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

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 OBJECIVES 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.

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