



Strategic Plan

The Chautauqua Model for Long Term Services and Supports – 2011 - 2013

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EXECUTIVE SUMMARY

The Long Term Care Council, as a condition of receiving a HRSA planning grant in 2010, set out to align existing long term care services to meet emerging community needs through the development of The Chautauqua Model for Long Term Services and Supports. This integrated long term continuum of care includes home care, primary care, acute care, palliative care, assisted living, adult homes, medical and social day care, as well as short term rehabilitation and skilled nursing facilities.

VISION FOR THE FUTURE

The Chautauqua Model for Long Term Services and Supports is expected to be an innovative, person-centered strategy designed to achieve efficiencies, expand access, coordinate and improve the quality of essential health care/long term care services, and strengthen the rural health care system as a whole.

GOAL

Chautauqua County residents will have, knowledge of and access to, an affordable and integrated continuum of high quality, person centered long term care services.

STRATEGIC OBJECTIVES IN PRIORITY ORDER

1. Strengthen and enhance Case Management and Referral Services
2. Increase awareness of need for affordable Home & Community Based Services
3. Address the shortage of residential mental health options for geriatric and developmentally disabled population

ANCILLARY AND SUPPORTIVE OBJECTIVES

Prior to the planning process, the Models Work Group, chaired by Dr. Mary Ann Spanos reviewed several models for linking individuals' medical needs with their living well needs. As a result of those discussions and to best implement The Chautauqua Model for Services and Supports, the LTCC will also:

- Explore linking together all the local IR& systems locally – New York Connects, 211 and Love, Inc. and develop a comprehensive data base which could be shared. This central entry point would be two-pronged and serve both the medical community and provide community access. It was perceived as being consumer friendly, streamlined with a comprehensive and integrated data base. Staff would make follow up calls after linkages or referrals were made and would continually monitor needed services which do not exist.
- Support efforts related to electronic medical record keeping and otherwise improve the ease of communicating electronically including electronic access to transition plans
- Support efforts related to the Medical Home Model which is evolving and provides reimbursement for physicians and hospitals. Seek funding for care coordinators and patient navigators in physician's offices and transitional coaches in the community

- Review and promote transitional coaching models including the work of Dr. Erik Coleman
- Develop a checklist or means for physicians to know who else is touching the patient requiring long term services
- Better market and promote New York Connects. While 80% of long term care admissions come from hospitals, a better job of informing the 20% who come on their own is necessary.
- Work closely with physicians since they are a “trusted source” for important decisions relating to long term care
- Explore possibility of becoming an Aging and Disability Resource Center
- Support efforts to establish a FQHC – Federally Qualified Health Center – in Dunkirk, New York
- Publicize the cost savings involved with keeping seniors in the community

ISSUES NOT ADDRESSED IN GAP ANALYSIS BUT POTENTIAL BARRIERS TO IMPLEMENTING THE CHAUTAUQUA MODELS

- 1) Shortage of providers of care especially Personal Care Aides & Home Health Aides
- 2) Shortage of Transportation
- 3) Shortage of Medicaid Managed Care providers, as well as fee-for-service Medicaid providers
- 4) Restructuring of reimbursement rates.
5. State solution to long term care is to push all Medicaid patients into managed care over the next 3 years
6. Medicaid Redesign Changes - Starting July 1, 2011

Regarding changes at the State level: In the absence of implementation details, there is skepticism among several LTCC members about the impending mandate to expand Medicaid Managed Care into skilled nursing and home health care. The system is far from rebalanced and yet the perception is that NYSDOH has little interest in further adjustments. Local providers are feeling somewhat abandoned, seeing that the priority issues they have identified cannot be adequately addressed via the proposed managed care system. They are also concerned that the plan is too aggressive and is putting both the local provider and payer panels in jeopardy for continued participation.

BENEFITS OF THE PLANNING PROCESS

Through the process, discussion and research it was evident that NY Connects and the Long Term Care Council need to step up their efforts to inform the community about the services available. A common theme that emerged was that NY Connects is an excellent entry point to the system, but that the general public is not aware of its existence.

The major players in the long term services and support arena are at the LTCC table and a level of trust and camaraderie has emerged through the planning process.

