

Agency: Commerce, Community and Economic Development**Grants to Named Recipients (AS 37.05.316)****Grant Recipient: Alaska Native Tribal Health Consortium****Federal Tax ID: 920162721****Project Title:****Project Type: New Construction and Land Acquisition**

Alaska Native Tribal Health Consortium - Anchorage Long Term Care Facility

State Funding Requested: \$20,000,000
One-Time Need

House District: Anchorage Areawide (16-32)**Brief Project Description:**

Long Term Care Facility Construction located in Anchorage and serving a statewide population
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Funding Plan:

Total Project Cost:	\$45,900,000
Funding Already Secured:	(\$7,500,000)
FY2012 State Funding Request:	<u>(\$20,000,000)</u>
Project Deficit:	\$18,400,000

Funding Details:

\$150,000 State of Alaska FY 08

\$7,500,000, State of Alaska FY 09

Detailed Project Description and Justification:

The Pacific Health Policy Group January 2007 report on the Alaska Medicaid Program identified that partnering with the Alaska Tribal Health System (ATHS) could save the state significant general fund dollars due to the fact that tribal providers receive 100% federal Medicaid funding. In FFY 09 the state paid non-tribal nursing and assisted living home providers approximately \$26 million for services provided to Alaska Native Medicaid clients. The state could save as much as \$13 million annually, and much more in the future, if these services were provided by tribal health organizations.

The ATHS developed a statewide tribal long term care facility plan with funding provided by the legislature under SB 61. This plan identifies the statewide need for long term care beds for Alaska Natives, and provides a phased approach to facility development. Included in Phase I of the implementation plan included Maniilaq Association's plan to build a nursing home wing onto their hospital in Kotzebue, the Yukon Kuskokwim Health Corporation's plans to build a nursing or assisted living home in Bethel, and the Alaska Native Tribal Health Consortium's (ANTHC) plan to construct and operate a tribal nursing home in Anchorage. The Maniilaq and YKHC projects have been fully funded and construction is underway. Funding is now needed for the Anchorage facility.

The need for a tribal long term care facility in Anchorage is widely acknowledged by tribal health leaders. In August 2010, ANTHC identified 318 Alaska Native (AN) people residing in Anchorage nursing and assisted living homes, 175 of whom are paid for by Medicaid. Department of Health & Social Services projections indicate that operation of a 100 bed tribal nursing home in Anchorage would save the State \$6.2 million in general funds during the first full year of operation (at 85% occupancy with 90% AN Medicaid eligible residents).

ANTHC contracted with consultants experienced in long term care development to complete a market assessment, and a financial analysis of the cost and feasibility of construction, maintenance and operation of a tribal long term care facility in Anchorage. The outcome indicates a need for 100 culturally appropriate nursing home units, to include 20 beds for skilled nursing and rehabilitation and 80 beds for custodial care.

The estimated cost of construction for the 100 bed nursing home is \$45,900,000. Square footage and construction is estimated utilizing the Green House® model of nursing home with 10 buildings of 10 units each, and a community/administration building. Construction estimates are based on a similar facility built recently in Seward, and an analysis of Anchorage construction costs in 2009. ANTHC has utilized a portion of the FY 09 state capital appropriation to cover these initial costs; the remaining funds will be applied toward construction. The request for FY 12 of \$38,400,000 will complete the project.

Project Timeline:

18-24 months to completion.

Entity Responsible for the Ongoing Operation and Maintenance of this Project:

Alaska Native Tribal Health Consortium

Grant Recipient Contact Information:

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Has this project been through a public review process at the local level and is it a community priority? Yes No

Alaska Tribal Health System

Tribal Long Term Care Service Development Plan

December 2008



Report produced and published by ANTHC under the guidance of the Alaska Tribal Health System's:

- Alaska Native Health Board
- Association of Tribal Health Directors
- ATHD Long Term Care Committee

Alaska Tribal Health System Tribal Long Term Care Service Development Plan



Prepared by:

**The Long Term Care Committee
of the Association of Tribal Health Directors**

Chair: Elizabeth Lee; see page 63 for full Committee Roster

With technical staff support from:

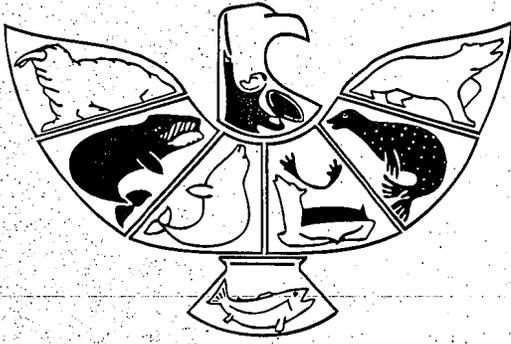
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4000 Ambassador Drive
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Funded by:

*The Alaska Department of Health & Social Services
Under the Senate Bill 61 Medicaid Reform Initiative*

December 2008



Alaska Native Health Board

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November 6, 2008

William H. Hogan, Commissioner
Department of Health & Social Services
State of Alaska
P.O. Box 110600
Juneau, AK 99811

Dear Commissioner Hogan:

The Alaska Native Health Board (ANHB) endorses the *"Tribal Long Term Care Service Development Plan"* as an official plan of the Alaska Tribal Health System (ATHS). Under the SB 61 Medicaid Reform Initiative, member organizations of ANHB have worked together to investigate barriers and identify strategies for increasing capacity in the ATHS for delivering long term care services. This work and detailed steps for implementing these strategies are documented in this plan.

Alaska Native elders and those with disabilities are valued members of our communities. Our primary interest through this planning effort has been to improve health status and access to care for our people. It is an added benefit that through increased capacity in the ATHS, we can help the state to make the Medicaid program more sustainable by bringing 100% reimbursement from the federal government for our services. In federal fiscal year 2007, the State of Alaska paid non-tribal providers nearly \$70 million for Medicaid supported long term care services for Alaska Natives and American Indians. Approximately half of those expenditures were comprised of state general funds which could have been saved had those same services been provided by the ATHS.

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALEUTIAN/PRIIBILOF ISLANDS ASSOCIATION
ARCTIC SLOPE NATIVE ASSOCIATION
BRISTOL BAY AREA HEALTH CORPORATION
CHUGACHMIUT
COPPER RIVER NATIVE ASSOCIATION
COUNCIL OF ATHABASCAN TRIBAL GOVERNMENTS
EASTERN ALEUTIAN TRIBES

KARLUK IRA TRIBAL COUNCIL
KENAITZE INDIAN TRIBE
KETCHIKAN INDIAN COMMUNITY
KODIAK AREA NATIVE ASSOCIATION
MANILAQ ASSOCIATION
METLAKATLA INDIAN COMMUNITY
MT. SANFORD TRIBAL CONSORTIUM
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NINILCHIK TRADITIONAL COUNCIL
NORTON SOUND HEALTH CORPORATION
SELDOVIA VILLAGE TRIBE
SOUTHCENTRAL FOUNDATION
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM
TANANA CHIEFS CONFERENCE
VALDEZ NATIVE TRIBE

I would like to express my appreciation for your support and the work of your staff over the past year in collaborating with the Alaska Tribal Health System on the development of this plan. I look forward to a continued partnership between the Department of Health & Social Services and the Alaska Tribal Health System to implement the documented strategies for increasing the delivery of Medicaid services by tribal health providers.

Sincerely,



Evangelyn Dotomain, MBA
President/CEO
Alaska Native Health Board

cc: The Honorable Lyman Hoffman, Senator, Alaska State Senate
Patrick Hefley, Deputy Commissioner, Department of Health & Social Services
William Streur, Deputy Commissioner, Department of Health & Social Services
Jerry Fuller, State Medicaid Director, Department of Health & Social Services
Renee Gayhart, Tribal Programs Mgr., Department of Health & Social Services
Don Kashevaroff, Chief Executive Officer, AK Native Tribal Health Consortium
Robert Clark, Chair, Alaska Tribal Health Directors

Tribal Long Term Care Service Development Plan
December 2008

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Executive Summary

Recent reports on the Alaska Medicaid program project a 5-fold increase in total spending on Medicaid services over the next 15 to 20 years. The Alaska Tribal Health System (ATHS) is an important partner for the State of Alaska in helping to control increasing Medicaid costs, as services provided by tribal health organizations are fully reimbursed by the federal government. Services provided by non-tribal providers are reimbursed at Alaska's Medicaid match rate (currently about 50%).

Long term care services for the elderly are identified as a leading cost driver for the future growth in Medicaid spending. In federal fiscal year 2007, Alaska Medicaid expenditures for long term care services for Alaska Native/American Indian beneficiaries totaled nearly \$45 million, only \$4.6 million of which was for services provided by the ATHS. Had all these services been provided by tribal health organizations, the resulting savings to the state in general fund dollars would have been approximately \$20 million for that one year alone.

The purpose of this plan is to develop a sustainable long term care service delivery system for the Alaska Tribal Health System (ATHS), while maximizing Medicaid cost savings for the State of Alaska.

The ATHS faces many barriers in building the capacity to provide and improve delivery of long term care services, including:

- **Financial barriers** - Medicaid reimbursement rates are not commensurate with the actual cost of providing services, particularly in rural areas. Lack of funding for non-Medicaid clients presents a dilemma to the ATHS since it does not coincide with their mission to provide services to all who are in need, with elders being the highest priority target group, and also because the Indian Health Service does not provide federal funding for most of these services.
- **Workforce barriers** - The availability of a well trained, competent, and caring workforce is crucial to the development of a successful long term care delivery system. Current workforce shortages are compounded by inadequate pay, lack of training, restrictive worker rules and requirements, and lack of career development opportunities.
- **Regulatory barriers** - Regulatory changes in recent years have forced the discontinuation or reduction of certain long term care services previously provided by some tribal health organizations. The current regulatory environment inhibits innovation, prevents efficiencies, complicates access to care, and doesn't always take into account differences between the tribal system of care and private providers.
- **Organizational capacity barriers** - Weaknesses in tribal health organization billing systems, fragmented information technology, and lack of continuity in program management are a few of the internal challenges faced by the ATHS in expanding the delivery of long term care services.

The plan for expanding the delivery of long term care services by the ATHS takes a 3-pronged approach:

- I. **Implement pilot projects to begin increasing the delivery of services under current home and community-based programs now.** Few tribal health organizations presently provide some services under current programs. Services have been declining or

discontinued in recent years due to the barriers noted above, and some are in jeopardy of closing altogether. The following strategies would allow them to maintain and expand services, while demonstrating the ability of the ATHS to develop and implement a comprehensive long term care delivery system:

- Improved timeliness of approvals for service
- Provision of Personal Care Assistant training in regional hubs
- Increased reimbursement or subsidy to cover the cost of service delivery
- Improved billing systems in the pilot organizations
- Adoption of quality assurance and monitoring systems by the pilot organizations

II. Create a comprehensive tribal home and community based service delivery system.

The emphasis of this report is on development of a system of care that will support individuals in maximizing their health, safety and independence, while enabling them to remain in their own homes and communities. Delaying or preventing the need for care in a residential facility not only honors the individual and their family, but is less costly. A tribal model for a comprehensive system of statewide home and community based services is proposed in this report. The following strategies are required for implementation of the model:

- Define the service package, program standards, and organizational structure for the delivery system
- Develop financing mechanisms that support cost-based reimbursement such as public entity rates
- Develop a “universal worker” workforce model for staff who provide direct care
- Improve regulations or receive waivers of regulatory provisions that hamper innovation and efficiency
- Strengthen capacity within tribal health organizations through improved billing, information technology, and program support systems

III. Develop ATHS administered nursing and assisted living homes. Even with the best system of care supporting individuals to remain in their own homes, those who are the most fragile will require care in a residential facility. The number of nursing home beds in Alaska has not increased in some time, and Alaska currently has the lowest nursing home bed ratio (for population) in the country. In order to meet the needs of the rapidly growing elderly population, facility-based services must be expanded. This report details a statewide ATHS long term care facility development plan, providing recommendations for:

- Long term care facility type by level of community
- Estimated baseline needs for numbers of beds for nursing and assisted living homes by region
- A phased approach to facility development based on regional need and organizational readiness

The Alaska Tribal Health System is prepared to take on development of a long term care delivery system that will meet the needs of Alaska Native elders and people with disabilities. A strong partnership with the State of Alaska will be essential to overcoming the challenges it will face in doing so. This report lays out the road map for the successful implementation of this initiative.

Part I: Project Purpose and Process

Section 1: Project Purpose

The purpose of the Tribal Medicaid Reform Initiative is to strengthen the Alaska tribal health system (ATHS) through enhanced service delivery systems and increased sustainable revenue streams, while maximizing Medicaid cost savings for State government. Currently, the full continuum of care for physical health, behavioral health, and long term care is not sustainable in the tribal health system. The Alaska Native Tribal Health Consortium (ANTHC) believes that, in cooperation with the Department of Health & Social Services, the Alaska Legislature, and partners within the ATHS, they can help turn the curve on projected growth in State Medicaid expenditures over the next several years, while building a sustainable, cost-effective, efficient, and high quality health system for Alaska's Native people.

The ANTHC is working on five projects under the Alaska Tribal Medicaid Reform Initiative, including:

- A managed care organization feasibility assessment
- A tribal behavioral health service delivery system plan
- A tribal long term care service delivery system plan
- A facility plan for addition of new and/or enhanced health care services
- A tribal health system financial infrastructure improvement plan

This report presents an overview of the efforts to develop the Tribal Long Term Care (LTC) Service Delivery System under the initiative, including a description of the planning process used and the Alaska Tribal Health System's proposed plan for the development of a LTC service delivery system. More specifically, this report offers a summary of the planning process followed, the players involved, the approaches applied and the guiding principles used throughout the effort; a brief discussion of the long term care system as it relates to Alaska Native people, including presentation of data indicating the need, a description of service delivery barriers and the current service delivery system; a description of the proposed service package; proposed tribal solutions and general strategies for providing the services; and finally a detailed action plan for implementation of the LTC service delivery system.

The purpose of this project is to create a system which provides the full continuum of long term care services at the appropriate level of care in each community across the state; and to strengthen the Alaska Tribal Health System's capacity to meet the long term care needs of Alaska Native elders and people with disabilities. The strategic focus areas of the Tribal Medicaid Reform Initiative include: Medicaid financing, service delivery improvement, workforce development and organizational capacity. The proposed timelines for the final outcomes will look at *short term* actions ready for implementation by 06/03/09; *long term* actions ready for implementation in 1 to 5 years; and *far term* actions ready for implementation in 5 to 10 years.

Development of a long term care delivery system within the ATHS faces special challenges not shared with other health care services. The single greatest feat is overcoming the perception of failure, as Tribal ventures into home and community based waiver and personal care services are struggling, have been forced to close, or are facing imminent closure. Unlike other health services, the LTC delivery system has no base federal funding from the IHS, and therefore has been solely dependent on state Medicaid and grant funds. Delayed assessments, lack of a rural cost factor for reimbursement, and loss of grant dollars meant that Tribal organizations had to financially support the services in place. Reduction and elimination of programs created

credibility issues for Tribal organizations with their beneficiaries, left elders without options for staying in their communities, and was a source of great embarrassment. Tribes will therefore be reluctant to startup new programs without assurance that the programs can be viable.

Nationally the continuum of long term care services is shifting away from nursing facility care toward more home and community based models of care. Public policy has been changed to allow for that shift, especially in the expansion of payments for home and community based services through Medicaid waivers. A brief look at the history of the provision of long term care services provides insight into the financial incentives that preceded the shift in care, and that the development of systems, or certain types of services, has an impact on the demand for services. For example, prior to the creation of Medicaid in the mid-1960s people were cared for in the home or in small board and care homes. After Medicaid began paying for nursing home care, the nursing home industry grew very rapidly, and nursing homes became the norm for someone requiring long term care. A similar phenomenon happened in Alaska in the mid-1990s, when the new assisted living regulations were promulgated. At that time there was a tremendous increase in the number of assisted living home openings, especially in the Anchorage area. Most of these assisted living homes were operated by individuals in their own private homes.

Section 2: Planning Process

The overall planning process focused on “thinking outside of the box” to come up with a new tribal long term care service delivery system that would be of high quality, accessible, affordable and sustainable over time. The LTC Committee approached the process by:

- Looking at all of the services currently available and identifying the tasks included in each: breaking down the system into the tasks that are considered vital to the long term care service delivery system allowed the LTC Committee to think more openly about how they could be addressed individually and then developing service packages that could deliver those services in the most feasible and streamlined approach.
- Focusing on creating the optimal service delivery system for Alaska Native elders and people with disabilities, rather than focusing on current barriers to services: the LTC Committee has a strong commitment to designing a system that is flexible to allow for changing needs of individuals and the local community, while also ensuring that the continuum of care available in the community or region allows individuals to “age in place.”
- Focusing on the strengths of tribal health organizations: the tribal health organizations are mission-driven to serve Alaska Native elders and people with disabilities in their regions and have a long history of doing so - they understand how to provide culturally appropriate services and the organizational capacity challenges of the tribal health organizations and how to address them.

The tribal health organizations decided that they need to:

- Have the capacity to identify service development and delivery issues on an on-going basis
- Partner with stakeholders to develop and implement improvement strategies
- Have the capacity to advocate for an effective long term care system to serve Alaska Native elders and people with disabilities
- Ensure that there is commitment to the process by the tribal health directors

The planning process formally began with the Alaska Tribal Health Directors Medicaid Reform Summit held January, 16 & 17, 2008. The purpose of the Medicaid Reform Summit was to identify individual tribal health organizations' plans for developing or enhancing behavioral health care services, long term care services, and other new health services or care models. The primary outcome of the Summit was a list of projects and ideas the tribal health organizations proposed for research and consideration. These lists will be used in Medicaid policy discussions with the State and for educating the State legislature about opportunities for investing in the Alaska Tribal Health System.

Subsequent to the Summit, the following activities regarding planning and development of the LTC Service Delivery System Plan have taken place or are still in progress:

- The LTC Committee continues to meet monthly and has completed the following documents and activities:
 - Developed “Guiding Principles” for Alaska's tribal long term care system
 - Defined the ideal “Tribal Long Term Care Service Array” by level of community
 - Provided guidance for the inventory of long term care services provided by region
 - Contributed information re: barriers to tribal delivery of long term care services
 - Created a subcommittee to identify facility-based care needs by region
 - Created a “Home and Community Based LTC Service Delivery Planning Tool” to document and guide the planning process
 - Developed a “Home and Community Based LTC Service Delivery System Development Action Plan”
 - Created a subcommittee to research and develop eligibility criteria and program standards
 - Created a subcommittee to review and revise the personal care training and testing process
 - Created a subcommittee to review and develop appropriate screening tools
 - Developed various “concept or white papers” for education purposes
 - Developed a working group, including both LTC Committee members and DHSS staff, to review current client processes and identify problem areas in order to streamline it
- The LTC Committee continues to research long term care system reform strategies for consideration - examples of strategies currently under consideration include Tribal Targeted Case Management for the frail elderly and a pilot project to test in-home telehealth applications to support chronic care management.
- The LTC Committee continues to gather information re: new Medicaid financing strategies - examples of strategies under consideration include development of a State Medicaid Waiver for tribal management of long term care services, the PACE Program (“Program for All-inclusive Care for the Elderly” - a State Medicaid option), and expanded use of Tribal Targeted Case Management for additional subgroups and in additional regions.
- The LTC Committee continues to research and gather information re: long term care service delivery system enhancement strategies - examples of some of the efforts to date include a plan to identify and overcome system barriers to tribal provision of home care services; a pilot program to monitor the health of all elders and ensure early intervention for illness and

other identified needs; creation of a special Community Health Aide Program (CHA/P) training module for elder care; and development of a statewide tribal long term care facility plan.

- Payer information is being collected to support analysis of services provided by non-tribal providers - this analysis will result in identification of priorities for new service development that would provide the biggest return for the State in terms of Federal Medical Assistance Percentage (FMAP) savings.

A) Committee

The success of this project to date is primarily due to the clear understanding by all the players that close coordination with the State and all ATHS partner organizations, plus the strong commitment of tribal leaders, was critical if they were to succeed. The list of players involved in this project, and listed below, is comprehensive and the dedication and hard work done by these groups has been extraordinary throughout the planning process.

- Alaska Tribal Health Directors
- Tribal Health Organization Chief Financial Officers (CFOs)
- Tribal Elder Program Managers
- Alaska Native Tribal Health Consortium
- Yukon Kuskokwim Health Corporation
- Southcentral Foundation
- Norton Sound Health Corporation
- Southeast Alaska Regional Health Consortium
- Maniilaq Association
- Bristol Bay Area Health Corporation
- Tanana Chiefs Conference
- Arctic Slope Native Association
- Native Village of Eyak
- Kenaitze Indian Tribe
- Ketchikan Indian Community
- Kodiak Area Native Association
- Eastern Aleutian Tribes
- Aleutian Pribilof Island Association
- Chugachmiut
- Mt. Sanford Tribal Council

The close coordination is fostered continually by the following ongoing efforts:

- Monthly meetings of Senior ANTHC staff meets monthly with DHSS officials to discuss progress and potential strategies
- ANTHC and DHSS staff consult informally on a weekly basis
- DHSS provides data and information in support of ANTHC planning efforts upon request
- LTC Committee, composed of Elder care program managers representing the tribal health organizations, meets monthly and works as the primary force in the development of the LTC Service Delivery System Plan

- Three subcommittees were formed from the LTC Committee as workgroups for specific focus areas, including: home and community based service delivery system plan and the statewide facility plan, and a feasibility study for a nursing/assisted living home in Anchorage.
- The LTC Committee was chartered by the Alaska Tribal Health Directors and approved by the Alaska Native Health Board in February 2008. The Committee Charter and list of committee members is included as Appendix B of this report.

B) Principles and Guidelines

To realize the goal of making long term care services available to Alaska Native elders and people with disabilities through the tribal health system, ANTHC and ATHS are working together to identify, develop and implement long term care services, including residential and home and community based services. The essential guiding principles adopted as necessary in all long term care services offered by the Alaska Native tribal health system ensure that all elders and persons with disabilities deserve:

- Access to the full range of LTC services within their home region
- To be served by an appropriately trained, culturally competent and compassionate workforce
- Access to services that are delivered in their community by local service providers to help them stay in their own homes and/or communities as long as possible
- To know which services could help them and where they could receive those services
- The right to choose their own care and to be actively involved in the development of their service plan
- To be served by a tribal health organization that takes a customer-centered approach to LTC service development
- To be served by a tribal health organization that delivers services that are financially feasible and sustainable over time

Part II: Background on Long Term Care for Alaska Native Individuals

Section 1: Continuum of Care and Service Array

Long term care is generally defined as the care of an elder or individual with a disability who requires on-going assistance with activities of daily living, such as bathing, dressing, grooming, eating, toileting, transferring, shopping and cooking. Long term care services provide support to clients and their families with medical, personal, and social services delivered over a sustained period of time in a variety of settings, ranging from a person's own home to institutional settings, to ensure quality of life, maximum independence and dignity. Long term care in Alaska Native and American Indian communities also includes the importance of maintaining cultural values in the delivery system.

The array of services offered in a long term care system is typically referred to as a continuum of care. The continuum of care describes the services in a linear manner, from least to most complex; however, people do not necessarily receive the services in this way. The timing of services needed is specific to each individual, and a person can receive any number of services along the continuum at the same time and/or at different stages of their life. Ideally, the continuum of care available in a community or region will have the range of care services needed so as not to overstress one type of service and to meet all the needs of elders. The range on that continuum would begin with the services that address those individuals who want to stay at home and just need their home modified to allow that independence; and then end with the services for individuals who need end of life care, such as palliative care and hospice. A well-developed care coordination or case management function that follows the client through the entire system is also vital.

Figure 1: Continuum of Long Term Care Services

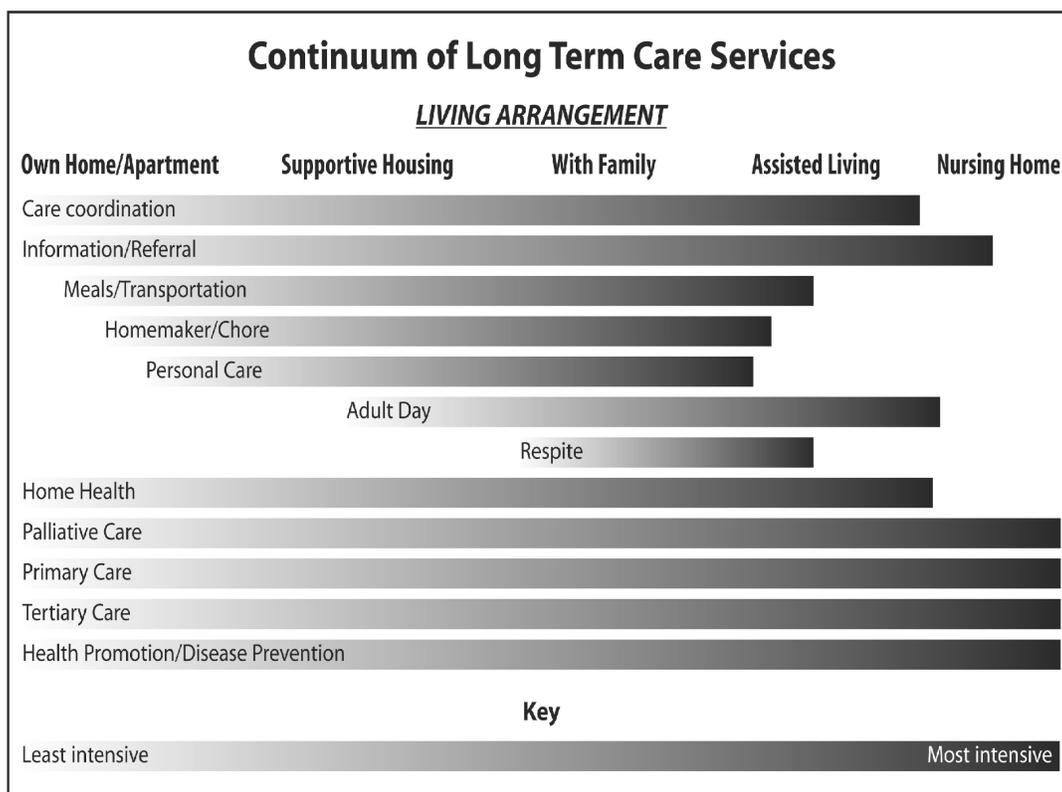


Figure 1 depicts the array of services in the long term care continuum presented in the linear model with housing options across the top and various home and community based and medical services.

The feasibility of the Alaska Tribal Health System offering all of the long term care services on the continuum is unlikely given current available resources; however, the Alaska Tribal Health System is committed to striving for a reasonable balance of these services statewide. The LTC Committee identified the ideal array of services they want to have available in the system; and Table 1 presents that array. The LTC Committee further agreed that it was neither financially or organizationally feasible for the tribal health organizations to provide all of the services directly through their organizations. Given the mission of the tribal health organizations focused on provision of health-related services, they decided that the tribal health organizations would provide the home and community based and the case management services. Realizing that the “other services” in the array are also important, but may not be within their organizational capacity, they will coordinate with other local organizations to ensure those services are available. Further details pertaining to this service array are specifically addressed in the “Home & Community Based LTC Service Delivery Planning Tool” included in Part III, Section 1B, of this report.

TABLE 1 : Ideal Array of Services Available to Elders and Persons with Disabilities in their Community		
Service	Provided by Tribal Health Organization	Provided by Tribal Health or other local organization
Home and Community Based Services		
Chore (includes special services in rural areas to help elders stay home, i.e. hauling water, cutting wood)	X	
Respite – in-home or mobile	X	
Personal Care	X	
Medication management	X	
Palliative Care / Hospice	X	
Home Health (CNA, RN, PT, OT)	X	
Case Management		
Comprehensive Elder Exam – age related preventive medicine visit	X	
Case management / care coordination	X	
Chronic care management	X	
Wellness & Prevention	X	
Other Services		
Congregate & home-delivered meals		X
Transportation		X
Companion care		X
Housing modifications		X

(Source: LTC Committee Meeting, February, 2008)

Section 2: General Population Data

Alaska's population age 65 and older is one of the most rapidly growing segments of the population in Alaska, expected to nearly triple by 2030 due to Alaska's large cohort of baby boomers reaching age 65 and beyond. Alaska Native elders are contributing to this growth. The proportion of the Alaska Native population age 65 and older is expected to increase from 6% in 2006 to 12% in 2030. According to the most recent estimates by the Alaska Department of Labor & Workforce Development, there are 7,212 Alaska Native people age 65 and older, and 8,360 between the ages of 55 and 64. *Table 2* depicts the projected growth for Alaska's Native population from 2006 to 2030 for ages 55 to 90 and older.

As reflected in *Table 2*, the most recent Alaska Department of Labor & Workforce Development figures indicate that Alaska's Native population is projected to experience stable growth throughout the period 2006 to 2030, from 118,884 in 2006 to 162,820 in 2030 - an overall increase of 37%. More specifically, in the over 65 age group the increase from 2006 to 2020 is projected to be 77%; and an additional 49% increase from 2020 to 2030.

TABLE 2: Alaska's Native Population - 2006 projected to 2030						
Age	2006	2010	2015	2020	2025	2030
55 - 59	4,953	6,013	6,999	7,551	6,600	5,976
60 - 64	3,407	4,292	5,626	6,579	7,120	6,236
65 - 69	2,501	3,016	3,889	5,128	6,028	6,554
70 - 74	1,913	2,038	2,618	3,403	4,512	5,339
75 - 79	1,411	1,527	1,634	2,122	2,779	3,715
80 - 84	778	951	1,084	1,167	1,534	2,033
85 - 89	357	441	560	645	698	930
90 +	252	231	262	325	388	433
Totals	118,884	125,728	135,070	144,324	153,440	162,820

(Source: Alaska Department of Labor & Workforce Development, Research & Analysis Section, Demographics Unit)

The total Alaska Native population is also projected to grow relative to the proportion of the overall State's population, from 17.7% in 2006 to 19.4% in 2030. High birth rates, aging and increases in the life expectancy of Alaska Natives are the primary factors contributing to this growth.

Though the life expectancy for Alaska Native people is increasing, life expectancy at birth in 2000 is 69.5, as opposed to the 71.5 seen in the total American Indian and Alaska Native population. Per the US Census, Alaska Native elders still fall 7.4 years below the life expectancy of 76.9 for the overall US population. The increases in life expectancy can lead to a higher prevalence of chronic disease, and along with it an increased incidence of disability and functional limitations. *Table 3* indicates high rates of growth in the 65 and older population in all age groupings. The combination of higher rates of disability and functional limitations with the increasing numbers of Alaska Native elders exacerbate the need for long term care service planning within the Alaska Tribal Health System.

Currently, the entire Alaska Tribal Health System serves approximately 130,000 Alaska Native people as represented in *Table 3*. The information presented in the table is provided only as a general overview of population numbers, as variations of 5-10% can occur at any time depending on migration.

TABLE 3: ATHS Service Population Breakdown		
<i>Region</i>	<i>Population Served</i>	<i>% of Total Served</i>
Anchorage/Mat-SU (SCF)	40,000	31%
Rural Anchorage Service Unit	12,000	9%
Arctic Slope	4,300	3%
Maniilaq	7,600	6%
Norton Sound	7,400	6%
Bristol Bay Area	5,300	4%
Yukon-Kuskokwim Delta	24,200	19%
Southeast Region	16,300	12%
Interior Region	13,000	10%
<i>Total all regions</i>	<i>130,600</i>	<i>100%</i>

(Source: Alaska Tribal Health System: Overview. ANTHC PowerPoint Presentation. February 2007)

Section 3: Description of the Current Long Term Care Delivery System

Currently, there is a vast array of home and community based long term care services available in Alaska; however, the types of LTC services available to Alaska Native elders and those with disabilities differ significantly depending on where the individual lives, their financial status and the capacity of local and regional health and social service providers. Services are provided by both tribal and non-tribal agencies; and most are funded through Medicaid and State grants since the Indian Health Service (IHS) does not provide funding for long term care services. The result is most provider agencies are dependent on an adequate appropriation to maintain the availability of these services throughout the state. At present, the State is actively encouraging tribal health organizations to provide more long term care and other services paid for by Medicaid.

Following is a description of the range of home and community based and also facility based LTC services currently offered in Alaska, accompanied by governing legislation where applicable, the funding streams supporting the service, and the status of the availability to Alaska Native elders and people with disabilities.

- *Congregate and home delivered meals, transportation and information and referral:* the federal Older Americans Act (OAA) regulates funding for nutrition, transportation and supportive services to seniors. Funds from Title III of the OAA pass through the State Department of Health & Social Services to non-profit agencies and governments around the state to provide these services. Title VI provides grants to Indian Tribes for similar services, but eligibility is dependent on different criteria set out by the funding source. Funding for Title VI flows directly from the federal Administration on Aging to tribes, however funding limitations at both the state and Tribal levels largely preclude support for these services in rural Alaska. Currently these services are also available in many areas of the state through Senior Centers, food box programs, local governments, tribal health organizations and social service agencies.
- *Independent Senior Housing:* These are apartments for seniors and adults with disabilities; and they may have a resident manager and common space for activities, but usually other services are not provided. Currently there are units located in every region coordinated by the local housing authority.
- *Personal Care Assistants (PCA):* This is an in-home care service that provides assistance to clients with their activities of daily living. There are two personal care program models available in Alaska: the *agency based PCA program* and the *consumer directed PCA program*. The agency based model allows consumers to receive services through an agency that oversees, manages and supervises their care. The consumer directed model allows each consumer to take a more direct role in managing his or her own care by selecting, hiring, firing, training and supervising their own PCA worker; and an agency provides administrative support to the consumer and the PCA by acting as a fiscal agent to bill for services and issue payroll. This service is regulated and managed by the State Division of Senior & Disabilities Services and funded by Medicaid. Currently the majority of PCA service is provided by several statewide private, for profit, agencies. The amount of PCA services provided by tribal organizations has been dramatically reduced in the last 5 years - only 3 tribal providers are still offering PCA services: YKHC, Maniilaq and Kenaitze Indian Tribe.

- *Medicaid Waivers*: Instituted in Alaska in 1995, Medicaid Waivers allow people who are eligible for nursing home admission to receive services in their home or another less restrictive community setting such as an assisted living home. To be eligible a person must meet financial eligibility guidelines for nursing home admission (includes income as well as assets) from the State Division of Public Assistance and meet nursing facility level of care.
- *Home and Community Based Services (HCBS)*: These services are provided in a person's home or in a community facility, including: respite care, environmental modifications, adult day care, transportation, specialized medical equipment, chore services, assisted living and private duty nursing. The services are funded by Medicaid, for individuals who meet the income guidelines and qualify for nursing home level of care. The availability of these services is not adequate to meet the need identified by the tribal health organizations. Also, State in-home service grants provide funding to a limited number of organizations, including two tribal health organizations, to provide respite and chore services.
- *Assisted Living Homes*: These are licensed residential settings that provide for personal and health care needs. Homes must provide three meals per day plus snacks, 24-hour supervision of residents, and assistance with activities of daily living. Assisted living can be a large multi-unit building or a small, private home. There are an abundance of assisted living homes in Anchorage and the Matanuska-Susitna Borough and several in Fairbanks, but very few in Southeast Alaska and rural areas of the state.
- *Case Management/Care Coordination*: Assistance to clients in gaining access to Medicaid waiver and other needed services. Care coordinators are responsible for initiating and overseeing the assessment and planning process, as well as the ongoing monitoring and annual review of a client's eligibility and plan of care. This service is funded by Medicaid, for individuals who meet the income guidelines and qualify for nursing home level of care. The service is also available to State in-home service grantees.
- *Home Health*: Home health is a federally controlled Medicare and Medicaid service that provides skilled nursing and therapy services to eligible homebound individuals. Home health agencies must be licensed by the Section of Certification and Licensing in the State Division of Public Health and be certified by Medicare. Home health services are intended to be part-time or intermittent, and there are strict criteria for the service to be covered by Medicare and Medicaid. Home health services are available in urban areas, with little or none available in the rural areas of Alaska.
- *Hospice and Palliative Care*: Palliative care is the active total care of the body, mind and spirit of the patient and family. The purpose of palliative care is to prevent or lessen the severity of pain and other symptoms and to achieve the best quality of life for people dying or suffering from a long-term disease. Comfort is the goal of palliative care. Comfort is also the goal for those patients still receiving potentially curative therapy. Hospice is a program that delivers palliative care to people who are dying and need treatment to prevent or manage pain and other symptoms even when cure is no longer possible. Hospice programs can be certified to bill Medicare and Medicaid, or provide services on a volunteer basis. There are hospice programs in urban areas and some communities in Southeast; however, the availability of hospice services in rural areas is minimal.
- *Swing Beds*: Rural hospitals with less than 100 beds that are more than 50 miles from a skilled nursing home and are Medicare and Medicaid certified may apply to operate swing

beds. These beds allow for the provision of nursing home care in empty hospital beds in rural areas and require compliance with nursing home admission standards and federal reporting requirements. There are six rural tribal hospitals in the state and one of those offer swing beds - Bristol Bay/Kanakanak Hospital has four beds.

- *Administrative Wait Beds:* Existing solely in Alaska, the administrative wait bed permits a hospital to designate and use beds as nursing home beds without meeting complex federal admission requirements and reporting standards in order to bill Medicaid for those services.
- *Nursing Home:* These are skilled care facilities operated independently or collocated with a hospital. Nursing homes are licensed by the State following national certification and licensing standards. The Certificate of Need process within the Department of Health and Social Services regulates the development of new nursing home beds in Alaska. There is one tribal nursing home operated by Norton Sound Health Corporation.

Table 4 lists Medicaid expenditures paid to both tribal and non-tribal providers for home and community based services, by service area, for FFY 2007. Please note that the Medicaid payment data presented is a “snap-shot in time.” The information covers only Medicaid services rendered to American Indians and Alaska Native people between the dates of October 1, 2006 through September 30, 2007. Recognizing the lag between the date of service and the billing of the claims payment system, payments data through December 31, 2007 are included. At this time the actual final total payments are understated and would not be known for another calendar year. Additionally, it should be noted that in the “Tribal Medicaid Activity Report, FY 2007”(from which this information is derived), both tribal and non-tribal expenditures are allocated to service areas based on the location at which the service was provided. This should not be confused with the provider’s “pay to address,” which is used to identify the location of clients and recipients in the “Tribal Medicaid Activity Report.”

