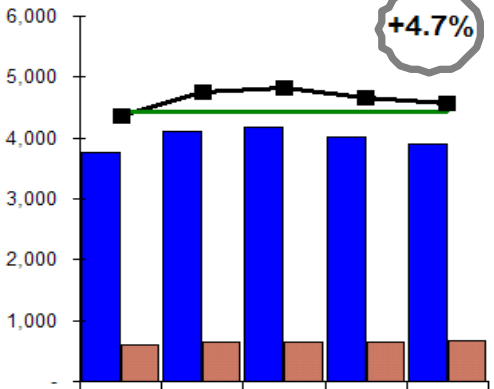
Net Annual % Change in 65+ Use Rates		0.00%
Region Use Rate	Currrent 299	2027 294
% Change in Acute Care Transfer % to SNF		+0%
Current = 24%	2027 = 24%	
Impact of Changes in Available Caregivers % of "At Risk" 85+ Utilizing Formal Services		0%

Nursing Facility Beds

Short Stay, Long Stay, Total Beds Current Supply

42 Beds / 1,000 65+ 37

+4.7%



	07	12	17	22	27
Long Stay	3,757	4,113	4,177	4,016	3,906
Short Stay	605	635	650	653	661
TOTAL	4,362	4,748	4,826	4,668	4,567
Current Beds	4,434	4,434	4,434	4,434	4,434

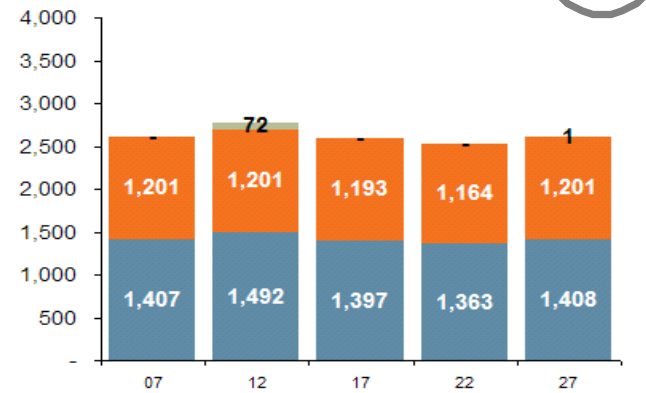
Lifestyle/Choice

Substitution of Housing/Service Alternatives for NF Care	None 0%
5 Year Transfer of "Low Acuity" NF Residents to AL	☑

Independent Living Units

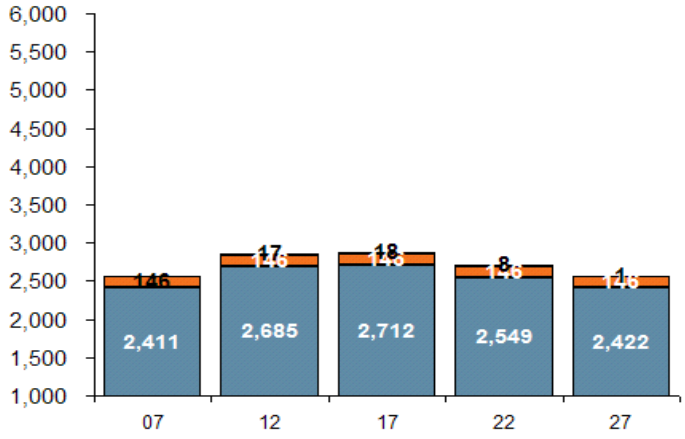
Market Rate, Affordable-Funded, Affordable-Unfunded

+0.1%



Assisted Living Units

+0.4%



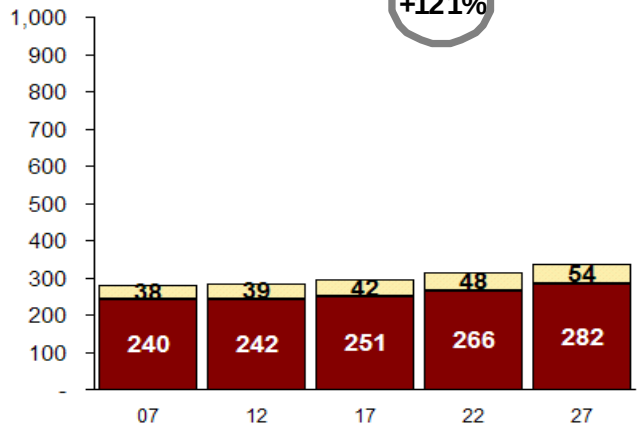
Public Funding

Net Increase in "Real" Annual HCBS Funding Dollars	+ $0.00M
50% AL Substitution - 50% Other HCBS	
User Defined Annual HCBS Funding (in Current Dollars)	
Current $442k	Proposed $440k 0%
Assumed State Savings - NH	0%

Home Care Visits

Medicare, HBCS Gov't Funded (Thousands)

+121%



Income & Wealth

Percentage Change of >85+ In Poverty by 2027 (vs. Current)		0.0%
	Currrent	2027
85+ Poverty %	11.5%	11.5%

Population 65+ CAGR = 0.9% (+20%) **Population 85+ CAGR = 0.0% (+0%)**

As Is Scenario – Niagara County

Erie Excluding Buffalo | Niagara | Buffalo

ERIE/NIAGARA AGING SERVICES DEMAND MODEL
NIAGARA ESTIMATE
Projected to 2027 with 2007 Base Year
4/13/2009 16:58

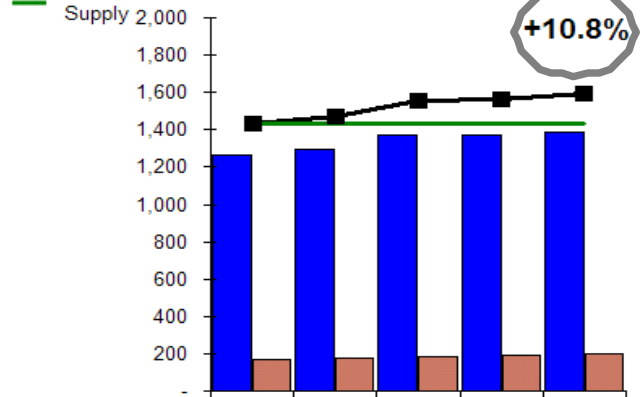
Show FULL Screen | Close FULL Screen | Senior Care Work Force Dashboard

Environmental

Net Annual % Change in 65+ Use Rates		0.00%
Region Use Rate	Currrent 299	2027 293
% Change in Acute Care Transfer % to SNF		+0%
	Current = 17%	2027 = 17%
Impact of Changes in Available Caregivers % of "At Risk" 85+ Utilizing Formal Services		0%

Nursing Facility Beds

Beds / 1,000 65+: 42 → 36 (+10.8%)