The group discussed having an if...then strategy around common issues. For example if funding becomes available for mental health training for skilled nursing facility staff or home health aides, there will be a plan in place to identify the lead and partner agencies.

MISSION OF THE CHAUTAUQUA COUNTY LONG TERM CARE COUNCIL

The Council will promote and work to assure that essential services are provided to enhance the quality of life for residents of all ages in Chautauqua County who have long term care needs. We will promote public awareness of long term care needs and the services available to meet those needs. Further, the Council will promote personal responsibility in preplanning for these needs by providing a forum to promote discussion of issues and the potential resolution of problems related to the Long Term Care System.

INTRODUCTION

The Long Term Care Council, as a condition of receiving a HRSA planning grant in 2010, set out to align existing long term care services to meet emerging community needs through the development of The Chautauqua Model for Long Term Services and Supports. This integrated long term continuum of care includes home care, primary care, acute care, palliative care, assisted living, adult homes, medical and social day care, as well as short term rehabilitation and skilled nursing facilities.

METHODOLOGY

A Gap Analysis was prepared by William Gormley, LLC to provide a baseline of current services and a projection of long term needs moving forward. The report enumerated nine significant findings which are detailed later in this report.

Patricia A. Smith, President of Management Strategies was retained to facilitate the planning process. An open invitation was issued to all LTCC members and the Strategic Planning Work Group chaired by Frank Bercik began their work in April of 2011. The committee met on April 6th, May 4th, May 18th, June 22nd, July 6th and July 29th, 2011. The meetings included small and large group discussion, the use of an opportunity matrix and various decision making and prioritizing tools, as well as in-depth discussion. A core group of Council members participated in all the planning meetings, while other members and invited guests attended one or two of the meetings. This report highlights the work of the group and will be presented to the LTCC at their September meeting for final approval. This document will also serve as the basis for submission of an implementation grant to HRSA in late 2011.

HISTORY

The first planning session began with a presentation on the history of the Long Term Care Council given by Dr. Mary Ann Spanos, Director of the Chautauqua County Office for the Aging. She detailed how the Council originated with the NY Connects Program, how the HRSA grant expanded the membership of the Council and the most recent move of the administration of NY Connects to the Office for the Aging.

STRENGTHS OF LTCC

The group then identified the strengths of the Council as follows:

- Well rounded, objective, engaged and informed membership
- Collaboration by and with the community and providers
- Members cooperate and listen to one another's ideas

- No other group is addressing the desires of the community to age in place
- LTCC has good cross section but need more people like MD and legislators to move the system forward
- Knowledge and commitment of the members
- Most community partners represented and we know what is missing
- Partners willing to come together and make a change
- Grass roots understanding of problems
- Diversity of members and exposure to broad needs
- Ability to drive consensus b/w stake holders
- LTCC representatives from many sectors, stand points and affected population
- Broad knowledge of many facets of LTC continuum of services
-

SHARED VALUES

The group next identified a number of shared core values which will guide how the group will work together in developing and implementing The Chautauqua Model. There was a pledge to be

- Open-minded
- Committed to improving the mental and physical health of the LTC community
- Flexible
- Honest
- Able to persevere and follow through
- Non-judgmental
- Willing to change
- Objective
- Collaborative
- Able to respectfully disagree
- Un-biased
- Inclusive
- Able to communicate openly
- Willing to challenge the Status Quo
- Able to think big and take a global approach
- Creative
- Consensus Driven
- Working for the good of the people

- Willing to negotiate
- Patient and exhibit a sense of humor!

EXTERNAL FACTORS or POSSIBLE BARRIERS TO SUCCESS

The group next assessed external factors which would impact their ability to develop The Chautauqua Model. The initial list included:

- Medicaid Redesign Plan and the push for managed Medicaid programs
- SAGE Commission & Government consolidation at the State level
- Federal redesign of Medicaid
- Privatization of Medicare
- Health Care Reform Act
- NY State budget: passed but don't understand all the implications
- Mental health home visits eliminated
- Class Act & Long term care insurance

All of the above issues are significant, but the full extent of their impact is not known at this point and the group was determined to move forward with a plan and deal with the barriers as needed.