An analysis of the information presented in *Table 4* indicates that non-tribal agencies are providing the majority of the home and community based services delivered in the rural service areas. More specifically, only 2 of the 10 regions displayed were served primarily by tribal providers, Northwest Arctic Borough and Yukon-Kuskokwim Delta. All other regions were served primarily by non-tribal providers - 4 were served exclusively by non-tribal providers and 4 were served by both tribal and non-tribal, with a greater share being non-tribal. Less than 2% of all PCA services provided in all regions were delivered by tribal providers; and 100% of adult day and chore services are provided by non-tribal providers.

Other pertinent service delivery data which is critical to the understanding of the tribal home and community based LTC service delivery system is the status of PCA services offered in rural areas. Unfortunately, specific data pertaining to those services has not been collected consistently over time in any standardized manner. Therefore, the LTC Committee cannot at this time present specific data, show trends or compare service delivery by regions in a statistically sound way. However, the following general information about the PCA program has been documented by the State and the tribal health system.

State regulations for PCA services have undergone changes over the past five years which have severely impacted service delivery, especially in rural areas. In fact, five tribal organizations used to operate home care programs offering an array of services, including PCA. The changes to the program have gradually forced three of those out of the PCA business (Bristol Bay Area Native Corporation, Tanana Chiefs Conference, and Norton Sound Health Corporation); and caused another (Yukon Kuskokwim Health Corporation) to dramatically

reduce the amount of PCA service provided in their region. For example, during FY 2005, the Yukon Kuskokwim Health Corporation provided PCA services; however the amount of billings for PCA services decreased by \$162,076 from FY 2004 to FY 2005, resulting in 50 fewer clients being served. Manillaq has also continued to provide personal care and other services to elders in their region at a strain to their organization's budget. Although there is a commitment to serving elders needs, without additional funding this program is also in jeopardy.

As fewer and fewer clients are receiving PCA services from the tribal system, these individuals must seek more expensive institutional care outside of the tribal system, thus costing the Alaska Medicaid program more in state general funds, as full federal reimbursement is not possible for services provided outside the tribal health system.

TABLE 4: Home & Community Based Services Medicaid Expenditures for FFY 2007								
Service Area & Type of Provider		PCA	Home Health & Palliative Care	Medicaid Waiver Services				TOTAL (all services by region)
				Care Coordination	Respite	Chore	Adult Day	
Northwest Arctic Borough Manillaq Kotzebue	Tribal	2,100		15,485	48,168			65,753
	Non-Tribal							0
Norton Sound	Tribal			8,640	24,024			32,664
	Non-Tribal	64,813		19,695		6,330	67,043	157,881
Southcentral (Anchorage, Mat- Su, Valdez, Glennallen, Cordova, Mt. Sanford)	Tribal		148,568	320,325				468,893
	Non-Tribal	6,000,711	64,717	902,347	974,915	166,327	397,990	8,507,007
Yukon- Kuskokwim Delta	Tribal	167,612		198,830	66,451			432,893
	Non-Tribal			7,640				7,640
Interior	Tribal			11,620	24,717			36,337
	Non-Tribal	665,609	506	122,540	34,194	29,185	6,864	858,898
Rural ASU - Kenai Peninsula	Tribal	9,487						9,487
	Non-Tribal	716,838	28,177	185,780	167,934	48,638	41,090	1,188,457
Barrow / North Slope Borough	Tribal							0
	Non-Tribal				20,493			20,493
Bristol Bay	Tribal							0
	Non-Tribal	373,401		18,210	8,261			399,872
Southeast	Tribal							0
	Non-Tribal	2,056,822	30,979	357,835	414,098	168,366	17,302	3,045,402
Rural ASU - Kodiak	Tribal							0
	Non-Tribal	55,566		42,545	4,915		12,893	115,919
TOTAL (per service type)	Tribal	179,199	148,568	554,900	163,360	0	0	1,046,027
	Non-Tribal	9,933,760	124,379	1,656,592	1,624,810	418,846	543,182	14,301,569

(Source: "Tribal Medicaid Activity Report, FY 2007," State Department of Health & Social Services, 2008)

It is also worth noting that in FY 2007 the Alaska Medicaid program spent nearly \$10 million on PCA services provided to Indian Health Service beneficiaries by non-tribal providers. Nearly \$5 million of which was State general fund dollars which could have been saved had the services been provided by tribal providers under conditions which would qualify the services for one hundred percent federal match (FMAP).

As noted above, the lack of PCA and other home and community based services compels some individuals to seek more expensive facility-based services outside the tribal system. In FY 2007 the Alaska Medicaid program spent nearly \$26 million on long term care facility services provided by the non-tribal sector. The combined expenditures in that fiscal year for all home and community based and facility based services provided by the non-tribal sector totaled over \$40 million, representing a cost of nearly \$20 million in state general funds that could have been avoided had these same services been provided by the ATHS.

Section 4: Barriers to Long Term Care Service Delivery

Not unlike the rest of the country, Alaska Native elders and people with disabilities are choosing to remain in their own homes and receive care there rather than moving to more expensive facility based care, which usually is not available in their home community. Recognizing the increased demand for home and community based LTC services, especially in the rural areas, the tribal health system has identified services for Alaska Native elders and people with disabilities as one of their top priorities. However, the Indian Health Service (IHS) does not provide funding for comprehensive LTC services, therefore presenting a dilemma requiring tribal health organizations to be creative in developing programs using other tribal funding sources or assets, as well as integrating State programs and other funding streams. In the past, some of the needed services, primarily PCA, were provided successfully by tribal health organizations with funding obtained through State grants and Medicaid. Due to changes in the State funding systems, such as the elimination of regional PCA grants, tribal health organizations unfortunately have not been able to sustain those services.

The following client story (included with permission from the client) is a typical example of the complexities experienced by clients, their families and providers throughout the process once an individual begins to need long term care services:

Mary Lou Mercurief was a devoted caretaker and wife to husband Alexay Mercurief. Both lived in St. Paul their entire lives and worked hard to support their family. The past few years were very difficult for this couple and Alexay's health declined dramatically. Although Alexay has recently passed on, Mary Lou wants to share their story about the struggles of receiving long term care services.

Beginning in 2005 Alexay's health began to decline and he became more dependent on his wife, Mary Lou. He needed help getting out of bed, getting dressed, going to the bathroom, taking a bath and more. As he became more and more sick, he was flown to ANMC for medical attention. St. Paul Island has a community health center and Anchorage is the hub where residents must travel nearly 800 miles to receive medical care in a hospital setting. Once in Anchorage, Alexay received medical care and the social workers at ANMC asked the family to consider nursing home care. Feelings of confusion and nervousness filled Mary Lou. She was scared at the thought of moving to the big city, away from her community and family she was so close to; but she knew her husband needed more care than she could give him.

Both Alexay and Mary Lou were retired, but their income exceeded the amount needed to qualify for the Medicaid waiver which covers the cost of nursing home care. They were told about the Millers Trust, and so they hired a lawyer to set up this trust account. This irrevocable trust was the couple's only option to receiving adequate care. Even now, Mary Lou said she feels like she doesn't fully understand how the system works. Once Alexay was admitted to Mary Conrad Nursing Home located in Anchorage she felt abandoned. She could not stay with her husband she had been married to for over 50 years. Once he was settled into Mary Conrad, no one seemed to care whether or not Mary Lou had housing. She ended up staying with one of her daughters who was living in Anchorage at the time. Mary Lou spent every day at the Mary Conrad Nursing Home with her husband.

After a period of time, Mary Lou and Alexay were able to return home, but, things were still difficult. Home and community based services were hard to find. Respite services were offered, but there was no one in the community that the family trusted enough to provide the service. Mary Lou had many sleepless nights. With her husband's sickness, he was awake a lot during the night and felt something was wrong with him. Mary Lou knew he was fine, but also felt the need for someone with medical experience to check on him. Mary Lou explained that the clinic staff used to do home visits, but they no long practiced this type of care.

Beginning in March 2008 Alexay started to develop bed sores. Mary Lou was told that the dressings to his wounds needed to be changed 2 times a day and Alexay needed to be turned 4 times a day to avoid developing more sores. No one showed her how to do this, nor did they ask if she had the strength to complete these tasks. Medical staff assumed the family would help to get the job done, but Alexay's health worsened. He kept getting more and more sores. He was in pain. It devastated Mary Lou as she watched her husband suffer. Finally she asked the St. Paul Health Center provider if they could travel to Anchorage for care. After consulting with ANMC, the provider informed them that they did not meet the criteria for a medevac and they could not be seen for wounds, but also informed Mary Lou that the sores could be life threatening. Alexay was being treated with antibiotics for his infected sores. She took

matters into her own hands and bought 2 one way tickets to Anchorage, and they traveled to Anchorage on May 13, 2008.

They visited the ER immediately upon arriving in Anchorage. After the long plane ride into Anchorage, Alexay could no longer straighten his legs and this worried Mary Lou. He was admitted to ANMC and began the paperwork to transfer him back into a nursing home. The sores worsened and the possibility of surgery seemed inevitable. He developed pneumonia and the family was told that the odds of Alexay surviving a surgery were slim. Mary Lou continued to collect proper paperwork for social services for the transfer into a nursing home. She almost felt hounded by some of the questions they repeatedly asked. They were having trouble enrolling in the Medicaid waiver program and needed to find the deed to her home, power of attorney paperwork, and the Millers Trust, to name only a few. At the time things felt chaotic for Mary Lou. She only prayed for her husband to get better. Unfortunately Alexay passed away on June 14, 2008 at the Alaska Native Medical Center.

A) Financing

The lack of adequate funding for home and community based LTC services in the current environment is a primary concern of tribal health organizations. With the limited amount of government funding available to provide the realm of services to Alaska Native people, the tribal health system needs a revenue source for any new programs or they must divert funding from other services. In the current service delivery environment, the home and community based LTC services are generally funded either by Medicaid or private pay and are less expensive than facility based care. For example, in Alaska the cost to Medicaid of an elder residing for one year in a rural nursing facility is around \$237,250; whereas, the Medicaid cost for an elder residing in a rural assisted living home might reach \$49,275 for one year; and the cost for an elder receiving 40 hours per week of PCA services in their own home for one year is currently \$43,680. With State and federal Medicaid expenditures growing and the number of people over 65 increasing, it is clear that personal care is the most cost effective option. However, the current Medicaid reimbursement for home and community based services is not sufficient to cover the actual cost of providing services, especially in rural areas. The lack of adequate funding has resulted in the inability of tribal health organizations to provide consistent, self-supporting and sustainable home and community based LTC services.

More specific financial and funding challenges faced by the tribal health organizations in the current service delivery environment include the following:

- *Medicaid reimbursement rates:* Reimbursement rates are not commensurate with the actual cost of providing services. To provide Agency-Based PCA services, the desired model to ensure high quality care, the tribal health organizations are required by regulation to have an RN on staff to review plans of care and provide supervision; provide 40 hours of training, ongoing first aid, and CPR renewal for their home care workers; have all workers submit to criminal history background checks; and travel for training and client visits. The funding for these mandated overhead program costs was covered by the State grants until 2004. The set reimbursement rate of \$21 per hour statewide was paid to all providers in addition to the grant money. When the grant program was eliminated in 2004, the justification included a plan by the State to provide a rural differential on the hourly reimbursement rate; however, the rates were never adjusted. Now costs for supervision, training, travel, etc. must be borne by the tribal health organization, since the grant subsidy was eliminated and the statewide rate has been maintained at \$21 per hour. YKHC estimates they spent over \$460,000 subsidizing the cost of their PCA program in FY 2006. The reimbursement rate for care coordination services per month per client is \$200, regardless of the amount of time and resources spent on that client and air travel costs required in rural Alaska to fly to villages for required face-to-face client meetings. Additionally, home and community based

service rates have not been adjusted as necessary for rising program costs or the cost of living. In recognition of the problems created by inadequate reimbursement rates, DHSS engaged the firm of Myers and Stauffer to provide assistance with developing and implementing a new reimbursement methodology for home and community based services. Myers and Stauffer has completed the research of the various reimbursement methodologies used for home and community based services; gathered information from DHSS staff and provider organizations, including the tribal providers; and produced a report which includes recommendations for revisions to the current home and community based services rate setting process, an overview of possible rate methodologies, and recommendations for the reimbursement of home and community based services. A future report from Myers and Stauffer will present a transition and implementation plan for the reimbursement methodology selected by DHSS.

- *Medicaid reimbursement methodology.* Reimbursement methodology does not take into consideration the additional costs of conducting programs in rural areas where costs are higher and economies of scale are not feasible given the small client base - there is no geographic differential allowed to accommodate these differences. Recent focus groups and community meetings have demonstrated that Alaska Native elders and people with disabilities prefer to be at home and in their own communities in the most independent setting as possible, and experts agree that home and community based LTC services are less expensive overall than facility based care. However, in the current financing environment it is generally easier to create a balanced budget for a nursing facility than any other type of LTC service due to the established reimbursement structure and methodology for determining rates.
- *Funding for non-Medicaid clients:* The tribal health organizations' mission is to provide quality services to all Alaska Natives and people with disabilities in need, not just those who are Medicaid eligible; but the lack of funding for non-Medicaid clients presents a dilemma to the tribal health system since it does not coincide with the mission to provide services to all who are in need. State grants were used to cover PCA services, subsidize services to clients with income just over the Medicaid eligibility level, or cover the cost of services while a client was awaiting their Medicaid eligibility determination, until 2004 when the grants were eliminated.
- *IHS funding:* Currently Indian Health Service provides funding at approximately 50% of the level needed to provide basic health care services to Alaska Native people; therefore any new service lines, such as long term care, would compete with an already financially stressed system with increasing needs. The Indian Health Service (IHS) does not provide funding for comprehensive LTC services, so tribal health organizations have to be creative in developing programs using other tribal funding sources or assets, as well as integrating State programs and other funding streams.

B) Workforce

The availability of a well trained, competent, and caring workforce is crucial to the development and successful delivery of home and community based LTC services in the tribal health system. Currently, in all areas of the state, recruitment and retention of qualified staff is a major challenge; and workforce shortages in this field, coupled with the increasing demand for services, are well documented in Alaska and nationally. Direct service workforce development initiatives in Alaska over the past ten years identify lack of support, literacy issues, cumbersome external workforce rules, low salaries, lack of benefits, unrealistic qualifications, unstable work

hours, lack of professional development and career ladders, lack of continuing education and lack of respect for their value as contributors to the undesirability of the job and the subsequent high turnover. There is also an emotional drain on home care workers related to the closeness of the relationship that develops with a client and grief issues when a client dies. Home care workers have identified the following basic needs in order to make the jobs more desirable:

- Respect for the worker from employers, the community and the medical field
- Pay and benefits commensurate with the position and the value of keeping Native elders and people with disabilities in their community and at home
- Support for the emotional aspects of their job
- Realistic training requirements
- Professional development and continuing education (career ladder or upward/lateral mobility)

The supply of workers statewide is not adequate due to many issues currently facing the tribal health system and the LTC industry in general. Those issues discussed below are complicated, interrelated and will need to be carefully researched and addressed to come up with viable solutions.

- *Recruitment and retention:* The ability to recruit and then retain an adequate supply of competent workers is a major barrier to service delivery. First of all, the pay and benefits offered currently are too low to allow individuals to earn a reasonable living. Along with the lack of realistic compensation, the workers are not supported with sufficient supervision; training, continuing education or professional development; or emotional and practical back-up systems.
- *Training and education:* There is no funding source available to train home care workers, thus limiting the supply of workers. The logistics of offering training in rural areas is difficult and expensive resulting in a lack of adequate training resources. Without training the worker supply is severely limited. In addition, the currently approved PCA training curriculum is not culturally appropriate and does not meet the needs of workers or their clients. Tribal health organizations are advocating for a skills-based training with more clinical and hands on practice, as well as competency based testing. The LTC Committee and DHSS staff are currently working together to develop a competency testing tool and process that will better meet the needs of workers in rural areas.
- *Marketing and community education:* The success of efforts to recruit, retain, and maintain a quality long term care workforce depends on a variety of related factors. One important influence on individuals' decisions to enter and remain in the long term care field is how society values the job. First of all, the lack of understanding of the aging process and the value of the long term care workforce is a national problem. In general, direct service worker jobs in long term care are viewed by the public as low wage, unpleasant occupations that involve primarily maid services and care of incontinent, cognitively unaware old people. This image is exacerbated by media reports that feature poor quality care by long term care workers. Stakeholders in long term care must organize to improve the image of direct care workers by collaborating with advocacy networks to promote public policy and community education that enhances and supports the workforce. Tribal health organizations will play an active role in advocating for change in their respective regions.

- *Worker rules and requirements:* State and federal Department of Labor rules, such as overtime rules and travel and mileage reimbursement, limit flexibility for home care workers. The work is usually less than full time and can be sporadic. Lacking regular hours - the number of hours worked can range from 2 hours one week to 10 hours another week and 35 the next - the workers cannot depend on a steady, predictable income. There are different rules and hiring requirements for each type of home care worker (respite, PCA, chore), which makes scheduling, hiring and training complicated.
- *Professional development and opportunities for upward and/or lateral mobility:* In the current delivery system the primary provider of direct services to clients are paraprofessionals – Personal Care Assistants (PCAs), Certified Nursing Assistants (CNAs), Chore Workers or Respite Workers. The same worker might be variously referred to under any one of these titles, depending on the tasks they are doing and the program under which they are being paid. For each of these worker types there are different qualifications, training requirements, compensation and work rules which can cause considerable confusion for the worker, the client and the provider. One individual worker may function as a PCA, a chore worker and a respite worker all in the same day. The documentation required to account and bill for this individual's time as the work role changes throughout the day is difficult at best. Or, a client may be confused when three different people come to their home in one day to provide their care - each doing a different set of tasks. The LTC Committee is currently working on the development of a "universal" worker position that would have three tiered levels --- Home Care Worker I, II, and III. The types of tasks and skill level needed by the worker would increase as they worked up the levels, which would enhance the versatility, the value and the pool of available workers.

C) Regulation

It is vital that the regulatory environment in which the tribal health system operates allow for the flexibility needed to build culturally relevant and sustainable home and community based programs. In the current service delivery environment, the State and federal regulations and subsequent policies for home and community based services do not foster or offer the flexibility needed for the development of such programs. Also, the fact that regulations change over time depending on the priorities of government, and such changes are often made without adequate and timely input by tribal health providers inhibits the provision of consistent services. Both the State and the tribal health system can benefit from designing a regulatory environment that promotes workforce development, provides adequate funding for the services, and fosters timely access to quality services for Alaska Native elders and people with disabilities.

The tribal health system is committed to developing and incorporating home and community based services into the tribal health service delivery system. In order to be successful in that effort, the tribal health organizations have identified regulatory issues that need review and improvement. More specifically, current regulations, including State and federal, pertaining to service flexibility; prior authorization and care plan approval processes; client assessment; Medicaid eligibility; guardianship/power of attorney issues; criminal history background checks; training and education requirements; and the monitoring processes all present challenges to the provision of timely, appropriate, culturally relevant and consistent services.

Regulatory changes over the last 7 to 8 years have impacted the ability of the service providers to meet the LTC needs of Alaska Native elders and people with disabilities. As a result, many tribal health organizations have elected to eliminate particular services, such as personal care,

respite, etc.; and other tribal health organizations have elected to offer home and community based services, such as respite, care coordination, and chore, only on a limited basis. Below is a brief summary of regulatory issues which have been identified by the tribal health organizations as impacting a clients' access to needed services and the viability and sustainability of the services in general:

- *Service flexibility:* Rules regarding who can provide the services, family member or trained staff, etc.; where the services can be provided, in the home or community, etc.; when the services can be provided; and the definitions of allowable and excluded services.

Rural home care staff report: *Our agency services 38 Interior villages in Alaska. Most villages can only be reached by air. In the past we had a very active PCA program serving our villages; however, the program was dropped back in 2005 when many of the regulations changed, funding was cut and we could not afford to train new providers for our Agency Based PCA Program. The Waiver program has also proved very difficult to maintain. One of the main hurdles has been the increase in the face-to-face visit requirement from 2 times a year to 4 times a year. The rising cost of fuel has increased the cost of flights to the village, as well as a tank of gas to drive to the village.*

- *Approval and prior authorization:* The system for approving care plans and authorizing services is costly and time consuming causing delays in access to services for clients and the inability of providers to sustain programs.

Client story demonstrating assessment delays due to inaccessibility of rural villages as reported by home care staff (included with permission from the client): *In February, I went to Minto to visit an elder who was crippled with arthritis and had great difficulty getting out of bed. Her family was providing 24 hour care for her and requested that she be screened and assessed for services. It is important to note that Minto is located on the road system north of Fairbanks and, half of the 8 hour drive is on a dirt road which crosses over a high pass and can be very dangerous when whiteout conditions occur in the winter. The road is not well traveled, so if something happens, especially when the temps can reach 60 below, it can be a very dangerous experience. There are only 3 flights a week to the village, so if you do want to fly over to see the clients, it is a 3 day trip. After visiting the elder in her home, I felt she would meet PCA and CHOICE Waiver criteria. I turned in a screening indicating her needs in late February and 2 months later I was contacted by the State nurse assessor asking me if I would accompany her on a day trip to Minto to assess the elder. She was surprised to hear that it is not just a "day trip" whether you drive or fly - more like a 3 day trip. By the time the nurse assessor completed the trip to Minto and approved services for her, it had been 3 months since I first visited the client in Minto. A full understanding of the rural areas and access issues is vital to getting needed services to our people.*

- *Gateway to services:* The current process required for a person to access the LTC system is difficult at best; specifically, assessing a clients' need for services is complicated with lots of paperwork, requires a long wait to get an assessment, is very costly (due to the need for RN level assessor to travel statewide to conduct assessments and then have follow up reviews by several other levels of staff), and is not always conducted in a culturally sensitive manner. There is a need for local assessors, one assessment tool for all services and "no wrong door" for accessing the system.

Client story that demonstrates the need for culturally sensitive and local assessment staff as reported by home care staff (included with permission from the client): *One of the State nurse assessors from Anchorage traveled to one of our villages to assess an 80 year old woman. In doing the cognitive screening part of the assessment, she gave the woman three words at the beginning of the interview and asked her to remember them (a standard test used in cognitive screenings). At the end of the interview the woman did not remember any of the words, and therefore was determined to have some cognitive problems - thus the assessment was completed and needed services identified and approved based on the client having cognitive difficulties. Our local staff tried the same test with the woman later, giving her the words in Yupik (because that is her primary language); and she remembered all the words with no problem. The client had no cognitive difficulties, but she did not fully understand English as it is not her first language. Therefore, the services approved for her were not appropriate, due to the inaccurate assessment of her needs.*

Home care staff report (included with permission from the client): *A 69 year old male at Providence Extended Care for a long term stay decided to leave the nursing home to live with his daughter. The client was discharged from the nursing home on 11/15/07 and the PCA agency was contacted to get PCA services started. The client waited for months to get PCA services in place. The client was informed at first that PCA hours could not be approved if the assessment was done in the nursing home (which was done prior to his discharge date). Next the client was informed there was a backlog of assessments and he would need to wait his turn, though he should have had services immediately as part of the discharge from the nursing home. He was then assessed in his home and had to wait for State staff to make a determination regarding how many hours he would receive. The client finally received notification of PCA hours on 3/26/08. He waited more than 4 months for services to begin - this situation placed an undue stress on him and his family.*

- *Medicaid eligibility:* Issues relating to eligibility for Alaska Natives receiving tribal dividends are complicated and prevent consistent delivery of services to clients. Many people are still reluctant to enroll in Medicaid; however, over the last several years tribal organizations have been very aggressive in educating communities regarding the need to enroll and have been successful in signing up more people and increasing their capacity for third party billing in general.
- *Power of attorney, guardianship and conservatorship requirements:* These legal tools are complicated and not used consistently across all service types. There is a need to investigate State and federal requirements and educate providers and care planners. Lack of understanding and use of these tools presents roadblocks which delay and/or can prevent access to services.
- *Criminal history background checks and fingerprinting process, including waivers and barrier crimes:* The system and rules are complicated and require research to determine the best way to apply the rules so as not to prevent workforce development, but also ensure safety of clients and workers, while not violating individual rights.
- *Program monitoring process:* The processes used currently to monitor and ensure the quality of service delivery is not adequate and does not foster quality improvement. Collaboration between the tribal health system and the State to develop an oversight and evaluation process that will ensure both parties that services are provided in compliance with State regulations and quality standards, and allow for feedback that can improve service delivery, is vital.

Client story demonstrating assessment delay resulting from inefficient communication and/or faulty system processes as reported by home care staff (included with permission from the clients): *Two clients were screened and admitted into assisted living in August, and confirmation of receipt of all necessary documents was received from the State the first week of September. For three months, when checking on the status of the assessment, we were told "any day now. The nurse will be there in a week or two." The residents were finally assessed in January. We received determinations at the end of February. When I asked if any consideration could be given to the fact that it took 5 months to get an assessment complete, I was told "you should have applied for General Relief; we only go back to the date of assessment". We would have applied for GR for our clients if we had anticipated that it would take 5 months to get an assessment, instead we were told the assessment would be in "a week or two" and so we kept waiting. We are unable to recoup any of the cost of the 5 months that the clients spent in the assisted living home waiting to be assessed.*

- *Worker training and education requirements:* Rules for testing are often complicated and not feasible in many rural areas, create barriers to workforce development, do not always meet the needs of clients, and need to be locally defined and/or based on client need. There is a need to research and design the best approach to meet the needs for developing an adequate number of competent and quality workers.

D) Organizational Capacity

In order to achieve the goal of developing a quality LTC service delivery system, tribal health organizations must be able to establish financially viable and self supporting programs. This means they must have the organizational capacity to bill Medicaid, and other payers for services provided within the tribal health system; encourage and support Medicaid enrollment of eligible clients throughout the state; ensure that program staff and financial staff are collaborating on the billing effort; make training and support available to all tribal provider billing departments and program managers; and develop a standardized approach to policies and procedures to ensure consistency and quality of services.

Many communities have the desire to provide LTC services, but the LTC services, but the vast array of funding sources and services is overwhelming and complicated. In the current service delivery environment, many are unable to build the organizational capacity, due to a lack of staff or the internal organizational structure and operating procedures needed to develop and deliver quality services. If there is inadequate capacity in any of the following areas, it creates a barrier to optimal service delivery:

- *Billing and other revenue support systems:* Developing and maintaining a competent billing office staff is a challenge in rural areas. Recruitment and retention of qualified accounting, business office and IT staff is an ongoing challenge; loss of billing personnel results in ongoing training and technical assistance needs from the state and state contractors. Tribal organizations have purchased billing and accounting systems but often do not have technical support from vendors or sufficient information technology staff to support their systems. The ATHS has promoted development of financial infrastructure through the CFO group and training opportunities, but this infrastructure is less developed than health care systems in urban areas.
- *Smaller organizations' inability to achieve economies of scale:* The high cost of delivering services, exacerbated by the small client base in rural communities, results in providers' inability to cover the overhead cost for the provision of services and impacts sustainability of those services.
- *Continuity and transition of program management:* In many long term care programs there are high rates of turnover in management staff, extended vacancies in key positions and a lack of organized transition plans. This can lead to lack of continuity in service delivery.
- *Coordination of care:* ATHS leaders recognize unresolved communication issues exist around the transfer of patients to and from the tertiary care facility and to the patient's home.
- *Workforce development and support issues, including worker supply and demand:* The provision of training at the local level is costly and must be provided on an ongoing basis to maintain adequate staffing levels in long term care.
- *Coordinated data collection systems:* There are disjointed systems within individual tribal health organizations and limited statewide data collection across tribal health organizations. Not all organizations are collecting the same information.

Communication technology from villages/clinics to regional and urban areas varies; there is no consistency in the types of systems used by all tribal health organizations

- *Communication and understanding between finance and program staff:* Often there is a disconnect between business office and program staff. Program staff need to understand the revenue cycle requirements in order to support proper billing and collection, and financial staff need to understand how the program operations work to ensure they are fully capturing all potential charges.

Part III: Home & Community Based Service Development

With a significant increase in State Medicaid funding for LTC services expected in the near future, the enhancement of LTC services offered by the tribal health system will provide a great benefit to the State and the tribal health system. The tribal health system is committed to working with the State to develop and incorporate home and community based LTC services into their tribal service delivery system. The primary goal is to offer home and community based LTC services that are financially viable, self supporting, culturally appropriate and delivered in a timely manner. To accomplish this goal, the tribal health organizations agreed to the following general approaches to guide them as they planned and worked to determine solutions and strategies to develop the LTC service delivery system that would meet the needs of Alaska Native elders and people with disabilities.

- Identify a committed group of people who can advocate for, develop and provide the services.
- Ensure that the leadership is fully committed to the development of LTC services.
- Ensure that cultural components, such as traditional foods and activities, are considered in the development of services.
- Always bring elders in as decision makers and advisors.
- Local, regional and State agencies must coordinate and cooperate to ensure the needs of elders are met.
- Include community outreach and education in the system.
- Find, train and retain a dedicated workforce – ensure they have understanding of the culture and are suited to LTC work.
- Develop ways to incorporate youth in the service delivery system. This will ensure longevity of workforce, encourage understanding and respect for elders, and increase value of elders in our society.
- Develop an effective care coordination system to ensure appropriate services get to elders, to promote quality, to ensure cost effectiveness and make the services available for all clients, not just Medicaid clients.

Section 1: Proposed Alaska Tribal Home & Community Based Service Delivery System

A) Need for Services

By analyzing population growth and estimating the functional abilities and limitations in the population, predictions can be made regarding the need for home and community based long term care services. When looking at population growth, it must be noted that much of the projected population change is based on rates of migration; and with the added effects of intrastate migration, Alaska's regions, boroughs and census areas are susceptible to much greater volatility than the state as a whole. The Alaska Department of Labor & Workforce Development projects a trend of rural to urban migration, with the most rapid increase occurring in Anchorage and the Mat-Su Valley - specifically expected to increase by approximately 36%, with a 1.26% average annual growth rate, from 359,987 in 2006 to 488,553 in 2030. In addition, the "Status of Alaska Natives Report 2004" shows a steady increase in the urban Native population due to migration from rural areas. Anecdotal information from Southcentral Foundation's Elder Program indicates a growing need for services and a high number of people moving to Anchorage and the Mat-Su Valley from more rural areas of the state.

Table 5 depicts the number of Alaska Native people in need of home and community based services in Alaska as a whole for 2004 and projected to 2020. The estimates were calculated by applying nationally accepted activities of daily living percentages to the Alaska Native population to determine the number of people with disability needs, as follows: 65–74 age group = 9.3% disabled; 75 - 84 age group = 25.9% disabled; 85+ age group = 34.9%. An additional 20% of the total number of estimated disabled over age 65 was added to account for the under 65 population who would likely be eligible for an Adults with Physical Disabilities Waiver or personal care services. From this total, the number of people predicted to be in a nursing or assisted living home was subtracted, resulting in the total estimated number of individuals needing home and community based services, including PCA, chore and respite services.

It is important to note that these estimates are based solely on population figures, and there have been changes in population between 2004 and today. However, current information on population by ethnicity, age group and region are not available. These figures also do not consider any in-state migration patterns. For example, the Anchorage 65+ Alaska Native population in 2004 was estimated at 1,054, whereas current numbers indicate there are 1,683 people in this category, an increase of 61%, which could be the result of in-migration. Calculating that increase would show that there are 215 people in Anchorage with a disability rather than 133.

TABLE 5: Projected Need for Home & Community Based Services Statewide Totals for Alaska Native/American Indians (2004 & 2020)			
<i>Age</i>	<i># of AN/AI Individuals</i>	<i>% at risk</i>	<i>Demand</i>
65-74	4,444	9.3%	413
75-84	1,980	25.9%	513
85+	580	34.9%	202
<i>2004 population Totals</i>	<i>7,004</i>		<i>1129</i>
20% of total for under 65			226
Total disability estimate			1354
less assisted living demand			203
less nursing home demand			160
<i>Total People with HCB needs in 2004</i>			<i>991</i>
2004 plus 77% pop growth			1998
20% of total for under 65			400
Total disability estimate			2397
less assisted living demand			360
less nursing home demand			283
<i>Total People with HCB needs in 2020</i>			<i>1754</i>

Table 6 presents a summary total of the need for home and community based services by region. The totals in the table show that there will be approximately a 75% increase in the number of people needing home and community based services from 2004 to 2020. Additional tables with specific data for each region or service unit is presented in Appendix C of this document.

TABLE 6: Total AN/AI Home & Community Based (HCB) Needs by Region (2004 & 2020)		
<i>Region</i>	<i>Total # People with HCB Needs in 2004</i>	<i>Total # People with HCB Needs in 2020</i>
Anchorage Service Unit	133	236
Barrow Service Area	45	79
Kotzebue Service Area	60	90
Norton Sound Service Area	75	132
Yukon Kuskokwim Delta	184	326
Bristol Bay Service Area	54	95
Aleutians - Rural Service Unit	17	32
Kodiak - Rural Service Unit	27	48
Anchorage Service Unit Mat-Su	28	51
Kenai Peninsula Rural Service Unit	44	78
Valdez & Cordova Rural Service Unit	30	38
Mt. Edgecumbe / Annette Is. Rural Service Unit	186	330
Interior Service Unit	126	224
<i>Total - All Regions</i>	<i>1009</i>	<i>1759</i>

(* Note: differences in the totals of the two tables are due to rounding)

B) Service Package

The following “Home & Community Based LTC Service Delivery Planning Tool” was used to gather information and formalize the ideas provided by the tribal health organizations as they began the journey to design a long term care service delivery system. The information presented in the tool provides a picture of the LTC service package that the Alaska Tribal Health System proposes to have available to Alaska Native elders and people with disabilities.

More specifically the tool provides the following information:

- The LTC tasks and/or functions that must be available to Alaska Native elders and people with disabilities
- A brief description of what is provided now, including what works and doesn't, and how it can be redesigned or fixed
- Detailed information about what the service delivery system will look like (who, what, where)
- Information about how the function will be supported or financed, including funding plans and ideas (some of the LTC services will be funded by Medicaid, but there are others for which other funding sources will be used - alternative ways of funding and/or supporting services will be researched and developed, including but not limited to grants, local sharing of resources, private pay, volunteer networks, etc)
- Information about how the Alaska Tribal Health System plans to make it happen (many of the services will be provided by the tribal health organizations, but some will be provided by other organizations in the local community - the tribal health organizations will coordinate with these other entities to ensure that Alaska Native elders and people with disabilities are served; to ensure that services are high quality and culturally sensitive; and to prevent unnecessary duplication of effort.)
- Eligibility (very general information about proposed eligibility for specific services is provided - more specific qualitative and quantitative information about what determines eligibility, such as levels of care, levels of impairment, cognitive issues and substantial human assistance needed, will be researched and developed)

It is important to note that the Tribal Home & Community Based LTC Service Package is not complete with all details at this point in time; rather it lays out what is known now and identifies areas, services and/or issues that need further research and development. The LTC Committee will form several subcommittees to focus on the next steps, including: prioritization of services needed; bundling of services into packages to be provided to individuals meeting eligibility requirements for that package; and identification of which service packages need to be implemented first in order to make basic services available as soon as possible and help to keep tribal health organizations operational while the building of the LTC system continues to develop.