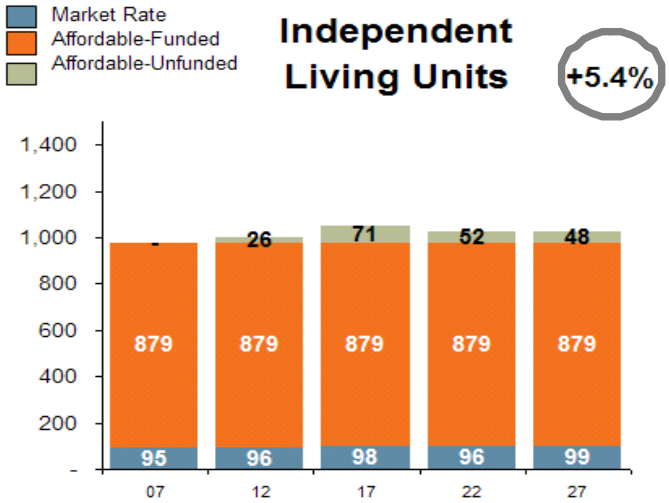
	07	12	17	22	27
Long Stay	1,264	1,296	1,368	1,369	1,390
Short Stay	172	175	186	192	201
TOTAL	1,435	1,471	1,554	1,562	1,591
Current Beds	1,430	1,430	1,430	1,430	1,430

Lifestyle/Choice

Substitution of Housing/Service Alternatives for NF Care	None 0%
5 Year Transfer of "Low Acuity" NF Residents to AL	☑

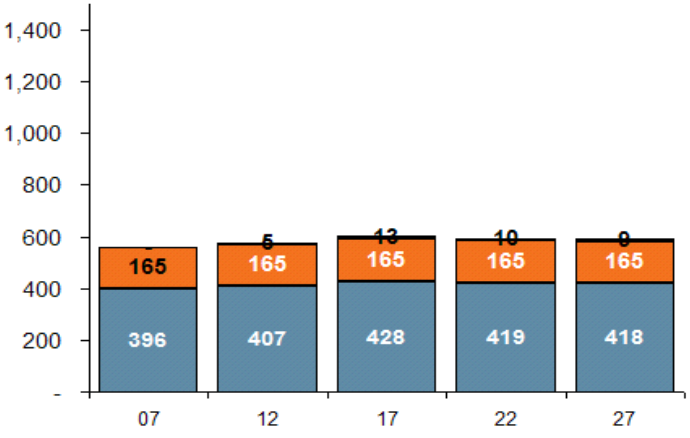
Independent Living Units

+5.4%



Assisted Living Units

+5.5%

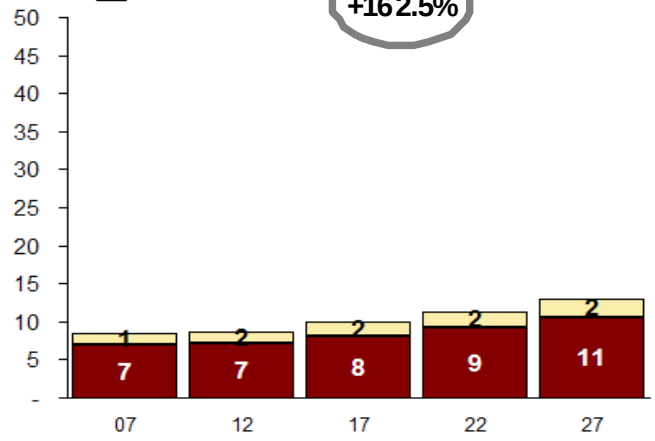


Public Funding

Net Increase in "Real" Annual HCBS Funding Dollars	+ $0.00M
50% AL Substitution - 50% Other HCBS	
User Defined Annual HCBS Funding (in Current Dollars)	
Current $500k → Proposed $474k	-5%
Assumed State Savings - NH	0%

Home Care Visits

Medicare
HBCS Gov't Funded
+162.5%
(Thousands)



Income & Wealth

Percentage Change of >85+ In Poverty by 2027 (vs. Current)		0.0%
85+ Poverty %	Currrent 16.6%	2027 16.6%

Population 65+ CAGR = 1.3% (+30%) **Population 85+ CAGR = 0.3% (+6%)**

Alternatives Maximized Scenario - Buffalo

Erie Excluding Buffalo | Niagara | Buffalo

ERIE/NIAGARA AGING SERVICES DEMAND MODEL
BUFFALO ESTIMATE
Projected to 2027 with 2007 Base Year

4/13/2009 15:31

Show FULL Screen | Close FULL Screen

Senior Care Work Force Dashboard

Environmental

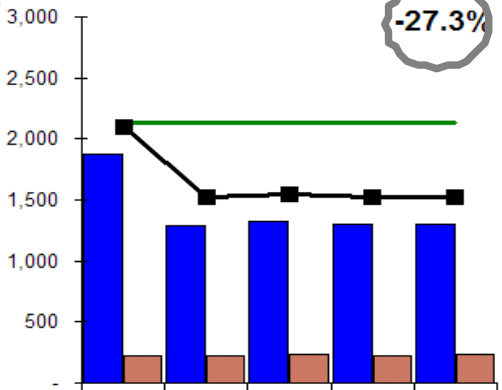
Net Annual % Change in 65+ Use Rates		-0.25%
Region Use Rate	Currrent 299	2027 280
% Change in Acute Care Transfer % to SNF		+0%
Current = 13%		2027 = 13%
Impact of Changes in Available Caregivers % of "At Risk" 85+ Utilizing Formal Services		25%

Nursing Facility Beds

Short Stay / Long Stay / Total Beds Current Supply

48 Beds / 1,000 65+ 31

-27.3%



	07	12	17	22	27
Long Stay	1,876	1,294	1,321	1,299	1,297
Short Stay	226	224	229	228	230
TOTAL	2,101	1,518	1,550	1,527	1,527
Current Beds	2,138	2,138	2,138	2,138	2,138

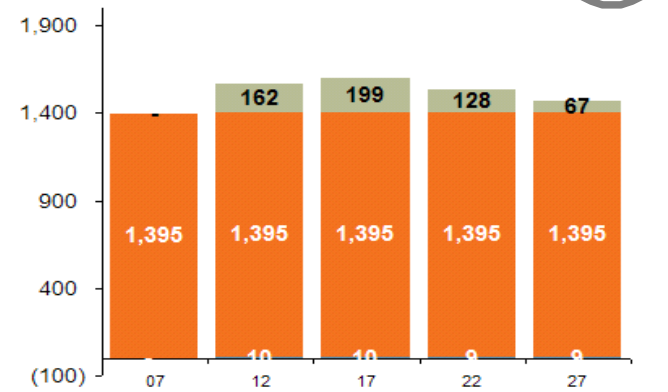
Lifestyle/Choice

Substitution of Housing/Service Alternatives for NF Care	Moderate 35%
5 Year Transfer of "Low Acuity" NF Residents to AL	☑