GAP ANALYSIS

The group reviewed the Gap Analysis and took exception to finding number three* regarding primary care physicians. There is a documented physician shortage and this is expected to worsen. When reviewing the findings the group was asked to be realistic in terms of its ability as an all-volunteer body to address the findings. There is an active group working on physician recruitment and the planning group determined we would be supportive of those efforts but concentrate our work on other priorities.

1. The need for long term care services in Chautauqua County will increase.
2. Affordability of long term care services is a key factor in meeting needs of Chautauqua County seniors.
3. The number of primary care physicians for Chautauqua County as a whole is within Council on Medical Graduate Education recommendations. However, primary care provider deficits occur in rural and low income areas of the County when using national indicators for defining medically underserved areas. This indicates a need for additional primary care providers. Consistent with national trends, demand for primary care providers is expected to increase in the future. While data prepared by CCHN appears to indicate that there may be a need for additional physicians in some specialties, a full analysis of the regional specialist supply and demand must be prepared in order to fully assess the need for specific specialty physicians.
4. Chautauqua County has excess skilled nursing facility capacity.
5. Chautauqua County appears to have a sufficient number of licensed adult care facilities in total. However, the number of Medicaid eligible units (ALP) and their geographic distribution may be insufficient.

6. There appears to be sufficient Certified Home Health Agency (CHHA) and hospice services to meet the County's needs.
7. There is a growing need for residential services for the geriatric mentally ill and developmentally disabled.
8. There is a growing need for subsidized/affordable home and community based services to provide support to enable the frail elderly to remain in the community.
9. Case management and referral services will become increasingly important to address prioritizing long term care service delivery due to Office for Aging budget cutbacks and growing need for services.

The group also identified priorities/issues not addressed in the Gap Analysis

- 1) Shortage of providers of care especially Personal Care Aides & Home Health Aides
- 2) Shortage of Transportation
- 3) Shortage of Medicaid Managed Care providers, as well as fee-for-service Medicaid providers
- 4) Restructuring of reimbursement rates.
5. State solution to long term care is to push all Medicaid patients into managed care over the next 3 years
6. Medicaid Redesign Changes - Starting July 1, 2011

Through a series of priority exercises four areas were identified as being consistent with the mission of the LTCC and a SWOT Analysis was developed for the four areas as follows:

SWOT ANALYSIS

Case Management & Referral Services

Strengths

Money follows the person
 Strong case management/referral system
 Lots of resources
 Providers work well together
 NY Connects
 Willingness to step up to the plate
 County Comprehensive Plan

Weaknesses

Limited capacity
 Funding limited and in jeopardy
 Lack of connectivity
 Limited care transition planning

Geographic distribution of services
Workforce capacity

Opportunities

Changes in reimbursement to support transition case management (3026)
HRSA implementing grant funding
Medicaid redesign
PACE program
Focus on prevention
Patient Centered Medical Home
RIO (Health-e Link)
Sage Commission

Threats

Medicaid redesign, force MA into HMO may drive current providers out
Sage Commission
Lack of transportation
Cost

SWOT ANALYSIS

Home & Community Based Services

Strengths

Current providers
Wide array of services

Weaknesses

Workforce capacity
Disconnect with Medical Community
Unequal distribution/location in county
Public unaware of services
Waiting lists

Opportunities

Increased caregiver funding
Increased focus/attention on home & community based services
Healthier baby boomers

Technology
Innovative solutions funding

Threats

Government regulations
Lack of funding
Growing over 85 population

SWOT ANALYSIS

Residential Mental Health & Dev. Disabled Services

Strengths

Current providers – STEL, Aspire, TRC
County Mental Health
Day hab

Weaknesses

Lack of Alzheimer’s & mental health services
No inpatient for dual diagnosis
Lack of services SPMI
Mental Health reps not currently at the table

Opportunities

Medicaid service coordination for OPWDD

Threats

People with developmental disabilities are living longer
State not doing Medicaid service coordination
Loss of Buffalo Psych Services
PCP’s uncomfortable treating this population