SERVICE PACKAGE

Home & Community Based LTC Service Delivery Planning Tool

LTC task or function that must be available for Alaska Native elders & people with disabilities	Is the function or task available now or not - does it need improvement?	Entity providing task or function now or entity proposed to provide it and where (THO, other provider, specific names)	Description of the LTC care task or function and how it will be offered within the tribal health system (Will it be centrally managed and by whom; home and community based or facility based; any other details that help ATHD and State understand what the service and the overall system will look like)	General plan for implementation of service (Redesign and/or improvement of current service delivery)	Staffing (Identify types of staff needed to provide the service)	Funding plan (Basic principles to be considered; details to be decided)
Home and Community Based Services						
<p>Assistance with the upkeep of the client's home, including cleaning, cooking, laundry, limited shopping</p> <p>(currently offered through "chore" and "PCA" programs)</p>	<p>Yes, available now but service levels have been reduced; only available for waiver clients and grants in some areas; needs to be available for all</p>	<p>Current = BBNA, Southeast Senior Services, TCC, Senior Citizens of Kodiak, Nome Community Center, Maniilaq</p> <p>Proposed = all THOs at village level</p>	<p>provide: surface cleaning of the home to ensure a safe & healthy environment, changing bed linens, laundry, meal preparation, limited shopping; heavy cleaning; in rural AK -chopping wood, empty honey buckets, haul water, hauling laundry to washeteria</p> <p>Home-based service (not facility based) provided & managed by THO under an agreement with the State</p> <p>Available for all clients who need the service, not just clients on a Medicaid waiver - even if they are not yet in need of higher levels of service (NF LOC)</p> <p>Provided by Home Care Worker Level 1 or in combination with other tasks provided by Level 2 and 3 workers</p> <p>Ensure adequate time allowed to do tasks</p>	<p>Qualifications/training: THOs to create Job Description to define worker qualifications; THOs to determine what training will be required</p> <p>Allowed tasks: define all tasks to be done on care plan for each client</p> <p>Eligibility: All assessed clients who have the need regardless of NF LOC, including elder who lives alone or has caregivers that do not provide cleaning, cooking, etc.</p> <p>Develop standardized time allowed to provide service - eliminate cumbersome "time per task" system</p>	<p>Home Care Worker Level 1 (entry level)</p>	<p>Seek other funding for non-Medicaid clients; make an agreement with the State</p> <p>Reimburse gas and/or mileage between clients</p> <p>Medicaid Cost-based reimbursement</p>

Home & Community Based LTC Service Delivery Planning Tool

LTC task or function that must be available for Alaska Native elders & people with disabilities	Is the function or task available now or not - does it need improvement?	Entity providing task or function now or entity proposed to provide it and where (THO, other provider, specific names)	Description of the LTC care task or function and how it will be offered within the tribal health system (Will it be centrally managed and by whom; home and community based or facility based; any other details that help ATHD and State understand what the service and the overall system will look like)	General plan for implementation of service (Redesign and/or improvement of current service delivery)	Staffing (Identify types of staff needed to provide the service)	Funding plan (Basic principles to be considered; details to be decided)
Home and Community Based Services (continued)						
<p>“Fill in” workers who function as surrogates for the primary caregivers; provides them with a break away from the day-to-day responsibilities of care giving</p> <p>(currently offered through “respite” programs)</p>	<p>Yes, available now but only on a limited basis to clients on a waiver and through DHSS grant funds; needs to be available for all who need it</p>	<p>Current = Norton Sound; TCC; Aleutians, BBNA; Center for Community, Alzheimer’s Resource Agency, etc.</p> <p>Proposed = by all THOs at village level</p>	<p>Worker will function as a “substitute” or “surrogate” for the primary caregiver to give that person a break providing tasks needed based on the client’s care plan</p> <p>Home-based service provided hourly or daily and managed by THO; or daily by adult day center or extended in AL home</p> <p>Available for all clients who need the service, not just clients on a Medicaid waiver - even if they are not yet in need of higher levels of service (NF LOC)</p> <p>Ensure service limits are adequate to meet needs</p> <p>Provided by Home Care Worker Level 1, 2 or 3 depending on types of tasks done by primary caregiver</p>	<p>Qualifications/training: THOs to create Job Description to define worker qualifications; THOs to determine what training will be required</p> <p>Type of worker for each client (Level 1,2,3) is dependent on level of care need of client</p> <p>All assessed clients are eligible - including elder whose caregiver goes to work or is out for subsistence, appointments, etc.</p> <p>Review assessment & care plan tools to ensure the need is defined & supported on care plan</p>	<p>Home Care Worker Level 1, 2 or 3 - based on level of care client receives from primary caregiver</p>	<p>Seek other funding for non-Medicaid</p> <p>Develop standardized hourly/ daily rates depending service location</p> <p>Medicaid Cost-based reimbursement</p> <p>Reimburse gas and/or mileage between clients</p>
<p>Socialization and companionship</p> <p>(often called companion care)</p>	<p>Currently not available</p>	<p>Current = none</p> <p>Proposed = by all THOs at village level</p>	<p>Types of tasks:</p> <ul style="list-style-type: none"> • Assistance with visiting friends & family • Letter writing & handling mail • Assistance in attending social activities • Activities to stimulate mobility • Activities offering mental stimulation • Basic meal prep for client only • Light housekeeping for client only • In-home respite for client only <p>Proposed in lieu of adult day & day habilitation programs that are not available in rural Alaska</p>	<p>Qualifications/training: THOs to create Job Description to define worker qualifications; THOs to determine what training will be required</p> <p>Non-ADL type of services defined on care plan for each client</p> <p>All clients meeting program criteria are eligible - including elder whose caregiver goes to work or is out for subsistence, appointments or elder who lives alone or alone majority of day</p> <p>Develop a volunteer network</p>	<p>Home Care Worker Level 1</p> <p>Volunteers</p>	<p>Seek other funding for non-Medicaid</p> <p>Research obtaining a waiver for this</p> <p>Volunteers (not billable)</p> <p>Medicaid Cost-based reimbursement</p>

Home & Community Based LTC Service Delivery Planning Tool						
LTC task or function that must be available for Alaska Native elders & people with disabilities	Is the function or task available now or not - does it need improvement?	Entity providing task or function now or entity proposed to provide it and where (THO, other provider, specific names)	Description of the LTC care task or function and how it will be offered within the tribal health system (Will it be centrally managed and by whom; home and community based or facility based; any other details that help ATHD and State understand what the service and the overall system will look like)	General plan for implementation of service (Redesign and/or improvement of current service delivery)	Staffing (Identify types of staff needed to provide the service)	Funding plan (Basic principles to be considered; details to be decided)
Home and Community Based Services (continued)						
<p>Assistance with basic daily living needs such as bathing, transferring, dressing, and grooming</p> <p>(currently offered through PCA programs, CHRs or CWAs)</p>	<p>Yes, but they have been dramatically reduced; services are available in 2 regions only; 3 regions discontinued services; needs to be expanded to meet needs in all regions</p>	<p>Current = THO in YK Region (YKHC), Northwest Arctic Borough (Maniilaq), and numerous private CDPCA agencies including but not limited to Consumer Direct Services, Access Alaska, Ready Care, Caridad, etc.</p> <p>Proposed = by all THOs at village level</p>	<p>Worker will provide: hands on & stand by assistance with bathing, dressing, eating, transferring, grooming, assistance to medical visits, all non-invasive and based on needs identified in each client's care plan</p> <p>Workers allowed to perform tasks trained by RNs, OTs, RTs and PTs within their scope of practice & supported by care plan (through telemed)</p> <p>Home & community based at village level - can be provided in client's home or other community location such as gym, MD office, tribal clinic, etc.</p> <p>THOs responsible for: assessment function, managing the program, providing monitoring & oversight to ensure compliance</p> <p>Serve Medicaid, non-Medicaid and private pay clients</p> <p>Allow flexibility in service to address rural and cultural differences</p> <p>All tools must be simplified, standardized, and coordinated with State, including: the assessment tool, the care plan and the charting system</p> <p>Consumer directed & agency based models redesigned into one model that allows best features of each</p>	<p>THOs will assign a committee to review current regulations & determine what needs revision</p> <p>THOs will collaborate with State to develop oversight & evaluation process</p> <p>Qualifications/training: THOs to define realistic qualifications for all worker levels; THOs will work with CHAP & State to set up training system, education & requirements that are standardized, allow lateral movement & specialty training areas for workers</p> <p>Research & redesign background check system to foster workforce development and client safety</p> <p>Review & revise CPR and FA requirements to address rural issues</p> <p>Allow only IADLS directly associated with ADL assistance, no heavy work - those needs should be met by services listed above - unless not available</p> <p>Clients who meet the need for at least 2 ADL needs are eligible</p>	<p>Home Care Worker Level 2 or 3, depending on client needs</p>	<p>Research other funding for non-Medicaid clients</p> <p>Reimburse gas and/or mileage between clients</p> <p>Medicaid Cost-based reimbursement</p>

Home & Community Based LTC Service Delivery Planning Tool

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Home and Community Based Services (continued)						
Assistance with dispensing medications	<p>Need more information</p> <p>Involve pharmacy providers in the process; set up a pharmacy work group</p>	<p>Current = All health corp pharmacies & CHA/P for their formulary; some health corp pharmacies do fill medisets or bubble packs</p> <p>Proposed = by all THOs at village level; not sure what type of worker; virtual support & training by centralized entity</p>	<p>Worker will provide: medication reminders, filling medisets, assist with taking medications, and "med checks" to ensure taking medications correctly</p> <p>Home and community based on the village level; and managed by the THO</p>	<p>Research regulations re: dispensing & administration of medication</p> <p>Research certification course to allow workers to administer and/or dispense meds</p> <p>Investigate home telehealth capacity; centralize training & support system (virtual); piloting in several THOs</p> <p>Eligible clients: any client taking 2 meds or more or has dementia</p> <p>Qualifications/training: THOs to define realistic qualifications for all workers; and develop standardized training process & procedures</p> <p>Collaborate with State - get buy-in</p>	<p>RN</p> <p>MLP</p> <p>CHA/P</p> <p>Rural pharmacy</p> <p>LPN</p> <p>Level 3 Home Care Worker, if they have a certified medication administration & dispensing course- if available in AK</p>	<p>Research & develop a way to reimburse for task</p> <p>Reimburse gas and/or mileage between clients</p> <p>Medicaid Cost-based reimbursement</p>
Assistance with taking medications	<p>Yes, provided by PCAs</p> <p>Needs to be better training, oversight and support</p> <p>Need better coordination with all health care providers</p>	<p>Current = PCAs</p> <p>Proposed = by all THOs at village level; Home Care Worker Level 2 & 3</p>	<p>Worker will: assist clients in getting medications out of bottle & to mouth, to get water; medication reminders, and "med checks" to ensure taking medications correctly under direction of MD, RN, MLP, Ph</p> <p>Prescribed type & amount of medication already determined; no judgment needed on part of worker</p> <p>Home and community based on the village level; and managed by the THO</p>	<p>Home telehealth capabilities (i.e. IMD - interactive medical device)</p> <p>Qualifications/training: THOs to define realistic qualifications for all workers; and develop standardized training process & procedures</p> <p>Collaborate with State - get buy-in</p> <p>Develop a centralized training & support system (virtual)</p>	<p>Home Care Worker Level 2 or 3</p> <p>CHA/P</p>	<p>Medicaid Cost-based reimbursement</p> <p>Reimburse gas and/or mileage between clients</p>

Home & Community Based LTC Service Delivery Planning Tool

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Home and Community Based Services (continued)						
<p>Care provided by skilled, licensed practitioners</p> <p>(RNs, Physical Therapists, Occupational Therapists, Speech Therapists, Respiratory Therapists, therapy assistants)</p>	<p>Service is not available in most regions; only a few providers of home health services in Anchorage</p>	<p>Current = SCF only</p> <p>Proposed = by THO or other organization at village level</p>	<p>Workers provide all medical & therapy services authorized by Medicare under rules for home health, respiratory therapy, and infusion pharmacy.</p> <p>Must be State licensed</p> <p>Centralized support & training (virtual)</p> <p>Skilled & licensed staff; others who are trained and supervised by licensed staff</p> <p>Offer in villages, but mostly hubs where skilled licensed providers are available</p>	<p>Research & develop regional satellite centers</p> <p>Institute standardized procedures, forms, etc. and train staff to use</p> <p>Eligible: any client that needs skilled care & has it documented in their care plan</p> <p>Look at insurance coverage for skilled professionals outside of medical facility</p> <p>Collaborate with State - get buy-in</p>	<p>RN</p> <p>Home Health Aide</p> <p>MLP (PA/ANP)</p> <p>Therapists: OT, PT, RT, ST</p> <p>Trained family member or Home Care Worker</p>	<p>Medicare</p> <p>Medicaid</p> <p>Cost-based reimbursement</p> <p>Private Insurance</p> <p>Reimbursement must include travel costs</p>
<p>Spiritual & Bereavement Care</p> <p>(pastoral care)</p>	<p>Available in Anchorage only on a very limited basis</p> <p>Needs to be available in all areas</p>	<p>Current = none other than SCF and ANMC pilot project</p> <p>Proposed = by THO or other entity at village level; or provided at home or in hospice beds at local hospital, NF or ALH; home care workers</p>	<p>Worker will provide: counseling & support; spiritual screening; psycho-social assessment; anticipatory care planning; ethical support (wills, POA, etc.); anticipatory grieving; may also include cultural activities & ceremonies</p> <p>Centralized support & training located at ANMC or ANTHC (virtual), including volunteers</p> <p>Offer in villages & regional satellite centers</p> <p>Specific services needed will be assessed & implemented as part of the care plan developed by Case Mgr or Care Coordinator</p>	<p>Look at informal systems used in communities now - collaborate with local pastors, THO counseling services, priests, etc.</p> <p>Research ways to formalize these systems</p> <p>Check possibilities of a volunteer network of professionals - area pastors or other clergy</p> <p>Offer bereavement counseling through palliative care</p> <p>Eligible: clients newly diagnosed with major disease or terminal diagnosis & their family members</p> <p>Collaborate with State - get buy-in</p>	<p>RN</p> <p>Social Worker</p> <p>CHA/P</p> <p>BHA</p> <p>Home Care Workers (with special training focus on death & dying)</p> <p>Pastors</p> <p>Volunteers</p>	<p>Research potential funding</p> <p>Volunteer services (not billable)</p>

Home & Community Based LTC Service Delivery Planning Tool

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Home and Community Based Services (continued)						
Palliative Care (pain management, education, end of life care)	Yes, service is available on a very limited basis; provided through pilot project (EAT); and non-tribal org in Norton Sound Needs to be available in all areas	Current = EAT, Norton; some others do informally (YKHC); ANMC pilot project provides education to terminal pts leaving ANMC; have \$\$ for RN to travel to train family/CHA/P, etc. Proposed = by THO or other entity at village level; or provided at home or in hospice beds at local hospital, NF or ALH; home care workers	Much like hospice care Services include: pain & symptom management; nursing care; medication management; infusion therapy; education & counseling re: end of life; and counseling re: goal shifting (i.e. realistic end of life goals) Eligible: clients diagnosed with terminal condition; care needs documented on their care plan Centralized support & training (virtual) Located at ANMC or ANTHC Regional satellite centers	THOs define worker qualifications Training: THOs develop standardized training process & procedures to be offered in central location such as ANMC, Providence or other IHS entity for staff interested in getting qualified to provide services as a THO team, e.g. nursing, pharmacy, counseling (SW or BHA), CHA, Home Care Worker and volunteers Collaborate with ANTHC/ANMC cancer program on training & implementation Consider: workers would be a part of THO Hospice/Palliative Care team; team to function like a Home Health Agency requiring a provider referral for services; initial assessment done by RN & care plan established for needs; volunteers to supplement team providing additional visits; recommend using community hospice agency model	RN Social Worker CHA/P Home Care Worker Level 1, 2, 3 BHA LPN Pastoral care provider Volunteers	Volunteer Program supported by THO (not billable) Medicaid Cost-based reimbursement Research waivers for this Research ways to tie tasks to reimbursable service
Access, Safety & Comfort in the home or community (Assistive technology & DME)	Generally there is no organized system THOs can enroll to provide but do not have volume to make it work & payment does not cover costs	Need more information	Service would provide medical equipment (DME) & assistive technology to help clients stay home or in community Must include assessment of client's need; referrals; coordination & expediting of equipment; transport; set up in the home; training re: use of equipment; and follow up THO to manage & centralize the effort	Clarify service definition, define THO role, develop standardized criteria & procedures so all client's have equal access Eligible: elders & people with disabilities with need for this on their care plan Provide & manage centralized DME "loan closet" to recycle items		Federal & State grants Medicaid cost-based reimbursement Private funding

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Case Management Services						
Assessment of current status and the need for services	<p>Yes, currently conducted by State staff for PCA, DD, & waiver clients; conducted by other entities for specific programs and grants</p> <p>Process needs improvement - local assessors, culturally sensitive, improve timeliness</p>	<p>Current = KANA has just begun the Comp Elder Exam; YKHC Chronic care pilot; BBAHC has grant funding for comp elder exam training and implementation</p> <p>Proposed = by all THOs at village level; one standardized assessment for each client to be used universally</p>	<p>Comprehensive Elder Exam (to be used for all programs, providers; one for each client; conducted by THOs in each region or village):</p> <ul style="list-style-type: none"> • Identify level of need • Identify available resources • Review or redo annually • Use standardized tool • Cognitive status assessment • Social network assessment • Depression scale • Home safety component • Gait & balance assessment • Medication review • Screenings for prevention (cancer, etc.) • Bio-psycho-social evaluation <p>Collaborate with State to define TTCM for THOs; define expectations; resolve payment issues</p>	<p>Implement Comprehensive Elder Assessment (use KANA model & tools):</p> <ul style="list-style-type: none"> • Tinetti Gait & Balance Assessment • Falls Risk Assessment • Med Review • Nutrition Assessment • Functional Status Assessment • Home Safety Assessment • Elder Assessment Interview • Mini-Cog exam <p>Worker must be: Trained assessor/coordinator</p> <p>Implement TTCM program</p> <p>Eligible: all elder and people with disabilities</p>	<p>Must have flexibility in staff level authorized to do the assessment - Geriatric Assessment Team:</p> <ul style="list-style-type: none"> • RN, LPN • MLP • MD • CHA • Social worker • Case Mgr • Pharmacy • BHA 	<p>Medicaid Cost-based reimbursement</p> <p>Research other possible funding sources</p>
Development of a care plan based on identified needs and available resources	<p>Yes, done now by all THOs</p> <p>System is very disjointed; different care plans done for different services or providers</p>	<p>Current = KANA, BBNA, Maniilaq; Norton Sound; SCF; YK; TCC; Aleutians; numerous non-tribal agencies</p> <p>Proposed = by all THOs at village level</p>	<p>Service includes: formulation of a plan of care based on assessed needs; assists client in locating resources & obtaining services; identifies wellness & prevention activities</p> <p>THO to manage & standardize the effort</p>	<p>Eligible: all elders and people with disabilities on a waiver or TTCM</p> <p>THO will develop & standardize the process & forms to foster consistency</p> <p>Research using "care plan software"</p>	<p>RN, LPN</p> <p>Trained Care coordinator</p> <p>Certified Case Manager</p> <p>Social worker</p>	<p>Medicaid Cost-based reimbursement</p> <p>Research other possible funding sources</p>

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Case Management Services (continued)						
Manage, support and monitor the care plan for the client (currently offered under Case Management or Care Coordination programs)	Yes, provided by all THOs on limited basis Needs improvement: process not standardized	Current = KANA process follows from the Geriatric Assessment Process; Maniilaq; Norton Sound; YK; SCF; TCC; Aleutians Proposed = all THOs village level	Service includes: <ul style="list-style-type: none"> • Case management • Chronic Care Management • Care coordination • Medication management • Assist with completing and understanding paperwork • Monitor success/quality of service delivery 	Improve care coordination Implement TTCM Implement CCM Program Use IHS iCare population management software - reviews every 3 months Incorporate home telehealth technology	RN, LPN CHA MLP	Medicaid Cost-based reimbursement Research other possible funding sources
Other Services						
Food & Nutrition (encourage good nutrition make healthy food available)	There are only a few funded nutrition programs in rural areas because many kitchens in villages do not meet DEC standards due to the unavailability of water and sewer services in many locations in the state.	Current = through Senior Center grants; AOA grants; private providers; local governments Proposed = by THO or other organization at village level	Service includes: <ul style="list-style-type: none"> • Congregate meals • Home-delivered meals • Food box program THOs need maximum flexibility in designing nutrition programs in rural areas to assure that clients receive adequate nutrition	Define & use local "community standards" for food service sites Screen for nutrition, referral & follow up, provide some education Develop screening tool; determine type of worker to do work Screening, referral & follow up education Training on screening tool; assessor – maybe a higher level CNA at minimum Eligible: all Elders and people with disabilities	Food service workers Drivers Dietitians Home Care Worker Level 3 (special training focus on nutrition, wellness & health promotion)	Federal & State grants Private funding Medicaid Cost-Based Reimbursement

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Other Services (continued)						
Provide or coordinate access to services (Transportation)	Yes, available in most areas Problems: not available to all in need; no drivers; not coordinated; for medical only; reimbursement rules too narrow	Current = most THOs but not all Proposed = by THOs or other organizations at village level	Coordinate all transportation needed by tribe - head start, meals, medical, shopping, etc. Provide actual transportation service - vans, cabs, snow machines, boats, four wheelers, vouchers, etc. Allow transportation for both medical & non-medical reasons Allow reimbursement for gas and/or mileage	THO to develop standardized voucher system for cabs; work out agreement with local cab companies or other public transportation companies THO to implement cost-sharing system whereby elders and disabled can purchase cab voucher booklets at 50% discount	THO staff coordinator for the program Someone who can organize, monitor and manage the process & the payment system	Medicaid Cost-Based Reimbursement (medical related travel) Federal/State grants Private funding
Accessible & safe housing	Yes, available in most areas Better coordination needed	Current = through assessment process by local housing authorities Proposed = same	Services include: • House modification program • Environmental modifications • Home safety assessment & inspection Utilize "construction trade" programs to do work; eliminate three bid requirement as availability of contractors is limited in villages. Assure adequate funds are available to cover the cost of materials, shipping of materials and maintenance of installations.	THO to coordinate with local Housing Authority Review & revise environmental modification provider type & rules Research using "construction trade" programs to do the work	No THO staff needed once the agreements are set up May need some staff time allotted to provide resource info	Federal housing funds Private grants Medicaid cost based for some EMs
Encourage wellness and healthy lifestyle (Wellness & Prevention)	Yes, some wellness and lifestyle activities are provided, but limited	Current = KIT has walking club, garden club; KANA has a gym program, a fall & balance program; APIA has a wellness education program & a yearly wellness convention	Services can include: • Prevention screenings • Gym time & exercise programs • Fall prevention & balance programs • Walking clubs • Garden clubs • Education programs - nutrition, wellness, prevention, health lifestyle	THO to develop standardized screening tool (flows & checklists) so all clients are approached the same way THO determine how education will be rendered (handouts, discussion, classes,) Eligible: All Elders & people with disabilities who want it	Home Care Worker Level 3 Combine the role with the assessment and screening staff to do the screenings Physical activity leaders	Private funding Coordinate with other entities - share local resources, such as gyms, pools Commit Medicaid funding for services

Home & Community Based LTC Service Delivery Planning Tool	
Feature	General Ideas for Framework of the LTC System
Staffing or Personnel for LTC work	<ul style="list-style-type: none"> Personnel for the LTC system will be Home Care Worker Levels 1, 2 or 3 <ul style="list-style-type: none"> Level 1 = qualified and trained to do Level 1 work in the client's home, including: chores; companion & socialization; respite at a Level 1 need; palliative care (with specific training) Level 2 = qualified and trained to do Level 1, 2 work in the client's home, including: chores; companion & socialization; respite at a Level 1 & 2; personal care & health related work; assistance with taking medications; palliative care (with specific training) Level 3 = qualified and trained to do Level 1, 2 & 3 work in the client's home, including: chores; companion & socialization; respite at a Level 1, 2 & 3; personal care & health related work; assistance with taking medications; nutrition education, wellness & health promotion (with specific training) The specific name of worker is yet to be determined; ideas = Home Care Worker, Elder Care Specialist, Community Outreach Worker, or term specific to the region, i.e. Sismisii, Iqayukti)
Training System & Requirements for LTC staff	<ul style="list-style-type: none"> Providing training and support for LTC worker positions will help to improve their status in the community by "professionalizing" them. By incorporating the positions into the CHA/P model, the workers will have opportunities for meaningful work and advancement through the tribal health system, thereby making these positions sought after for their importance in the functioning of each THO. The training system will be modeled after the CHA/P program. It will offer basic standard training for Levels 1, 2, 3 Home Care Workers. There will be additional modules or specialty trainings that all levels can add to their basic standardized training, including: medication administration; palliative care; end-of-life care; nutrition education, health & wellness promotion. This will allow workers to move laterally and be part of one system; no separate PCA, respite, chore, etc.; part of a "universal" worker system that addresses all needs of clients in the tribal health system. The training and support will be offered through a "virtual" approach to increase efficiency and decrease the costs. Combining and coordinating the use of higher level staff (who travel routinely to local satellites to provide some skilled care and oversight anyway) with the "virtual" system will allow necessary support and training to be on-going. Form committee to research and develop distance delivery system; collaborate with UAA Center for Human Development and Geriatric Education Center, as well as other partners, to share ideas and resources Collaborate with ANTHC/ANMC cancer program on training & implementation of palliative care tasks. Collaborate with Behavioral Health Committee
Funding Issues	<ul style="list-style-type: none"> Use cost-based reimbursement for HCB Services: define tribal delivery model; draft reimbursement methodology Develop reimbursement for Elder Health Care Exam (YKHC is piloting this program development) Research & consider Public Entity Waiver for HCB package of services: communicate concept & questions to CMS; define tribal LTC delivery model Research & consider PACE-type (capitated managed care) model: HCB LTC subcommittee has begun investigation; ANTHC consultants, Health Dimensions indicated that PACE is not feasible in the Anchorage area for the Alaska Native population, based on a demand analysis using a standard model for the U.S. general population. Discuss ways to tie palliative care tasks to a reimbursable service--i.e. call it something other than palliative care, like pain management, etc
Assessment Function	<ul style="list-style-type: none"> Function needs to be conducted and monitored by local provider (THO), in collaboration with the State Implement a "universal" tool that can follow client to whatever provider they see Assess everyone wherever and whenever they access the tribal health system - implement the Comprehensive Elder Exam
New Approaches to Service Delivery	<ul style="list-style-type: none"> Telehealth systems Distance education Home Teleassistance Technology
Organizational Capacity	<ul style="list-style-type: none"> Development of standardized manuals for operating tribal home & community based programs Develop & finalize business plan tool Development of billing system & revenue system tools

C) Organizational Structure

To help frame the thinking about the ideal organizational structure for the AHS LTC Delivery System, the LTC Committee first considered what a completely centralized system would look like and how it might operate. “Centralized” was defined as meaning all service delivery statewide would be administered by a single, statewide tribal health organization. That organization would not necessarily be ANTHC but potentially a new organization formed just for this purpose. The LTC Committee could not identify any real benefits of such a structure, but they were able to identify the downsides to a centralized organizational structure, including:

- It would not be an efficient way to use the existing regionalized AHS structure
- It would not support self-determination
- Training is better provided regionally to regional workers
- Centralized billing would be too cumbersome, take too long to get reimbursement, be more difficult to follow-up, and be more time consuming overall

The committee also considered a completely decentralized organizational structure. This structure would maintain all governmental functions with the state and federal governments as currently structured; leave direct service provision to the local and regional tribal health organizations, but incorporating the government policy and funding changes that have been requested; and develop and maintain a technical assistance and committee support role for the statewide tribal health organization.

Finally, the committee concluded that a combination of the strengths of both of these models, centralized and decentralized, would result in the ideal AHS LTC Delivery System organizational structure. This ideal structure would maintain a role for state government; however, some of the current state roles and responsibilities would be delegated to a statewide tribal health organization that would function somewhat like a county government in providing technical assistance, monitoring and support. (In the lower 48 some states use this “county” model successfully). The regional and local tribal health organizations would be the direct service provider and would assume more local responsibility and control. Under this envisioned ideal structure, roles and responsibilities would be divided as follows:

- State Government
 - Explain and interpret State and Federal Regulations and policies
 - Establish waivers, demonstration projects, etc.
 - Administer Medicaid program; provide cost-based funding
 - Compliance reviews, system evaluation, and quality improvement
- Statewide Tribal Health Organization
 - Support standardization of all regional tribal LTC programs
 - Policies
 - Training (Standardized curriculum and tests)
 - Forms and tools
 - Monitoring, including compliance, evaluation, and quality improvement
 - Data collection and analysis
 - Advocacy
 - Consultants, including clinical, pharmacy, physical and occupational therapy
 - Support statewide committee which would serve as the decision-making body

- Regional and Local Tribal Health Organizations
 - Direct service provider (employer of LTC workers)
 - Conduct assessments
 - Provide workers training locally
 - Conduct monitoring and oversight activities locally
 - Billing
 - Outreach and education for clients and potential clients
 - Continuing education for staff
 - Leadership

The committee also identified the “pros and cons” of the ideal ATHS LTC Delivery System organizational structure as described above, which include:

- Pros
 - THO’s have an established understanding of their people, including their challenges and opportunities
 - THO’s have greater understanding of the culture and appropriate approaches to respect and preserve the culture
 - Increased local control and management
 - Greater choice for clients
 - Increased size of client pool due to better access to services
 - Improved recruitment and retention of staff
 - Better allocation of resources through standardization and efficiency
 - Local control of business management, such as hiring practices, etc.
 - Increased tribal participation
 - 100% Federal reimbursement of State expenditures for state government
 - Requires less State staff to deliver services
 - Easier for State to work with the tribal system
- Cons
 - Implementation of new structure will take a lot of dedication and hard work
 - Increased resources such as staff, capacity & funding will be needed
 - The structure would create an additional layer of administration
 - There would be less State government control

The committee also recognizes that tribal health organizations have varying organizational capacities and some of the smaller tribal health organizations may need additional support to successfully fulfill the necessary roles and responsibilities in this ideal structure. To address this, the committee decided this ideal organizational structure could also be modified to add a component of technical assistance and administrative support to be provided by the Statewide Tribal Health Organization and available to all tribal health organizations as needed. With that kind of administrative support, smaller tribes would have the opportunity to provide LTC services without having to hire unnecessary administrative staff, thus making the cost of delivering the service impossible.

D) Program Standards and Definitions

Given the reality that there are a limited amount of resources available for LTC services, the tribal health organizations are committed to ensuring that there be an equitable approach to selecting and serving only those individuals most in need of services; and that the services they

receive are appropriate to those needs. The ATHS is aware of the fact that serving all people in need is not realistic given the limited resources. In an effort to determine appropriate eligibility and program standards, the LTC Committee developed a Subcommittee on Eligibility and Program Standards to focus on this work.

Presented here is the conceptual framework used by the subcommittee to develop factors to be considered when determining an individual's appropriateness for LTC services. A number of actual tools for screening and assessment were also reviewed, but in order to come up with a tool that will accurately and appropriately determine needs, while also using a measurable and practical approach, the subcommittee found it necessary to step back and determine what factors need to be considered to get an overall picture of the individual and their LTC needs. The subcommittee recommended that more specific qualitative and quantitative information about what determines eligibility, such as levels of care, levels of impairment, cognitive issues and the need for substantial human assistance, be researched further before beginning the next step of practical thinking about, and actual development of, the tool(s) that will appropriately and fairly select and prioritize clients to be served.

Overarching Concepts / Guiding Principles:

The following concepts and/or principles guided the sub-committee's work on eligibility:

- We cannot serve everyone so there must be criteria for determining the type of client/needs to be served by each program. It is too costly in terms of financial, workforce and organizational capacity to serve all.
- There must be a formal standardized prioritization tool used to determine who gets services when more clients are determined eligible than can be served. The tool(s) must offer an initial screening function, an assessment function, a scoring mechanism and a prioritization process.
- The tool must be designed to capture all who actually need the services; it must look at both medical/health issues & psycho/social issues.
- The process must consider psycho/social elements, in addition to medical model aspects, when assessing & scoring client needs; not just medical diagnosis & health status but also living environment, informal supports, resources or services available.

Approach:

- Identify factors to be considered when looking at client needs (need to consider the conceptual first - then move to practical tool - must be systematic & used consistently by all organizations)
- Identify HCB programs & functions/tasks to be offered under each service package (Look at prioritizing which programs will be implemented first in order to get services out to the regions in the short term. Future planning can continue but people need some services now.)
- Determine program standards & criteria a client must meet to gain access to each package of services

- Develop a tool or tools that will determine a client's needs; identify which program package can meet that need; determine whether or not the client meets the criteria to receive the services offered by the program package; and prioritize clients to be served (Don't reinvent the wheel, many samples available, State CAT/PCAT good but too complicated & long, contact Alzheimer's to obtain cognitive tools)
- Define the process to be used to screen, assess, score, identify resources & services, prioritize

Factors to be considered when determining eligibility criteria:

1. *Physical Health Status*
 - Acute and Chronic Diagnosis
 - Skilled Nursing needs
 - Medical equipment needs (oxygen, feeding tube, colostomy, catheters)
 - Mobility and safety equipment
 - Medication (number of Rx's and type)
 - Pain status
2. *Cognitive Status*
 - Orientation
 - Coping skills
 - Mental Health Issues
 - ETOH/Drug Abuse Issues
3. *Functional Limitations*
 - Ability to Perform ADLs: feeding (diet & nutrition), bathing, transfers, dressing, grooming, toileting, ambulation, mobility, medication administration, falls risk
 - Ability to Perform IADLs: prepare meals, housekeeping, laundry, shopping
4. *Family/Social Supports- Primary Caregivers*
 - Employment status
 - Physical Limitations
 - Emotional Health
 - Abuse & neglect issues
 - Power of Attorney/Guardian supports
 - Extended family supports (cultural issues)
 - Other supports (friends, church)
 - Community supports (Elder care or LTC)
 - Back up plan
5. *Financial*
 - IHS Beneficiary or non-beneficiary
 - Medicaid/Medicare eligibility
 - Private Pay
 - 3rd Party insurance
 - Tribal resources
6. *Environmental / Living situation*
 - Ability to maintain home
 - Type of housing (running water, sewer, heat source, infection control)
 - Accessibility
 - Fire & home safety

The factors have been identified and the groundwork has been laid; and now the next step will be for the Subcommittee on Eligibility and Program Standards to focus on the development of

specific program standards, eligibility requirements, and the practical tools needed to assess an individual's eligibility. These steps include: identify service packages and prioritize which need to be implemented first; determine program standards and eligibility criteria for each of those service packages; develop screening, assessment, scoring and prioritization tool(s); and define the standard policies and procedures for the entire process.

Section 2: Tribal Solutions to HCB Service Development and Sustainability

Once the tribal health organizations completed the inventory of what the service delivery system offers now, identified needs and gaps in that system, and assessed successes and failures, they then determined specific tribal solutions and/or strategies, as they relate to financing, workforce, regulations and organizational capacity. They believe the following strategies and solutions will lead to the implementation of a high quality, accessible, affordable and sustainable service array.

Financing

To address the financing situation, the tribal health system recommends the following solutions and strategies:

- Develop diversified and new revenue sources, so the system is not completely dependent on Medicaid; including advocating for increased IHS and other federal funding, researching State and other grants that support infrastructure/core capacity and/or offer start-up, demonstration, or pilot projects
- Explore waiver and other special Medicaid funding streams that would support cost-based reimbursement; include study of feasibility and required approach to planning for capitation. Investigate with the state the possibility of a public entity waiver from CMS. Because tribally operated health care programs are considered units of government under federal law, Alaska's tribal health organizations may be considered public entities under federal Medicaid rules, and thus eligible for payment based on cost. Include PACE and other models such as demonstration projects when considering options.
- Ensure all eligible clients are enrolled in Medicaid - provide on-going education of beneficiaries about importance of enrolling in Medicaid, Medicare, and use of other 3rd party payers
- Implement Tribal Targeted Case Management (short term strategy to provide necessary case management services to identified populations in need)
- Investigate LTC insurance or insurance pool for all Alaska Native people
- Commit to supporting LTC programs and identify revenue sources
- Work to ensure the reimbursement rates are adequate to cover costs, including implementing cost based reimbursement rates for individual services and ensuring reimbursement rates reflect the higher cost of delivering services in rural areas

- Research CMS waiver options for a package of HCB services for nursing facility level of care eligible clients (HCBS Strategies is doing the research for DHSS, the LTC Committee will make recommendations based on the results)
- Research subsidies for private pay clients and grants for program operational costs

Workforce

In order to ensure the development and retention of a quality workforce, the tribal health system recommends the following solutions and strategies:

- Research innovative approaches to improve recruitment and retention: this will be done by identifying employment resources to increase the size of the workforce; developing a “worker pipeline” by working with schools to motivate youth to join the workforce; ensuring adequate training is available to improve competency of the workforce; building adequate pay and benefits into the development of the service delivery system to improve the consistency and satisfaction level of the workforce; and ensuring that the workforce is recognized and supported by the tribal health organization, including at the top levels.
- Review and analyze criminal history background check and barrier crime regulations and requirements to prevent unnecessary barriers to recruiting and retaining workers
- Create culturally appropriate training programs and curriculum, including revising the competency test for home care workers so that it is culturally appropriate and skills-based
- Collaborate with the State to define realistic parameters for training requirements and prerequisites for workers in rural areas - take into consideration the availability of training programs, CPR and first aid courses in rural areas
- Increase training opportunities statewide by investigating alternative training modalities, including distance delivery, web cast, video conference and online courses
- Investigate partnerships with other education systems (e.g., UAA, tribal colleges, Older Persons Action Group (OPAG), local school districts, telehealth and distance education)
- Establish a mentorship program in a variety of settings and fields
- Establish funding sources or other resources to provide the required training - people to provide training; funding for training; alternative CPR/First Aid curriculum
- Marketing and education internal to tribal health organizations and within communities about the value of the role of workers at the village level
- Develop and implement a three-tiered level of direct care workers (universal worker) such as Home Care Worker I, II, and III and define practice standards for three levels of workers

Regulatory

The approach to designing and/or revising regulations to support needed improvements in the service delivery system must include a collaborative process that seeks to fulfill the ultimate goal of providing a home and community based LTC services system that best meets the LTC needs of Alaska Native elders and people with disabilities and supports the sustainability of the

tribally managed programs. To define and detail specific statutory or regulatory changes and/or language needed would be premature at this time. Rather, the LTC Committee recommends the following process by which the State and the tribal health organizations can come up with a mutually agreeable list of regulations and statutes that need changing and a plan for doing so.

- Strengthen the communication and partnership between the State agency and the tribal health system
- Define and understand the challenges and/or problems that need to be overcome
- Identify which requirements are statutory vs. regulatory and State vs. federal
- Specify and agree on needed regulatory and/or statutory changes
- Negotiate a solution agreeable to both the State agency and the tribal health system
- Investigate opportunities for partnering with other LTC providers
- Investigate options for adding regulatory waiver provisions
- Collaborate with the State to develop an oversight and evaluation process that will ensure both parties that services are provided in compliance with State regulations and quality standards.

Organizational Capacity

There is no standard set of solutions to issues pertaining to organizational capacity - the appropriate approach and solutions are specific to each individual tribal health organization. There are unique differences in the needs of an organization depending on many variables, including, but not limited to, location (rural, urban), the size of the organization and the population served. For example, a large tribal health organization with an entire billing department may not have the need for a centralized tribal billing system; whereas a small tribal health organization with one business office staff person may benefit greatly from having access to a centralized tribal billing system.

To begin the work of building adequate organizational capacity it is necessary to first sort out the differences in the tribal health organizations and identify the specific support needs of each. The tribal health system can then develop a support system that includes all the resources needed to provide adequate support to each individual organization. The goal is to ensure that all tribal health organizations have the capacity to bill Medicaid, and other payers; to encourage and support Medicaid enrollment of eligible clients; to make necessary training and support available to all staff and program managers; to operate programs using standardized policies and procedures; and to implement monitoring and evaluation practices to ensure consistency and quality.

Some of the types of support recommended as necessary to develop organizational capacity include:

- Training and technical assistance regarding the billing of home and community based services to ensure the billing office staff and program staff have an understanding of the reimbursement process and billing system operations

- Development of opportunities for sharing resources; consolidating, centralizing, or regionalizing administrative support (e.g. billing systems), consulting services, etc.
- Creation of standardized policies and procedure manual templates for LTC managers to foster consistent service delivery regardless of staff turnover
- Provision of on site technical assistance and/or shadowing and mentoring opportunities for LTC services program managers
- Development of a LTC program manager “alumni” pool or registry for providing consultation to new LTC service managers
- Collaboration with ATHS Medical Services Networking Committee on the Care Coordination Initiative
- Development of community partnerships with other tribal and non-tribal providers of services, such as housing authorities, senior centers, school districts, aging & disability resource centers to avoid duplication of services and resources
- Provision of on-going education of beneficiaries about the importance of enrolling in Medicaid, Medicare, and the use of other 3rd party payers
- Development of support systems for information technology, including coordination with statewide IT group and development of an IT process that can collect data and share between organizations

Section 3: 12-Month Action Plan for Comprehensive Delivery System Development (July 2008 – June 2009)

The LTC Committee proposes the following strategies to support implementation of the comprehensive tribal home & community based LTC service delivery system defined in this report.