Independent Living Units

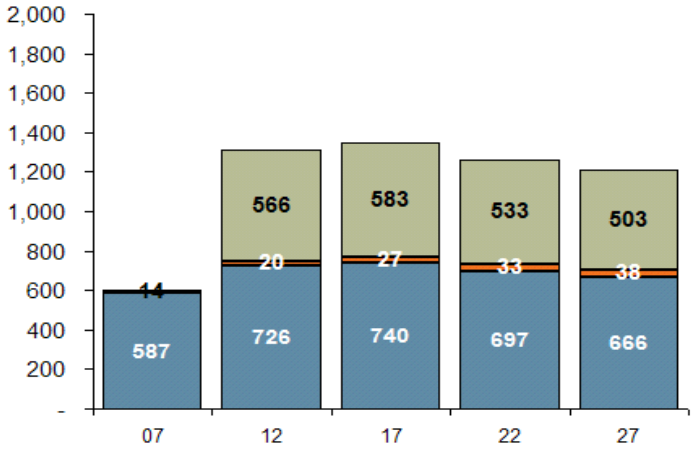
+5.5%

Market Rate / Affordable-Funded / Affordable-Unfunded



Assisted Living Units

+101.0%



Public Funding

Net Increase in "Real" Annual HCBS Funding Dollars	+ $0.13M

30% AL Substitution - 70% Other HCBS

User Defined Annual HCBS Funding (in Current Dollars)

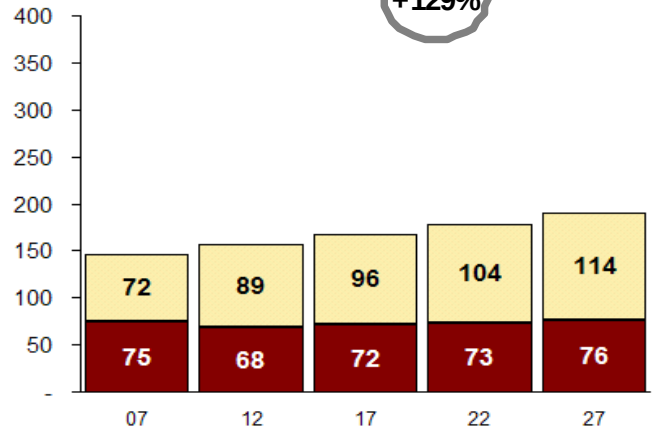
Current $630k → Proposed $1,026k +63%

Assumed State Savings - NH 20%

Home Care Visits

Medicare / HBCS Gov't Funded (Thousands)

+129%



Income & Wealth

Percentage Change of >85+ In Poverty by 2027 (vs. Current)		2.0%
85+ Poverty %	Currrent 20.9%	2027 22.9%

Population 65+ CAGR = 0.5% (+12%) **Population 85+ CAGR = -0.2% (-4%)**

Alternatives Maximized Scenario – Erie County w/o Buffalo

Erie Excluding Buffalo | Niagara | Buffalo

ERIE/NIAGARA AGING SERVICES DEMAND MODEL
ERIE EXCEPT BUFFALO ESTIMATE
Projected to 2027 with 2007 Base Year
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Show FULL Screen | Close FULL Screen

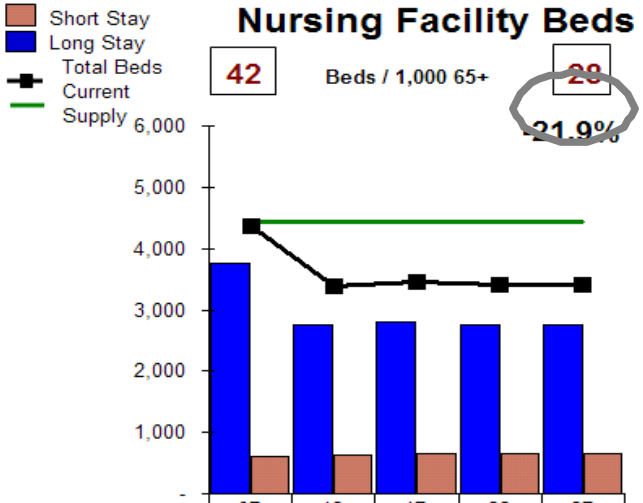
Senior Care Work Force Dashboard

Environmental

Net Annual % Change in 65+ Use Rates		-0.25%
Region Use Rate	Currrent 299	2027 280
% Change in Acute Care Transfer % to SNF		+0%
Current = 24%	2027 = 24%	
Impact of Changes in Available Caregivers % of "At Risk" 85+ Utilizing Formal Services		25%

Nursing Facility Beds

42 Beds / 1,000 65+ 29 -21.9%

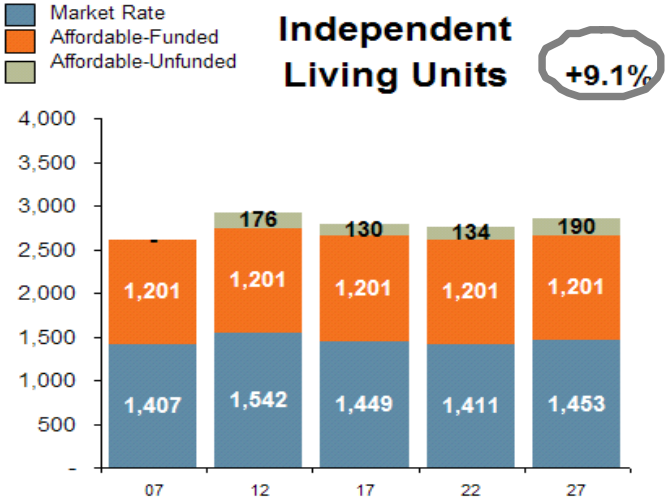


	07	12	17	22	27
Long Stay	3,757	2,757	2,809	2,756	2,756
Short Stay	605	637	650	646	651
TOTAL	4,362	3,394	3,458	3,402	3,407
Current Beds	4,434	4,434	4,434	4,434	4,434