SWOT ANALYSIS

Affordable Universal Housing

Strengths

“nice partners”
Partial list of accessible & subsidized housing

Weaknesses

Age of housing stock
Slum landlords
Increased hoarding
No comprehensive inventory
Distribution of housing resources
Only 5% of subsidize housing is accessible

Opportunities

Neighborhood revitalization plan
Old school buildings could be utilized
Some resources to modify housing

Threats

Increased hoarding

Through a series of additional prioritizing exercises, an opportunity matrix and in depth discussion, the group finalized their vision and overriding goal as follows:

VISION FOR THE FUTURE

The Chautauqua Model for Long Term Services and Supports will be an innovative, person-centered strategy designed to achieve efficiencies, expand access, coordinate and improve the quality of essential health care/long term care services, and strengthen the rural health care system as a whole.

GOAL

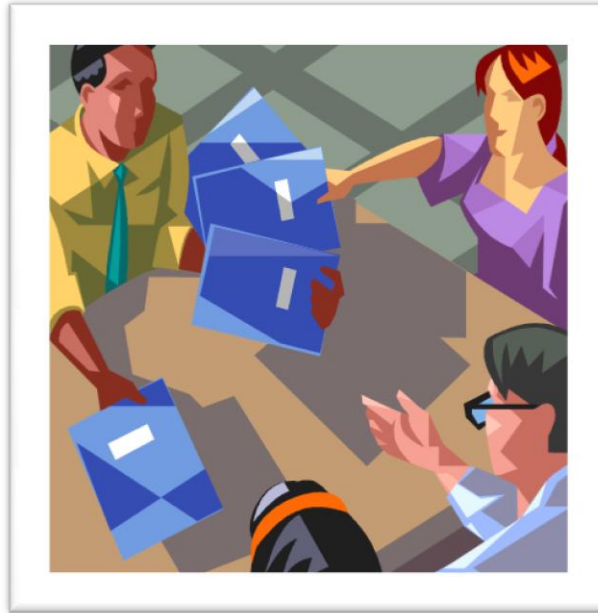
Chautauqua County residents will have, knowledge of and access to, an affordable and integrated continuum of high quality, person centered long term care services.

With this goal in mind, the group identified their top three strategic objectives or priority areas. Again, the objectives were selected for their relevance to LTCC mission, capacity of the LTCC to significantly address them and their ranking by the group in terms of their importance to seniors in Chautauqua County.

STRATEGIC OBJECTIVES IN PRIORITY ORDER OF IMPORTANCE

1. **Strengthen and enhance Case Management and Referral Services**
2. **Increase awareness of need for affordable Home & Community Based Services**
3. **Address the shortage of residential mental health options for geriatric and developmentally disabled population**

For each of the strategic objectives, smaller work groups developed tactical plans, responsibilities, timelines, anticipated costs and funding sources. The goal sheets for each objective follow this section of the narrative.



		costs for Exchange link will need to be covered in grant and how on-going				
<p>Identify gaps and opportunities in the system:</p> <ul style="list-style-type: none"> • Discharge planning absent • D/C's happening without services in place. • Other gaps may be realized or emerge as significant once the data exchange is in place so that should be the priority. 	<p>Hospital discharge planning department will have to address their process but may be improved with what is being done around transitions of care.</p>					
<p>Recommend realignment of resource allocation to home and community based services.</p>						<p>Hospitals will be rewarded or penalized for readmissions</p>

<p>Streamline Eligibility</p> <ul style="list-style-type: none"> - Big picture done at the state level. -improve communication b/w all county human services that have mutual clients. Specific problem to start would be b/w OFA & DSS on senior clients who are looking for community MA home care or LTC but mistakenly apply only for MSP, are not able to gather documents so get rejected for lack of follow-up by the client etc. 	<p>County Human Services Department starting with OFA & DSS and clients that are either transitioning from one service to another or mutual clients who are applying for MA.</p>	<p>Examine some cases to see where there is communication break down and how it can be improved on both ends to speed the process of getting them into the service they are looking for in a timely manner. Ideas include flagging the MA application with the what service they want under MA. Adding a cover letter to the client, encouraging them to come in to review the application with a county worker.</p>	<p>Staff time</p>	<p>Can be done under current funding.</p>	
<p>Transitions of Care</p>	<p>CCHN & OFA</p>	<p>Conversation with the Hospitals scheduled August.</p>		<p>3026 Funding</p>	