Strategies	Description	Responsible Agency Or Group	Timeline
<i>Determine Organizational Structure</i>	<ul style="list-style-type: none"> Define & describe organizational structure options, roles & responsibilities & pros & cons of each 	<ul style="list-style-type: none"> LTC Committee 	<ul style="list-style-type: none"> 7/31/08 <i>Done</i>
	<ul style="list-style-type: none"> Define organizational structure for tribal LTC system, including specific roles & responsibilities 	<ul style="list-style-type: none"> LTC Committee 	<ul style="list-style-type: none"> 11/08 <i>Done</i>
<i>Define Standards</i>	<ul style="list-style-type: none"> Eligibility standards Program standards Service delivery standards 	<ul style="list-style-type: none"> Tribal health organizations & LTC Committee 	<ul style="list-style-type: none"> 12/31/08 Initial standards drafted.
<i>Develop Tools</i>	<ul style="list-style-type: none"> Assessment Screening Care plans Business planning Standardized templates for operating, information dissemination & education 	<ul style="list-style-type: none"> Tribal health organizations, LTC committee, subcommittees for specific subject areas, technical experts as needed Collaborate with State for approval of tools 	<ul style="list-style-type: none"> 6/30/09 Screening tool finalized 11/14/08
<i>Define Due Process System</i>	<ul style="list-style-type: none"> Guarantee patients rights Complaint process Appeal & fair hearing process 	<ul style="list-style-type: none"> State & tribal health organizations 	<ul style="list-style-type: none"> 6/30/09
<i>Define Intake, Advocacy, Referral Systems</i>	<ul style="list-style-type: none"> Collaborative efforts Outreach Education re: what is available & how to access 	<ul style="list-style-type: none"> Tribal health organizations, LTC Committee & other local providers, and State new Aging and Disability Resource Centers 	<ul style="list-style-type: none"> 6/30/09
<i>Develop Quality Assurance & Quality Control Program</i>	<ul style="list-style-type: none"> Technical assistance Monitoring Data collection process & analysis Evaluation & feedback 	<ul style="list-style-type: none"> State & tribal health organizations 	<ul style="list-style-type: none"> 6/30/09
<i>Define Legal Representation Requirements (Re: Clients)</i>	<ul style="list-style-type: none"> Power of Attorney Guardianship Conservators Freedom of choice 	<ul style="list-style-type: none"> State & tribal health organizations 	<ul style="list-style-type: none"> 6/30/09
<i>Define & Establish Workforce Development Plan</i>	<ul style="list-style-type: none"> Home Care Worker classification & description - define by Levels 1, 2, 3 - include: tasks, required skills & education & knowledge requirements, training needs & competency levels Research & define capacity needed Criminal history background check Training system - consider virtual, centralized, alternative delivery methods, feasible in rural areas Recruitment & retention plan 	<ul style="list-style-type: none"> Tribal health organizations & LTC Committee in collaboration with the State and the University of Alaska 	<ul style="list-style-type: none"> 6/30/09
<i>Review State & Federal Regulations & Statutes</i>	<ul style="list-style-type: none"> Identify pertinent rules & regulations and changes needed to implement the tribal LTC service delivery system Draft information re: waivers, etc. for legislature 	<ul style="list-style-type: none"> Tribal health organizations & LTC Committee in collaboration with the State 	<ul style="list-style-type: none"> 6/30/09

<i>Identify & Develop Financing</i>	<ul style="list-style-type: none"> Describe & establish financing for all HCB services Establish Medicaid financing 	<ul style="list-style-type: none"> Tribal health organizations & LTC Committee in collaboration with State (Myers & Stauffer rate study recommendations) 	<ul style="list-style-type: none"> 6/30/09
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Section 4: Action Plan for Short-Term HCB Service Expansion through Pilot Projects

The LTC Committee proposes a pilot project to allow continued provision of existing HCB services by the tribal health organizations currently delivering these services in rural and village Alaska, and support expansion of these services. These projects will not only support increased service delivery in the near term while the comprehensive system is being developed, but will demonstrate the ability of the ATHS to successfully implement these programs. As information is obtained through the pilot project and successful models and/or approaches to service delivery are determined, the eventual expansion of these services to other target populations can occur. A copy of the pilot project proposal is included as Appendix E.

Strategies	Description	Responsible Agency or Group	Timeline
<i>Improve Timeliness for Approvals</i>	<ul style="list-style-type: none"> Develop and implement a joint improvement plan that shortens the clients' wait time for service delivery, 	<ul style="list-style-type: none"> LTC HCB Pilot Project Subcommittee State of AK DHSS 	<ul style="list-style-type: none"> 6/30/09
<i>Cover Cost of Service Delivery</i>	<ul style="list-style-type: none"> Identify funding to support the additional cost of providing services in rural and village Alaska 	<ul style="list-style-type: none"> State of AK DHSS 	<ul style="list-style-type: none"> 6/30/09
<i>Provide Regional PCA Training</i>	<ul style="list-style-type: none"> Adapt curriculum and tests so that they are culturally appropriate and skills-based Schedule and organize training program Identify funding to support travel for trainees from the villages to the regional hub 	<ul style="list-style-type: none"> LTC HCB Pilot Project Subcommittee State of AK DHSS 	<ul style="list-style-type: none"> 6/30/09
<i>Improve Tribal Health Organization Billing Systems</i>	<ul style="list-style-type: none"> Develop performance measures Implement billing cycle review and improvement plan 	<ul style="list-style-type: none"> LTC HCB Pilot Project Subcommittee State of AK DHSS 	<ul style="list-style-type: none"> 6/30/09
<i>Develop Quality Assurance & Monitoring Program</i>	<ul style="list-style-type: none"> Describe QA and service monitoring standards Define data collection & analysis process Develop evaluation tools 	<ul style="list-style-type: none"> LTC HCB Pilot Project Subcommittee 	<ul style="list-style-type: none"> 6/30/09

Part IV: Facility-Based Service Development

This Facility-Based Service Development plan provides information and guidelines for tribal health organizations considering the addition of skilled nursing and/or assisted living as a new service line. It includes recommended facility type by level of community; estimated baseline needs for numbers of beds for nursing and assisted living homes by region; general information on the barriers to new facility development that may exist and some strategies for addressing them; and finally a specific action plan that presents a phased approach to long term care facility development in the Alaska Tribal Health System. Three new long term care facility projects were identified early in the Tribal Medicaid Reform Initiative as ready for planning based on community need and organizational readiness, and received special project funding for state fiscal year 2009. These Phase I projects, as well as a series of recently identified Phase II projects, are described in the final Section of this plan.

Section 1: Recommended Bed Capacity by Community Level & Region

In analyzing the need for facility capacity, the LTC Committee first considered the facility type needed by level of community. Recommendations regarding long term care facility availability by level of community had previously been defined specifically for assisted living. Those original recommendations were developed by the “Alaska Coming Home Program” in the Division of Senior and Disability Services, Alaska Department of Health & Social Services, in 2003 in consultation with numerous financing and advocacy organizations. The committee reviewed and accepted those recommendations for the tribal health system, and added recommendations for nursing homes and swing beds as presented in *Table 7*.

TABLE 7: Recommended LTC Facility Type Availability				
<i>Community Level</i>	<i>Population</i>	<i>Health Services</i>	<i>General Access</i>	<i>Recommended SNF & ALH Availability</i>
<i>Level I Village</i>	50 – 1,000	Community clinic with CHA or EMT	Limited air or marine highway access to a Level III or higher community; road access exceeds 60 miles	Home & community based services in lieu of facility based services
<i>Level II Subregional Center</i>	500 – 3,000	Community clinic with PA, NP, MD, or DO	Marine highway or daily air access to closest Level III or higher community; year round 60-minute or less road access	Assisted living in communities of 1,000 or greater if community resources can adequately support
<i>Level III Large Town or Regional Center</i>	2,000 – 10,000+	Community hospital and physicians	Daily airline service to Level II, IV, and V communities; air service to Level I communities in area; road & marine highway access all year (if on road or marine highway system)	Assisted living Swing beds Nursing home beds
<i>Level IV Small City</i>	10,000 – 100,000	Hospitals with 24-hr staffed ER & full continuum of care; multiple providers of health care & other services	Daily airline service to Level II, III, IV, & V communities; road or marine highway access all year	Assisted living Swing beds Nursing home beds
<i>Level V Urban Center</i>	100,000+	Some specialized medical and rehabilitation services for low incidence problems	Daily airline service to Level II, III, IV, and V communities; road or marine highway access all year.	Assisted living Administrative wait beds Nursing home beds

Next the committee considered current nursing home level of care needs of Alaska Natives and compared current need to current service availability as depicted in *Tables 8 & 9*. The 2004 base estimates presented in *Table 9* are based on population data from the 2005 report, "The LTC Needs of Alaska Native Elders." The projections for the year 2020 presented in *Table 9* are based on the Alaska Department of Labor estimates for 2008, in which they project a 77% increase in the Alaska Native population over the age of 65.

TABLE 8: Current Statewide Availability of Assisted Living and Nursing Homes		
Service Area	Current 2008 Total Assisted Living Beds*	Current 2008 Nursing Home Beds*
Kotzebue	20 (Tribal)	0
Norton Sound	0	15 (Tribal)
Yukon Kuskokwim Delta	0	0
Anchorage & Matanuska Susitna Borough	796 in small homes 165 Anchorage Pioneer Home 82 Horizon House 112 Marlow Manor	314 Anchorage
Barrow	7	0
Bristol Bay	15 Dillingham	0
Southeast	15 Petersburg 5 Wrangell 5 Juneau 48 Juneau Pioneer Home 75 Sitka Pioneer Home 48 Ketchikan Pioneer Home	15 Petersburg 14 Wrangell 49 Juneau 15 Sitka 29 Ketchikan
Fairbanks/Interior	75 Fairbanks in small homes 93 Fairbanks Pioneer Home 14 Tanana	90 Fairbanks
Kodiak	10	19
Kenai	19 Kenai in small homes 45 Soldotna in small homes 66 Homer (Friendship Terrace & small homes)	60 Soldotna 25 Homer 43 Seward
Valdez/Cordova	0	10 Cordova 10 Valdez
Totals	20 Tribal 1,695 Non-Tribal	15 Tribal 693 Non-Tribal

(Source: "LTC Needs of Alaska Native Elders, 2005" - *information non-tribal unless otherwise indicated)

TABLE 9: Estimate of Assisted Living & Nursing Home Need Statewide for Alaska Native Elders and Persons with Disabilities						
Service Area	2004 Base Assisted Living Need	2004 Base Nursing Home Need	2004 Base Total Bed Need	2020 Base Assisted Living Need	2020 Base Nursing Home Need	2020 Base Total Bed Need
Kotzebue	10	8	18	18	14	32
Norton Sound	15	11	26	27	20	47
Yukon/Kuskokwim	37	28	65	66	50	116
Anchorage/Mat-Su	35	29	64	59	52	111
Barrow	9	7	16	16	13	29
Bristol Bay	11	9	20	20	15	35
Southeast	38	30	68	67	53	120
Interior	26	20	46	46	35	81
Kodiak	5	4	9	9	7	16
Kenai	9	7	16	16	12	28
Valdez/Cordova	4	3	7	8	6	14
Aleutians	4	2	6	6	4	10
Total	203	158	361	358	281	639

(Source: 2008 Alaska Department of Labor estimates)

Methodology

More specific information regarding the demand for assisted living and nursing homes is presented in the tables in *Appendix C* of this document. The following methodology was used to develop those tables:

- The demand for assisted living was calculated by applying activities of daily living percentages that are used nationally to estimate the number of people with disability needs to the Alaska Native population as follows: 65 – 74 age group – 9.3% disabled; 75 - 84 age group – 25.9% disabled; 85+ age group – 34.9%. Of this total, a penetration rate of 15% was used, assuming that the remainder would receive care at home or in a nursing home. An additional 20% of beds were added to account for the population under age 65. ANMC discharge data indicates that there are a significant number of younger adults discharged to assisted living (2005 ANTHC report).
- The nursing home demand was estimated according to the current utilization rate for Alaska Native people, which is 1.92%, rounded down to 1.9% of the over 65 population. As with assisted living, an additional 20% of beds were added to account for the population under age 65.

It is important to note that the estimates presented here pertaining to facility-based service development are population based only, and do not consider in-state migration, discharge patterns, sub acute or other transitional care needs. Each tribal health organization will need to conduct a more thorough demand analysis for their population and service area, taking into consideration the desired package of services for both assisted living and nursing homes. These estimates are also based on the assumption of the consistent availability of home and community based services for Alaska Native elders and persons with disabilities, as outlined in the “Home & Community Based LTC Service Delivery Planning Tool” included in this document. If those services are not routinely available, more people would likely need nursing home and assisted living home care.

Section 2: Barriers to Facility Development and Sustainability

Financial Barriers

A number of financial barriers to facility development and sustainability will need to be overcome by tribal health organizations considering this new service line:

- Construction costs: The cost of construction for new nursing homes and assisted living facilities are not likely to be supportable by tribal health organizations, and the federal funding process for new tribal health facilities through the Indian Health Services can take many years (generally a decade or longer).
- Medicaid reimbursement: The current rate of reimbursement does not cover the cost of operating an assisted living facility, as the room and board related costs are not included.
- Variability of Medicare eligibility: Eligibility for Medicare is based on an individual's, or their spouse's, work history and payments to Social Security. Because of the lack of formal employment over their life time, some Alaska Native elders do not qualify for Medicare. Medicare pays for time limited nursing home stays that are transitional and rehabilitative in

nature. Medicare will also cover time limited home health services if registered nurse oversight is required and the services are therapeutic in nature.

- Long term care services are not historically funded by IHS: Tribal health organizations have a commitment to providing services for all Alaska Natives, not just those who are Medicaid eligible, however funding for this service for non-Medicaid beneficiaries is not included in IHS funding agreements.

A variety of solutions will be required to address the needs for financing construction costs, and for ensuring sustainability through appropriate reimbursement that covers operational costs.

- Tribal health organizations will need to work with a variety of statewide and community partners for construction financing. Capital construction grants will most likely be required for these projects.
- Medicaid rate setting cycles for nursing homes should be shortened to more adequately support nursing home operations.
- The methodology for determining assisted living home rates must be fixed to prevent pressure in the system that forces nursing home development where less costly assisted living is the preferred and more appropriate level of care.
- Tribal health organizations must be prepared to consider and answer some challenging policy questions, such as how they will include the service in their funding agreement with IHS, whether their new facility will accept non-IHS beneficiaries, will they require self-pay/cost-sharing, will they impose a limit on non-reimbursable days, and how will they pay for non-reimbursable residents.

Regulatory Barriers

Potential regulatory barriers to facility development and operations include:

- Certain state Medicaid regulations and policies, such as those regarding assessments and in-person reviews by an individual not part of the provider agency, will be problematic for assisted living projects.
- Coordination of State licensure regulations and policies, such as those regarding environmental and fire safety inspections, could pose problems for facility projects in rural areas.
- Criminal history background check regulations and policies are complicated and require research to determine the best way to apply the rules so as to not prevent workforce development, while at the same time ensuring safety of residents and workers and protecting individual rights.

Overcoming regulatory barriers will require thorough review of applicable state reimbursement and licensure laws and regulations, and technical assistance with application of the rules from state agencies. For example, AHS Phase I planning has included technical assistance sessions between tribal health organization project staff and DHSS Certification and Licensing, Certificate of Need, and Office of Rate Review staff. The process has been mutually beneficial in learning about requirements, procedures and timing, and informing state staff about the AHS facility planning efforts.

Certain regulations have been identified which require advocacy for change to alleviate an undue burden placed on providers, such as the criminal history background check and barrier crimes regulations. A plan for conducting a legal analysis and identifying specific changes required for these regulations is identified in the comprehensive action plan in Part III, Section 3 of this report.

Workforce Barriers

There is general difficulty with workforce recruitment and retention in the long term care industry, which will be compounded in rural areas of Alaska. Tribal health organizations developing long term care facilities will face the same workforce challenges as described in the Home and Community Based Services part of this report (Part II, Section 4.B).

The need for a workforce development plan is identified and included in the timeline of the comprehensive action plan in Part III, Section 3 of this report. The workforce development plan will include identification of positions and qualifications needed, assessment of the availability of in-state training from a variety of sources and modalities (Tribal, University and private; in-person and audio/web-based), and recommended recruitment and retention strategies. In addition, organizations' individual business planning efforts for facility development must include a facility-specific plan for workforce development based on the strengths, challenges and resources of the community and region.

Organizational Capacity Barriers

Tribal health organizations must have sufficient capacity within their organization to meet the challenge of adding a new service line and building and operating a new care facility, including:

- Executive leadership support, with an understanding of and commitment to the time required for themselves and their senior managers, project planners, and program staff to ensure the success of the new program.
- Sound revenue cycle operations, including systems for client enrollment, registration, documentation, billing for services, and cost accounting and reporting, in order to maximize reimbursement and ensure financial viability.
- Information technology systems that support the data collection and management requirements of the new program.
- Standardized policies and processes that will ensure the quality of care and provide measurable outcomes of successful service delivery.

Strategies for strengthening revenue cycle operations, meeting IT needs, and achieving other system and infrastructure improvements and administrative efficiencies are addressed through other components of the Tribal Medicaid Reform and additional AHTS initiatives. Financially sustainable facility projects will be an indicator of THO willingness to move forward with development. The AHTS LTC plan includes a process for building capacity of organizations through sharing of standardized policies and procedure manuals, technical assistance and mentoring. As facilities mature through the development process and procedures are created, information will be compiled and shared.

Section 3: Sustainable Business Planning Guidelines

Sound business planning is required to ensure the success and financial sustainability of a new long term care facility. Tribal health organizations are advised to utilize the guidelines outlined in the material for the Alaska Coming Home project developed in 2004, revised February 2008, which is available on the Alaska Housing Finance Corporation and DHSS Senior and Disabilities Services, Rural Long Term Care web sties. The following elements must be included in the business plan for each proposed facility development project:

- Project description
- Project site information
- Documentation of community and regional support
- Market analysis and needs assessment
- Architectural plans
- Capacity of lead development team and organization responsible
- Operational management and staffing plan
- Match and leverage contributions
- Development cost estimates
- Operational financial feasibility analysis
- Risk analysis

The tools available from the Alaska Coming Home project include a spreadsheet for determining financial feasibility for assisted living. In addition, business planning tools created by individual tribal health organizations involved in Phase I long term care facility project development (see Section 5) may be modified and utilized in other areas of the state.

Section 4: 18-Month Action Plan (January 2008 – June 2009)

Planning for development of new tribal long term care facilities began system wide within the ATHS at the Tribal Medicaid Reform Summit in January 2008. Following is the action plan that begins with the identification of Phase I projects at the Summit, and continues through the life of the SB 61-funded project (June 2009).

Action Item	Lead Organization(s)	Timeframe
<i>Phase I Facility Projects identified</i>	Association of Tribal Health Directors	By 01/31/08 done
<i>SFY 09 Capital project funding requests for Phase I submitted to State DHSS and Legislature</i>	ANTHC, YKHC, NSHC, Maniilaq	By 02/15/08 done
<i>Statewide Tribal Long Term Care Facility Plan developed</i>	ANTHC	By 11/30/08 done
<i>Phase II Facility Projects identified</i>	ATHS	By 11/30/08 done
<i>Develop planning tool for tribal health organizations to guide decisions regarding level and model of facility-based care that is the best fit for their community(ies)</i>	ANTHC Incorporate Alaska Coming Home materials	By 11/30/08 done
<i>SFY 10 Capital project funding requests for Phase I submitted to State DHSS and Legislature</i>	ATHS	By 12/31/08 done
<i>Facility business planning for Phase I Projects</i>	ANTHC, YKHC, Maniilaq	By 1/31/09
<i>Tribal long term care facility workforce development planning</i>	ATHD Long Term Care Committee	By 06/30/09

Section 5: Phase I & Phase II ATHS Long Term Care Facility Projects

Phase I

The Tribal Health Directors identified the Phase I projects at their February 2008 meeting. These projects were identified based both on known need, and organizational readiness. Capital funding was requested from the state legislature to support the first year of Phase I development. The following projects received funding appropriated by the legislature for the state 2009 fiscal year (beginning July 2008):

- *Kotzebue – 18 Bed Nursing Home:* The Maniilaq Association received \$7 million to support roughly half the estimated construction cost for building an 18-bed skilled nursing facility wing onto the existing hospital in Kotzebue.
- *Bethel – 18 Bed Nursing Home and/or Assisted Living Facility:* The Yukon Kuskokwim Health Corporation received \$8 million to support roughly half the estimated construction cost for building a stand-alone nursing home or assisted living facility in Bethel. The exact bed-type mix will be determined based on business plans under development by the corporation.¹
- *Anchorage – 100 Bed Nursing Home and Assisted Living Complex:* The Alaska Native Tribal Health Consortium received \$7.5 million to support planning for a 100 bed nursing home and assisted living complex in Anchorage.

A fourth project, \$250,000 for Norton Sound Health Corporation to incorporate planning for an 18-bed skilled nursing facility wing into planning for the new hospital in Nome, was requested under the Phase I development plan but was not funded.

As of the publication of this report, projects funded for Bethel and Anchorage are completing business plans, and the Kotzebue project has completed business and construction plans and is ready to award a construction contract pending completion of the construction financing package. All three projects have requested additional state funding for the 2010 state fiscal year. Funding for the Nome project has also been requested for 2010. In addition, federal funds have been requested through the economic stimulus package opportunity, and business planning efforts are evaluating the possibility of debt funding for supporting a portion of construction costs.

Phase II

Projects for Phase II for ATHS long term care facility development focus on regional and community planning for assisted living facilities, and have been identified by individual tribal health organizations based on need and organizational readiness.

- *Prince of Wales Island Assisted Living Facility Planning:* The Southeast Alaska Regional Health Corporation has requested \$150,000 for project planning for a 6 to 10 bed Green House style assisted living home in Klawock, Alaska for the residents of Prince of Wales Island.

¹ YKHC, ANTHC and APIA are considering the Green House model of long term care facility. A brief description of this model is included as Appendix D.

- Upper Tanana Assisted Living Community Planning: Tanana Chiefs Conference has requested \$50,000 for community planning for a 6 to 10 bed Green House style assisted living home in Northway, Alaska for the residents of the Upper Tanana Subregion.
- Aleutian Region/Anchorage Assisted Living Facility Planning: The Aleutian/Pribilof Islands Association has requested \$150,000 for project planning for a 6 to 10 bed Green House style assisted living home located in Anchorage for the residents of the Aleutian Region.

Appendix A

Definitions

1. *ADL – Activities of Daily Living:* The activities of daily living is the measure of the functional status most frequently used in determining an individual's need for long term care services. The six primary ADL are bathing, dressing, grooming, eating, moving around and toileting. Increasing disability can affect an individual's ability to perform these tasks independently.
2. *Administrative Wait Beds:* Beds designated by a hospital for use as nursing home beds when needed are called administrative wait beds. These beds do not have to meet complex federal admission requirements and reporting standards in order to bill Medicaid for those services. This type of bed exists solely in Alaska.
3. *ANTHC – Alaska Native Tribal Health Consortium:* ANTHC is part of the Alaska Tribal Health System, a network of tribes linked by common goals and objectives. ANTHC provides specialty medical care, community health services, construction of clean-water and sanitation facilities, information technology, training and educational support, and a host of other health services. ANTHC is the largest and most comprehensive tribal health organization in the country. ANTHC was formed in December 1997 to manage statewide health services for Alaska Natives. All Alaska Natives, through their tribal governments and through their regional nonprofit organizations, own the Consortium. ANTHC employs approximately 1,800 people and has an operating budget of more than \$300 million.
4. *ATHS – Alaska Tribal Health System:* A voluntary affiliation of over 30 Alaskan tribes and tribal organizations providing health services to Alaska Natives and American Indians. Each tribe or tribal health organization serves a specific geographical area. The entire Alaska Tribal Health System serves approximately 130,000 Alaska Natives.
5. *CHA/P – Community Health Aide/Practitioner Program:* This program of the Alaska Tribal Health System trains and manages paraprofessional workers, known as Community Health Aides and Community Health Practitioners, to provide primary health care in rural Alaska villages. There are approximately 176 Community Health Aide Clinics across rural Alaska employing over 500 Community Health Aide Practitioners.
6. *CON - Certificate of Need:* The Certificate of Need is a certification and licensing standards process within the Department of Health and Social Services that regulates the development of new nursing home beds in Alaska and throughout the nation.
7. *CMS - Center for Medicare & Medicaid Services:* The federal agency with a mandate to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries.
8. *DHSS – State of Alaska, Department of Health and Social Services:* This is the State department that manages and oversees all health and social services in the state, including long term care.
9. *DOL - State of Alaska, Department of Labor:* The State department that manages, regulates and oversees all issues pertaining to employment, including wage and hour laws, employment security, etc.

10. *DSDS - State of Alaska, Division of Senior and Disability Services*: This State agency regulates and manages services for the aging population, adults with physical disabilities, and persons with developmental disabilities. The Medicaid waivers are managed by this agency.
11. *FMAP - Federal Medical Assistance Percentage*: The Federal Government pays a share of the medical assistance expenditures under each state's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. The current FMAP for Alaska is 50%. The FMAP for services provided by the IHS and 638 Tribal organizations is 100%; the facility from which services are provided must be included on the facility list compiled by the IHS.
12. *HCBS - Home and Community Based Services*: Services provided in a person's home or in a community facility. Types of services include respite care, environmental modifications, adult day care, transportation, specialized medical equipment, chore services, assisted living, private duty nursing and congregate or home-delivered meals.
13. *Home Health*: Home health is a federally controlled Medicare and Medicaid service that provides skilled nursing and therapy services to eligible individuals at home. Home health agencies must be certified by the Section of Certification and Licensing in the Division of Public Health. Home health services are intended to be part-time or intermittent, and there are strict criteria for the service to be covered by Medicare and Medicaid.
14. *Hospice and Palliative Care*: Palliative care is the active total care of the body, mind and spirit of the patient and family. The purpose of palliative care is to prevent or lessen the severity of pain and other symptoms and to achieve the best quality of life for people dying or suffering from a long-term disease. Comfort is the goal of palliative care. Comfort is also the goal for those patients still receiving potentially curative therapy. Hospice is a program that delivers palliative care to people who are dying and need treatment to prevent or manage pain and other symptoms even when cure is no longer possible. Hospice programs can be certified to bill Medicare, or provide services on a volunteer basis.
15. *IADL – Instrumental Activities of Daily Living*: : The instrumental activities of daily living is a secondary measure of the functional status most frequently used in determining an individual's need for long term care services. Being unable to do these tasks may compromise an individual's ability to live independently. IADL includes the ancillary activities, such as housekeeping, meal preparation, shopping, using the telephone and managing money and medications.
16. *IHS – Indian Health Service*: The Indian Health Service is the federal government agency that manages and oversees all health care services and programs serving Alaska Natives and American Indians.
17. *LTC – Long Term Care*: Long term care refers to the provision of services, including health care, personal care, social services and economic assistance, delivered over a sustained period of time in a variety of settings, ranging from a client's own home to institutional settings, to ensure quality of life and maximum independence.

18. *Medicaid*: A federal and State financed program that provides health care coverage for eligible children, families, disabled adults, the elderly and pregnant women. Medicaid eligibility is based on financial need, and both income and assets are considered in determining eligibility (except for pregnant women and children who have no asset standard). Regular Medicaid is the primary payment source for nursing home care and home and community based services in Alaska and the lower 48. Medicaid also pays for in home personal care services.
19. *Medicaid Waivers*: Instituted in Alaska in 1995, Medicaid Waivers (Project CHOICE) provide people who are eligible for nursing home admission services in their home or another less restrictive community setting such as an assisted living home. To be eligible a person must meet the financial eligibility guidelines from the State Division of Public Assistance and meet nursing home level of care.
20. *Medicare*: Medicare is a federally-funded health insurance program available to U.S. citizens age 65 and older and certain disabled people. Medicare pays for very limited long term care services. Eligibility for Medicare is based on an individual's or their spouse's work history and payments to Social Security. Because of the lack of formal employment over their life time, some Alaska Native elders do not qualify for Medicare. Medicare pays for time limited nursing home stays that are transitional and rehabilitative in nature; and it will pay for limited home health services if there is registered nurse oversight and the services are therapeutic in nature.
21. *Nursing Home*: Skilled care facilities operated independently or collocated with a hospital. Nursing homes are licensed by the State following national certification and licensing standards. The Certificate of Need (CON) process within the Department of Health and Social Services regulates the development of new nursing home beds in Alaska.
22. *OA - Older Alaskans Waiver*: One of the Medicaid waivers that allows people who are eligible for nursing home admission to receive services in their home or another, less restrictive, community setting such as an assisted living home.
23. *OAA - Older Americans Act*: The federal act regulating funding for nutrition, transportation and supportive services to seniors. Funds from Title III of the OAA pass through the State Department of Health & Social Services to non-profit agencies and governments around the state to provide these services. Title VI is grants to Indian Tribes for similar services. Funding for Title VI flows directly from the federal government to Tribes. Services are typically congregate and home delivered meals, transportation and information and referral.
24. *PACE - Program for the All-Inclusive Care for the Elderly*: PACE is a planned approach to chronic care that serves individuals 55 and over who meet nursing home level of care. It is a risk-based, capitated, managed care program that includes all medical and supportive services, including nursing home, hospital care, case management and personal care in the home. PACE is reimbursable through both Medicaid and Medicare and requires sponsoring organizations to take full financial risk for all the care needs of their clients. There are no PACE programs in Alaska currently.
25. *PCA - Personal Care Assistance*: A Medicaid program where personal care assistants assist clients with the activities of daily living. There are two types of personal care programs in Alaska. The agency based program, in which a registered nurse oversees the services and the personal care assistants; and the consumer directed program, where the

consumer takes a more direct role in training and supervising their assistant, and an agency acts as a fiscal agent to bill for services and issue payroll.

26. *Swing Beds*: Rural hospitals with less than 100 beds that are more than 50 miles from a skilled nursing home and are Medicare and Medicaid certified may apply to operate swing beds. These beds allow for the provision of nursing home care in empty hospital beds in rural areas.

Appendix B

ATHS Long Term Care Committee Charter & Membership Roster

ALASKA TRIBAL HEALTH DIRECTORS LONG TERM CARE COMMITTEE CHARTER

February 11, 2008

I. Vision

Alaska Native elders and those with disabilities have access to the long term care services necessary to keep them as close to home as possible, as healthy and safe as possible, and that affords them as much independence as possible.

II. Purpose

To create a system which provides the full continuum of long term care services at the appropriate level of care in each community across the state.

III. Objectives

Strengthen the Alaska Tribal Health System's capacity to meet the long term care needs of elders and persons with disabilities by 1) ongoing identification of service development and delivery issues, 2) partnering with stakeholders to develop and implement improvement strategies, and 3) advocating for an effective long term care system.

IV. Guiding Principles

- All elders and persons with disabilities deserve access to the full range of long term care services within their home region.
- All elders and persons with disabilities deserve to be served by an appropriately trained, culturally competent and compassionate workforce.
- All elders and persons with disabilities deserve access to services that are delivered in their community by local service providers to help them stay in their own homes and/or communities as long as possible.
- All elders and persons with disabilities, and their families, deserve to know which services could help them and where they could receive those services.
- All elders and persons with disabilities have the right to choose their own care and to be actively involved in the development of their service plan.
- All elders and persons with disabilities deserve to be served by a tribal health organization that takes a customer-centered approach to long term care service development.
- All elders and persons with disabilities deserve to be served by a tribal health organization that delivers services that are financially feasible and sustainable over time.

V. Definition

Long term care is the care of an elder or individual with a disability who requires on-going assistance with daily living activities such as bathing, dressing, eating, shopping & cooking. Long term care services support elders and their families with medical, personal, and social services delivered in a variety of settings, ranging from a person's own home to institutional settings, to ensure quality of life, maximum independence and dignity.

VI. Membership

There will be one primary representative from each of the tribal health organizations; other or alternate members may also attend meetings.

VII. Process

- The committee will select a chair and co-chair
- The group will meet regularly (approximately once per month) by teleconference
- In-person meetings will be planned when needed and as resources allow.

- All primary representatives will participate on an equal basis
- Meetings will be organized and staffed by the Alaska Native Tribal Health Consortium
- Advance notice and materials will be provided for all meetings

VIII. Meeting Ground Rules

- Be willing to support our vision and purpose.
- Listen actively and respectfully, and acknowledge whatever is being communicated as true for the speaker at that moment. Active listening guidelines:
 - No interrupting
 - No side conversations
 - Cell phones on mute or vibrate
 - Focus on the speaker
 - Encourage active participation of all present
 - Do not criticize or make judgments of the speaker
- Always tell your truth with compassion for others

**Alaska Tribal Health Directors
Long Term Care Committee**

Committee Membership Roster

Updated: 09-25-08

Tribal Health Organization	Official Representative
Alaska Native Tribal Health Consortium	Kay Branch
Aleutian Pribilof Islands Association	Paul Allis
Arctic Slope Native Association	
Council of Athabascan Tribal Gov'ts	
Bristol Bay Area Health Corporation	Rose Heyano
Chugachmiut	Taren Klingler
Copper River Native Association	Crystal Talyat
Eastern Aleutian Tribes	Katherine Cart
Native Village of Eklutna	
Native Village of Eyak	Joan Domnick
Karluck IRA Tribal Council	
Kenaitze Indian Tribe, IRA	Jaylene Peterson-Nyren
Ketchikan Indian community	Sue Pickrell
Kodiak Area Native Association	Mary Hogan-Rijos
Maniilaq Association	Kellie Haas
Metlakatla Indian Community	Opal Hudson
Mt. Sanford Tribal Council	Wilson Justin
Ninilchik Village Traditional Council	
Norton Sound Health Corporation	Angela Gorn
Seldovia Village Tribe	
SE Alaska Regional Health Corporation	Nancy Jo Bleier
Southcentral Foundation	Kim Thorp
Tanana Chiefs Conference	Cyndi Nation
Native Village of Tyonek	
Valdez Native Tribe	
Yukon Kuskokwim Health Corporation	Liz Lee*

Additional Committee Participants

Alaska Native Tribal Health Consortium

Aleutian Pribilof Islands Association

Bristol Bay Area Health Corporation

Bristol Bay Native Association

Kenaitze Indian Tribe, IRA

Maniilaq Association

Norton Sound Health Corporation

SE Alaska Regional Health Corporation

Southcentral Foundation

Tanana Chiefs Conference

Yukon Kuskokwim Health Corporation

*** Committee Chairperson**

Valerie Davidson, Garvin Federenko, Charles Fagerstrom, Tim Gilbert, Gwen Obermiller, Susan Cook, Paul Sherry, Deb Erickson

Carolyn Crowder, Michelle Klass, Renee Kochuten, Tina Woods, Diana Mack (Gundersen)

Robert Clark, Sue Mulkeit, Bob Swope

Carolyn Smith

Dave Segura

Paul Hansen, Mary Shaeffer, Kevin Smalley

Nat Palaniappan

Frank Sutton, Patricia Atkinson, Sara Beaber-Fjioka, Norma Perkins

Doug Eby, Fred Kopacz, Dave Morgan, Chris Bragg

Lisa Donat, Victor Joseph

Tommy Tompkins, Fran Buckley, Nancy Weller

Appendix C

Tables: Projected HCB Service Needs by Region

The following 13 tables present projections of the number of Alaska Native people in need of home and community based services beginning in 2004 and projected to 2020. The estimates were calculated by applying nationally accepted activities of daily living percentages to determine the number of people with disability needs to the Alaska Native population as follows: 65–74 age group = 9.3% disabled; 75 - 84 age group = 25.9% disabled; 85+ age group = 34.9%. An additional 20% of this total was added to account for the under 65 population who would likely be eligible for an Adults with Physical Disabilities Waiver or Personal Care Services. From this total, the number of people predicted to be in a nursing or assisted living home was subtracted, resulting in the total estimate needing home and community based services. It is important to note that these estimates are based solely on population figures, and there have been changes in population between 2004 and today. However, current information on population by ethnicity, age group and region are not available. These figures also do not consider any in-state migration patterns.