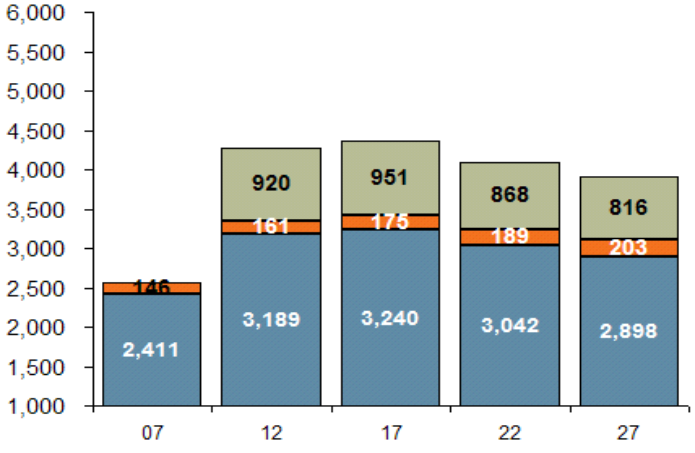
Lifestyle/Choice

Substitution of Housing/Service Alternatives for NF Care		Moderate 35%
5 Year Transfer of "Low Acuity" NF Residents to AL		☑

Independent Living Units +9.1%



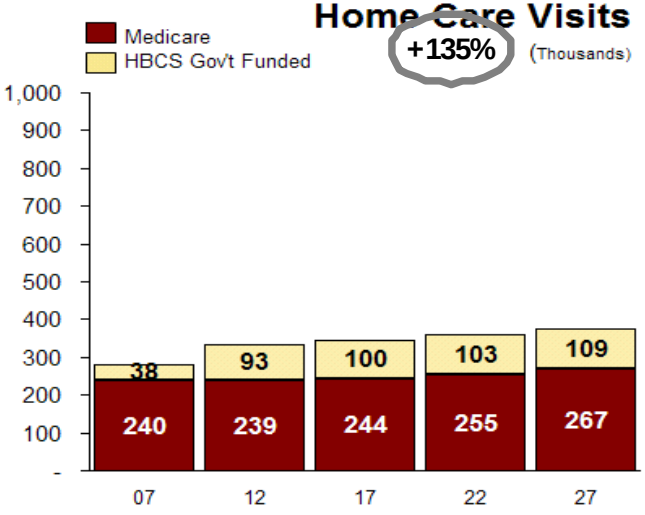
Assisted Living Units +53.1%



Public Funding

Net Increase in "Real" Annual HCBS Funding Dollars		+ $0.30M
30% AL Substitution - 70% Other HCBS		
User Defined Annual HCBS Funding (in Current Dollars)		
Current $442k	Proposed $813k	+84%
Assumed State Savings - NH		20%

Home Care Visits +135%



Income & Wealth

Percentage Change of >85+ In Poverty by 2027 (vs. Current)		2.0%
	Currrent	2027
85+ Poverty %	11.5%	13.5%

Population 65+ CAGR = 0.9% (+20%) **Population 85+ CAGR = 0.0% (+0%)**

Alternatives Maximized Scenario – Niagara County

Erie Excluding Buffalo | Niagara | Buffalo

ERIE/NIAGARA AGING SERVICES DEMAND MODEL

NIAGARA ESTIMATE

Projected to 2027 with 2007 Base Year

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Show FULL Screen | Close FULL Screen

Senior Care Work Force Dashboard

Environmental

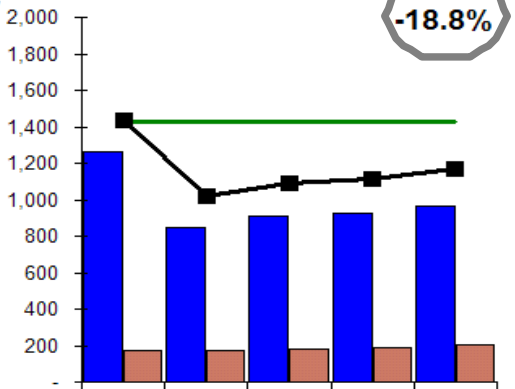
Net Annual % Change in 65+ Use Rates		-0.25%
Region Use Rate	Currrent 299	2027 278
% Change in Acute Care Transfer % to SNF		+0%
Current = 17%		2027 = 17%
Impact of Changes in Available Caregivers		
% of "At Risk" 85+ Utilizing Formal Services		25%

Nursing Facility Beds

Short Stay, Long Stay, Total Beds, Current Supply

42 Beds / 1,000 65+ 26

-18.8%



	07	12	17	22	27
Long Stay	1,264	849	906	924	964
Short Stay	172	171	184	191	201
TOTAL	1,435	1,020	1,090	1,115	1,165
Current Beds	1,430	1,430	1,430	1,430	1,430

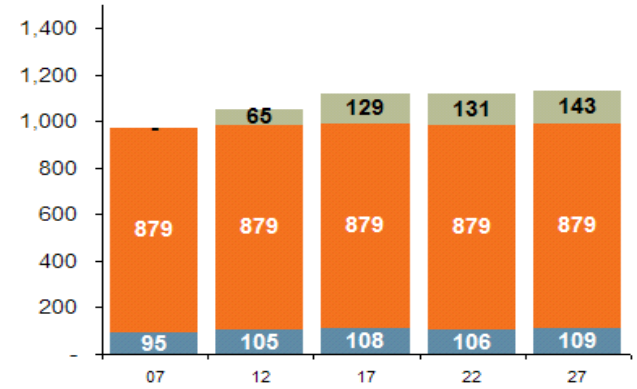
Lifestyle/Choice

Substitution of Housing/Service Alternatives for NF Care	Moderate 35%
5 Year Transfer of "Low Acuity" NF Residents to AL	☑

Market Rate, Affordable-Funded, Affordable-Unfunded

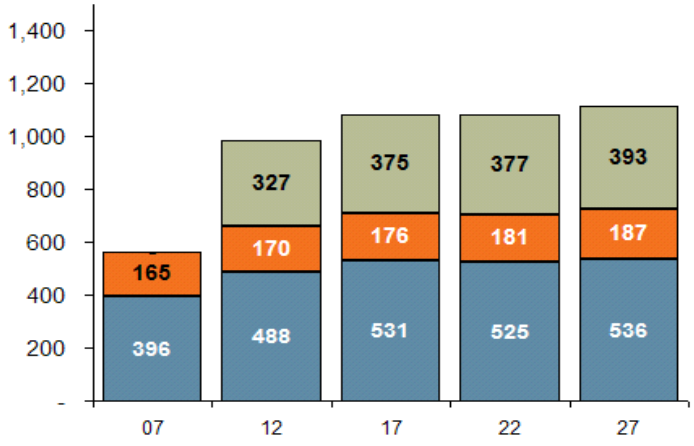
Independent Living Units

+16.2%



Assisted Living Units

+98.8%



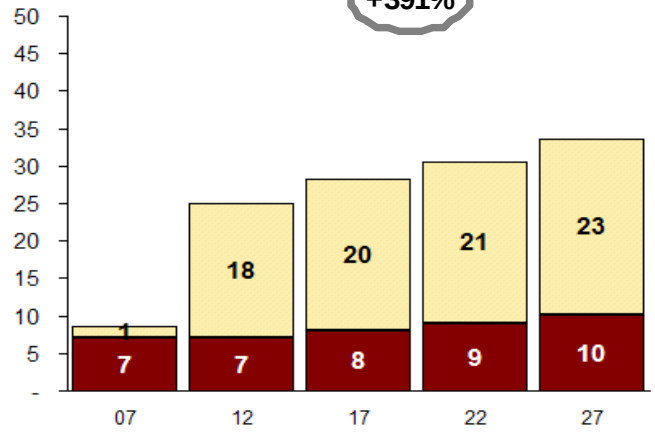
Public Funding

Net Increase in "Real" Annual HCBS Funding Dollars	+ $0.12M
30% AL Substitution - 70% Other HCBS	
User Defined Annual HCBS Funding (in Current Dollars)	
Current $500k → Proposed $847k	+69%
Assumed State Savings - NH	20%