Goal: *Chautauqua County residents will have knowledge of and access to, an affordable and integrated continuum of high quality, person-centered long term care services*

Strategic Objective: *Increase awareness of need for affordable home and community based services.*

Tactical Planning	Responsibility	Timeline	Cost	Funding Source	Assumptions
<p>Educate and advocate about the cost effectiveness and need for subsidized/affordable home and community based services for frail elderly and people of all ages with disabilities</p>	<p>Education-LTCC & NY Connects web sites, stake holder providers i.e. HCA's, schools</p> <p>Advocacy- LTCC inviting legislature/gov. and service providers/trainers to participate on the LTCC with the intent of sharing knowledge of gaps in services and encouraging expansion of</p>	<p>Immediate and ongoing structured approach</p>	<p>Education: web site development/hosting Printing vs. media releases</p> <p>Hosting Web</p> <p>Advocacy-0 cost</p>	<p>HRSA</p> <p>Community Partners:</p> <p>AOA</p>	<p>Inclusive positioned for providers and consumers. Research based data projections with examples of ages+ programs=cost savings</p> <p>Advocacy-preparing examples of research/data to illustrate the cost savings associated with HCBS vs. higher levels of care. Child w/LTC needs at home vs. institutionalized care, TBI waiver/DDSO HCBS</p>

	providers and providers of training for care providers				programs vs. institutionalized care, NHTW care costs vs. institutionalized care costs, senior care HCBS vs. AL/traditional LTC costs-posting on web and/or article/series of articles from LTCC illustrating cost savings to consumers/community
Promote self directed long term care planning *Affordable Care Act	NY Connects MA Expert HICAP Affordable care act contact	Quarterly presentations	? possibly none	HRSA Community Partners	NY Connects MA Expert HICAP Affordable Care Act contact educate in web site context resources for above listing of experts Advocacy-partner with LTCC participants to post NY connects links on their web sites or hand out materials for

					long term self directed care planning/HICAP
Educate and advocate for non-subsidized affordable housing for elderly and individuals with disabilities.	Education using gap analysis and census data, possible survey data & Advocacy-LTCC partners w/COI,CC planning dept, CC housing authorities and landlord associations for needs of clients served with regards to housing	Quarterly review at meetings and ongoing communication between partners with reporting to LTCC and media notifications regarding	? possibly none	HRSA Community Partners	Educate Providers to become part of NY Connects data base for non-subsidized housing choices her in Chautauqua County Educate -LTCC participants partner to add NY Connects link on their web sites to link housing opportunities Advocacy- partners in participation in the LTCC can assist housing providers to add/modulate housing to accommodate accessible housing options in Chautauqua County

Goal: *Chautauqua County residents will have knowledge of and access to, an affordable and integrated continuum of high quality, person-centered long term care services*

Strategic Objective: *Address the shortage of residential mental health options for geriatric and developmentally disabled*

Outcome Measures

Tactical Planning	Responsibility	Timeline	Cost	Funding Source	Assumptions
Advocate for additional residential mental health facilities for geriatric and developmentally disabled population	MH Association DOH Legislature		\$ for letters		Cost savings will warrant training dollars for staff retraining and education.
Educate about the need for residential mental health facilities for geriatric and developmentally disabled population.	Contact Commission on Quality of Care to see if they can provide funding for training		\$ for letters	COCPD Medicaid Redesign	
Develop trained clinicians to diagnose and treat	Corry Facility		\$ for letters	DOH	Be aware of law differences in NY and PA
Use Corry Hospital staff to train	Contact Corry		\$ for letters		

local staff in specialty.						
Adequate reimbursement for high level needs individuals	Contact Medicaid Redesign Team		\$ for letters			
Heritage Connections program for long term dementia	Contact Corry					
Track grant possibilities for mental Health	Pat Brinkman					