1. Anchorage Service Unit			
Age	Total #	% at risk	Demand
65-74	735	9.3%	68
75-84	272	25.9%	70
85+	47	34.9%	16
<i>Total</i>	<i>1,054</i>		<i>155</i>
20% of total for under 65			31
Total disability estimate			186
less assisted living demand			29
less nursing home demand			24
<i>Total HCB need 2004</i>			<i>133</i>
2020 plus 77% pop growth			275
20% of total for under 65			55
Total disability estimate			330
less assisted living demand			51
less nursing home demand			43
<i>Total HCB need 2020</i>			<i>236</i>

2. Barrow Service Area			
Age	Total #	% at risk	Demand
65-74	215	9.3%	20
75-84	88	25.9%	23
85+	23	34.9%	8
<i>Total</i>	<i>326</i>		<i>51</i>
20% of total for under 65			10
Total disability estimate			61
less assisted living demand			9
less nursing home demand			7
<i>Total HCB need 2004</i>			<i>45</i>
2020 plus 77% pop growth			90
20% of total for under 65			18
Total disability estimate			108
less assisted living demand			16
less nursing home demand			13
<i>Total HCB need 2020</i>			<i>79</i>

3. Kotzebue Service Area			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	223	9.3%	21
75-84	110	25.9%	28
85+	23	34.9%	8
<i>Total</i>	<i>356</i>		<i>57</i>
20% of total for under 65			20
Total disability estimate			78
less assisted living demand			10
less nursing home demand			8
<i>Total HCB need 2004</i>			<i>60</i>
2020 plus 77% pop growth			101
20% of total for under 65			20
Total disability estimate			122
less assisted living demand			18
less nursing home demand			14
<i>Total HCB need 2020</i>			<i>90</i>

4. Norton Sound Service Area			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	292	9.3%	27
75-84	147	25.9%	38
85+	55	34.9%	19
<i>Total</i>	<i>494</i>		<i>84</i>
20% of total for under 65			17
Total disability estimate			101
less assisted living demand			15
less nursing home demand			11
<i>Total HCB need 2004</i>			<i>75</i>
2020 plus 77% pop growth			149
20% of total for under 65			30
Total disability estimate			179
less assisted living demand			27
less nursing home demand			20
<i>Total HCB need 2020</i>			<i>132</i>

5. Yukon Kuskokwim Delta			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	757	9.3%	70
75-84	361	25.9%	93
85+	126	34.9%	44
<i>Total</i>	<i>1,244</i>		<i>208</i>
20% of total for under 65			42
Total disability estimate			249
less assisted living demand			37
less nursing home demand			28
<i>Total HCB need 2004</i>			<i>184</i>
2020 plus 77% pop growth			368
20% of total for under 65			74
Total disability estimate			442
less assisted living demand			66
less nursing home demand			50
<i>Total HCB need 2020</i>			<i>326</i>

6. Bristol Bay Service Area			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	237	9.3%	22
75-84	111	25.9%	29
85+	30	34.9%	10
<i>Total</i>	<i>378</i>		<i>61</i>
20% of total for under 65			12
Total disability estimate			74
less assisted living demand			11
less nursing home demand			9
<i>Total HCB need 2004</i>			<i>54</i>
2020 plus 77% pop growth			108
20% of total for under 65			22
Total disability estimate			130
less assisted living demand			20
less nursing home demand			15
<i>Total HCB need 2020</i>			<i>95</i>

7. Rural Service Unit - Aleutians			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	80	9.3%	7
75-84	36	25.9%	9
85+	8	34.9%	3
<i>Total</i>	<i>124</i>		<i>20</i>
20% of total for under 65			4
Total disability estimate			23
less assisted living demand			4
less nursing home demand			2
<i>Total HCB need 2004</i>			<i>17</i>
2020 plus 77% pop growth			35
20% of total for under 65			7
Total disability estimate			42
less assisted living demand			6
less nursing home demand			4
<i>Total HCB need 2020</i>			<i>32</i>

8. Rural Service Unit - Kodiak			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	110	9.3%	10
75-84	40	25.9%	10
85+	26	34.9%	9
<i>Total</i>	<i>176</i>		<i>30</i>
20% of total for under 65			6
Total disability estimate			36
less assisted living demand			5
less nursing home demand			4
<i>Total HCB need 2004</i>			<i>27</i>
2020 plus 77% pop growth			53
20% of total for under 65			11
Total disability estimate			64
less assisted living demand			9
less nursing home demand			7
<i>Total HCB need 2020</i>			<i>48</i>

9. Anchorage Service Unit - Mat-Su			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	156	9.3%	15
75-84	57	25.9%	15
85+	10	34.9%	3
<i>Total</i>	<i>223</i>		<i>33</i>
20% of total for under 65			7
Total disability estimate			39
less assisted living demand			6
less nursing home demand			5
<i>Total HCB need 2004</i>			<i>28</i>
2020 plus 77% pop growth			58
20% of total for under 65			12
Total disability estimate			70
less assisted living demand			10
less nursing home demand			9
<i>Total HCB need 2020</i>			<i>51</i>

10. Rural Service Unit - Kenai Peninsula			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	195	9.3%	18
75-84	87	25.9%	23
85+	26	34.9%	9
<i>Total</i>	<i>308</i>		<i>50</i>
20% of total for under 65			10
Total disability estimate			60
less assisted living demand			9
less nursing home demand			7
<i>Total HCB need 2004</i>			<i>44</i>
2020 plus 77% pop growth			88
20% of total for under 65			18
Total disability estimate			106
less assisted living demand			16
less nursing home demand			12
<i>Total HCB need 2020</i>			<i>78</i>

11. Rural Service Unit - Valdez & Cordova			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	83	9.3%	8
75-84	49	25.9%	13
85+	12	34.9%	4
<i>Total</i>	<i>144</i>		<i>25</i>
20% of total for under 65			5
Total disability estimate			30
less assisted living demand			4
less nursing home demand			3
<i>Total HCB need 2004</i>			<i>30</i>
2020 plus 77% pop growth			44
20% of total for under 65			9
Total disability estimate			52
less assisted living demand			8
less nursing home demand			6
<i>Total HCB need 2020</i>			<i>38</i>

12. Mt. Edgecumbe & Annette Island			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	828	9.3%	77
75-84	372	25.9%	96
85+	110	34.9%	38
<i>Total</i>	<i>1,310</i>		<i>212</i>
20% of total for under 65			42
Total disability estimate			254
less assisted living demand			38
less nursing home demand			2630
<i>Total HCB need 2004</i>			<i>186</i>
2020 plus 77% pop growth			375
20% of total for under 65			75
Total disability estimate			450
less assisted living demand			67
less nursing home demand			53
<i>Total HCB need 2020</i>			<i>330</i>

13. Interior Service Unit			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	533	9.3%	50
75-84	250	25.9%	65
85+	84	34.9%	29
<i>Total</i>	<i>867</i>		<i>144</i>
20% of total for under 65			29
Total disability estimate			172
less assisted living demand			26
less nursing home demand			20
<i>Total HCB need 2004</i>			<i>126</i>
2020 plus 77% pop growth			254
20% of total for under 65			51
Total disability estimate			305
less assisted living demand			46
less nursing home demand			35
<i>Total HCB need 2020</i>			<i>224</i>

Appendix D

Facility-Based Care Model

Green House Model of Nursing or Assisted Living Care

Green House is a model of care for facility-based long term care services that focuses on creating a home-like environment for residents. It represents a shift from the more traditional institutional, medical model of care, to a social model of care that fosters an atmosphere of greater autonomy, privacy and choice for residents.

The model features a series of 10-unit homes with a staffing plan that increases the responsibilities of the direct care provider, and utilizes a clinical support team from a larger institution who visit the home at regular weekly intervals, providing nursing, physical and occupational therapy and other clinical services.

Basic Components:

- Architecture—structurally independent houses for up to 10 residents to include private bedrooms with baths, open living and kitchen areas, large dining table for family-style meals, ceiling lifts in all bedrooms, and outdoor area.
- Organizational structure—self-managed work team of direct care providers assigned to each house. Clinical support team itinerant to home. Administrator oversees all self-managed work teams and clinical support teams.
- Philosophy—the Green House is the elders' home. It serves as a place where elders can receive assistance and support with activities of daily living and clinical care, without the assistance and care becoming the focus of their existence.

Other Considerations:

- Need an umbrella organization to provide clinical services. The umbrella organization can be a hospital, nursing home or home health agency.
- The goal is to decrease face time of clinical staff, but increase the quality of that time.
- Rigorous training for direct staff includes housekeeping, cooking and menu planning, house management skills, etc. 120 hours of training in addition to formal Certified Nursing Assistant or Personal Care Assistant training.
- Ongoing educational process is needed to maintain the philosophy (emphasize that this is not a medical model of care).

Appendix E

Tribal HCB Services Pilot Project Plan Alaska Native Tribal Health Consortium October 2008

Purpose of Pilot Project

Expand and maintain HCB Services currently offered by YKHC, TCC & Maniilaq to demonstrate the tribal health system's ability to:

- Improve the quality and access to HCB services for clients in rural areas and to provide such services in a timely and effective manner in compliance with State rules and regulations
- Maintain and support the provision of HCB services to clients in rural areas to ensure the sustainability of tribal HCB programs

HCB services to be addressed by all 3 tribal health organizations in this pilot project:

- PCA
- Chore
- Respite
- Care Coordination

Pilot Project Timeline

The pilot project will be conducted over a period of two (2) to three (3) years - actual time period and start date to be determined.

Goals & Objectives

Goal #1: Improve access to services for clients in rural areas

A. Improve assessment process

1. Streamline and standardize client screening process
2. Simplify process for referring client to State for assessment
3. Use same process and tools for all HCB services (PCA and waiver)
4. Revise process so THOs evaluate the client to determine needs and initiate some basic transitional services while waiting for State assessor to complete the assessment and the plan of care (POC)
5. Identify specific State Assessor to consistently serve each THO (to develop relationship and standardize process in order to optimize learning from the pilot project)

B. Support THOs in managing and delivering HCB services

1. Approve use of revised intake/screening tool and process for referral of client to the State
2. Research sources for "start-up" funding to support the pilot project (identify specific costs to be covered by "start-up" funds, including training; determine total amount for each THO)
3. Research development of transitional services package to provide service while client waits for final POC approval
4. Develop system to identify where problems or breakdowns exist in current system (evaluation/process improvement cycle)

Goal #2: Increase capacity of THOs to sustain HCB programs in rural areas

- A. Develop THO infrastructure to develop capacity to determine actual cost of service delivery (cost reports)
- B. Improve the THO billing systems to ensure all services are billed and reimbursed
- C. Increase coordination between program and billing staff so all costs pertaining to services are identified and reimbursed

Goal #3: Improve the quality and increase size of the workforce in rural areas

- A. Make regional PCA and CNA training available in rural areas
 - 1. Look at what can be adapted in the interim to get more workers trained and continue to develop longer term solutions
- B. Develop and implement expedited process for training and/or certification of workers
 - 1. RNs or HC Director sign-off options
 - 2. Scale down curriculum and make pertinent to actual client needs in rural areas
 - 3. Recognize current skills, past training and education of worker
 - 4. Allow alternate testing methods - such as skills and competency-based testing
- C. Support THOs to manage and provide worker training
 - 1. Provide interim funding to THOs to expedite training in rural areas (amount of funding to be included in "start-up" cost to be determined)

Goal #4: Improve effectiveness and efficiencies in HCB service delivery in rural areas

- A. Develop quality assurance and monitoring system for THOs in coordination with State
- B. Develop necessary tracking system and tools

Desired Outcomes

- 1. A more timely and efficient assessment process used by THOs resulting in quicker service delivery of appropriate services to clients
 - o Decrease in time between client intake and service delivery
- 2. Improved capacity of THOs to support and sustain HCB services in their regions
 - o Decrease in time between service delivery and billing
 - o Improved capture rate (reimbursement)
 - o THO infrastructure capable of identifying the actual cost of the service
 - o Better tracking system for determining success and identifying problems or needed changes in the system
- 3. A workforce in each region made up of certified workers adequate in numbers to meet the need
 - o Increase of HCB staff resources available in each region
 - o Increase in the education and/or experience levels of workers in each region
- 4. A functioning quality assurance program within each THO
 - o Increased communication between THO and State re: quality issues
 - o A viable data collection and tracking system that will result in quality monitoring

Tracking System

The tracking of identified data elements for this pilot project is critical in being able to quantitatively measure the success of the pilot project; identify needed changes in process and/or approach; understand how the system is working to know where to intervene as problems arise; and provide feedback to the THOs and the State. It is proposed that there will be tracking systems to capture programmatic information and billing and reimbursement issues. It is understood that there must be a process whereby all of the data collected by those systems is analyzed together in order to be able to quantitatively measure the success. The process for doing such analysis is yet to be determined; however, it will undoubtedly require increased communication and coordination between program and billing staff in each THO.

The specific tools to be used to track the data have yet to be finalized; however, a preliminary list of potential data elements and ideas has been proposed, including:

- Identify where service commencement timeline decreases (or perhaps acuity of patients or breadth of services) due to greater availability of trained workforce
- Track dates for each of the steps in the referral process through the billing process
 - Time between patient referral date and initial screening
 - Time between intake/screening and request for assessment
 - Time between request to State for assessment and completion of assessment
 - Time between assessment and POC returned to THO
 - Time between POC approval and beginning of services - track two time categories for workers available and workers not available
- Track worker availability at time of interim assessment
- Track and collect time-in and time-out vs. time approved on POC - can give State & THOs ideas for acuity levels and potential service packages
- Identify what services are reimbursed, which are not reimbursed, and why
- Client log, including: date of referral, date of requested additional info, date of approval, date of service commencement, type of service delivery
- Identify clearly the direct costs and track reimbursement directly back to the program
Identify services provided but not presently included in the list of Medicaid covered services to show the need
- Identify the actual costs of each service – could use Myers & Stauffer template or modified FQHC template
- Billing system data elements - from referral to service delivery & referral to billing & reimbursement

Referral to Service Delivery Process & Timeline

Action Step		Timeframe
1	Client and/or family contacts THO to request help	Start tracking
2	THO conducts intake and screening of client	2 working days to complete
3	THO completes paperwork and refers client to the State for assessment	1 working day to complete
4	State puts client in system; State assessor travels to client, completes assessment, determines eligibility and produces a Plan of Care; State distributes POC to THO	2 weeks to complete all
5	THO begins service delivery to the client	3 days if worker is available; if worker not available document & track; services begin as soon as a worker is available
6	THO billing department submits the billing for the services	Specific process & timelines TBD
7	THO receives payment	Specific process & timelines TBD

Tribal Long Term Care Facility in Anchorage

The Alaska Native Tribal Health Consortium is seeking \$38.4 million in capital funds to build a 100-bed long term care facility in Anchorage. In 2009 ANTHC received \$7.5 million for long term care planning from the Alaska Legislature.

A market study and feasibility analysis show that the Anchorage facility will meet the needs of Alaska Native elders and people with disabling conditions who currently reside in the area. The facility will also help others who have received medical care in Anchorage, but need additional care before returning to their home communities. It is one of three initial projects identified in the State/Tribal Long Term Care recommendations to save State Medicaid general funds; facilities in Bethel and Kotzebue have been funded. ANTHC continues to work with tribal and state partners to increase the availability of home and community-based care in all regions of the state.

Need for nursing home beds in Anchorage:

- There are currently 314 nursing home beds in Anchorage.
- An additional 96 nursing home beds will be needed in the Anchorage/Mat Su area by 2015, and 194 beds by 2020, according to recent DHSS calculations.
- Plans to rebuild Providence Extended Care Center would result in a reduction of 90 nursing home beds in Anchorage at a time when the senior population and the expected need for nursing home care is increasing.



Savings to State Medicaid Budget:

\$6 – 7 million General Fund savings in State Medicaid costs each year

Total Project Cost:

\$45.9 million

FY2012 Capital Request:

\$38.4 million

Facts:

- Alaska has the fastest-growing senior population in the United States.
- The number of seniors in the Southcentral region has increased 60% in the last seven years.

Valerie Davidson,
Senior Director,
Legal & Intergovernmental Affairs
through Pat Jackson
(907) 523-0363
pajackson@anthc.org



Home Regions of Current Anchorage LTC Residents:

- Yukon-Kuskokwim - 40
- Southcentral - 57
- Kenai, Kodiak, Aleutians - 25
- Lower 48, American Indian/ Alaska Native - 18
- Norton Sound - 19
- Interior - 25
- Bristol Bay - 17
- Arctic Slope - 17
- Southeast - 13
- NW Arctic - 5
- Region unknown - 82
- Total - 318*

Sources: State General Relief Program, Anchorage nursing homes and care coordinators.

*175 of the 318 are nursing home level of care and the services are paid by Medicaid.

Related reports:

2006 - Lewin Group and ECONorthwest Report to DHSS

2007 - Pacific Health Policy Group report to Senate Finance Committee

2007 - SB 61 Medicaid Reform Initiative

2008 - SB 61 Medicaid Reform Initiative: Alaska Tribal Health System Tribal Long Term Care Service Development Plan (December 2008)

2010 - Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplemental 2009-2029

State General Fund Savings:

The creation of a tribal long-term care facility has significant implications for Alaska's Medicaid budget. Nearly 40% of Medicaid clients are Alaska Native and an equal amount of program expenditures are made on their behalf. Alaska Native people are more likely to utilize health care services provided by the tribal health care system if available. Medicaid services provided by tribal organizations to IHS beneficiaries receive full federal reimbursement providing an exceptional benefit to the state's Medicaid budget.

Serving Alaska Native people statewide:

- The primary market area for the facility is Anchorage and the Matanuska-Susitna Valley.
- Shifts in population are creating additional demand in Southcentral Alaska.
- While home and community based services are preferred, some people need specialized care and equipment in a nursing home setting.
- More than 300 Alaska Native people currently reside in Anchorage nursing and assisted living homes, 75% are from outside of Anchorage.

Facility Design:

ANTHC would like to use the latest model in nursing home care at the Anchorage campus - the GREEN HOUSE® model. The Green House model de-institutionalizes the nursing home by creating a community of small homes (10 – 12 individuals) where meaningful lives and relationships are supported with licensed nursing home services organized to allow true self-direction. The homes operate with specially trained direct care staff that provide a wide range of assistance.



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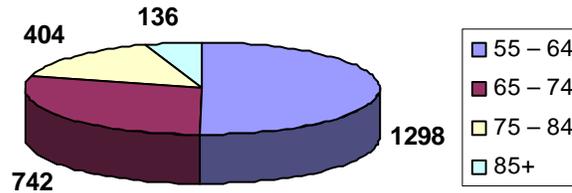
Yukon Kuskokwim Health Corporation

Regional Overview of Long Term Care Services

2009 Population Estimates¹

The over 65 Alaska Native population is expected to increase 75% by 2030.

55 – 64 =	1298
65 – 74 =	742
75 – 84 =	404
85 =	136
Total	2580



Estimated need for long term care services (based on 2009 and 2030 population numbers)²

- 2009 – 265 individuals with significant disability requiring either residential or home and community based long term care services.
- 2030 – 464 individuals will require this care.

Residential Long Term Care Services

- **Nursing Home:** None.
- **Assisted Living:** None. YKHC will be constructing an 18-unit assisted living home, which will open in FY13.

Home and Community Based (HCB) Long Term Care Services

- **Personal Care Assistant:** YKHC formerly had one of the most robust PCA programs in rural Alaska. Due to changes in state regulations and lack of sufficient reimbursement to meet costs, these services have declined. In FFY09 there were only 7,360 hours of PCA services provided throughout the region.
- **Care Coordination, Chore and Respite:** Care Coordination is somewhat available in the region, although there are few services to coordinate. Chore and respite for the over 21 eligible individuals has not been provided as a Medicaid service since FFY06.
- **Adult Day Services:** Adult day services are provided in the upper floor of the Chief Eddie Hoffman Senior Center. Services were initially operated by the City of Bethel, transferring to Orutsararmuit Native Council (ONC) in 2005.

Current Anchorage Facility Usage by Persons from Region³

Currently in Anchorage there are approximately 9 people from the region in nursing homes (3 additional in Seward) and 39 people in assisted living homes; 23 on a Medicaid waiver who meet nursing home level of care.

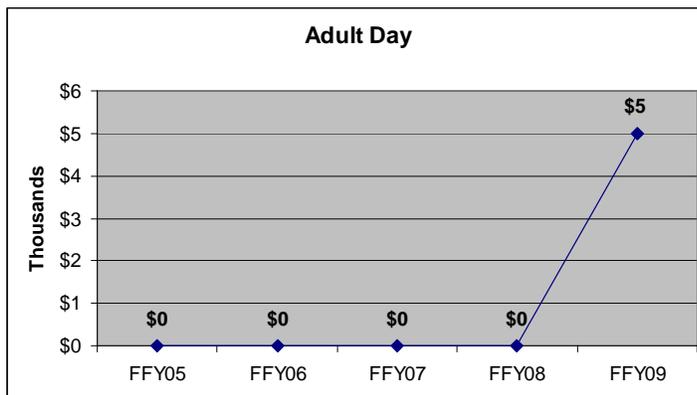
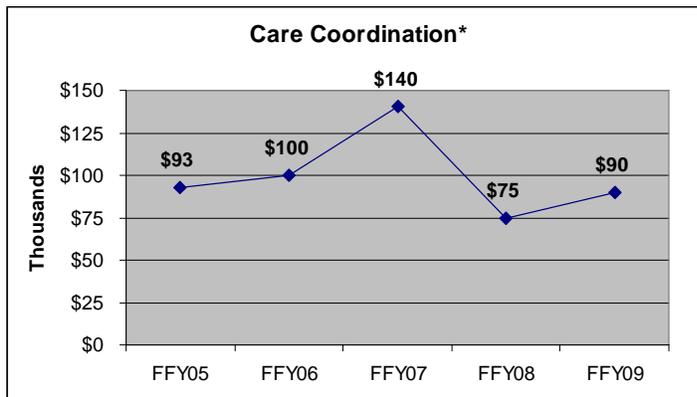
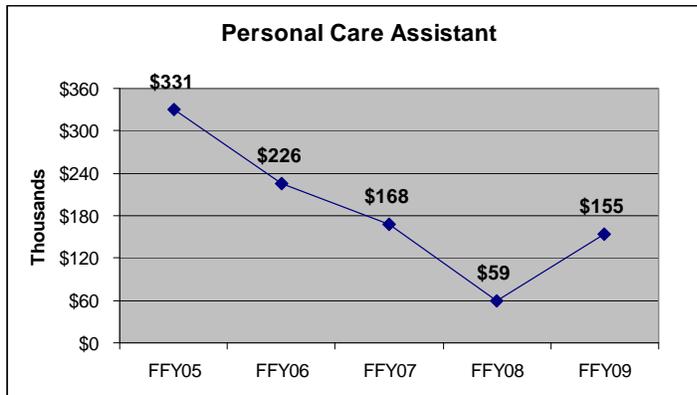
¹ State of Alaska, Dept of Labor, Research & Analysis Section Population Projections 2007 – 2030.

² Estimates of disability are based on a nationally used percentage of each age group, plus an estimated percentage to account for individuals under 65.

³ Figures are approximate based on information available from Providence Extended Care, Prestige Care, State of Alaska General Relief program, Southcentral Foundation and other Anchorage Care Coordinators. There may be additional people from the region who have not been identified.

Regional Medicaid Expenditures Over Five Years⁴

The following charts indicate the amount of Medicaid spent in the region for facility and HCB services for Alaska Native people⁵.



⁴ Tribal Medicaid Activity Report, FY05, FY06, FY07, FY08, FY09, State Department of Health & Social Services.

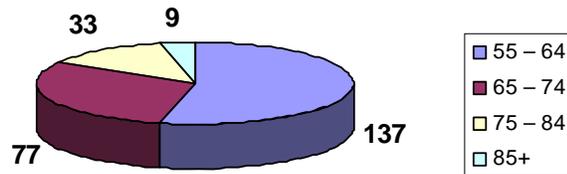
⁵ Includes services to individuals on Adults with Physical Disabilities and Older Alaskans waiver, individuals 21 years and older.

Aleutian Region Regional Overview of Long Term Care Services

2009 Population Estimates¹

The over 65 Alaska Native population is expected to increase 75% by 2030.

55 – 64 =	137
65 – 74 =	77
75 – 84 =	33
85+ =	9
Total	256



Estimated Need for Long Term Care Services (based on 2009 and 2030 population numbers)²

- 2009 – 23 individuals with significant disability requiring either residential or home and community based long term care services.
- 2030 – 40 individuals will require this care.

Residential Long Term Care Services in Region

- **Nursing Home:** None
- **Assisted Living:** None

Home and Community Based (HCB) Long Term Care Services

- Medicaid home and community based services are not widely available in this region.
- FFY09 shows a small amount of Care Coordination and about 2400 hours of PCA services.

Current Anchorage Facility Usage by Persons from Region³

Currently in Anchorage there are no individuals from the region in nursing homes and approximately 6 people in assisted living homes; all are on a Medicaid waiver meeting nursing home level of care.

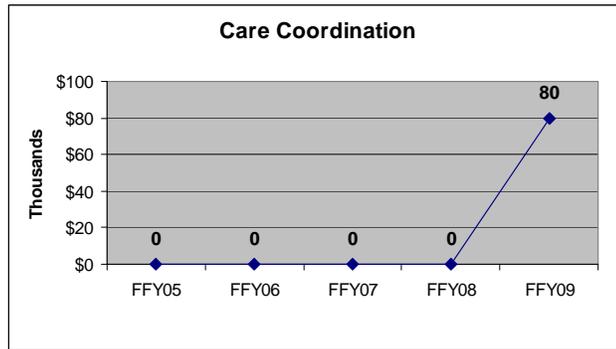
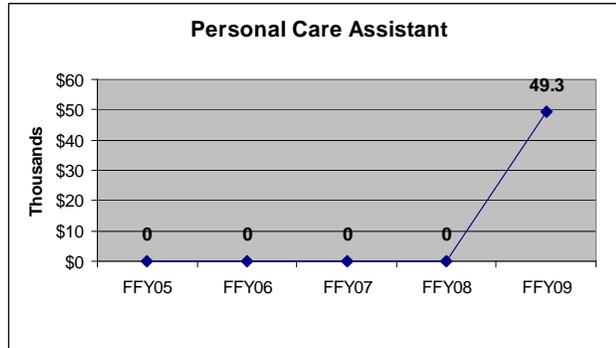
¹ State of Alaska, Dept of Labor, Research & Analysis Section Population Projections 2007 – 2030.

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Projected GF Reduction
Alaska Tribal Health System Long Term Care Plan
 February 2010

	<u>Maniiaq Assoc</u>	<u>YKHC</u>	<u>ANTHC</u>
Construction Capital Costs	\$17,805,373	\$12,202,585	\$43,310,905
Less FY 2009 Planning Funds Available			-\$6,200,000
FY 2011 Capital Funding Request			\$37,110,905
Number of Beds	18	18	100
Estimated Opening Assumption	2011	2011	2011
Yearly depreciation recognized using 17 year life (componentized)	\$1,047,374.88	\$717,799.12	\$2,547,700.29
Estimated Annual Occupancy (in Bed Days) ((# of Beds * 85% Occupancy) * 365 Days)	5,585	5,585	31,025
Estimated capital cost per day at 85% occupancy	\$187.55	\$128.53	\$82.12
Estimated daily rate for each facility (current regulations) (2011 Non-Capital Component + facilities capital)	\$613.29	\$554.27	\$507.86

	2008	2009	2010	2011
Medicaid Average Statewide Nursing Facility Rate				
Capital Component	\$37.14	\$39.72	\$40.59	\$41.00
Non-Capital Component	\$359.67	\$395.92	\$413.34	\$425.74
Total	\$396.81	\$435.64	\$453.93	\$466.74
Inflation Factor Forecast				
Skilled Nursing Facility Capital *				1.0%
Hospital Prospective Market Basket **				3.0%

Estimate Annual Medicaid Payments to Tribal Facility (100% Tribal) **\$3,424,921.03** **\$3,095,345.26** **\$15,756,290.00**

Scenario if Tribal Facilities Are Not Built:
GF Cost of Natives entering non-Tribal facilities (50% FMAP) **\$1,303,243.88** **\$1,303,243.88** **\$7,240,243.75**
*(Statewide Rate in 2011 * Estimated Annual Occupancy @ 85%)*

Net Annual GF Reduction from Building at Percent of Native Occupancy			
99.0%	\$1,286,119.27	\$1,287,767.15	\$7,161,462.30
95.0%	\$1,217,620.85	\$1,225,860.24	\$6,846,336.50
90.0%	\$1,131,997.82	\$1,148,476.61	\$6,452,429.25
85.0%	\$1,046,374.80	\$1,071,092.98	\$6,058,522.00

Net Impact is the "GF Cost If Tribal Facilities Are Not Built" minus the estimated non-Native occupancy at the Tribal facility.

Facility Capital Construction Cost Estimates

Construction costs have been updated with information supplied by providers to Office of Rate Review as of 2009.

Assumptions:

- * 50% FMAP (federal medical assistance percentage)
- * 85% total (all races) occupancy rate. This is an annual estimate. Facilities do not usually open or achieve full occupancy in first year of operation
- * All clients are Medicaid eligible.
- * Based on Current State Medicaid Regulations
- * Based on the Lewin Report's estimate of the increasing 65 and older population; there is no impact projected on the balance of the LTC beds in the state based on this tribal health system plan.

These calculations do not take into account the impact of removing approximately 115 native patients from the current system, the impact on Medicaid LTC rates, or its effect on access to care.

Inflation Factor Data Source

Source: Global Insights 3rd Quarter 2009

* SNF Calendar Year 2004=1 Page 59

** 1992 Based CMS Nursing Home Without Capital Market Basket Page 64

Projected GF Reduction
Alaska Tribal Health System Long Term Care Plan
February 2010

17 years depreciation
85% occupancy

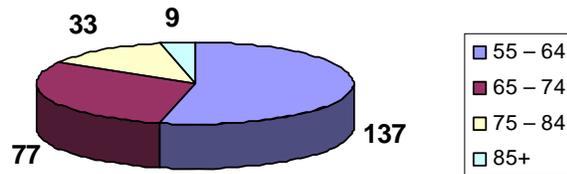
Current Medicaid Rate Setting Regulations for a new facility adjust the capital costs of the statewide average rate for the new facility's capital costs: recognizes 85% of the facilities capital costs with an average 17 year depreciation life of the assets assuming an 85% occupancy rate for the year.

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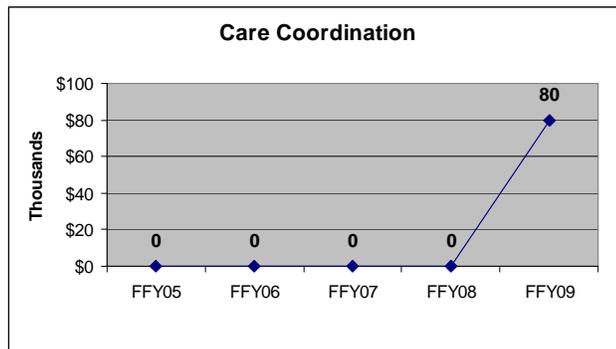
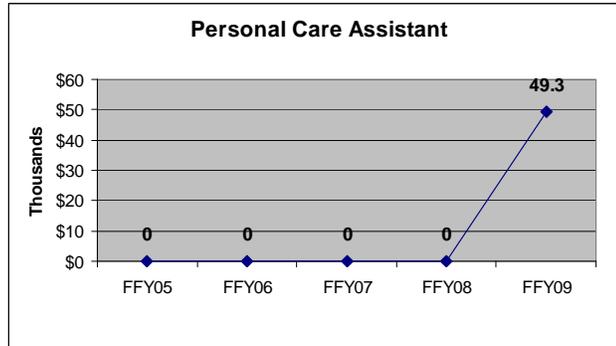
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Alaska Native Tribal Health Consortium

Administration • 4000 Ambassador Drive • Anchorage, Alaska 99508 • Phone: (907) 729-1900 • Fax: (907) 729-1901 • www.anthc.org

February 1, 2011

Senator Bert Stedman, Co-Chair
Senator Lyman Hoffman, Co-Chair
Senate Finance Committee
State Capitol
Juneau, Alaska 99801

Representative Bill Stoltze, Co-Chair
Representative Bill Thomas, Co-Chair
House Finance Committee
State Capitol
Juneau, Alaska 99801

RE: ANTHC Long Term Care Facility
Capital Funding Request

Dear Senators Stedman and Hoffman and Representatives Stoltze and Joule:

The Alaska Native Tribal Health Consortium is seeking \$38.4 million in State Capital Budget funding for a 100-bed tribal long term care facility to be built in Anchorage. A single year appropriation would mean we could break ground in the fall of 2011 and target opening in the spring or summer of 2013. If funded in two phases, the request would change to \$20 million in each of two years. ANTHC received \$7.5 million in Fiscal Years 2008 and 2009 for feasibility and planning. We are finalizing a land purchase decision and we are prepared to move expeditiously when funds are secured.

A tribal long term care facility built in Anchorage is projected to save the state general fund Medicaid expenditures of \$6-7 million each year, based on the federal government's payment of 100% Federal Medicaid Assistance Percentage (FMAP) for Alaska Natives served in a tribal facility. The Pacific Health Policy Group January 2007 report on the Alaska Medicaid Program first identified that partnering with the Alaska Tribal Health System (ATHS) could save the state significant general fund dollars due to the fact that tribal providers receive 100% federal Medicaid funding. In FFY 09 the state paid non-tribal nursing and assisted living home providers approximately \$26 million for services provided to Alaska Native Medicaid clients. The PHPC found state could save as much as \$13 million annually, and much more in the future, if these services were provided by tribal health organizations.

The ATHS developed a statewide tribal long term care facility plan with funding provided by the legislature under SB 61. This plan identifies the statewide need for long term care beds for Alaska Natives, and provides a phased approach to facility development. Included in Phase I of the implementation plan included Maniilaq Association's plan to build a nursing home wing onto their hospital in Kotzebue, the Yukon Kuskokwim Health Corporation's plans to build a nursing or assisted living home in Bethel, and the Alaska Native Tribal Health Consortium's (ANTHC) plan to construct and operate a tribal nursing home in Anchorage. The Maniilaq and YKHC projects have been fully funded and construction is underway. Funding is now needed for the Anchorage facility.

The need for a tribal long term care facility in Anchorage is widely acknowledged by tribal health leaders. In August 2010, ANTHC identified 318 Alaska Native (AN) people residing in Anchorage nursing and assisted living homes, 175 of whom are paid for by Medicaid. Department of Health & Social Services projections indicate that operation of a 100 bed tribal nursing home in Anchorage would save the State \$6.2 million in general funds during the first full year of operation (at 85% occupancy with 90% AN Medicaid eligible residents).

ANTHC contracted with consultants experienced in long term care development to complete a market assessment, and a financial analysis of the cost and feasibility of construction, maintenance and operation of a tribal long term care facility in Anchorage. The outcome indicates a need for 100 culturally appropriate nursing home units, to include 20 beds for skilled nursing and rehabilitation and 80 beds for custodial care.

The estimated cost of construction for the 100 bed nursing home is \$45,900,000. Square footage and construction is estimated utilizing the Green House® model of nursing home with 10 buildings of 10 units each, and a community/administration building. Construction estimates are based on a similar facility built recently in Seward, and an analysis of Anchorage construction costs in 2009. ANTHC has utilized a portion of the FY 09 state capital appropriation to cover these initial costs; the remaining funds will be applied toward construction. The request for FY 12 of \$38,400,000 will complete the project.

If you have questions or would like further detail on the Anchorage Long Term Care Facility proposal, please feel free to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'DK', with a long, sweeping flourish extending to the right.

Don Kashevaroff
Chief Executive Officer

Alaska Tribal Health System

Tribal Long Term Care Service Development Plan

December 2008



Report produced and published by ANTHC under the guidance of the Alaska Tribal Health System's:

- Alaska Native Health Board
- Association of Tribal Health Directors
- ATHD Long Term Care Committee

Alaska Tribal Health System Tribal Long Term Care Service Development Plan



Prepared by:

**The Long Term Care Committee
of the Association of Tribal Health Directors**

Chair: Elizabeth Lee; see page 63 for full Committee Roster

With technical staff support from:

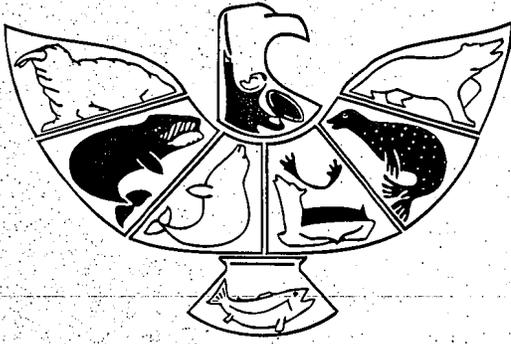
Kay Branch, Elder Health Program Coordinator
Susan Cook, Long Term Care Consultant
Deborah Erickson, Tribal Medicaid Reform Initiative Coordinator
Gwen Obermiller, Medicaid Consultant

Alaska Native Tribal Health Consortium
4000 Ambassador Drive
Anchorage, Alaska 99508

Funded by:

*The Alaska Department of Health & Social Services
Under the Senate Bill 61 Medicaid Reform Initiative*

December 2008



Alaska Native Health Board

4000 Ambassador Drive, C-ANHB
Anchorage, Alaska 99508

Phone: (907) 562-6006
Fax: (907) 563-2001

November 6, 2008

William H. Hogan, Commissioner
Department of Health & Social Services
State of Alaska
P.O. Box 110600
Juneau, AK 99811

Dear Commissioner Hogan:

The Alaska Native Health Board (ANHB) endorses the "*Tribal Long Term Care Service Development Plan*" as an official plan of the Alaska Tribal Health System (ATHS). Under the SB 61 Medicaid Reform Initiative, member organizations of ANHB have worked together to investigate barriers and identify strategies for increasing capacity in the ATHS for delivering long term care services. This work and detailed steps for implementing these strategies are documented in this plan.

Alaska Native elders and those with disabilities are valued members of our communities. Our primary interest through this planning effort has been to improve health status and access to care for our people. It is an added benefit that through increased capacity in the ATHS, we can help the state to make the Medicaid program more sustainable by bringing 100% reimbursement from the federal government for our services. In federal fiscal year 2007, the State of Alaska paid non-tribal providers nearly \$70 million for Medicaid supported long term care services for Alaska Natives and American Indians. Approximately half of those expenditures were comprised of state general funds which could have been saved had those same services been provided by the ATHS.

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION
ARCTIC SLOPE NATIVE ASSOCIATION
BRISTOL BAY AREA HEALTH CORPORATION
CHUGACHMIUT
COPPER RIVER NATIVE ASSOCIATION
COUNCIL OF ATHABASCAN TRIBAL GOVERNMENTS
EASTERN ALEUTIAN TRIBES

KARLUK IRA TRIBAL COUNCIL
KENAITZE INDIAN TRIBE
KETCHIKAN INDIAN COMMUNITY
KODIAK AREA NATIVE ASSOCIATION
MANILAQ ASSOCIATION
METLAKATLA INDIAN COMMUNITY
MT. SANFORD TRIBAL CONSORTIUM
NATIVE VILLAGE OF EKLUTNA

NATIVE VILLAGE OF TYONEK
NINILCHIK TRADITIONAL COUNCIL
NORTON SOUND HEALTH CORPORATION
SELDOVIA VILLAGE TRIBE
SOUTHCENTRAL FOUNDATION
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM
TANANA CHIEFS CONFERENCE
VALDEZ NATIVE TRIBE

I would like to express my appreciation for your support and the work of your staff over the past year in collaborating with the Alaska Tribal Health System on the development of this plan. I look forward to a continued partnership between the Department of Health & Social Services and the Alaska Tribal Health System to implement the documented strategies for increasing the delivery of Medicaid services by tribal health providers.