Home Care Visits

Medicare, HBCS Gov't Funded (Thousands)

+391%



Income & Wealth

Percentage Change of >85+ In Poverty by 2027 (vs. Current)		2.0%
85+ Poverty %	Currrent 16.6%	2027 18.6%

Population 65+ CAGR = 1.3% (+30%) **Population 85+ CAGR = 0.3% (+6%)**

Demand Influencer: Caregiver Availability

Today

5.6 Caregivers

2027

4.6 Caregivers
(both counties)

Projected declines in caregiver availability for Erie and Niagara

	2007E	2027P
Erie	5.7	4.7
Niagara	5.2	4.2

Caregiver Ratio = Women 45-64 per person 85+

Changes in the availability of family members to provide unpaid help is expected to challenge the formal systems. The decline in an available, younger workforce will also create problems in assuring the needs are met.

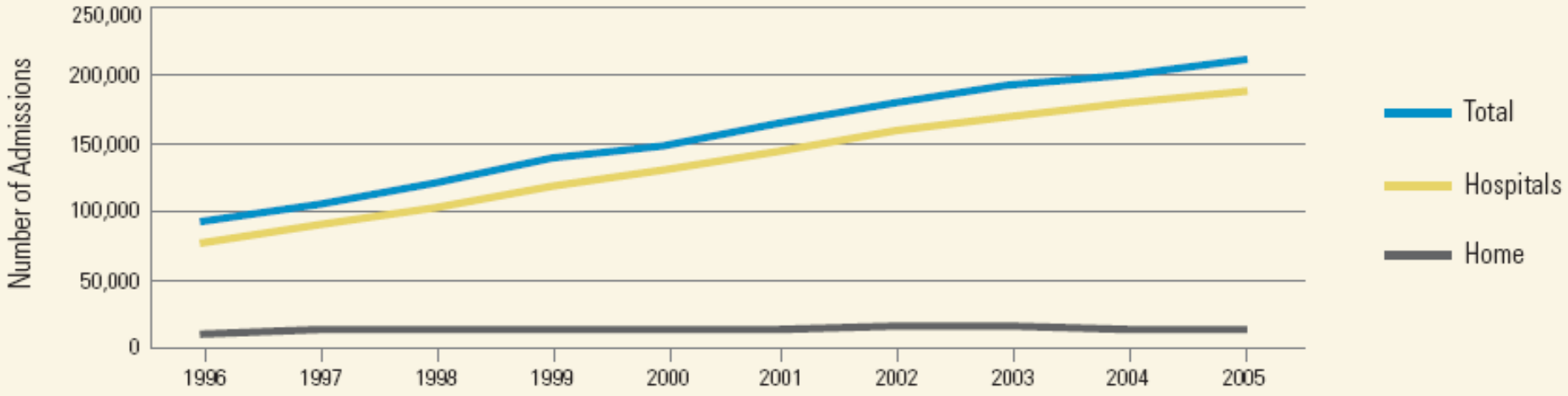
Hospital Use Rates

•*Use of housing or skilled care is frequently triggered by a health event that may require a hospital admission.*

- Historically, about 13% of older adults plan for where they will live or how they will manage following a health event that might leave them frail or disabled.
- The hospital use rate in Erie and Niagara counties for those 65+ is higher than some other parts of New York.
- Part of the higher use rates are believed due to a shortage of primary care physicians to care for elders resulting in delay in treatments that lead to hospitalizations.
- The hospitals' lengths of stay and costs are increasing in part due to difficult to place patients requiring services post-acute which are not currently available.

Increasingly Residents Are Admitted Post-acute

Nursing Home Admissions, by Selected Source



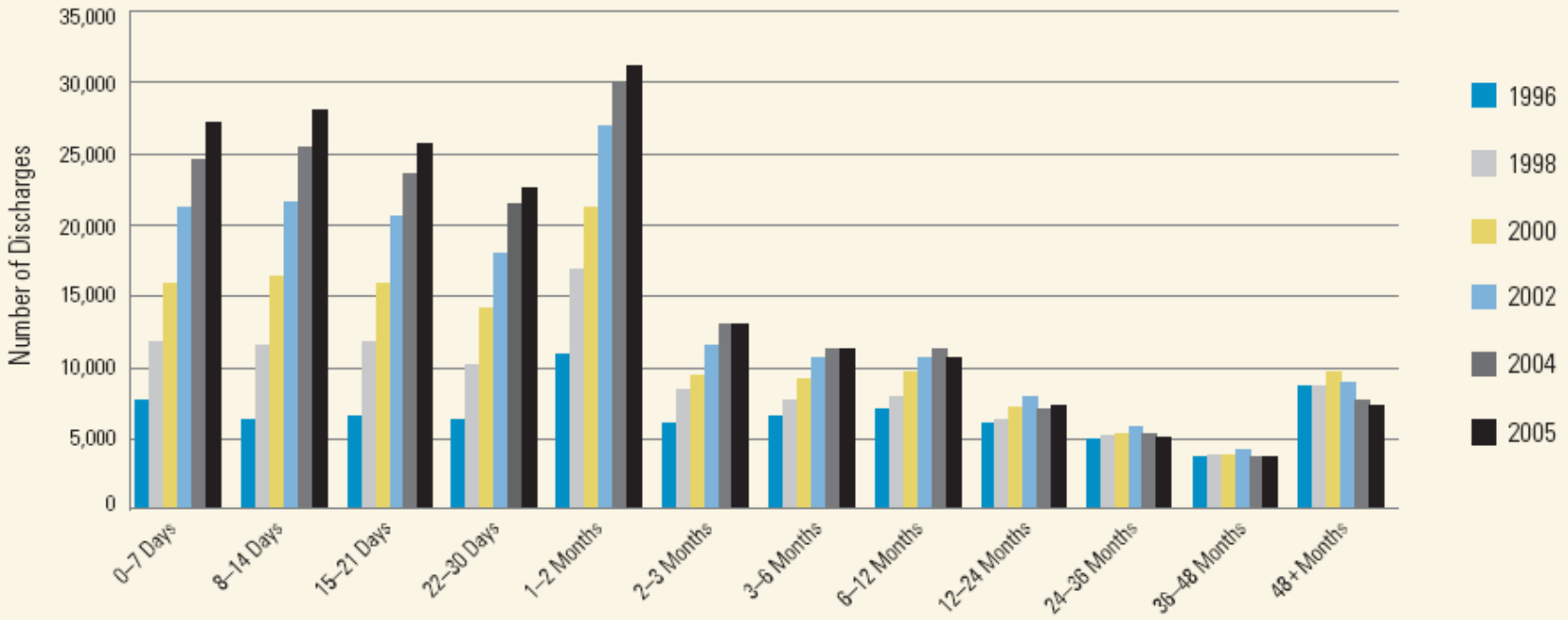
Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005.
Data obtained from Healthcare Association of New York State.