MODEL DEVELOPMENT

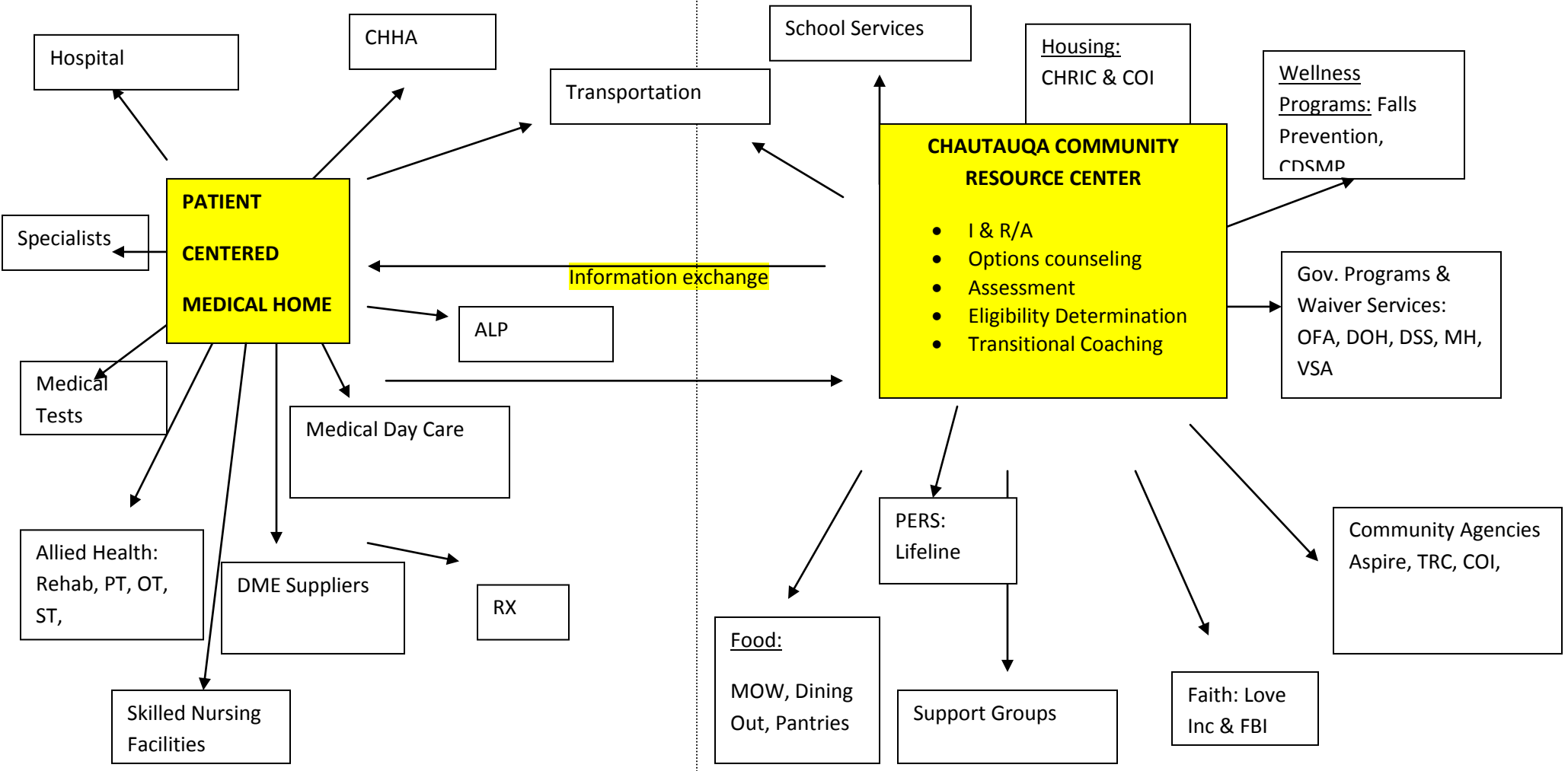
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- Support efforts related to the Medical Home Model ;which is evolving and provides reimbursement for physicians and hospitals. Seek funding for care coordinators and patient navigators in physician’s offices and transitional coaches in the community
- Review and promote transitional coaching models including the work of Dr. Erik Coleman (<http://www.caretransitions.org>)
- Develop a checklist or means for physicians to know who else is touching the patient requiring long term services
- Better market and promote New York Connects. While 80% of long term care admissions come from hospitals, a better job of informing the 20% who come on their own is necessary.
- Work closely with physicians since they are a “trusted source” for important decisions relating to long term care
- Explore feasibility of becoming an Aging and Disability Resource Center
- Support efforts to establish a FQHC – Federally Qualified Health Center – in Dunkirk, New York
- Educate decision makers about the cost savings involved with keeping seniors in the community