Sincerely,



Evangelyn Dotomain, MBA
President/CEO
Alaska Native Health Board

cc: The Honorable Lyman Hoffman, Senator, Alaska State Senate
Patrick Hefley, Deputy Commissioner, Department of Health & Social Services
William Streur, Deputy Commissioner, Department of Health & Social Services
Jerry Fuller, State Medicaid Director, Department of Health & Social Services
Renee Gayhart, Tribal Programs Mgr., Department of Health & Social Services
Don Kashevaroff, Chief Executive Officer, AK Native Tribal Health Consortium
Robert Clark, Chair, Alaska Tribal Health Directors

Tribal Long Term Care Service Development Plan
December 2008

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Executive Summary

Recent reports on the Alaska Medicaid program project a 5-fold increase in total spending on Medicaid services over the next 15 to 20 years. The Alaska Tribal Health System (ATHS) is an important partner for the State of Alaska in helping to control increasing Medicaid costs, as services provided by tribal health organizations are fully reimbursed by the federal government. Services provided by non-tribal providers are reimbursed at Alaska's Medicaid match rate (currently about 50%).

Long term care services for the elderly are identified as a leading cost driver for the future growth in Medicaid spending. In federal fiscal year 2007, Alaska Medicaid expenditures for long term care services for Alaska Native/American Indian beneficiaries totaled nearly \$45 million, only \$4.6 million of which was for services provided by the ATHS. Had all these services been provided by tribal health organizations, the resulting savings to the state in general fund dollars would have been approximately \$20 million for that one year alone.

The purpose of this plan is to develop a sustainable long term care service delivery system for the Alaska Tribal Health System (ATHS), while maximizing Medicaid cost savings for the State of Alaska.

The ATHS faces many barriers in building the capacity to provide and improve delivery of long term care services, including:

- **Financial barriers** - Medicaid reimbursement rates are not commensurate with the actual cost of providing services, particularly in rural areas. Lack of funding for non-Medicaid clients presents a dilemma to the ATHS since it does not coincide with their mission to provide services to all who are in need, with elders being the highest priority target group, and also because the Indian Health Service does not provide federal funding for most of these services.
- **Workforce barriers** - The availability of a well trained, competent, and caring workforce is crucial to the development of a successful long term care delivery system. Current workforce shortages are compounded by inadequate pay, lack of training, restrictive worker rules and requirements, and lack of career development opportunities.
- **Regulatory barriers** - Regulatory changes in recent years have forced the discontinuation or reduction of certain long term care services previously provided by some tribal health organizations. The current regulatory environment inhibits innovation, prevents efficiencies, complicates access to care, and doesn't always take into account differences between the tribal system of care and private providers.
- **Organizational capacity barriers** - Weaknesses in tribal health organization billing systems, fragmented information technology, and lack of continuity in program management are a few of the internal challenges faced by the ATHS in expanding the delivery of long term care services.

The plan for expanding the delivery of long term care services by the ATHS takes a 3-pronged approach:

- I. **Implement pilot projects to begin increasing the delivery of services under current home and community-based programs now.** Few tribal health organizations presently provide some services under current programs. Services have been declining or

discontinued in recent years due to the barriers noted above, and some are in jeopardy of closing altogether. The following strategies would allow them to maintain and expand services, while demonstrating the ability of the ATHS to develop and implement a comprehensive long term care delivery system:

- Improved timeliness of approvals for service
- Provision of Personal Care Assistant training in regional hubs
- Increased reimbursement or subsidy to cover the cost of service delivery
- Improved billing systems in the pilot organizations
- Adoption of quality assurance and monitoring systems by the pilot organizations

II. Create a comprehensive tribal home and community based service delivery system.

The emphasis of this report is on development of a system of care that will support individuals in maximizing their health, safety and independence, while enabling them to remain in their own homes and communities. Delaying or preventing the need for care in a residential facility not only honors the individual and their family, but is less costly. A tribal model for a comprehensive system of statewide home and community based services is proposed in this report. The following strategies are required for implementation of the model:

- Define the service package, program standards, and organizational structure for the delivery system
- Develop financing mechanisms that support cost-based reimbursement such as public entity rates
- Develop a “universal worker” workforce model for staff who provide direct care
- Improve regulations or receive waivers of regulatory provisions that hamper innovation and efficiency
- Strengthen capacity within tribal health organizations through improved billing, information technology, and program support systems

III. Develop ATHS administered nursing and assisted living homes. Even with the best system of care supporting individuals to remain in their own homes, those who are the most fragile will require care in a residential facility. The number of nursing home beds in Alaska has not increased in some time, and Alaska currently has the lowest nursing home bed ratio (for population) in the country. In order to meet the needs of the rapidly growing elderly population, facility-based services must be expanded. This report details a statewide ATHS long term care facility development plan, providing recommendations for:

- Long term care facility type by level of community
- Estimated baseline needs for numbers of beds for nursing and assisted living homes by region
- A phased approach to facility development based on regional need and organizational readiness

The Alaska Tribal Health System is prepared to take on development of a long term care delivery system that will meet the needs of Alaska Native elders and people with disabilities. A strong partnership with the State of Alaska will be essential to overcoming the challenges it will face in doing so. This report lays out the road map for the successful implementation of this initiative.

Part I: Project Purpose and Process

Section 1: Project Purpose

The purpose of the Tribal Medicaid Reform Initiative is to strengthen the Alaska tribal health system (ATHS) through enhanced service delivery systems and increased sustainable revenue streams, while maximizing Medicaid cost savings for State government. Currently, the full continuum of care for physical health, behavioral health, and long term care is not sustainable in the tribal health system. The Alaska Native Tribal Health Consortium (ANTHC) believes that, in cooperation with the Department of Health & Social Services, the Alaska Legislature, and partners within the ATHS, they can help turn the curve on projected growth in State Medicaid expenditures over the next several years, while building a sustainable, cost-effective, efficient, and high quality health system for Alaska's Native people.

The ANTHC is working on five projects under the Alaska Tribal Medicaid Reform Initiative, including:

- A managed care organization feasibility assessment
- A tribal behavioral health service delivery system plan
- A tribal long term care service delivery system plan
- A facility plan for addition of new and/or enhanced health care services
- A tribal health system financial infrastructure improvement plan

This report presents an overview of the efforts to develop the Tribal Long Term Care (LTC) Service Delivery System under the initiative, including a description of the planning process used and the Alaska Tribal Health System's proposed plan for the development of a LTC service delivery system. More specifically, this report offers a summary of the planning process followed, the players involved, the approaches applied and the guiding principles used throughout the effort; a brief discussion of the long term care system as it relates to Alaska Native people, including presentation of data indicating the need, a description of service delivery barriers and the current service delivery system; a description of the proposed service package; proposed tribal solutions and general strategies for providing the services; and finally a detailed action plan for implementation of the LTC service delivery system.

The purpose of this project is to create a system which provides the full continuum of long term care services at the appropriate level of care in each community across the state; and to strengthen the Alaska Tribal Health System's capacity to meet the long term care needs of Alaska Native elders and people with disabilities. The strategic focus areas of the Tribal Medicaid Reform Initiative include: Medicaid financing, service delivery improvement, workforce development and organizational capacity. The proposed timelines for the final outcomes will look at *short term* actions ready for implementation by 06/03/09; *long term* actions ready for implementation in 1 to 5 years; and *far term* actions ready for implementation in 5 to 10 years.

Development of a long term care delivery system within the ATHS faces special challenges not shared with other health care services. The single greatest feat is overcoming the perception of failure, as Tribal ventures into home and community based waiver and personal care services are struggling, have been forced to close, or are facing imminent closure. Unlike other health services, the LTC delivery system has no base federal funding from the IHS, and therefore has been solely dependent on state Medicaid and grant funds. Delayed assessments, lack of a rural cost factor for reimbursement, and loss of grant dollars meant that Tribal organizations had to financially support the services in place. Reduction and elimination of programs created

credibility issues for Tribal organizations with their beneficiaries, left elders without options for staying in their communities, and was a source of great embarrassment. Tribes will therefore be reluctant to startup new programs without assurance that the programs can be viable.

Nationally the continuum of long term care services is shifting away from nursing facility care toward more home and community based models of care. Public policy has been changed to allow for that shift, especially in the expansion of payments for home and community based services through Medicaid waivers. A brief look at the history of the provision of long term care services provides insight into the financial incentives that preceded the shift in care, and that the development of systems, or certain types of services, has an impact on the demand for services. For example, prior to the creation of Medicaid in the mid-1960s people were cared for in the home or in small board and care homes. After Medicaid began paying for nursing home care, the nursing home industry grew very rapidly, and nursing homes became the norm for someone requiring long term care. A similar phenomenon happened in Alaska in the mid-1990s, when the new assisted living regulations were promulgated. At that time there was a tremendous increase in the number of assisted living home openings, especially in the Anchorage area. Most of these assisted living homes were operated by individuals in their own private homes.

Section 2: Planning Process

The overall planning process focused on “thinking outside of the box” to come up with a new tribal long term care service delivery system that would be of high quality, accessible, affordable and sustainable over time. The LTC Committee approached the process by:

- Looking at all of the services currently available and identifying the tasks included in each: breaking down the system into the tasks that are considered vital to the long term care service delivery system allowed the LTC Committee to think more openly about how they could be addressed individually and then developing service packages that could deliver those services in the most feasible and streamlined approach.
- Focusing on creating the optimal service delivery system for Alaska Native elders and people with disabilities, rather than focusing on current barriers to services: the LTC Committee has a strong commitment to designing a system that is flexible to allow for changing needs of individuals and the local community, while also ensuring that the continuum of care available in the community or region allows individuals to “age in place.”
- Focusing on the strengths of tribal health organizations: the tribal health organizations are mission-driven to serve Alaska Native elders and people with disabilities in their regions and have a long history of doing so - they understand how to provide culturally appropriate services and the organizational capacity challenges of the tribal health organizations and how to address them.

The tribal health organizations decided that they need to:

- Have the capacity to identify service development and delivery issues on an on-going basis
- Partner with stakeholders to develop and implement improvement strategies
- Have the capacity to advocate for an effective long term care system to serve Alaska Native elders and people with disabilities
- Ensure that there is commitment to the process by the tribal health directors

The planning process formally began with the Alaska Tribal Health Directors Medicaid Reform Summit held January, 16 & 17, 2008. The purpose of the Medicaid Reform Summit was to identify individual tribal health organizations' plans for developing or enhancing behavioral health care services, long term care services, and other new health services or care models. The primary outcome of the Summit was a list of projects and ideas the tribal health organizations proposed for research and consideration. These lists will be used in Medicaid policy discussions with the State and for educating the State legislature about opportunities for investing in the Alaska Tribal Health System.

Subsequent to the Summit, the following activities regarding planning and development of the LTC Service Delivery System Plan have taken place or are still in progress:

- The LTC Committee continues to meet monthly and has completed the following documents and activities:
 - Developed “Guiding Principles” for Alaska's tribal long term care system
 - Defined the ideal “Tribal Long Term Care Service Array” by level of community
 - Provided guidance for the inventory of long term care services provided by region
 - Contributed information re: barriers to tribal delivery of long term care services
 - Created a subcommittee to identify facility-based care needs by region
 - Created a “Home and Community Based LTC Service Delivery Planning Tool” to document and guide the planning process
 - Developed a “Home and Community Based LTC Service Delivery System Development Action Plan”
 - Created a subcommittee to research and develop eligibility criteria and program standards
 - Created a subcommittee to review and revise the personal care training and testing process
 - Created a subcommittee to review and develop appropriate screening tools
 - Developed various “concept or white papers” for education purposes
 - Developed a working group, including both LTC Committee members and DHSS staff, to review current client processes and identify problem areas in order to streamline it
- The LTC Committee continues to research long term care system reform strategies for consideration - examples of strategies currently under consideration include Tribal Targeted Case Management for the frail elderly and a pilot project to test in-home telehealth applications to support chronic care management.
- The LTC Committee continues to gather information re: new Medicaid financing strategies - examples of strategies under consideration include development of a State Medicaid Waiver for tribal management of long term care services, the PACE Program (“Program for All-inclusive Care for the Elderly” - a State Medicaid option), and expanded use of Tribal Targeted Case Management for additional subgroups and in additional regions.
- The LTC Committee continues to research and gather information re: long term care service delivery system enhancement strategies - examples of some of the efforts to date include a plan to identify and overcome system barriers to tribal provision of home care services; a pilot program to monitor the health of all elders and ensure early intervention for illness and

other identified needs; creation of a special Community Health Aide Program (CHA/P) training module for elder care; and development of a statewide tribal long term care facility plan.

- Payer information is being collected to support analysis of services provided by non-tribal providers - this analysis will result in identification of priorities for new service development that would provide the biggest return for the State in terms of Federal Medical Assistance Percentage (FMAP) savings.

A) Committee

The success of this project to date is primarily due to the clear understanding by all the players that close coordination with the State and all ATHS partner organizations, plus the strong commitment of tribal leaders, was critical if they were to succeed. The list of players involved in this project, and listed below, is comprehensive and the dedication and hard work done by these groups has been extraordinary throughout the planning process.

- Alaska Tribal Health Directors
- Tribal Health Organization Chief Financial Officers (CFOs)
- Tribal Elder Program Managers
- Alaska Native Tribal Health Consortium
- Yukon Kuskokwim Health Corporation
- Southcentral Foundation
- Norton Sound Health Corporation
- Southeast Alaska Regional Health Consortium
- Maniilaq Association
- Bristol Bay Area Health Corporation
- Tanana Chiefs Conference
- Arctic Slope Native Association
- Native Village of Eyak
- Kenaitze Indian Tribe
- Ketchikan Indian Community
- Kodiak Area Native Association
- Eastern Aleutian Tribes
- Aleutian Pribilof Island Association
- Chugachmiut
- Mt. Sanford Tribal Council

The close coordination is fostered continually by the following ongoing efforts:

- Monthly meetings of Senior ANTHC staff meets monthly with DHSS officials to discuss progress and potential strategies
- ANTHC and DHSS staff consult informally on a weekly basis
- DHSS provides data and information in support of ANTHC planning efforts upon request
- LTC Committee, composed of Elder care program managers representing the tribal health organizations, meets monthly and works as the primary force in the development of the LTC Service Delivery System Plan

- Three subcommittees were formed from the LTC Committee as workgroups for specific focus areas, including: home and community based service delivery system plan and the statewide facility plan, and a feasibility study for a nursing/assisted living home in Anchorage.
- The LTC Committee was chartered by the Alaska Tribal Health Directors and approved by the Alaska Native Health Board in February 2008. The Committee Charter and list of committee members is included as Appendix B of this report.

B) Principles and Guidelines

To realize the goal of making long term care services available to Alaska Native elders and people with disabilities through the tribal health system, ANTHC and ATHS are working together to identify, develop and implement long term care services, including residential and home and community based services. The essential guiding principles adopted as necessary in all long term care services offered by the Alaska Native tribal health system ensure that all elders and persons with disabilities deserve:

- Access to the full range of LTC services within their home region
- To be served by an appropriately trained, culturally competent and compassionate workforce
- Access to services that are delivered in their community by local service providers to help them stay in their own homes and/or communities as long as possible
- To know which services could help them and where they could receive those services
- The right to choose their own care and to be actively involved in the development of their service plan
- To be served by a tribal health organization that takes a customer-centered approach to LTC service development
- To be served by a tribal health organization that delivers services that are financially feasible and sustainable over time

Part II: Background on Long Term Care for Alaska Native Individuals

Section 1: Continuum of Care and Service Array

Long term care is generally defined as the care of an elder or individual with a disability who requires on-going assistance with activities of daily living, such as bathing, dressing, grooming, eating, toileting, transferring, shopping and cooking. Long term care services provide support to clients and their families with medical, personal, and social services delivered over a sustained period of time in a variety of settings, ranging from a person's own home to institutional settings, to ensure quality of life, maximum independence and dignity. Long term care in Alaska Native and American Indian communities also includes the importance of maintaining cultural values in the delivery system.

The array of services offered in a long term care system is typically referred to as a continuum of care. The continuum of care describes the services in a linear manner, from least to most complex; however, people do not necessarily receive the services in this way. The timing of services needed is specific to each individual, and a person can receive any number of services along the continuum at the same time and/or at different stages of their life. Ideally, the continuum of care available in a community or region will have the range of care services needed so as not to overstress one type of service and to meet all the needs of elders. The range on that continuum would begin with the services that address those individuals who want to stay at home and just need their home modified to allow that independence; and then end with the services for individuals who need end of life care, such as palliative care and hospice. A well-developed care coordination or case management function that follows the client through the entire system is also vital.

Figure 1: Continuum of Long Term Care Services

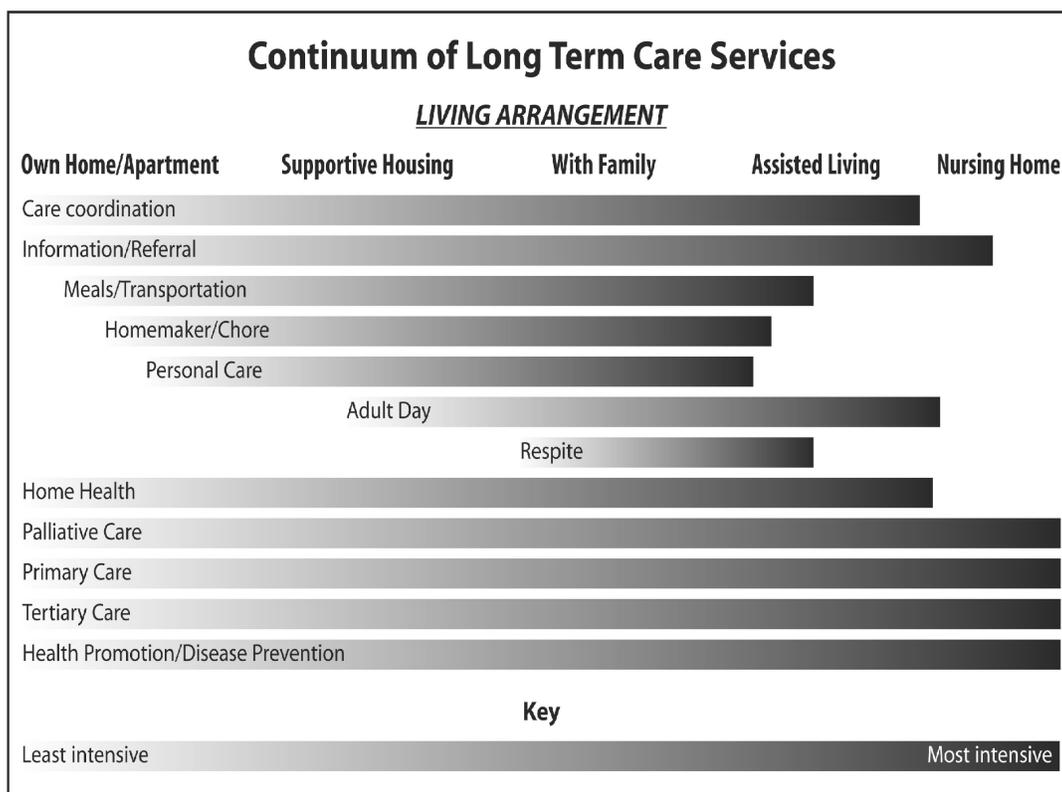


Figure 1 depicts the array of services in the long term care continuum presented in the linear model with housing options across the top and various home and community based and medical services.

The feasibility of the Alaska Tribal Health System offering all of the long term care services on the continuum is unlikely given current available resources; however, the Alaska Tribal Health System is committed to striving for a reasonable balance of these services statewide. The LTC Committee identified the ideal array of services they want to have available in the system; and Table 1 presents that array. The LTC Committee further agreed that it was neither financially or organizationally feasible for the tribal health organizations to provide all of the services directly through their organizations. Given the mission of the tribal health organizations focused on provision of health-related services, they decided that the tribal health organizations would provide the home and community based and the case management services. Realizing that the “other services” in the array are also important, but may not be within their organizational capacity, they will coordinate with other local organizations to ensure those services are available. Further details pertaining to this service array are specifically addressed in the “Home & Community Based LTC Service Delivery Planning Tool” included in Part III, Section 1B, of this report.

TABLE 1 : Ideal Array of Services Available to Elders and Persons with Disabilities in their Community		
Service	Provided by Tribal Health Organization	Provided by Tribal Health or other local organization
Home and Community Based Services		
Chore (includes special services in rural areas to help elders stay home, i.e. hauling water, cutting wood)	X	
Respite – in-home or mobile	X	
Personal Care	X	
Medication management	X	
Palliative Care / Hospice	X	
Home Health (CNA, RN, PT, OT)	X	
Case Management		
Comprehensive Elder Exam – age related preventive medicine visit	X	
Case management / care coordination	X	
Chronic care management	X	
Wellness & Prevention	X	
Other Services		
Congregate & home-delivered meals		X
Transportation		X
Companion care		X
Housing modifications		X

(Source: LTC Committee Meeting, February, 2008)

Section 2: General Population Data

Alaska's population age 65 and older is one of the most rapidly growing segments of the population in Alaska, expected to nearly triple by 2030 due to Alaska's large cohort of baby boomers reaching age 65 and beyond. Alaska Native elders are contributing to this growth. The proportion of the Alaska Native population age 65 and older is expected to increase from 6% in 2006 to 12% in 2030. According to the most recent estimates by the Alaska Department of Labor & Workforce Development, there are 7,212 Alaska Native people age 65 and older, and 8,360 between the ages of 55 and 64. *Table 2* depicts the projected growth for Alaska's Native population from 2006 to 2030 for ages 55 to 90 and older.

As reflected in *Table 2*, the most recent Alaska Department of Labor & Workforce Development figures indicate that Alaska's Native population is projected to experience stable growth throughout the period 2006 to 2030, from 118,884 in 2006 to 162,820 in 2030 - an overall increase of 37%. More specifically, in the over 65 age group the increase from 2006 to 2020 is projected to be 77%; and an additional 49% increase from 2020 to 2030.

TABLE 2: Alaska's Native Population - 2006 projected to 2030						
Age	2006	2010	2015	2020	2025	2030
55 - 59	4,953	6,013	6,999	7,551	6,600	5,976
60 - 64	3,407	4,292	5,626	6,579	7,120	6,236
65 - 69	2,501	3,016	3,889	5,128	6,028	6,554
70 - 74	1,913	2,038	2,618	3,403	4,512	5,339
75 - 79	1,411	1,527	1,634	2,122	2,779	3,715
80 - 84	778	951	1,084	1,167	1,534	2,033
85 - 89	357	441	560	645	698	930
90 +	252	231	262	325	388	433
Totals	118,884	125,728	135,070	144,324	153,440	162,820

(Source: Alaska Department of Labor & Workforce Development, Research & Analysis Section, Demographics Unit)

The total Alaska Native population is also projected to grow relative to the proportion of the overall State's population, from 17.7% in 2006 to 19.4% in 2030. High birth rates, aging and increases in the life expectancy of Alaska Natives are the primary factors contributing to this growth.

Though the life expectancy for Alaska Native people is increasing, life expectancy at birth in 2000 is 69.5, as opposed to the 71.5 seen in the total American Indian and Alaska Native population. Per the US Census, Alaska Native elders still fall 7.4 years below the life expectancy of 76.9 for the overall US population. The increases in life expectancy can lead to a higher prevalence of chronic disease, and along with it an increased incidence of disability and functional limitations. *Table 3* indicates high rates of growth in the 65 and older population in all age groupings. The combination of higher rates of disability and functional limitations with the increasing numbers of Alaska Native elders exacerbate the need for long term care service planning within the Alaska Tribal Health System.

Currently, the entire Alaska Tribal Health System serves approximately 130,000 Alaska Native people as represented in *Table 3*. The information presented in the table is provided only as a general overview of population numbers, as variations of 5-10% can occur at any time depending on migration.

TABLE 3: ATHS Service Population Breakdown		
<i>Region</i>	<i>Population Served</i>	<i>% of Total Served</i>
Anchorage/Mat-SU (SCF)	40,000	31%
Rural Anchorage Service Unit	12,000	9%
Arctic Slope	4,300	3%
Maniilaq	7,600	6%
Norton Sound	7,400	6%
Bristol Bay Area	5,300	4%
Yukon-Kuskokwim Delta	24,200	19%
Southeast Region	16,300	12%
Interior Region	13,000	10%
<i>Total all regions</i>	<i>130,600</i>	<i>100%</i>

(Source: Alaska Tribal Health System: Overview. ANTHC PowerPoint Presentation. February 2007)

Section 3: Description of the Current Long Term Care Delivery System

Currently, there is a vast array of home and community based long term care services available in Alaska; however, the types of LTC services available to Alaska Native elders and those with disabilities differ significantly depending on where the individual lives, their financial status and the capacity of local and regional health and social service providers. Services are provided by both tribal and non-tribal agencies; and most are funded through Medicaid and State grants since the Indian Health Service (IHS) does not provide funding for long term care services. The result is most provider agencies are dependent on an adequate appropriation to maintain the availability of these services throughout the state. At present, the State is actively encouraging tribal health organizations to provide more long term care and other services paid for by Medicaid.

Following is a description of the range of home and community based and also facility based LTC services currently offered in Alaska, accompanied by governing legislation where applicable, the funding streams supporting the service, and the status of the availability to Alaska Native elders and people with disabilities.

- *Congregate and home delivered meals, transportation and information and referral:* the federal Older Americans Act (OAA) regulates funding for nutrition, transportation and supportive services to seniors. Funds from Title III of the OAA pass through the State Department of Health & Social Services to non-profit agencies and governments around the state to provide these services. Title VI provides grants to Indian Tribes for similar services, but eligibility is dependent on different criteria set out by the funding source. Funding for Title VI flows directly from the federal Administration on Aging to tribes, however funding limitations at both the state and Tribal levels largely preclude support for these services in rural Alaska. Currently these services are also available in many areas of the state through Senior Centers, food box programs, local governments, tribal health organizations and social service agencies.
- *Independent Senior Housing:* These are apartments for seniors and adults with disabilities; and they may have a resident manager and common space for activities, but usually other services are not provided. Currently there are units located in every region coordinated by the local housing authority.
- *Personal Care Assistants (PCA):* This is an in-home care service that provides assistance to clients with their activities of daily living. There are two personal care program models available in Alaska: the *agency based PCA program* and the *consumer directed PCA program*. The agency based model allows consumers to receive services through an agency that oversees, manages and supervises their care. The consumer directed model allows each consumer to take a more direct role in managing his or her own care by selecting, hiring, firing, training and supervising their own PCA worker; and an agency provides administrative support to the consumer and the PCA by acting as a fiscal agent to bill for services and issue payroll. This service is regulated and managed by the State Division of Senior & Disabilities Services and funded by Medicaid. Currently the majority of PCA service is provided by several statewide private, for profit, agencies. The amount of PCA services provided by tribal organizations has been dramatically reduced in the last 5 years - only 3 tribal providers are still offering PCA services: YKHC, Maniilaq and Kenaitze Indian Tribe.

- *Medicaid Waivers*: Instituted in Alaska in 1995, Medicaid Waivers allow people who are eligible for nursing home admission to receive services in their home or another less restrictive community setting such as an assisted living home. To be eligible a person must meet financial eligibility guidelines for nursing home admission (includes income as well as assets) from the State Division of Public Assistance and meet nursing facility level of care.
- *Home and Community Based Services (HCBS)*: These services are provided in a person's home or in a community facility, including: respite care, environmental modifications, adult day care, transportation, specialized medical equipment, chore services, assisted living and private duty nursing. The services are funded by Medicaid, for individuals who meet the income guidelines and qualify for nursing home level of care. The availability of these services is not adequate to meet the need identified by the tribal health organizations. Also, State in-home service grants provide funding to a limited number of organizations, including two tribal health organizations, to provide respite and chore services.
- *Assisted Living Homes*: These are licensed residential settings that provide for personal and health care needs. Homes must provide three meals per day plus snacks, 24-hour supervision of residents, and assistance with activities of daily living. Assisted living can be a large multi-unit building or a small, private home. There are an abundance of assisted living homes in Anchorage and the Matanuska-Susitna Borough and several in Fairbanks, but very few in Southeast Alaska and rural areas of the state.
- *Case Management/Care Coordination*: Assistance to clients in gaining access to Medicaid waiver and other needed services. Care coordinators are responsible for initiating and overseeing the assessment and planning process, as well as the ongoing monitoring and annual review of a client's eligibility and plan of care. This service is funded by Medicaid, for individuals who meet the income guidelines and qualify for nursing home level of care. The service is also available to State in-home service grantees.
- *Home Health*: Home health is a federally controlled Medicare and Medicaid service that provides skilled nursing and therapy services to eligible homebound individuals. Home health agencies must be licensed by the Section of Certification and Licensing in the State Division of Public Health and be certified by Medicare. Home health services are intended to be part-time or intermittent, and there are strict criteria for the service to be covered by Medicare and Medicaid. Home health services are available in urban areas, with little or none available in the rural areas of Alaska.
- *Hospice and Palliative Care*: Palliative care is the active total care of the body, mind and spirit of the patient and family. The purpose of palliative care is to prevent or lessen the severity of pain and other symptoms and to achieve the best quality of life for people dying or suffering from a long-term disease. Comfort is the goal of palliative care. Comfort is also the goal for those patients still receiving potentially curative therapy. Hospice is a program that delivers palliative care to people who are dying and need treatment to prevent or manage pain and other symptoms even when cure is no longer possible. Hospice programs can be certified to bill Medicare and Medicaid, or provide services on a volunteer basis. There are hospice programs in urban areas and some communities in Southeast; however, the availability of hospice services in rural areas is minimal.
- *Swing Beds*: Rural hospitals with less than 100 beds that are more than 50 miles from a skilled nursing home and are Medicare and Medicaid certified may apply to operate swing

beds. These beds allow for the provision of nursing home care in empty hospital beds in rural areas and require compliance with nursing home admission standards and federal reporting requirements. There are six rural tribal hospitals in the state and one of those offer swing beds - Bristol Bay/Kanakanak Hospital has four beds.

- *Administrative Wait Beds:* Existing solely in Alaska, the administrative wait bed permits a hospital to designate and use beds as nursing home beds without meeting complex federal admission requirements and reporting standards in order to bill Medicaid for those services.
- *Nursing Home:* These are skilled care facilities operated independently or collocated with a hospital. Nursing homes are licensed by the State following national certification and licensing standards. The Certificate of Need process within the Department of Health and Social Services regulates the development of new nursing home beds in Alaska. There is one tribal nursing home operated by Norton Sound Health Corporation.

Table 4 lists Medicaid expenditures paid to both tribal and non-tribal providers for home and community based services, by service area, for FFY 2007. Please note that the Medicaid payment data presented is a “snap-shot in time.” The information covers only Medicaid services rendered to American Indians and Alaska Native people between the dates of October 1, 2006 through September 30, 2007. Recognizing the lag between the date of service and the billing of the claims payment system, payments data through December 31, 2007 are included. At this time the actual final total payments are understated and would not be known for another calendar year. Additionally, it should be noted that in the “Tribal Medicaid Activity Report, FY 2007”(from which this information is derived), both tribal and non-tribal expenditures are allocated to service areas based on the location at which the service was provided. This should not be confused with the provider’s “pay to address,” which is used to identify the location of clients and recipients in the “Tribal Medicaid Activity Report.”

An analysis of the information presented in *Table 4* indicates that non-tribal agencies are providing the majority of the home and community based services delivered in the rural service areas. More specifically, only 2 of the 10 regions displayed were served primarily by tribal providers, Northwest Arctic Borough and Yukon-Kuskokwim Delta. All other regions were served primarily by non-tribal providers - 4 were served exclusively by non-tribal providers and 4 were served by both tribal and non-tribal, with a greater share being non-tribal. Less than 2% of all PCA services provided in all regions were delivered by tribal providers; and 100% of adult day and chore services are provided by non-tribal providers.

Other pertinent service delivery data which is critical to the understanding of the tribal home and community based LTC service delivery system is the status of PCA services offered in rural areas. Unfortunately, specific data pertaining to those services has not been collected consistently over time in any standardized manner. Therefore, the LTC Committee cannot at this time present specific data, show trends or compare service delivery by regions in a statistically sound way. However, the following general information about the PCA program has been documented by the State and the tribal health system.

State regulations for PCA services have undergone changes over the past five years which have severely impacted service delivery, especially in rural areas. In fact, five tribal organizations used to operate home care programs offering an array of services, including PCA. The changes to the program have gradually forced three of those out of the PCA business (Bristol Bay Area Native Corporation, Tanana Chiefs Conference, and Norton Sound Health Corporation); and caused another (Yukon Kuskokwim Health Corporation) to dramatically

reduce the amount of PCA service provided in their region. For example, during FY 2005, the Yukon Kuskokwim Health Corporation provided PCA services; however the amount of billings for PCA services decreased by \$162,076 from FY 2004 to FY 2005, resulting in 50 fewer clients being served. Manillaq has also continued to provide personal care and other services to elders in their region at a strain to their organization's budget. Although there is a commitment to serving elders needs, without additional funding this program is also in jeopardy.

As fewer and fewer clients are receiving PCA services from the tribal system, these individuals must seek more expensive institutional care outside of the tribal system, thus costing the Alaska Medicaid program more in state general funds, as full federal reimbursement is not possible for services provided outside the tribal health system.

TABLE 4: Home & Community Based Services Medicaid Expenditures for FFY 2007								
Service Area & Type of Provider		PCA	Home Health & Palliative Care	Medicaid Waiver Services				TOTAL (all services by region)
				Care Coordination	Respite	Chore	Adult Day	
Northwest Arctic Borough Manillaq Kotzebue	Tribal	2,100		15,485	48,168			65,753
	Non-Tribal							0
Norton Sound	Tribal			8,640	24,024			32,664
	Non-Tribal	64,813		19,695		6,330	67,043	157,881
Southcentral (Anchorage, Mat- Su, Valdez, Glennallen, Cordova, Mt. Sanford)	Tribal		148,568	320,325				468,893
	Non-Tribal	6,000,711	64,717	902,347	974,915	166,327	397,990	8,507,007
Yukon- Kuskokwim Delta	Tribal	167,612		198,830	66,451			432,893
	Non-Tribal			7,640				7,640
Interior	Tribal			11,620	24,717			36,337
	Non-Tribal	665,609	506	122,540	34,194	29,185	6,864	858,898
Rural ASU - Kenai Peninsula	Tribal	9,487						9,487
	Non-Tribal	716,838	28,177	185,780	167,934	48,638	41,090	1,188,457
Barrow / North Slope Borough	Tribal							0
	Non-Tribal				20,493			20,493
Bristol Bay	Tribal							0
	Non-Tribal	373,401		18,210	8,261			399,872
Southeast	Tribal							0
	Non-Tribal	2,056,822	30,979	357,835	414,098	168,366	17,302	3,045,402
Rural ASU - Kodiak	Tribal							0
	Non-Tribal	55,566		42,545	4,915		12,893	115,919
TOTAL (per service type)	Tribal	179,199	148,568	554,900	163,360	0	0	1,046,027
	Non-Tribal	9,933,760	124,379	1,656,592	1,624,810	418,846	543,182	14,301,569

(Source: "Tribal Medicaid Activity Report, FY 2007," State Department of Health & Social Services, 2008)

It is also worth noting that in FY 2007 the Alaska Medicaid program spent nearly \$10 million on PCA services provided to Indian Health Service beneficiaries by non-tribal providers. Nearly \$5 million of which was State general fund dollars which could have been saved had the services been provided by tribal providers under conditions which would qualify the services for one hundred percent federal match (FMAP).

As noted above, the lack of PCA and other home and community based services compels some individuals to seek more expensive facility-based services outside the tribal system. In FY 2007 the Alaska Medicaid program spent nearly \$26 million on long term care facility services provided by the non-tribal sector. The combined expenditures in that fiscal year for all home and community based and facility based services provided by the non-tribal sector totaled over \$40 million, representing a cost of nearly \$20 million in state general funds that could have been avoided had these same services been provided by the ATHS.

Section 4: Barriers to Long Term Care Service Delivery

Not unlike the rest of the country, Alaska Native elders and people with disabilities are choosing to remain in their own homes and receive care there rather than moving to more expensive facility based care, which usually is not available in their home community. Recognizing the increased demand for home and community based LTC services, especially in the rural areas, the tribal health system has identified services for Alaska Native elders and people with disabilities as one of their top priorities. However, the Indian Health Service (IHS) does not provide funding for comprehensive LTC services, therefore presenting a dilemma requiring tribal health organizations to be creative in developing programs using other tribal funding sources or assets, as well as integrating State programs and other funding streams. In the past, some of the needed services, primarily PCA, were provided successfully by tribal health organizations with funding obtained through State grants and Medicaid. Due to changes in the State funding systems, such as the elimination of regional PCA grants, tribal health organizations unfortunately have not been able to sustain those services.

The following client story (included with permission from the client) is a typical example of the complexities experienced by clients, their families and providers throughout the process once an individual begins to need long term care services:

Mary Lou Merculief was a devoted caretaker and wife to husband Alexay Merculief. Both lived in St. Paul their entire lives and worked hard to support their family. The past few years were very difficult for this couple and Alexay's health declined dramatically. Although Alexay has recently passed on, Mary Lou wants to share their story about the struggles of receiving long term care services.

Beginning in 2005 Alexay's health began to decline and he became more dependent on his wife, Mary Lou. He needed help getting out of bed, getting dressed, going to the bathroom, taking a bath and more. As he became more and more sick, he was flown to ANMC for medical attention. St. Paul Island has a community health center and Anchorage is the hub where residents must travel nearly 800 miles to receive medical care in a hospital setting. Once in Anchorage, Alexay received medical care and the social workers at ANMC asked the family to consider nursing home care. Feelings of confusion and nervousness filled Mary Lou. She was scared at the thought of moving to the big city, away from her community and family she was so close to; but she knew her husband needed more care than she could give him.

Both Alexay and Mary Lou were retired, but their income exceeded the amount needed to qualify for the Medicaid waiver which covers the cost of nursing home care. They were told about the Millers Trust, and so they hired a lawyer to set up this trust account. This irrevocable trust was the couple's only option to receiving adequate care. Even now, Mary Lou said she feels like she doesn't fully understand how the system works. Once Alexay was admitted to Mary Conrad Nursing Home located in Anchorage she felt abandoned. She could not stay with her husband she had been married to for over 50 years. Once he was settled into Mary Conrad, no one seemed to care whether or not Mary Lou had housing. She ended up staying with one of her daughters who was living in Anchorage at the time. Mary Lou spent every day at the Mary Conrad Nursing Home with her husband.