Hospitals have become the primary referral source for SNF admissions. Most residents begin with a short stay funded by Medicare and then about 44% continue as a long stay resident.

Source: Changes in Nursing Home Care 1996 – 2005: New York; Medicaid Institute at the United Hospital Fund, 2/08 accessed by Larsonallen 4/08

Length of Stay in SNFs Will Continue to Decline

Figure 6
Nursing Home Discharges by Selected Length of Stay and Year



Source: Cost reports for all nursing facilities, filed with the New York State Department of Health for 1996-2005.
Data obtained from Healthcare Association of New York State.

Statewide the length of stay of SNF residents is declining for stays over 12 months and growing for 0 to 2 months.

Source: Changes in Nursing Home Care 1996 – 2005: New York; Medicaid Institute at the United Hospital Fund, 2/08 accessed by Larsonallen 4/08

Short Stay Skilled Nursing Facility Care is Changing….

		2006 Medicare		% Change	
Rank	State	Discharges	ALOS	Discharges	ALOS
1	FL	142,427	33.9	-0.5%	2.2%
2	CA	108,813	36.9	7.2%	0.1%
3	TX	89,062	43.8	5.6%	0.1%
4	NY	83,417	46.8	-4.3%	5.2%
5	NJ	76,888	30.7	0.9%	0.7%
6	PA	69,915	42.4	-7.0%	6.0%
7	MI	62,004	36.9	-1.3%	4.7%
8	IL	61,018	37.0	2.4%	1.8%
9	MA	55,825	35.6	0.8%	-0.2%
10	NC	43,766	42.6	4.3%	-1.2%
	US	**1,446,384**	**37.9**	2.5%	0.3%

New York ranks 4th in the country in the number of Medicare discharges to SNF and has a length of stay that is about 9 day longer than the national average. If the length of stay declines will fewer short stay rehab beds be required? Can home based care be used to help residents transition home earlier?

Source: Medicare 2006 & 2005 Cost Reports as filed by 10/08; Analysis completed by LarsonAllen LLP

Care at End of Life Varies Across the Region

Medicare spending during last two years of life per decedent

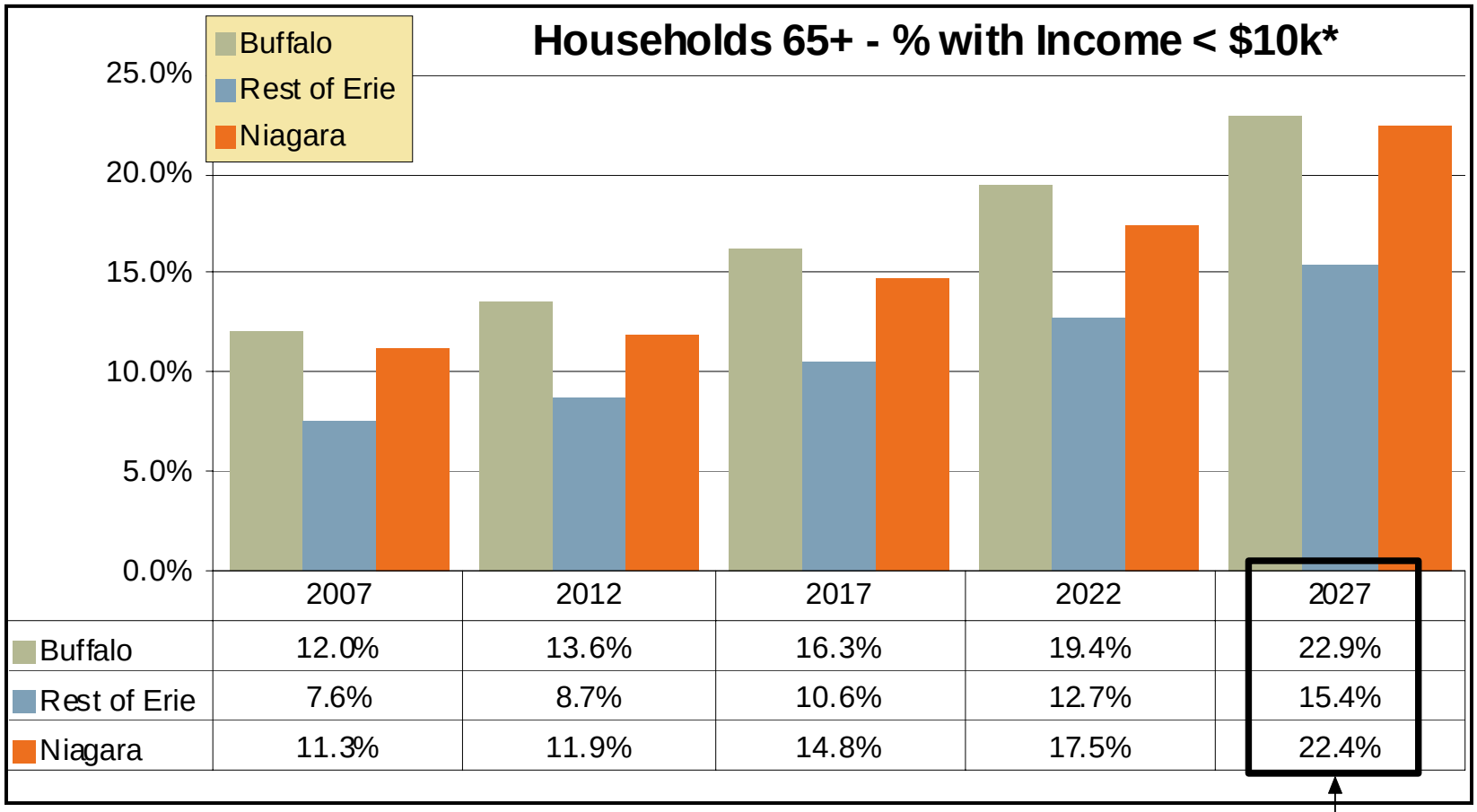
Hospital Names	Total Medicare spending	SNF/LTC	Home health	Hospice
Mount St. Mary's Hospital	$43,915	$5,872	$2,777	$2,611
Niagara Falls Memorial Med Ctr	$43,033	$5,811	$2,940	$2,132
Inter-Community Memorial Hosp	$39,426	$9,233	$1,218	$1,628
Sisters of Charity Hospital	$44,771	$7,453	$2,323	$1,470
Roswell Park Cancer Institute	$69,483	$1,573	$1,841	$3,500
Lockport Memorial Hospital	$39,760	$6,231	$1,668	$1,429
Kaleida Health-Buffalo Gen Hosp	$46,077	$6,709	$2,412	$1,395
Mercy Hospital	$41,237	$7,244	$2,240	$1,259
Erie County Medical Center	$45,891	$7,760	$1,821	$555
Bertrand Chaffee Hospital	$36,804	$5,008	$1,832	$1,130

What are the implications to LTC if the patterns of care become more consistent?