The Chautauqua Model: Maintaining People with Long Term Health Needs

MEDICAL NEEDS

LIVING WELL NEEDS



SUMMARY AND CONCLUSIONS

Through a series of discussions and data review, the Long Term Care Council has developed a plan to rebalance the long term care services in Chautauqua County. The completion of the plan is not the end, but the beginning. There are myriad challenges, as well as a number of unknowns related to Medicaid Redesign and Health Reform. However, the Council is dedicated to moving forward with the plan. The time and energy that individual members have given to the planning process is impressive and also indicative of a high level of commitment. By focusing on a limited number of strategic objectives, the Council will develop systems, policies and processes that are designed to bring about the desired results.

This plan will serve as the basis for an Implementation Grant and other funding opportunities. As the worksheets reveal, some of the work can be done without significant expenditures. Some of the work will be aided by new regulations that support electronic record keeping and rewards for keeping people healthy and in the community. By articulating a vision and developing tactical plans, the Council has begun the journey.

NEXT STEPS

The draft of the plan will be distributed to all members of the Long Term Care Council for review. It will also be shared with the medical and legislative community. It will be presented for approval at the September 7th, 2011 meeting of the Council. Once approved, activities which support the plan and do not have a high cost will be identified and implemented. A public relations campaign will be undertaken and new alliances will be formed.

THANKS TO ALL WHO PARTICIPATED SO ACTIVELY IN THE STRATEGIC PLANNING PROCESS INCLUDING:

Ann Morse Abdella – Executive Director - Chautauqua County Health Network
Frank Bercik – Executive Director - Chautauqua Adult Day Care Centers, Inc.
Patricia Brinkman – Director CC Department of Mental Hygiene
Marie Carrubba, Esq.- Executive Director - Southwestern Independent Living Center
Dana Corwin, RN, Registered Professional Nurse II –CC Office For Aging
Mary Lou Costanzo – Consumer representative
Wendy Douglas – Senior Project Coordinator CC DSS
Mary Jo Foti Hause – Hospice of Chautauqua County
Timothy Hellwig – Administrator – Chautauqua County Home
Carmen Hlosta – Director of Certification CC DSS
Tom Holt – President- CEO - Lutheran Social Services
Terri Johnson – Business & Support Administrator, The Resource Center
Helen Kern – Consumer Advocate, Southwestern Independent Living Center
Patti Anne Kirst –Deputy Commissioner CCDSS
Joy Kurtz – Consumer representative
Karen Lucks – Associate Director, Chautauqua Adult Day Care Centers, Inc.
Laurie Mead, LTHHCOP Lake Shore Hospital
Dan O’Neill –VP for Healthcare Services, Lutheran Social Services
Gail Saunders, Home Services Director Aspire WNY
Christine Schuyler – CC - Commissioner of Human Services
David Smeltzer – Executive Director, Heritage Ministries
Deborah Smith, RN BSN, Administrator – St. Vincent’s Home for the Aged
Mark Smith, Senior Coordinator/Planner, CC Office for Aging
Dr. Mary Ann Spanos – Director - CC Office For Aging
Carol Wright, Adult SPOA Coordinator – CC Department of Mental Hygiene
Legislator Mark Tarbrake
Legislator Jay Gould
Ron Lemon – Clerk of CC Legislature

Patricia A. Smith, President - Management Strategies - Facilitator

This plan is dedicated to Mary Lou Costanzo who was a long time member of the LTCC and participated enthusiastically in the early planning meetings before her death in May 2011.

For further information about New York Connects call 716-753-4582 or
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Unanimously Approved by LTCC - September 7, 2011