After a period of time, Mary Lou and Alexay were able to return home, but, things were still difficult. Home and community based services were hard to find. Respite services were offered, but there was no one in the community that the family trusted enough to provide the service. Mary Lou had many sleepless nights. With her husband's sickness, he was awake a lot during the night and felt something was wrong with him. Mary Lou knew he was fine, but also felt the need for someone with medical experience to check on him. Mary Lou explained that the clinic staff used to do home visits, but they no long practiced this type of care.

Beginning in March 2008 Alexay started to develop bed sores. Mary Lou was told that the dressings to his wounds needed to be changed 2 times a day and Alexay needed to be turned 4 times a day to avoid developing more sores. No one showed her how to do this, nor did they ask if she had the strength to complete these tasks. Medical staff assumed the family would help to get the job done, but Alexay's health worsened. He kept getting more and more sores. He was in pain. It devastated Mary Lou as she watched her husband suffer. Finally she asked the St. Paul Health Center provider if they could travel to Anchorage for care. After consulting with ANMC, the provider informed them that they did not meet the criteria for a medevac and they could not be seen for wounds, but also informed Mary Lou that the sores could be life threatening. Alexay was being treated with antibiotics for his infected sores. She took

matters into her own hands and bought 2 one way tickets to Anchorage, and they traveled to Anchorage on May 13, 2008.

They visited the ER immediately upon arriving in Anchorage. After the long plane ride into Anchorage, Alexay could no longer straighten his legs and this worried Mary Lou. He was admitted to ANMC and began the paperwork to transfer him back into a nursing home. The sores worsened and the possibility of surgery seemed inevitable. He developed pneumonia and the family was told that the odds of Alexay surviving a surgery were slim. Mary Lou continued to collect proper paperwork for social services for the transfer into a nursing home. She almost felt hounded by some of the questions they repeatedly asked. They were having trouble enrolling in the Medicaid waiver program and needed to find the deed to her home, power of attorney paperwork, and the Millers Trust, to name only a few. At the time things felt chaotic for Mary Lou. She only prayed for her husband to get better. Unfortunately Alexay passed away on June 14, 2008 at the Alaska Native Medical Center.

A) Financing

The lack of adequate funding for home and community based LTC services in the current environment is a primary concern of tribal health organizations. With the limited amount of government funding available to provide the realm of services to Alaska Native people, the tribal health system needs a revenue source for any new programs or they must divert funding from other services. In the current service delivery environment, the home and community based LTC services are generally funded either by Medicaid or private pay and are less expensive than facility based care. For example, in Alaska the cost to Medicaid of an elder residing for one year in a rural nursing facility is around \$237,250; whereas, the Medicaid cost for an elder residing in a rural assisted living home might reach \$49,275 for one year; and the cost for an elder receiving 40 hours per week of PCA services in their own home for one year is currently \$43,680. With State and federal Medicaid expenditures growing and the number of people over 65 increasing, it is clear that personal care is the most cost effective option. However, the current Medicaid reimbursement for home and community based services is not sufficient to cover the actual cost of providing services, especially in rural areas. The lack of adequate funding has resulted in the inability of tribal health organizations to provide consistent, self-supporting and sustainable home and community based LTC services.

More specific financial and funding challenges faced by the tribal health organizations in the current service delivery environment include the following:

- *Medicaid reimbursement rates:* Reimbursement rates are not commensurate with the actual cost of providing services. To provide Agency-Based PCA services, the desired model to ensure high quality care, the tribal health organizations are required by regulation to have an RN on staff to review plans of care and provide supervision; provide 40 hours of training, ongoing first aid, and CPR renewal for their home care workers; have all workers submit to criminal history background checks; and travel for training and client visits. The funding for these mandated overhead program costs was covered by the State grants until 2004. The set reimbursement rate of \$21 per hour statewide was paid to all providers in addition to the grant money. When the grant program was eliminated in 2004, the justification included a plan by the State to provide a rural differential on the hourly reimbursement rate; however, the rates were never adjusted. Now costs for supervision, training, travel, etc. must be borne by the tribal health organization, since the grant subsidy was eliminated and the statewide rate has been maintained at \$21 per hour. YKHC estimates they spent over \$460,000 subsidizing the cost of their PCA program in FY 2006. The reimbursement rate for care coordination services per month per client is \$200, regardless of the amount of time and resources spent on that client and air travel costs required in rural Alaska to fly to villages for required face-to-face client meetings. Additionally, home and community based

service rates have not been adjusted as necessary for rising program costs or the cost of living. In recognition of the problems created by inadequate reimbursement rates, DHSS engaged the firm of Myers and Stauffer to provide assistance with developing and implementing a new reimbursement methodology for home and community based services. Myers and Stauffer has completed the research of the various reimbursement methodologies used for home and community based services; gathered information from DHSS staff and provider organizations, including the tribal providers; and produced a report which includes recommendations for revisions to the current home and community based services rate setting process, an overview of possible rate methodologies, and recommendations for the reimbursement of home and community based services. A future report from Myers and Stauffer will present a transition and implementation plan for the reimbursement methodology selected by DHSS.

- *Medicaid reimbursement methodology.* Reimbursement methodology does not take into consideration the additional costs of conducting programs in rural areas where costs are higher and economies of scale are not feasible given the small client base - there is no geographic differential allowed to accommodate these differences. Recent focus groups and community meetings have demonstrated that Alaska Native elders and people with disabilities prefer to be at home and in their own communities in the most independent setting as possible, and experts agree that home and community based LTC services are less expensive overall than facility based care. However, in the current financing environment it is generally easier to create a balanced budget for a nursing facility than any other type of LTC service due to the established reimbursement structure and methodology for determining rates.
- *Funding for non-Medicaid clients:* The tribal health organizations' mission is to provide quality services to all Alaska Natives and people with disabilities in need, not just those who are Medicaid eligible; but the lack of funding for non-Medicaid clients presents a dilemma to the tribal health system since it does not coincide with the mission to provide services to all who are in need. State grants were used to cover PCA services, subsidize services to clients with income just over the Medicaid eligibility level, or cover the cost of services while a client was awaiting their Medicaid eligibility determination, until 2004 when the grants were eliminated.
- *IHS funding:* Currently Indian Health Service provides funding at approximately 50% of the level needed to provide basic health care services to Alaska Native people; therefore any new service lines, such as long term care, would compete with an already financially stressed system with increasing needs. The Indian Health Service (IHS) does not provide funding for comprehensive LTC services, so tribal health organizations have to be creative in developing programs using other tribal funding sources or assets, as well as integrating State programs and other funding streams.

B) Workforce

The availability of a well trained, competent, and caring workforce is crucial to the development and successful delivery of home and community based LTC services in the tribal health system. Currently, in all areas of the state, recruitment and retention of qualified staff is a major challenge; and workforce shortages in this field, coupled with the increasing demand for services, are well documented in Alaska and nationally. Direct service workforce development initiatives in Alaska over the past ten years identify lack of support, literacy issues, cumbersome external workforce rules, low salaries, lack of benefits, unrealistic qualifications, unstable work

hours, lack of professional development and career ladders, lack of continuing education and lack of respect for their value as contributors to the undesirability of the job and the subsequent high turnover. There is also an emotional drain on home care workers related to the closeness of the relationship that develops with a client and grief issues when a client dies. Home care workers have identified the following basic needs in order to make the jobs more desirable:

- Respect for the worker from employers, the community and the medical field
- Pay and benefits commensurate with the position and the value of keeping Native elders and people with disabilities in their community and at home
- Support for the emotional aspects of their job
- Realistic training requirements
- Professional development and continuing education (career ladder or upward/lateral mobility)

The supply of workers statewide is not adequate due to many issues currently facing the tribal health system and the LTC industry in general. Those issues discussed below are complicated, interrelated and will need to be carefully researched and addressed to come up with viable solutions.

- *Recruitment and retention:* The ability to recruit and then retain an adequate supply of competent workers is a major barrier to service delivery. First of all, the pay and benefits offered currently are too low to allow individuals to earn a reasonable living. Along with the lack of realistic compensation, the workers are not supported with sufficient supervision; training, continuing education or professional development; or emotional and practical back-up systems.
- *Training and education:* There is no funding source available to train home care workers, thus limiting the supply of workers. The logistics of offering training in rural areas is difficult and expensive resulting in a lack of adequate training resources. Without training the worker supply is severely limited. In addition, the currently approved PCA training curriculum is not culturally appropriate and does not meet the needs of workers or their clients. Tribal health organizations are advocating for a skills-based training with more clinical and hands on practice, as well as competency based testing. The LTC Committee and DHSS staff are currently working together to develop a competency testing tool and process that will better meet the needs of workers in rural areas.
- *Marketing and community education:* The success of efforts to recruit, retain, and maintain a quality long term care workforce depends on a variety of related factors. One important influence on individuals' decisions to enter and remain in the long term care field is how society values the job. First of all, the lack of understanding of the aging process and the value of the long term care workforce is a national problem. In general, direct service worker jobs in long term care are viewed by the public as low wage, unpleasant occupations that involve primarily maid services and care of incontinent, cognitively unaware old people. This image is exacerbated by media reports that feature poor quality care by long term care workers. Stakeholders in long term care must organize to improve the image of direct care workers by collaborating with advocacy networks to promote public policy and community education that enhances and supports the workforce. Tribal health organizations will play an active role in advocating for change in their respective regions.

- *Worker rules and requirements:* State and federal Department of Labor rules, such as overtime rules and travel and mileage reimbursement, limit flexibility for home care workers. The work is usually less than full time and can be sporadic. Lacking regular hours - the number of hours worked can range from 2 hours one week to 10 hours another week and 35 the next - the workers cannot depend on a steady, predictable income. There are different rules and hiring requirements for each type of home care worker (respite, PCA, chore), which makes scheduling, hiring and training complicated.
- *Professional development and opportunities for upward and/or lateral mobility:* In the current delivery system the primary provider of direct services to clients are paraprofessionals – Personal Care Assistants (PCAs), Certified Nursing Assistants (CNAs), Chore Workers or Respite Workers. The same worker might be variously referred to under any one of these titles, depending on the tasks they are doing and the program under which they are being paid. For each of these worker types there are different qualifications, training requirements, compensation and work rules which can cause considerable confusion for the worker, the client and the provider. One individual worker may function as a PCA, a chore worker and a respite worker all in the same day. The documentation required to account and bill for this individual’s time as the work role changes throughout the day is difficult at best. Or, a client may be confused when three different people come to their home in one day to provide their care - each doing a different set of tasks. The LTC Committee is currently working on the development of a “universal” worker position that would have three tiered levels --- Home Care Worker I, II, and III. The types of tasks and skill level needed by the worker would increase as they worked up the levels, which would enhance the versatility, the value and the pool of available workers.

C) Regulation

It is vital that the regulatory environment in which the tribal health system operates allow for the flexibility needed to build culturally relevant and sustainable home and community based programs. In the current service delivery environment, the State and federal regulations and subsequent policies for home and community based services do not foster or offer the flexibility needed for the development of such programs. Also, the fact that regulations change over time depending on the priorities of government, and such changes are often made without adequate and timely input by tribal health providers inhibits the provision of consistent services. Both the State and the tribal health system can benefit from designing a regulatory environment that promotes workforce development, provides adequate funding for the services, and fosters timely access to quality services for Alaska Native elders and people with disabilities.

The tribal health system is committed to developing and incorporating home and community based services into the tribal health service delivery system. In order to be successful in that effort, the tribal health organizations have identified regulatory issues that need review and improvement. More specifically, current regulations, including State and federal, pertaining to service flexibility; prior authorization and care plan approval processes; client assessment; Medicaid eligibility; guardianship/power of attorney issues; criminal history background checks; training and education requirements; and the monitoring processes all present challenges to the provision of timely, appropriate, culturally relevant and consistent services.

Regulatory changes over the last 7 to 8 years have impacted the ability of the service providers to meet the LTC needs of Alaska Native elders and people with disabilities. As a result, many tribal health organizations have elected to eliminate particular services, such as personal care,

respite, etc.; and other tribal health organizations have elected to offer home and community based services, such as respite, care coordination, and chore, only on a limited basis. Below is a brief summary of regulatory issues which have been identified by the tribal health organizations as impacting a clients' access to needed services and the viability and sustainability of the services in general:

- *Service flexibility:* Rules regarding who can provide the services, family member or trained staff, etc.; where the services can be provided, in the home or community, etc.; when the services can be provided; and the definitions of allowable and excluded services.

Rural home care staff report: *Our agency services 38 Interior villages in Alaska. Most villages can only be reached by air. In the past we had a very active PCA program serving our villages; however, the program was dropped back in 2005 when many of the regulations changed, funding was cut and we could not afford to train new providers for our Agency Based PCA Program. The Waiver program has also proved very difficult to maintain. One of the main hurdles has been the increase in the face-to-face visit requirement from 2 times a year to 4 times a year. The rising cost of fuel has increased the cost of flights to the village, as well as a tank of gas to drive to the village.*

- *Approval and prior authorization:* The system for approving care plans and authorizing services is costly and time consuming causing delays in access to services for clients and the inability of providers to sustain programs.

Client story demonstrating assessment delays due to inaccessibility of rural villages as reported by home care staff (included with permission from the client): *In February, I went to Minto to visit an elder who was crippled with arthritis and had great difficulty getting out of bed. Her family was providing 24 hour care for her and requested that she be screened and assessed for services. It is important to note that Minto is located on the road system north of Fairbanks and, half of the 8 hour drive is on a dirt road which crosses over a high pass and can be very dangerous when whiteout conditions occur in the winter. The road is not well traveled, so if something happens, especially when the temps can reach 60 below, it can be a very dangerous experience. There are only 3 flights a week to the village, so if you do want to fly over to see the clients, it is a 3 day trip. After visiting the elder in her home, I felt she would meet PCA and CHOICE Waiver criteria. I turned in a screening indicating her needs in late February and 2 months later I was contacted by the State nurse assessor asking me if I would accompany her on a day trip to Minto to assess the elder. She was surprised to hear that it is not just a "day trip" whether you drive or fly - more like a 3 day trip. By the time the nurse assessor completed the trip to Minto and approved services for her, it had been 3 months since I first visited the client in Minto. A full understanding of the rural areas and access issues is vital to getting needed services to our people.*

- *Gateway to services:* The current process required for a person to access the LTC system is difficult at best; specifically, assessing a clients' need for services is complicated with lots of paperwork, requires a long wait to get an assessment, is very costly (due to the need for RN level assessor to travel statewide to conduct assessments and then have follow up reviews by several other levels of staff), and is not always conducted in a culturally sensitive manner. There is a need for local assessors, one assessment tool for all services and "no wrong door" for accessing the system.

Client story that demonstrates the need for culturally sensitive and local assessment staff as reported by home care staff (included with permission from the client): *One of the State nurse assessors from Anchorage traveled to one of our villages to assess an 80 year old woman. In doing the cognitive screening part of the assessment, she gave the woman three words at the beginning of the interview and asked her to remember them (a standard test used in cognitive screenings). At the end of the interview the woman did not remember any of the words, and therefore was determined to have some cognitive problems - thus the assessment was completed and needed services identified and approved based on the client having cognitive difficulties. Our local staff tried the same test with the woman later, giving her the words in Yupik (because that is her primary language); and she remembered all the words with no problem. The client had no cognitive difficulties, but she did not fully understand English as it is not her first language. Therefore, the services approved for her were not appropriate, due to the inaccurate assessment of her needs.*

Home care staff report (included with permission from the client): *A 69 year old male at Providence Extended Care for a long term stay decided to leave the nursing home to live with his daughter. The client was discharged from the nursing home on 11/15/07 and the PCA agency was contacted to get PCA services started. The client waited for months to get PCA services in place. The client was informed at first that PCA hours could not be approved if the assessment was done in the nursing home (which was done prior to his discharge date). Next the client was informed there was a backlog of assessments and he would need to wait his turn, though he should have had services immediately as part of the discharge from the nursing home. He was then assessed in his home and had to wait for State staff to make a determination regarding how many hours he would receive. The client finally received notification of PCA hours on 3/26/08. He waited more than 4 months for services to begin - this situation placed an undue stress on him and his family.*

- *Medicaid eligibility:* Issues relating to eligibility for Alaska Natives receiving tribal dividends are complicated and prevent consistent delivery of services to clients. Many people are still reluctant to enroll in Medicaid; however, over the last several years tribal organizations have been very aggressive in educating communities regarding the need to enroll and have been successful in signing up more people and increasing their capacity for third party billing in general.
- *Power of attorney, guardianship and conservatorship requirements:* These legal tools are complicated and not used consistently across all service types. There is a need to investigate State and federal requirements and educate providers and care planners. Lack of understanding and use of these tools presents roadblocks which delay and/or can prevent access to services.
- *Criminal history background checks and fingerprinting process, including waivers and barrier crimes:* The system and rules are complicated and require research to determine the best way to apply the rules so as not to prevent workforce development, but also ensure safety of clients and workers, while not violating individual rights.
- *Program monitoring process:* The processes used currently to monitor and ensure the quality of service delivery is not adequate and does not foster quality improvement. Collaboration between the tribal health system and the State to develop an oversight and evaluation process that will ensure both parties that services are provided in compliance with State regulations and quality standards, and allow for feedback that can improve service delivery, is vital.

Client story demonstrating assessment delay resulting from inefficient communication and/or faulty system processes as reported by home care staff (included with permission from the clients): *Two clients were screened and admitted into assisted living in August, and confirmation of receipt of all necessary documents was received from the State the first week of September. For three months, when checking on the status of the assessment, we were told "any day now. The nurse will be there in a week or two." The residents were finally assessed in January. We received determinations at the end of February. When I asked if any consideration could be given to the fact that it took 5 months to get an assessment complete, I was told "you should have applied for General Relief; we only go back to the date of assessment". We would have applied for GR for our clients if we had anticipated that it would take 5 months to get an assessment, instead we were told the assessment would be in "a week or two" and so we kept waiting. We are unable to recoup any of the cost of the 5 months that the clients spent in the assisted living home waiting to be assessed.*

- *Worker training and education requirements:* Rules for testing are often complicated and not feasible in many rural areas, create barriers to workforce development, do not always meet the needs of clients, and need to be locally defined and/or based on client need. There is a need to research and design the best approach to meet the needs for developing an adequate number of competent and quality workers.

D) Organizational Capacity

In order to achieve the goal of developing a quality LTC service delivery system, tribal health organizations must be able to establish financially viable and self supporting programs. This means they must have the organizational capacity to bill Medicaid, and other payers for services provided within the tribal health system; encourage and support Medicaid enrollment of eligible clients throughout the state; ensure that program staff and financial staff are collaborating on the billing effort; make training and support available to all tribal provider billing departments and program managers; and develop a standardized approach to policies and procedures to ensure consistency and quality of services.

Many communities have the desire to provide LTC services, but the LTC services, but the vast array of funding sources and services is overwhelming and complicated. In the current service delivery environment, many are unable to build the organizational capacity, due to a lack of staff or the internal organizational structure and operating procedures needed to develop and deliver quality services. If there is inadequate capacity in any of the following areas, it creates a barrier to optimal service delivery:

- *Billing and other revenue support systems:* Developing and maintaining a competent billing office staff is a challenge in rural areas. Recruitment and retention of qualified accounting, business office and IT staff is an ongoing challenge; loss of billing personnel results in ongoing training and technical assistance needs from the state and state contractors. Tribal organizations have purchased billing and accounting systems but often do not have technical support from vendors or sufficient information technology staff to support their systems. The ATHS has promoted development of financial infrastructure through the CFO group and training opportunities, but this infrastructure is less developed than health care systems in urban areas.
- *Smaller organizations' inability to achieve economies of scale:* The high cost of delivering services, exacerbated by the small client base in rural communities, results in providers' inability to cover the overhead cost for the provision of services and impacts sustainability of those services.
- *Continuity and transition of program management:* In many long term care programs there are high rates of turnover in management staff, extended vacancies in key positions and a lack of organized transition plans. This can lead to lack of continuity in service delivery.
- *Coordination of care:* ATHS leaders recognize unresolved communication issues exist around the transfer of patients to and from the tertiary care facility and to the patient's home.
- *Workforce development and support issues, including worker supply and demand:* The provision of training at the local level is costly and must be provided on an ongoing basis to maintain adequate staffing levels in long term care.
- *Coordinated data collection systems:* There are disjointed systems within individual tribal health organizations and limited statewide data collection across tribal health organizations. Not all organizations are collecting the same information.

Communication technology from villages/clinics to regional and urban areas varies; there is no consistency in the types of systems used by all tribal health organizations

- *Communication and understanding between finance and program staff:* Often there is a disconnect between business office and program staff. Program staff need to understand the revenue cycle requirements in order to support proper billing and collection, and financial staff need to understand how the program operations work to ensure they are fully capturing all potential charges.

Part III: Home & Community Based Service Development

With a significant increase in State Medicaid funding for LTC services expected in the near future, the enhancement of LTC services offered by the tribal health system will provide a great benefit to the State and the tribal health system. The tribal health system is committed to working with the State to develop and incorporate home and community based LTC services into their tribal service delivery system. The primary goal is to offer home and community based LTC services that are financially viable, self supporting, culturally appropriate and delivered in a timely manner. To accomplish this goal, the tribal health organizations agreed to the following general approaches to guide them as they planned and worked to determine solutions and strategies to develop the LTC service delivery system that would meet the needs of Alaska Native elders and people with disabilities.

- Identify a committed group of people who can advocate for, develop and provide the services.
- Ensure that the leadership is fully committed to the development of LTC services.
- Ensure that cultural components, such as traditional foods and activities, are considered in the development of services.
- Always bring elders in as decision makers and advisors.
- Local, regional and State agencies must coordinate and cooperate to ensure the needs of elders are met.
- Include community outreach and education in the system.
- Find, train and retain a dedicated workforce – ensure they have understanding of the culture and are suited to LTC work.
- Develop ways to incorporate youth in the service delivery system. This will ensure longevity of workforce, encourage understanding and respect for elders, and increase value of elders in our society.
- Develop an effective care coordination system to ensure appropriate services get to elders, to promote quality, to ensure cost effectiveness and make the services available for all clients, not just Medicaid clients.

Section 1: Proposed Alaska Tribal Home & Community Based Service Delivery System

A) Need for Services

By analyzing population growth and estimating the functional abilities and limitations in the population, predictions can be made regarding the need for home and community based long term care services. When looking at population growth, it must be noted that much of the projected population change is based on rates of migration; and with the added effects of intrastate migration, Alaska's regions, boroughs and census areas are susceptible to much greater volatility than the state as a whole. The Alaska Department of Labor & Workforce Development projects a trend of rural to urban migration, with the most rapid increase occurring in Anchorage and the Mat-Su Valley - specifically expected to increase by approximately 36%, with a 1.26% average annual growth rate, from 359,987 in 2006 to 488,553 in 2030. In addition, the "Status of Alaska Natives Report 2004" shows a steady increase in the urban Native population due to migration from rural areas. Anecdotal information from Southcentral Foundation's Elder Program indicates a growing need for services and a high number of people moving to Anchorage and the Mat-Su Valley from more rural areas of the state.

Table 5 depicts the number of Alaska Native people in need of home and community based services in Alaska as a whole for 2004 and projected to 2020. The estimates were calculated by applying nationally accepted activities of daily living percentages to the Alaska Native population to determine the number of people with disability needs, as follows: 65–74 age group = 9.3% disabled; 75 - 84 age group = 25.9% disabled; 85+ age group = 34.9%. An additional 20% of the total number of estimated disabled over age 65 was added to account for the under 65 population who would likely be eligible for an Adults with Physical Disabilities Waiver or personal care services. From this total, the number of people predicted to be in a nursing or assisted living home was subtracted, resulting in the total estimated number of individuals needing home and community based services, including PCA, chore and respite services.

It is important to note that these estimates are based solely on population figures, and there have been changes in population between 2004 and today. However, current information on population by ethnicity, age group and region are not available. These figures also do not consider any in-state migration patterns. For example, the Anchorage 65+ Alaska Native population in 2004 was estimated at 1,054, whereas current numbers indicate there are 1,683 people in this category, an increase of 61%, which could be the result of in-migration. Calculating that increase would show that there are 215 people in Anchorage with a disability rather than 133.

TABLE 5: Projected Need for Home & Community Based Services Statewide Totals for Alaska Native/American Indians (2004 & 2020)			
<i>Age</i>	<i># of AN/AI Individuals</i>	<i>% at risk</i>	<i>Demand</i>
65-74	4,444	9.3%	413
75-84	1,980	25.9%	513
85+	580	34.9%	202
<i>2004 population Totals</i>	<i>7,004</i>		<i>1129</i>
20% of total for under 65			226
Total disability estimate			1354
less assisted living demand			203
less nursing home demand			160
<i>Total People with HCB needs in 2004</i>			<i>991</i>
2004 plus 77% pop growth			1998
20% of total for under 65			400
Total disability estimate			2397
less assisted living demand			360
less nursing home demand			283
<i>Total People with HCB needs in 2020</i>			<i>1754</i>

Table 6 presents a summary total of the need for home and community based services by region. The totals in the table show that there will be approximately a 75% increase in the number of people needing home and community based services from 2004 to 2020. Additional tables with specific data for each region or service unit is presented in Appendix C of this document.

TABLE 6: Total AN/AI Home & Community Based (HCB) Needs by Region (2004 & 2020)		
<i>Region</i>	<i>Total # People with HCB Needs in 2004</i>	<i>Total # People with HCB Needs in 2020</i>
Anchorage Service Unit	133	236
Barrow Service Area	45	79
Kotzebue Service Area	60	90
Norton Sound Service Area	75	132
Yukon Kuskokwim Delta	184	326
Bristol Bay Service Area	54	95
Aleutians - Rural Service Unit	17	32
Kodiak - Rural Service Unit	27	48
Anchorage Service Unit Mat-Su	28	51
Kenai Peninsula Rural Service Unit	44	78
Valdez & Cordova Rural Service Unit	30	38
Mt. Edgecumbe / Annette Is. Rural Service Unit	186	330
Interior Service Unit	126	224
<i>Total - All Regions</i>	<i>1009</i>	<i>1759</i>

(* Note: differences in the totals of the two tables are due to rounding)

B) Service Package

The following “Home & Community Based LTC Service Delivery Planning Tool” was used to gather information and formalize the ideas provided by the tribal health organizations as they began the journey to design a long term care service delivery system. The information presented in the tool provides a picture of the LTC service package that the Alaska Tribal Health System proposes to have available to Alaska Native elders and people with disabilities.

More specifically the tool provides the following information:

- The LTC tasks and/or functions that must be available to Alaska Native elders and people with disabilities
- A brief description of what is provided now, including what works and doesn't, and how it can be redesigned or fixed
- Detailed information about what the service delivery system will look like (who, what, where)
- Information about how the function will be supported or financed, including funding plans and ideas (some of the LTC services will be funded by Medicaid, but there are others for which other funding sources will be used - alternative ways of funding and/or supporting services will be researched and developed, including but not limited to grants, local sharing of resources, private pay, volunteer networks, etc)
- Information about how the Alaska Tribal Health System plans to make it happen (many of the services will be provided by the tribal health organizations, but some will be provided by other organizations in the local community - the tribal health organizations will coordinate with these other entities to ensure that Alaska Native elders and people with disabilities are served; to ensure that services are high quality and culturally sensitive; and to prevent unnecessary duplication of effort.)
- Eligibility (very general information about proposed eligibility for specific services is provided - more specific qualitative and quantitative information about what determines eligibility, such as levels of care, levels of impairment, cognitive issues and substantial human assistance needed, will be researched and developed)

It is important to note that the Tribal Home & Community Based LTC Service Package is not complete with all details at this point in time; rather it lays out what is known now and identifies areas, services and/or issues that need further research and development. The LTC Committee will form several subcommittees to focus on the next steps, including: prioritization of services needed; bundling of services into packages to be provided to individuals meeting eligibility requirements for that package; and identification of which service packages need to be implemented first in order to make basic services available as soon as possible and help to keep tribal health organizations operational while the building of the LTC system continues to develop.

SERVICE PACKAGE

Home & Community Based LTC Service Delivery Planning Tool

LTC task or function that must be available for Alaska Native elders & people with disabilities	Is the function or task available now or not - does it need improvement?	Entity providing task or function now or entity proposed to provide it and where (THO, other provider, specific names)	Description of the LTC care task or function and how it will be offered within the tribal health system (Will it be centrally managed and by whom; home and community based or facility based; any other details that help ATHD and State understand what the service and the overall system will look like)	General plan for implementation of service (Redesign and/or improvement of current service delivery)	Staffing (Identify types of staff needed to provide the service)	Funding plan (Basic principles to be considered; details to be decided)
Home and Community Based Services						
<p>Assistance with the upkeep of the client's home, including cleaning, cooking, laundry, limited shopping</p> <p>(currently offered through "chore" and "PCA" programs)</p>	<p>Yes, available now but service levels have been reduced; only available for waiver clients and grants in some areas; needs to be available for all</p>	<p>Current = BBNA, Southeast Senior Services, TCC, Senior Citizens of Kodiak, Nome Community Center, Maniilaq</p> <p>Proposed = all THOs at village level</p>	<p>provide: surface cleaning of the home to ensure a safe & healthy environment, changing bed linens, laundry, meal preparation, limited shopping; heavy cleaning; in rural AK -chopping wood, empty honey buckets, haul water, hauling laundry to washeteria</p> <p>Home-based service (not facility based) provided & managed by THO under an agreement with the State</p> <p>Available for all clients who need the service, not just clients on a Medicaid waiver - even if they are not yet in need of higher levels of service (NF LOC)</p> <p>Provided by Home Care Worker Level 1 or in combination with other tasks provided by Level 2 and 3 workers</p> <p>Ensure adequate time allowed to do tasks</p>	<p>Qualifications/training: THOs to create Job Description to define worker qualifications; THOs to determine what training will be required</p> <p>Allowed tasks: define all tasks to be done on care plan for each client</p> <p>Eligibility: All assessed clients who have the need regardless of NF LOC, including elder who lives alone or has caregivers that do not provide cleaning, cooking, etc.</p> <p>Develop standardized time allowed to provide service - eliminate cumbersome "time per task" system</p>	<p>Home Care Worker Level I (entry level)</p>	<p>Seek other funding for non-Medicaid clients; make an agreement with the State</p> <p>Reimburse gas and/or mileage between clients</p> <p>Medicaid Cost-based reimbursement</p>

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Home and Community Based Services (continued)						
<p>“Fill in” workers who function as surrogates for the primary caregivers; provides them with a break away from the day-to-day responsibilities of care giving</p> <p>(currently offered through “respite” programs)</p>	Yes, available now but only on a limited basis to clients on a waiver and through DHSS grant funds; needs to be available for all who need it	<p>Current = Norton Sound; TCC; Aleutians, BBNA; Center for Community, Alzheimer’s Resource Agency, etc.</p> <p>Proposed = by all THOs at village level</p>	<p>Worker will function as a “substitute” or “surrogate” for the primary caregiver to give that person a break providing tasks needed based on the client’s care plan</p> <p>Home-based service provided hourly or daily and managed by THO; or daily by adult day center or extended in AL home</p> <p>Available for all clients who need the service, not just clients on a Medicaid waiver - even if they are not yet in need of higher levels of service (NF LOC)</p> <p>Ensure service limits are adequate to meet needs</p> <p>Provided by Home Care Worker Level 1, 2 or 3 depending on types of tasks done by primary caregiver</p>	<p>Qualifications/training: THOs to create Job Description to define worker qualifications; THOs to determine what training will be required</p> <p>Type of worker for each client (Level 1,2,3) is dependent on level of care need of client</p> <p>All assessed clients are eligible - including elder whose caregiver goes to work or is out for subsistence, appointments, etc.</p> <p>Review assessment & care plan tools to ensure the need is defined & supported on care plan</p>	Home Care Worker Level 1, 2 or 3 - based on level of care client receives from primary caregiver	<p>Seek other funding for non-Medicaid</p> <p>Develop standardized hourly/ daily rates depending service location</p> <p>Medicaid Cost-based reimbursement</p> <p>Reimburse gas and/or mileage between clients</p>
<p>Socialization and companionship</p> <p>(often called companion care)</p>	Currently not available	<p>Current = none</p> <p>Proposed = by all THOs at village level</p>	<p>Types of tasks:</p> <ul style="list-style-type: none"> • Assistance with visiting friends & family • Letter writing & handling mail • Assistance in attending social activities • Activities to stimulate mobility • Activities offering mental stimulation • Basic meal prep for client only • Light housekeeping for client only • In-home respite for client only <p>Proposed in lieu of adult day & day habilitation programs that are not available in rural Alaska</p>	<p>Qualifications/training: THOs to create Job Description to define worker qualifications; THOs to determine what training will be required</p> <p>Non-ADL type of services defined on care plan for each client</p> <p>All clients meeting program criteria are eligible - including elder whose caregiver goes to work or is out for subsistence, appointments or elder who lives alone or alone majority of day</p> <p>Develop a volunteer network</p>	Home Care Worker Level 1 Volunteers	<p>Seek other funding for non-Medicaid</p> <p>Research obtaining a waiver for this</p> <p>Volunteers (not billable)</p> <p>Medicaid Cost-based reimbursement</p>

Home & Community Based LTC Service Delivery Planning Tool						
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Home and Community Based Services (continued)						
Assistance with basic daily living needs such as bathing, transferring, dressing, and grooming (currently offered through PCA programs, CHRs or CWAs)	Yes, but they have been dramatically reduced; services are available in 2 regions only; 3 regions discontinued services; needs to be expanded to meet needs in all regions	Current = THO in YK Region (YKHC), Northwest Arctic Borough (Maniilaq), and numerous private CDPCA agencies including but not limited to Consumer Direct Services, Access Alaska, Ready Care, Caridad, etc. Proposed = by all THOs at village level	<p>Worker will provide: hands on & stand by assistance with bathing, dressing, eating, transferring, grooming, assistance to medical visits, all non-invasive and based on needs identified in each client's care plan</p> <p>Workers allowed to perform tasks trained by RNs, OTs, RTs and PTs within their scope of practice & supported by care plan (through telemed)</p> <p>Home & community based at village level - can be provided in client's home or other community location such as gym, MD office, tribal clinic, etc.</p> <p>THOs responsible for: assessment function, managing the program, providing monitoring & oversight to ensure compliance</p> <p>Serve Medicaid, non-Medicaid and private pay clients</p> <p>Allow flexibility in service to address rural and cultural differences</p> <p>All tools must be simplified, standardized, and coordinated with State, including: the assessment tool, the care plan and the charting system</p> <p>Consumer directed & agency based models redesigned into one model that allows best features of each</p>	<p>THOs will assign a committee to review current regulations & determine what needs revision</p> <p>THOs will collaborate with State to develop oversight & evaluation process</p> <p>Qualifications/training: THOs to define realistic qualifications for all worker levels; THOs will work with CHAP & State to set up training system, education & requirements that are standardized, allow lateral movement & specialty training areas for workers</p> <p>Research & redesign background check system to foster workforce development and client safety</p> <p>Review & revise CPR and FA requirements to address rural issues</p> <p>Allow only IADLS directly associated with ADL assistance, no heavy work - those needs should be met by services listed above - unless not available</p> <p>Clients who meet the need for at least 2 ADL needs are eligible</p>	Home Care Worker Level 2 or 3, depending on client needs	<p>Research other funding for non-Medicaid clients</p> <p>Reimburse gas and/or mileage between clients</p> <p>Medicaid Cost-based reimbursement</p>

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Home and Community Based Services (continued)						
Assistance with dispensing medications	<p>Need more information</p> <p>Involve pharmacy providers in the process; set up a pharmacy work group</p>	<p>Current = All health corp pharmacies & CHA/P for their formulary; some health corp pharmacies do fill medisets or bubble packs</p> <p>Proposed = by all THOs at village level; not sure what type of worker; virtual support & training by centralized entity</p>	<p>Worker will provide: medication reminders, filling medisets, assist with taking medications, and "med checks" to ensure taking medications correctly</p> <p>Home and community based on the village level; and managed by the THO</p>	<p>Research regulations re: dispensing & administration of medication</p> <p>Research certification course to allow workers to administer and/or dispense meds</p> <p>Investigate home telehealth capacity; centralize training & support system (virtual); piloting in several THOs</p> <p>Eligible clients: any client taking 2 meds or more or has dementia</p> <p>Qualifications/training: THOs to define realistic qualifications for all workers; and develop standardized training process & procedures</p> <p>Collaborate with State - get buy-in</p>	<p>RN</p> <p>MLP</p> <p>CHA/P</p> <p>Rural pharmacy</p> <p>LPN</p> <p>Level 3 Home Care Worker, if they have a certified medication administration & dispensing course- if available in AK</p>	<p>Research & develop a way to reimburse for task</p> <p>Reimburse gas and/or mileage between clients</p> <p>Medicaid Cost-based reimbursement</p>
Assistance with taking medications	<p>Yes, provided by PCAs</p> <p>Needs to be better training, oversight and support</p> <p>Need better coordination with all health care providers</p>	<p>Current = PCAs</p> <p>Proposed = by all THOs at village level; Home Care Worker Level 2 & 3</p>	<p>Worker will: assist clients in getting medications out of bottle & to mouth, to get water; medication reminders, and "med checks" to ensure taking medications correctly under direction of MD, RN, MLP, Ph</p> <p>Prescribed type & amount of medication already determined; no judgment needed on part of worker</p> <p>Home and community based on the village level; and managed by the THO</p>	<p>Home telehealth capabilities (i.e. IMD - interactive medical device)</p> <p>Qualifications/training: THOs to define realistic qualifications for all workers; and develop standardized training process & procedures</p> <p>Collaborate with State - get buy-in</p> <p>Develop a centralized training & support system (virtual)</p>	<p>Home Care Worker Level 2 or 3</p> <p>CHA/P</p>	<p>Medicaid Cost-based reimbursement</p> <p>Reimburse gas and/or mileage between clients</p>