The care for Medicare beneficiaries of Erie & Niagara counties during the last 2 years of life vary. Some residents receive more post acute care or are enrolled more frequently in hospice depending on the physician practices at area hospitals.

Source: Dartmouth Atlas of Healthcare; Hospital Care Index benchmarking based on 2005 Medicare data; accessed by LarsonAllen 5/08

Demand Influencer: Poverty/Income Status



	2007	2012	2017	2022	2027
Buffalo	12.0%	13.6%	16.3%	19.4%	22.9%
Rest of Erie	7.6%	8.7%	10.6%	12.7%	15.4%
Niagara	11.3%	11.9%	14.8%	17.5%	22.4%

** - Cost of living adjusted at 2.5% per annum*

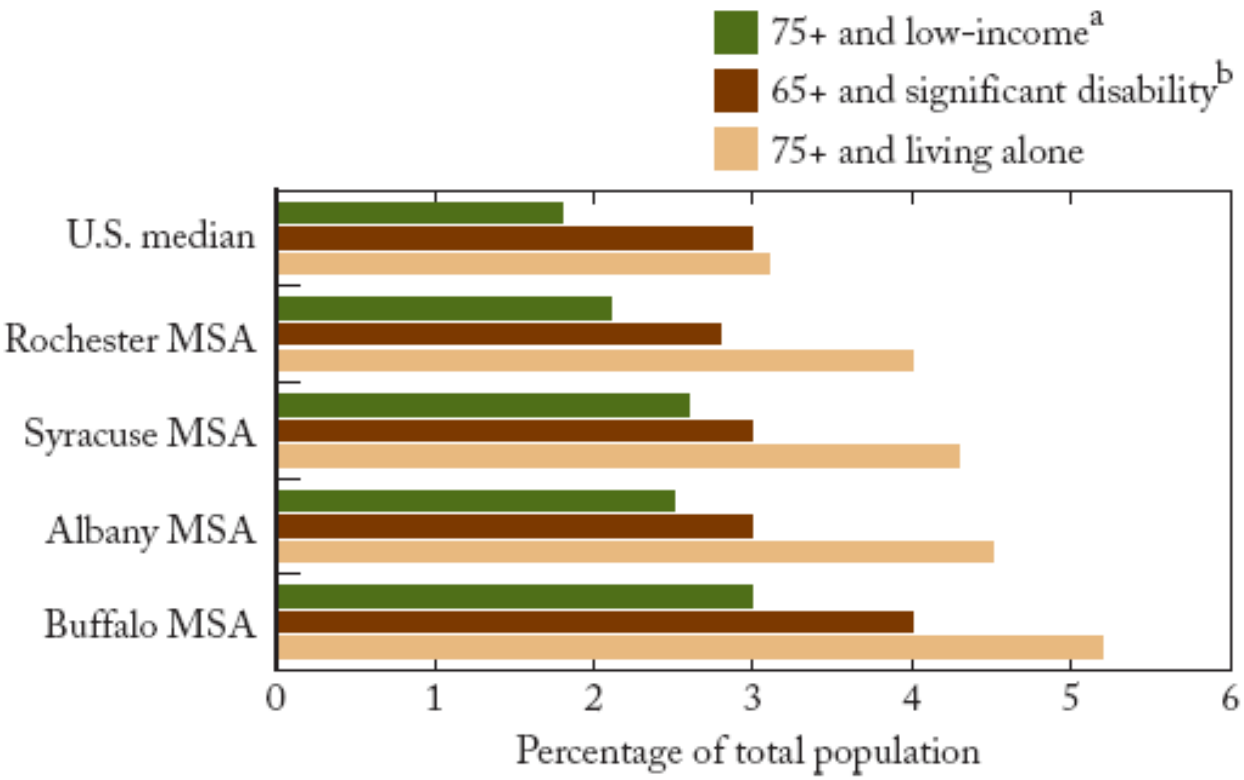
Observation

Significant increase in 65+ households with < $10k Income*
in relation to total 65+ population

Buffalo MSA Has High Concentration of Frail, Poor Elders

Concentration of High-Needs Elderly in Large Metropolitan Statistical Areas (MSAs)

Upstate New York and U.S. Median, 2000



Source: U.S. Census Bureau, Census 2000.

Source: Upstate NY Regional Review; Vol.No 2; Issue 1; 2007; The Demand for Local Services and nfrastructure created by Aging Population; Richard Dietz and Roman Garcia.

Medicare Advantage Plans Are Changing Care

Medicare Advantage Enrollment			2003 Acute
Rank	State	2007	DC/1000 65+
	United States	8,386,625	360
1	California	1,449,282	310
2	Florida	771,603	369
3	Pennsylvania	675,179	405
4	New York	674,029	377
5	Texas	373,014	372
6	Ohio	315,607	400
7	Arizona	263,637	318
8	Michigan	237,200	374
9	Oregon	215,613	259
10	Minnesota	206,593	341

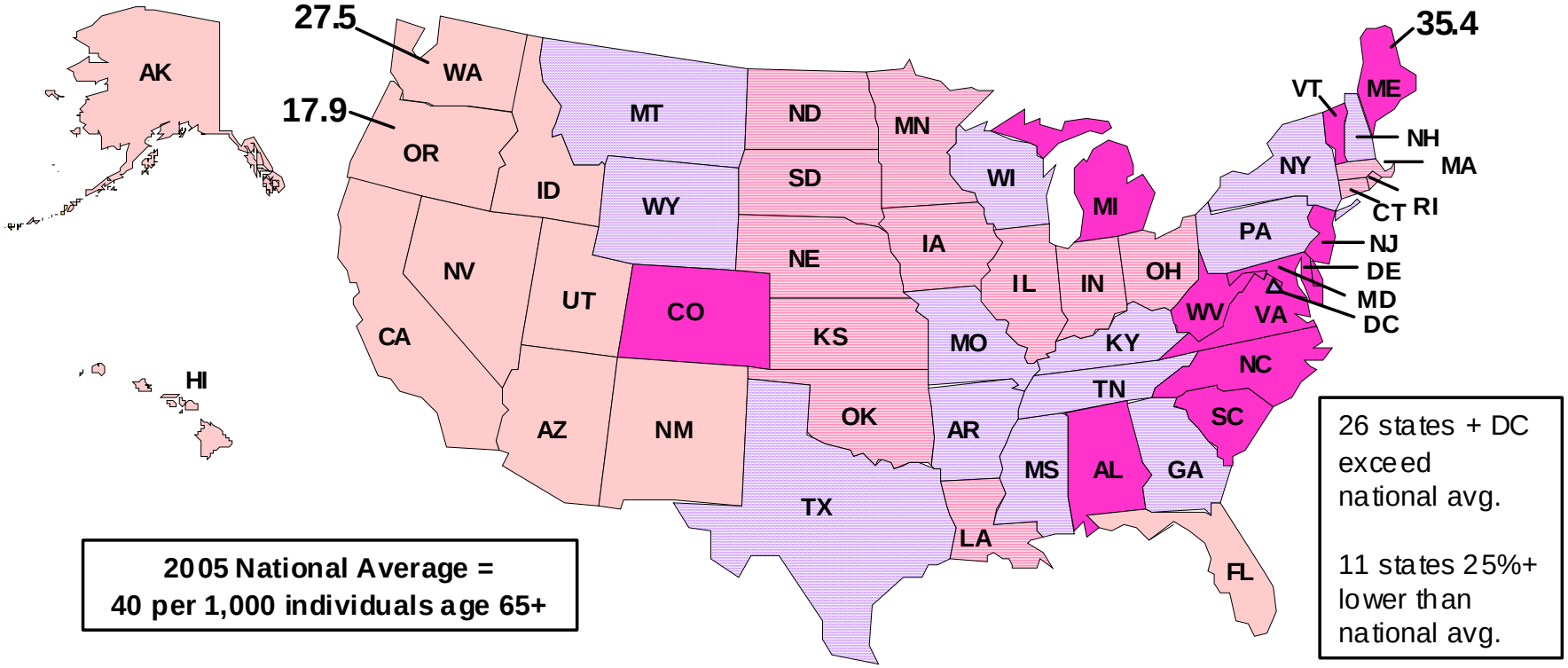
The Hospital discharge rate for Medicare for Buffalo MSA in 2005 is 303 substantially lower than the State average in 2003.

Medicare Managed care came back into vogue about 2006 and enrollment in Medicare Advantage plans and Special Needs managed care plans have increased.

The use of acute and post-acute services by these plans is not clear yet.

Source: Kaiser Family Foundation, Statehealthfacts.com; accessed 2/08;

SNF Residents per 1,000 Individuals Age 65+-2005



14 – 30 res. per 1,000

Alaska
Arizona
California
Florida
Hawaii
Idaho
Oregon
Nevada
New Mexico
Utah
Washington

31-40 res. per 1,000*

Alabama
Colorado
Delaware
Maine
Maryland
Michigan
New Jersey
North Carolina
South Carolina
Texas
Vermont
Virginia
West Virginia

41-49 res. per 1,000

Arkansas
District of Columbia
Georgia
Kentucky
Mississippi
Missouri
Montana
New Hampshire
New York
Oklahoma
Pennsylvania
Tennessee
Wisconsin
Wyoming

52 – 65 res. per 1,000

Connecticut
Illinois
Indiana
Iowa
Kansas
Louisiana
Massachusetts
Minnesota
Nebraska
North Dakota
Ohio
Rohde Island
South Dakota

Source: *The* Lewin Group an Ingenix Company; *Projecting Maine's LTC Use,* 2/29/08

ERIE/NIAGARA AGING SERVICES DEMAND MODEL
Demand Scenario Assumption Development Template

Visioning Scenario: October 3, 2008

Demand Influencer	Assumption Required	Range of Assumptions	YOUR SCENARIO	*Low SNF Demand*	Mid SNF Demand	*High SNF Demand*
REGION	Select Model Region	Erie, Erie Except Buffalo or Buffalo				
DEMAND INFLUENCERS: ENVIRONMENTAL						
Hospital Use Rate Change	Annual % Change in 65+ Hospital Use Rate	-2.0% to +1.0% in 0.25% Increments		*-1.00% / Yr*	**-0.25% / Yr**	*No Change*
Caregiver Impact	% of "At Risk" 85+ Who Will Utilize Formal Services	0%, 10%, 25%,35%, 50%		*10% of "At Risk" 85+ Utilize Formal Services*	**35% of "At Risk" 85+ Utilize Formal Services**	*50% of "At Risk" 85+ Utilize Formal Services*
DEMAND INFLUENCERS: LIFESTYLE/CHOICE						
Substitution	% of Current NF Residents Who Will Utilize Other Housing and Service Alternatives by 2027	0%,15%, 35%, 50% or user definable % between 5% and 60%		*50%*	**20%**	*15%*
Assume Transfer of "Low Acuity" NF Residents to AL	Will Current "Low Acuity" NF Residents (33% of total) Be Transferred to AL by 2012?	Yes or No		*No*	**No**	*No*
DEMAND INFLUENCER: PUBLIC FUNDING						
HCBS Funding	Annual Increase in "Real" HCBS Funding vs. Current Levels	User Definable between 5% Decrease and +/- 500% Increase		*500%+ Increase in Per Capita HCBS Funding (Approximates 60% / 40% NF / HCBS Funding by 2027 with 50% of funding for AL)* *$2.27M Erie Except Buffalo, $0.98M Buffalo, $0.88M Niagara*	375%+ Increase in Per Capita HCBS Funding (Approximates 75% / 25% NF / HCBS Funding by 2027 with 75% of funding for AL) $1.77M Erie Except Buffalo, $0.76M Buffalo,$0.69M Niagara	*Sufficient to Fund Substitution Only* *$0.69M Erie Except Buffalo, $0.38M Buffalo,$0.27M Niagara*
HCBS Funding Mix	% of HCBS Funding to Assisted Living vs. Other HCBS Services	AL Between 0% and 100% in 5% Increments / Other HCBS is 100% less AL %		*50% AL / 50% Other*	**50% AL / 50% Other**	*50% AL / 50% Other*
State Savings %	% NF Savings for HCBS Investments	-20% to 40% in 5% increments		*20%*	**20%**	*20%*
DEMAND INFLUENCER: INCOME & WEALTH						
Poverty % of 85+ Population	Future Change from Current % of 85+ Population in Poverty	-3% to +14% in 1% increments		*No change*	**No change**	*No Change*