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Home and Community Based Services (continued)						
Care provided by skilled, licensed practitioners (RNs, Physical Therapists, Occupational Therapists, Speech Therapists, Respiratory Therapists, therapy assistants)	Service is not available in most regions; only a few providers of home health services in Anchorage	Current = SCF only Proposed = by THO or other organization at village level	Workers provide all medical & therapy services authorized by Medicare under rules for home health, respiratory therapy, and infusion pharmacy. Must be State licensed Centralized support & training (virtual) Skilled & licensed staff; others who are trained and supervised by licensed staff Offer in villages, but mostly hubs where skilled licensed providers are available	Research & develop regional satellite centers Institute standardized procedures, forms, etc. and train staff to use Eligible: any client that needs skilled care & has it documented in their care plan Look at insurance coverage for skilled professionals outside of medical facility Collaborate with State - get buy-in	RN Home Health Aide MLP (PA/ANP) Therapists: OT, PT, RT, ST Trained family member or Home Care Worker	Medicare Medicaid Cost-based reimbursement Private Insurance Reimbursement must include travel costs
Spiritual & Bereavement Care (pastoral care)	Available in Anchorage only on a very limited basis Needs to be available in all areas	Current = none other than SCF and ANMC pilot project Proposed = by THO or other entity at village level; or provided at home or in hospice beds at local hospital, NF or ALH; home care workers	Worker will provide: counseling & support; spiritual screening; psycho-social assessment; anticipatory care planning; ethical support (wills, POA, etc.); anticipatory grieving; may also include cultural activities & ceremonies Centralized support & training located at ANMC or ANTHC (virtual), including volunteers Offer in villages & regional satellite centers Specific services needed will be assessed & implemented as part of the care plan developed by Case Mgr or Care Coordinator	Look at informal systems used in communities now - collaborate with local pastors, THO counseling services, priests, etc. Research ways to formalize these systems Check possibilities of a volunteer network of professionals - area pastors or other clergy Offer bereavement counseling through palliative care Eligible: clients newly diagnosed with major disease or terminal diagnosis & their family members Collaborate with State - get buy-in	RN Social Worker CHA/P BHA Home Care Workers (with special training focus on death & dying) Pastors Volunteers	Research potential funding Volunteer services (not billable)

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Home and Community Based Services (continued)						
Palliative Care (pain management, education, end of life care)	Yes, service is available on a very limited basis; provided through pilot project (EAT); and non-tribal org in Norton Sound Needs to be available in all areas	Current = EAT, Norton; some others do informally (YKHC); ANMC pilot project provides education to terminal pts leaving ANMC; have \$\$ for RN to travel to train family/CHA/P, etc. Proposed = by THO or other entity at village level; or provided at home or in hospice beds at local hospital, NF or ALH; home care workers	Much like hospice care Services include: pain & symptom management; nursing care; medication management; infusion therapy; education & counseling re: end of life; and counseling re: goal shifting (i.e. realistic end of life goals) Eligible: clients diagnosed with terminal condition; care needs documented on their care plan Centralized support & training (virtual) Located at ANMC or ANTHC Regional satellite centers	THOs define worker qualifications Training: THOs develop standardized training process & procedures to be offered in central location such as ANMC, Providence or other IHS entity for staff interested in getting qualified to provide services as a THO team, e.g. nursing, pharmacy, counseling (SW or BHA), CHA, Home Care Worker and volunteers Collaborate with ANTHC/ANMC cancer program on training & implementation Consider: workers would be a part of THO Hospice/Palliative Care team; team to function like a Home Health Agency requiring a provider referral for services; initial assessment done by RN & care plan established for needs; volunteers to supplement team providing additional visits; recommend using community hospice agency model	RN Social Worker CHA/P Home Care Worker Level 1, 2, 3 BHA LPN Pastoral care provider Volunteers	Volunteer Program supported by THO (not billable) Medicaid Cost-based reimbursement Research waivers for this Research ways to tie tasks to reimbursable service
Access, Safety & Comfort in the home or community (Assistive technology & DME)	Generally there is no organized system THOs can enroll to provide but do not have volume to make it work & payment does not cover costs	Need more information	Service would provide medical equipment (DME) & assistive technology to help clients stay home or in community Must include assessment of client's need; referrals; coordination & expediting of equipment; transport; set up in the home; training re: use of equipment; and follow up THO to manage & centralize the effort	Clarify service definition, define THO role, develop standardized criteria & procedures so all client's have equal access Eligible: elders & people with disabilities with need for this on their care plan Provide & manage centralized DME "loan closet" to recycle items		Federal & State grants Medicaid cost-based reimbursement Private funding

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Case Management Services						
Assessment of current status and the need for services	<p>Yes, currently conducted by State staff for PCA, DD, & waiver clients; conducted by other entities for specific programs and grants</p> <p>Process needs improvement - local assessors, culturally sensitive, improve timeliness</p>	<p>Current = KANA has just begun the Comp Elder Exam; YKHC Chronic care pilot; BBAHC has grant funding for comp elder exam training and implementation</p> <p>Proposed = by all THOs at village level; one standardized assessment for each client to be used universally</p>	<p>Comprehensive Elder Exam (to be used for all programs, providers; one for each client; conducted by THOs in each region or village):</p> <ul style="list-style-type: none"> • Identify level of need • Identify available resources • Review or redo annually • Use standardized tool • Cognitive status assessment • Social network assessment • Depression scale • Home safety component • Gait & balance assessment • Medication review • Screenings for prevention (cancer, etc.) • Bio-psycho-social evaluation <p>Collaborate with State to define TTCM for THOs; define expectations; resolve payment issues</p>	<p>Implement Comprehensive Elder Assessment (use KANA model & tools):</p> <ul style="list-style-type: none"> • Tinetti Gait & Balance Assessment • Falls Risk Assessment • Med Review • Nutrition Assessment • Functional Status Assessment • Home Safety Assessment • Elder Assessment Interview • Mini-Cog exam <p>Worker must be: Trained assessor/coordinator</p> <p>Implement TTCM program</p> <p>Eligible: all elder and people with disabilities</p>	<p>Must have flexibility in staff level authorized to do the assessment - Geriatric Assessment Team:</p> <ul style="list-style-type: none"> • RN, LPN • MLP • MD • CHA • Social worker • Case Mgr • Pharmacy • BHA 	<p>Medicaid Cost-based reimbursement</p> <p>Research other possible funding sources</p>
Development of a care plan based on identified needs and available resources	<p>Yes, done now by all THOs</p> <p>System is very disjointed; different care plans done for different services or providers</p>	<p>Current = KANA, BBNA, Maniilaq; Norton Sound; SCF; YK; TCC; Aleutians; numerous non-tribal agencies</p> <p>Proposed = by all THOs at village level</p>	<p>Service includes: formulation of a plan of care based on assessed needs; assists client in locating resources & obtaining services; identifies wellness & prevention activities</p> <p>THO to manage & standardize the effort</p>	<p>Eligible: all elders and people with disabilities on a waiver or TTCM</p> <p>THO will develop & standardize the process & forms to foster consistency</p> <p>Research using "care plan software"</p>	<p>RN, LPN</p> <p>Trained Care coordinator</p> <p>Certified Case Manager</p> <p>Social worker</p>	<p>Medicaid Cost-based reimbursement</p> <p>Research other possible funding sources</p>

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Case Management Services (continued)						
Manage, support and monitor the care plan for the client (currently offered under Case Management or Care Coordination programs)	Yes, provided by all THOs on limited basis Needs improvement: process not standardized	Current = KANA process follows from the Geriatric Assessment Process; Maniilaq; Norton Sound; YK; SCF; TCC; Aleutians Proposed = all THOs village level	Service includes: <ul style="list-style-type: none"> • Case management • Chronic Care Management • Care coordination • Medication management • Assist with completing and understanding paperwork • Monitor success/quality of service delivery 	Improve care coordination Implement TTCM Implement CCM Program Use IHS iCare population management software - reviews every 3 months Incorporate home telehealth technology	RN, LPN CHA MLP	Medicaid Cost-based reimbursement Research other possible funding sources
Other Services						
Food & Nutrition (encourage good nutrition make healthy food available)	There are only a few funded nutrition programs in rural areas because many kitchens in villages do not meet DEC standards due to the unavailability of water and sewer services in many locations in the state.	Current = through Senior Center grants; AOA grants; private providers; local governments Proposed = by THO or other organization at village level	Service includes: <ul style="list-style-type: none"> • Congregate meals • Home-delivered meals • Food box program THOs need maximum flexibility in designing nutrition programs in rural areas to assure that clients receive adequate nutrition	Define & use local "community standards" for food service sites Screen for nutrition, referral & follow up, provide some education Develop screening tool; determine type of worker to do work Screening, referral & follow up education Training on screening tool; assessor – maybe a higher level CNA at minimum Eligible: all Elders and people with disabilities	Food service workers Drivers Dietitians Home Care Worker Level 3 (special training focus on nutrition, wellness & health promotion)	Federal & State grants Private funding Medicaid Cost-Based Reimbursement

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Other Services (continued)						
Provide or coordinate access to services (Transportation)	Yes, available in most areas Problems: not available to all in need; no drivers; not coordinated; for medical only; reimbursement rules too narrow	Current = most THOs but not all Proposed = by THOs or other organizations at village level	Coordinate all transportation needed by tribe - head start, meals, medical, shopping, etc. Provide actual transportation service - vans, cabs, snow machines, boats, four wheelers, vouchers, etc. Allow transportation for both medical & non-medical reasons Allow reimbursement for gas and/or mileage	THO to develop standardized voucher system for cabs; work out agreement with local cab companies or other public transportation companies THO to implement cost-sharing system whereby elders and disabled can purchase cab voucher booklets at 50% discount	THO staff coordinator for the program Someone who can organize, monitor and manage the process & the payment system	Medicaid Cost-Based Reimbursement (medical related travel) Federal/State grants Private funding
Accessible & safe housing	Yes, available in most areas Better coordination needed	Current = through assessment process by local housing authorities Proposed = same	Services include: • House modification program • Environmental modifications • Home safety assessment & inspection Utilize "construction trade" programs to do work; eliminate three bid requirement as availability of contractors is limited in villages. Assure adequate funds are available to cover the cost of materials, shipping of materials and maintenance of installations.	THO to coordinate with local Housing Authority Review & revise environmental modification provider type & rules Research using "construction trade" programs to do the work	No THO staff needed once the agreements are set up May need some staff time allotted to provide resource info	Federal housing funds Private grants Medicaid cost based for some EMs
Encourage wellness and healthy lifestyle (Wellness & Prevention)	Yes, some wellness and lifestyle activities are provided, but limited	Current = KIT has walking club, garden club; KANA has a gym program, a fall & balance program; APIA has a wellness education program & a yearly wellness convention	Services can include: • Prevention screenings • Gym time & exercise programs • Fall prevention & balance programs • Walking clubs • Garden clubs • Education programs - nutrition, wellness, prevention, health lifestyle	THO to develop standardized screening tool (flows & checklists) so all clients are approached the same way THO determine how education will be rendered (handouts, discussion, classes,) Eligible: All Elders & people with disabilities who want it	Home Care Worker Level 3 Combine the role with the assessment and screening staff to do the screenings Physical activity leaders	Private funding Coordinate with other entities - share local resources, such as gyms, pools Commit Medicaid funding for services

Home & Community Based LTC Service Delivery Planning Tool	
Feature	General Ideas for Framework of the LTC System
Staffing or Personnel for LTC work	<ul style="list-style-type: none"> Personnel for the LTC system will be Home Care Worker Levels 1, 2 or 3 <ul style="list-style-type: none"> Level 1 = qualified and trained to do Level 1 work in the client's home, including: chores; companion & socialization; respite at a Level 1 need; palliative care (with specific training) Level 2 = qualified and trained to do Level 1, 2 work in the client's home, including: chores; companion & socialization; respite at a Level 1 & 2; personal care & health related work; assistance with taking medications; palliative care (with specific training) Level 3 = qualified and trained to do Level 1, 2 & 3 work in the client's home, including: chores; companion & socialization; respite at a Level 1, 2 & 3; personal care & health related work; assistance with taking medications; nutrition education, wellness & health promotion (with specific training) The specific name of worker is yet to be determined; ideas = Home Care Worker, Elder Care Specialist, Community Outreach Worker, or term specific to the region, i.e. Sismisii, Iqayukti)
Training System & Requirements for LTC staff	<ul style="list-style-type: none"> Providing training and support for LTC worker positions will help to improve their status in the community by "professionalizing" them. By incorporating the positions into the CHA/P model, the workers will have opportunities for meaningful work and advancement through the tribal health system, thereby making these positions sought after for their importance in the functioning of each THO. The training system will be modeled after the CHA/P program. It will offer basic standard training for Levels 1, 2, 3 Home Care Workers. There will be additional modules or specialty trainings that all levels can add to their basic standardized training, including: medication administration; palliative care; end-of-life care; nutrition education, health & wellness promotion. This will allow workers to move laterally and be part of one system; no separate PCA, respite, chore, etc.; part of a "universal" worker system that addresses all needs of clients in the tribal health system. The training and support will be offered through a "virtual" approach to increase efficiency and decrease the costs. Combining and coordinating the use of higher level staff (who travel routinely to local satellites to provide some skilled care and oversight anyway) with the "virtual" system will allow necessary support and training to be on-going. Form committee to research and develop distance delivery system; collaborate with UAA Center for Human Development and Geriatric Education Center, as well as other partners, to share ideas and resources Collaborate with ANTHC/ANMC cancer program on training & implementation of palliative care tasks. Collaborate with Behavioral Health Committee
Funding Issues	<ul style="list-style-type: none"> Use cost-based reimbursement for HCB Services: define tribal delivery model; draft reimbursement methodology Develop reimbursement for Elder Health Care Exam (YKHC is piloting this program development) Research & consider Public Entity Waiver for HCB package of services: communicate concept & questions to CMS; define tribal LTC delivery model Research & consider PACE-type (capitated managed care) model: HCB LTC subcommittee has begun investigation; ANTHC consultants, Health Dimensions indicated that PACE is not feasible in the Anchorage area for the Alaska Native population, based on a demand analysis using a standard model for the U.S. general population. Discuss ways to tie palliative care tasks to a reimbursable service--i.e. call it something other than palliative care, like pain management, etc
Assessment Function	<ul style="list-style-type: none"> Function needs to be conducted and monitored by local provider (THO), in collaboration with the State Implement a "universal" tool that can follow client to whatever provider they see Assess everyone wherever and whenever they access the tribal health system - implement the Comprehensive Elder Exam
New Approaches to Service Delivery	<ul style="list-style-type: none"> Telehealth systems Distance education Home Teleassistance Technology
Organizational Capacity	<ul style="list-style-type: none"> Development of standardized manuals for operating tribal home & community based programs Develop & finalize business plan tool Development of billing system & revenue system tools

C) Organizational Structure

To help frame the thinking about the ideal organizational structure for the AHS LTC Delivery System, the LTC Committee first considered what a completely centralized system would look like and how it might operate. "Centralized" was defined as meaning all service delivery statewide would be administered by a single, statewide tribal health organization. That organization would not necessarily be ANTHC but potentially a new organization formed just for this purpose. The LTC Committee could not identify any real benefits of such a structure, but they were able to identify the downsides to a centralized organizational structure, including:

- It would not be an efficient way to use the existing regionalized AHS structure
- It would not support self-determination
- Training is better provided regionally to regional workers
- Centralized billing would be too cumbersome, take too long to get reimbursement, be more difficult to follow-up, and be more time consuming overall

The committee also considered a completely decentralized organizational structure. This structure would maintain all governmental functions with the state and federal governments as currently structured; leave direct service provision to the local and regional tribal health organizations, but incorporating the government policy and funding changes that have been requested; and develop and maintain a technical assistance and committee support role for the statewide tribal health organization.

Finally, the committee concluded that a combination of the strengths of both of these models, centralized and decentralized, would result in the ideal AHS LTC Delivery System organizational structure. This ideal structure would maintain a role for state government; however, some of the current state roles and responsibilities would be delegated to a statewide tribal health organization that would function somewhat like a county government in providing technical assistance, monitoring and support. (In the lower 48 some states use this "county" model successfully). The regional and local tribal health organizations would be the direct service provider and would assume more local responsibility and control. Under this envisioned ideal structure, roles and responsibilities would be divided as follows:

- State Government
 - Explain and interpret State and Federal Regulations and policies
 - Establish waivers, demonstration projects, etc.
 - Administer Medicaid program; provide cost-based funding
 - Compliance reviews, system evaluation, and quality improvement
- Statewide Tribal Health Organization
 - Support standardization of all regional tribal LTC programs
 - Policies
 - Training (Standardized curriculum and tests)
 - Forms and tools
 - Monitoring, including compliance, evaluation, and quality improvement
 - Data collection and analysis
 - Advocacy
 - Consultants, including clinical, pharmacy, physical and occupational therapy
 - Support statewide committee which would serve as the decision-making body

- Regional and Local Tribal Health Organizations
 - Direct service provider (employer of LTC workers)
 - Conduct assessments
 - Provide workers training locally
 - Conduct monitoring and oversight activities locally
 - Billing
 - Outreach and education for clients and potential clients
 - Continuing education for staff
 - Leadership

The committee also identified the “pros and cons” of the ideal ATHS LTC Delivery System organizational structure as described above, which include:

- Pros
 - THO’s have an established understanding of their people, including their challenges and opportunities
 - THO’s have greater understanding of the culture and appropriate approaches to respect and preserve the culture
 - Increased local control and management
 - Greater choice for clients
 - Increased size of client pool due to better access to services
 - Improved recruitment and retention of staff
 - Better allocation of resources through standardization and efficiency
 - Local control of business management, such as hiring practices, etc.
 - Increased tribal participation
 - 100% Federal reimbursement of State expenditures for state government
 - Requires less State staff to deliver services
 - Easier for State to work with the tribal system
- Cons
 - Implementation of new structure will take a lot of dedication and hard work
 - Increased resources such as staff, capacity & funding will be needed
 - The structure would create an additional layer of administration
 - There would be less State government control

The committee also recognizes that tribal health organizations have varying organizational capacities and some of the smaller tribal health organizations may need additional support to successfully fulfill the necessary roles and responsibilities in this ideal structure. To address this, the committee decided this ideal organizational structure could also be modified to add a component of technical assistance and administrative support to be provided by the Statewide Tribal Health Organization and available to all tribal health organizations as needed. With that kind of administrative support, smaller tribes would have the opportunity to provide LTC services without having to hire unnecessary administrative staff, thus making the cost of delivering the service impossible.

D) Program Standards and Definitions

Given the reality that there are a limited amount of resources available for LTC services, the tribal health organizations are committed to ensuring that there be an equitable approach to selecting and serving only those individuals most in need of services; and that the services they

receive are appropriate to those needs. The ATHS is aware of the fact that serving all people in need is not realistic given the limited resources. In an effort to determine appropriate eligibility and program standards, the LTC Committee developed a Subcommittee on Eligibility and Program Standards to focus on this work.

Presented here is the conceptual framework used by the subcommittee to develop factors to be considered when determining an individual's appropriateness for LTC services. A number of actual tools for screening and assessment were also reviewed, but in order to come up with a tool that will accurately and appropriately determine needs, while also using a measurable and practical approach, the subcommittee found it necessary to step back and determine what factors need to be considered to get an overall picture of the individual and their LTC needs. The subcommittee recommended that more specific qualitative and quantitative information about what determines eligibility, such as levels of care, levels of impairment, cognitive issues and the need for substantial human assistance, be researched further before beginning the next step of practical thinking about, and actual development of, the tool(s) that will appropriately and fairly select and prioritize clients to be served.

Overarching Concepts / Guiding Principles:

The following concepts and/or principles guided the sub-committee's work on eligibility:

- We cannot serve everyone so there must be criteria for determining the type of client/needs to be served by each program. It is too costly in terms of financial, workforce and organizational capacity to serve all.
- There must be a formal standardized prioritization tool used to determine who gets services when more clients are determined eligible than can be served. The tool(s) must offer an initial screening function, an assessment function, a scoring mechanism and a prioritization process.
- The tool must be designed to capture all who actually need the services; it must look at both medical/health issues & psycho/social issues.
- The process must consider psycho/social elements, in addition to medical model aspects, when assessing & scoring client needs; not just medical diagnosis & health status but also living environment, informal supports, resources or services available.

Approach:

- Identify factors to be considered when looking at client needs (need to consider the conceptual first - then move to practical tool - must be systematic & used consistently by all organizations)
- Identify HCB programs & functions/tasks to be offered under each service package (Look at prioritizing which programs will be implemented first in order to get services out to the regions in the short term. Future planning can continue but people need some services now.)
- Determine program standards & criteria a client must meet to gain access to each package of services

- Develop a tool or tools that will determine a client's needs; identify which program package can meet that need; determine whether or not the client meets the criteria to receive the services offered by the program package; and prioritize clients to be served (Don't reinvent the wheel, many samples available, State CAT/PCAT good but too complicated & long, contact Alzheimer's to obtain cognitive tools)
- Define the process to be used to screen, assess, score, identify resources & services, prioritize

Factors to be considered when determining eligibility criteria:

1. *Physical Health Status*
 - Acute and Chronic Diagnosis
 - Skilled Nursing needs
 - Medical equipment needs (oxygen, feeding tube, colostomy, catheters)
 - Mobility and safety equipment
 - Medication (number of Rx's and type)
 - Pain status
2. *Cognitive Status*
 - Orientation
 - Coping skills
 - Mental Health Issues
 - ETOH/Drug Abuse Issues
3. *Functional Limitations*
 - Ability to Perform ADLs: feeding (diet & nutrition), bathing, transfers, dressing, grooming, toileting, ambulation, mobility, medication administration, falls risk
 - Ability to Perform IADLs: prepare meals, housekeeping, laundry, shopping
4. *Family/Social Supports- Primary Caregivers*
 - Employment status
 - Physical Limitations
 - Emotional Health
 - Abuse & neglect issues
 - Power of Attorney/Guardian supports
 - Extended family supports (cultural issues)
 - Other supports (friends, church)
 - Community supports (Elder care or LTC)
 - Back up plan
5. *Financial*
 - IHS Beneficiary or non-beneficiary
 - Medicaid/Medicare eligibility
 - Private Pay
 - 3rd Party insurance
 - Tribal resources
6. *Environmental / Living situation*
 - Ability to maintain home
 - Type of housing (running water, sewer, heat source, infection control)
 - Accessibility
 - Fire & home safety

The factors have been identified and the groundwork has been laid; and now the next step will be for the Subcommittee on Eligibility and Program Standards to focus on the development of

specific program standards, eligibility requirements, and the practical tools needed to assess an individual's eligibility. These steps include: identify service packages and prioritize which need to be implemented first; determine program standards and eligibility criteria for each of those service packages; develop screening, assessment, scoring and prioritization tool(s); and define the standard policies and procedures for the entire process.

Section 2: Tribal Solutions to HCB Service Development and Sustainability

Once the tribal health organizations completed the inventory of what the service delivery system offers now, identified needs and gaps in that system, and assessed successes and failures, they then determined specific tribal solutions and/or strategies, as they relate to financing, workforce, regulations and organizational capacity. They believe the following strategies and solutions will lead to the implementation of a high quality, accessible, affordable and sustainable service array.

Financing

To address the financing situation, the tribal health system recommends the following solutions and strategies:

- Develop diversified and new revenue sources, so the system is not completely dependent on Medicaid; including advocating for increased IHS and other federal funding, researching State and other grants that support infrastructure/core capacity and/or offer start-up, demonstration, or pilot projects
- Explore waiver and other special Medicaid funding streams that would support cost-based reimbursement; include study of feasibility and required approach to planning for capitation. Investigate with the state the possibility of a public entity waiver from CMS. Because tribally operated health care programs are considered units of government under federal law, Alaska's tribal health organizations may be considered public entities under federal Medicaid rules, and thus eligible for payment based on cost. Include PACE and other models such as demonstration projects when considering options.
- Ensure all eligible clients are enrolled in Medicaid - provide on-going education of beneficiaries about importance of enrolling in Medicaid, Medicare, and use of other 3rd party payers
- Implement Tribal Targeted Case Management (short term strategy to provide necessary case management services to identified populations in need)
- Investigate LTC insurance or insurance pool for all Alaska Native people
- Commit to supporting LTC programs and identify revenue sources
- Work to ensure the reimbursement rates are adequate to cover costs, including implementing cost based reimbursement rates for individual services and ensuring reimbursement rates reflect the higher cost of delivering services in rural areas

- Research CMS waiver options for a package of HCB services for nursing facility level of care eligible clients (HCBS Strategies is doing the research for DHSS, the LTC Committee will make recommendations based on the results)
- Research subsidies for private pay clients and grants for program operational costs

Workforce

In order to ensure the development and retention of a quality workforce, the tribal health system recommends the following solutions and strategies:

- Research innovative approaches to improve recruitment and retention: this will be done by identifying employment resources to increase the size of the workforce; developing a “worker pipeline” by working with schools to motivate youth to join the workforce; ensuring adequate training is available to improve competency of the workforce; building adequate pay and benefits into the development of the service delivery system to improve the consistency and satisfaction level of the workforce; and ensuring that the workforce is recognized and supported by the tribal health organization, including at the top levels.
- Review and analyze criminal history background check and barrier crime regulations and requirements to prevent unnecessary barriers to recruiting and retaining workers
- Create culturally appropriate training programs and curriculum, including revising the competency test for home care workers so that it is culturally appropriate and skills-based
- Collaborate with the State to define realistic parameters for training requirements and prerequisites for workers in rural areas - take into consideration the availability of training programs, CPR and first aid courses in rural areas
- Increase training opportunities statewide by investigating alternative training modalities, including distance delivery, web cast, video conference and online courses
- Investigate partnerships with other education systems (e.g., UAA, tribal colleges, Older Persons Action Group (OPAG), local school districts, telehealth and distance education)
- Establish a mentorship program in a variety of settings and fields
- Establish funding sources or other resources to provide the required training - people to provide training; funding for training; alternative CPR/First Aid curriculum
- Marketing and education internal to tribal health organizations and within communities about the value of the role of workers at the village level
- Develop and implement a three-tiered level of direct care workers (universal worker) such as Home Care Worker I, II, and III and define practice standards for three levels of workers

Regulatory

The approach to designing and/or revising regulations to support needed improvements in the service delivery system must include a collaborative process that seeks to fulfill the ultimate goal of providing a home and community based LTC services system that best meets the LTC needs of Alaska Native elders and people with disabilities and supports the sustainability of the

tribally managed programs. To define and detail specific statutory or regulatory changes and/or language needed would be premature at this time. Rather, the LTC Committee recommends the following process by which the State and the tribal health organizations can come up with a mutually agreeable list of regulations and statutes that need changing and a plan for doing so.

- Strengthen the communication and partnership between the State agency and the tribal health system
- Define and understand the challenges and/or problems that need to be overcome
- Identify which requirements are statutory vs. regulatory and State vs. federal
- Specify and agree on needed regulatory and/or statutory changes
- Negotiate a solution agreeable to both the State agency and the tribal health system
- Investigate opportunities for partnering with other LTC providers
- Investigate options for adding regulatory waiver provisions
- Collaborate with the State to develop an oversight and evaluation process that will ensure both parties that services are provided in compliance with State regulations and quality standards.

Organizational Capacity

There is no standard set of solutions to issues pertaining to organizational capacity - the appropriate approach and solutions are specific to each individual tribal health organization. There are unique differences in the needs of an organization depending on many variables, including, but not limited to, location (rural, urban), the size of the organization and the population served. For example, a large tribal health organization with an entire billing department may not have the need for a centralized tribal billing system; whereas a small tribal health organization with one business office staff person may benefit greatly from having access to a centralized tribal billing system.

To begin the work of building adequate organizational capacity it is necessary to first sort out the differences in the tribal health organizations and identify the specific support needs of each. The tribal health system can then develop a support system that includes all the resources needed to provide adequate support to each individual organization. The goal is to ensure that all tribal health organizations have the capacity to bill Medicaid, and other payers; to encourage and support Medicaid enrollment of eligible clients; to make necessary training and support available to all staff and program managers; to operate programs using standardized policies and procedures; and to implement monitoring and evaluation practices to ensure consistency and quality.

Some of the types of support recommended as necessary to develop organizational capacity include:

- Training and technical assistance regarding the billing of home and community based services to ensure the billing office staff and program staff have an understanding of the reimbursement process and billing system operations

- Development of opportunities for sharing resources; consolidating, centralizing, or regionalizing administrative support (e.g. billing systems), consulting services, etc.
- Creation of standardized policies and procedure manual templates for LTC managers to foster consistent service delivery regardless of staff turnover
- Provision of on site technical assistance and/or shadowing and mentoring opportunities for LTC services program managers
- Development of a LTC program manager “alumni” pool or registry for providing consultation to new LTC service managers
- Collaboration with ATHS Medical Services Networking Committee on the Care Coordination Initiative
- Development of community partnerships with other tribal and non-tribal providers of services, such as housing authorities, senior centers, school districts, aging & disability resource centers to avoid duplication of services and resources
- Provision of on-going education of beneficiaries about the importance of enrolling in Medicaid, Medicare, and the use of other 3rd party payers
- Development of support systems for information technology, including coordination with statewide IT group and development of an IT process that can collect data and share between organizations

Section 3: 12-Month Action Plan for Comprehensive Delivery System Development (July 2008 – June 2009)

The LTC Committee proposes the following strategies to support implementation of the comprehensive tribal home & community based LTC service delivery system defined in this report.

Strategies	Description	Responsible Agency Or Group	Timeline
<i>Determine Organizational Structure</i>	<ul style="list-style-type: none"> Define & describe organizational structure options, roles & responsibilities & pros & cons of each 	<ul style="list-style-type: none"> LTC Committee 	<ul style="list-style-type: none"> 7/31/08 <i>Done</i>
	<ul style="list-style-type: none"> Define organizational structure for tribal LTC system, including specific roles & responsibilities 	<ul style="list-style-type: none"> LTC Committee 	<ul style="list-style-type: none"> 11/08 <i>Done</i>
<i>Define Standards</i>	<ul style="list-style-type: none"> Eligibility standards Program standards Service delivery standards 	<ul style="list-style-type: none"> Tribal health organizations & LTC Committee 	<ul style="list-style-type: none"> 12/31/08 Initial standards drafted.
<i>Develop Tools</i>	<ul style="list-style-type: none"> Assessment Screening Care plans Business planning Standardized templates for operating, information dissemination & education 	<ul style="list-style-type: none"> Tribal health organizations, LTC committee, subcommittees for specific subject areas, technical experts as needed Collaborate with State for approval of tools 	<ul style="list-style-type: none"> 6/30/09 Screening tool finalized 11/14/08
<i>Define Due Process System</i>	<ul style="list-style-type: none"> Guarantee patients rights Complaint process Appeal & fair hearing process 	<ul style="list-style-type: none"> State & tribal health organizations 	<ul style="list-style-type: none"> 6/30/09
<i>Define Intake, Advocacy, Referral Systems</i>	<ul style="list-style-type: none"> Collaborative efforts Outreach Education re: what is available & how to access 	<ul style="list-style-type: none"> Tribal health organizations, LTC Committee & other local providers, and State new Aging and Disability Resource Centers 	<ul style="list-style-type: none"> 6/30/09
<i>Develop Quality Assurance & Quality Control Program</i>	<ul style="list-style-type: none"> Technical assistance Monitoring Data collection process & analysis Evaluation & feedback 	<ul style="list-style-type: none"> State & tribal health organizations 	<ul style="list-style-type: none"> 6/30/09
<i>Define Legal Representation Requirements (Re: Clients)</i>	<ul style="list-style-type: none"> Power of Attorney Guardianship Conservators Freedom of choice 	<ul style="list-style-type: none"> State & tribal health organizations 	<ul style="list-style-type: none"> 6/30/09
<i>Define & Establish Workforce Development Plan</i>	<ul style="list-style-type: none"> Home Care Worker classification & description - define by Levels 1, 2, 3 - include: tasks, required skills & education & knowledge requirements, training needs & competency levels Research & define capacity needed Criminal history background check Training system - consider virtual, centralized, alternative delivery methods, feasible in rural areas Recruitment & retention plan 	<ul style="list-style-type: none"> Tribal health organizations & LTC Committee in collaboration with the State and the University of Alaska 	<ul style="list-style-type: none"> 6/30/09
<i>Review State & Federal Regulations & Statutes</i>	<ul style="list-style-type: none"> Identify pertinent rules & regulations and changes needed to implement the tribal LTC service delivery system Draft information re: waivers, etc. for legislature 	<ul style="list-style-type: none"> Tribal health organizations & LTC Committee in collaboration with the State 	<ul style="list-style-type: none"> 6/30/09

<i>Identify & Develop Financing</i>	<ul style="list-style-type: none"> Describe & establish financing for all HCB services Establish Medicaid financing 	<ul style="list-style-type: none"> Tribal health organizations & LTC Committee in collaboration with State (Myers & Stauffer rate study recommendations) 	<ul style="list-style-type: none"> 6/30/09
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Section 4: Action Plan for Short-Term HCB Service Expansion through Pilot Projects

The LTC Committee proposes a pilot project to allow continued provision of existing HCB services by the tribal health organizations currently delivering these services in rural and village Alaska, and support expansion of these services. These projects will not only support increased service delivery in the near term while the comprehensive system is being developed, but will demonstrate the ability of the ATHS to successfully implement these programs. As information is obtained through the pilot project and successful models and/or approaches to service delivery are determined, the eventual expansion of these services to other target populations can occur. A copy of the pilot project proposal is included as Appendix E.

Strategies	Description	Responsible Agency or Group	Timeline
<i>Improve Timeliness for Approvals</i>	<ul style="list-style-type: none"> Develop and implement a joint improvement plan that shortens the clients' wait time for service delivery, 	<ul style="list-style-type: none"> LTC HCB Pilot Project Subcommittee State of AK DHSS 	<ul style="list-style-type: none"> 6/30/09
<i>Cover Cost of Service Delivery</i>	<ul style="list-style-type: none"> Identify funding to support the additional cost of providing services in rural and village Alaska 	<ul style="list-style-type: none"> State of AK DHSS 	<ul style="list-style-type: none"> 6/30/09
<i>Provide Regional PCA Training</i>	<ul style="list-style-type: none"> Adapt curriculum and tests so that they are culturally appropriate and skills-based Schedule and organize training program Identify funding to support travel for trainees from the villages to the regional hub 	<ul style="list-style-type: none"> LTC HCB Pilot Project Subcommittee State of AK DHSS 	<ul style="list-style-type: none"> 6/30/09
<i>Improve Tribal Health Organization Billing Systems</i>	<ul style="list-style-type: none"> Develop performance measures Implement billing cycle review and improvement plan 	<ul style="list-style-type: none"> LTC HCB Pilot Project Subcommittee State of AK DHSS 	<ul style="list-style-type: none"> 6/30/09
<i>Develop Quality Assurance & Monitoring Program</i>	<ul style="list-style-type: none"> Describe QA and service monitoring standards Define data collection & analysis process Develop evaluation tools 	<ul style="list-style-type: none"> LTC HCB Pilot Project Subcommittee 	<ul style="list-style-type: none"> 6/30/09

Part IV: Facility-Based Service Development

This Facility-Based Service Development plan provides information and guidelines for tribal health organizations considering the addition of skilled nursing and/or assisted living as a new service line. It includes recommended facility type by level of community; estimated baseline needs for numbers of beds for nursing and assisted living homes by region; general information on the barriers to new facility development that may exist and some strategies for addressing them; and finally a specific action plan that presents a phased approach to long term care facility development in the Alaska Tribal Health System. Three new long term care facility projects were identified early in the Tribal Medicaid Reform Initiative as ready for planning based on community need and organizational readiness, and received special project funding for state fiscal year 2009. These Phase I projects, as well as a series of recently identified Phase II projects, are described in the final Section of this plan.

Section 1: Recommended Bed Capacity by Community Level & Region

In analyzing the need for facility capacity, the LTC Committee first considered the facility type needed by level of community. Recommendations regarding long term care facility availability by level of community had previously been defined specifically for assisted living. Those original recommendations were developed by the “Alaska Coming Home Program” in the Division of Senior and Disability Services, Alaska Department of Health & Social Services, in 2003 in consultation with numerous financing and advocacy organizations. The committee reviewed and accepted those recommendations for the tribal health system, and added recommendations for nursing homes and swing beds as presented in *Table 7*.

TABLE 7: Recommended LTC Facility Type Availability				
<i>Community Level</i>	<i>Population</i>	<i>Health Services</i>	<i>General Access</i>	<i>Recommended SNF & ALH Availability</i>
<i>Level I Village</i>	50 – 1,000	Community clinic with CHA or EMT	Limited air or marine highway access to a Level III or higher community; road access exceeds 60 miles	Home & community based services in lieu of facility based services
<i>Level II Subregional Center</i>	500 – 3,000	Community clinic with PA, NP, MD, or DO	Marine highway or daily air access to closest Level III or higher community; year round 60-minute or less road access	Assisted living in communities of 1,000 or greater if community resources can adequately support
<i>Level III Large Town or Regional Center</i>	2,000 – 10,000+	Community hospital and physicians	Daily airline service to Level II, IV, and V communities; air service to Level I communities in area; road & marine highway access all year (if on road or marine highway system)	Assisted living Swing beds Nursing home beds
<i>Level IV Small City</i>	10,000 – 100,000	Hospitals with 24-hr staffed ER & full continuum of care; multiple providers of health care & other services	Daily airline service to Level II, III, IV, & V communities; road or marine highway access all year	Assisted living Swing beds Nursing home beds
<i>Level V Urban Center</i>	100,000+	Some specialized medical and rehabilitation services for low incidence problems	Daily airline service to Level II, III, IV, and V communities; road or marine highway access all year.	Assisted living Administrative wait beds Nursing home beds

Next the committee considered current nursing home level of care needs of Alaska Natives and compared current need to current service availability as depicted in *Tables 8 & 9*. The 2004 base estimates presented in *Table 9* are based on population data from the 2005 report, "The LTC Needs of Alaska Native Elders." The projections for the year 2020 presented in *Table 9* are based on the Alaska Department of Labor estimates for 2008, in which they project a 77% increase in the Alaska Native population over the age of 65.

TABLE 8: Current Statewide Availability of Assisted Living and Nursing Homes		
Service Area	Current 2008 Total Assisted Living Beds*	Current 2008 Nursing Home Beds*
Kotzebue	20 (Tribal)	0
Norton Sound	0	15 (Tribal)
Yukon Kuskokwim Delta	0	0
Anchorage & Matanuska Susitna Borough	796 in small homes 165 Anchorage Pioneer Home 82 Horizon House 112 Marlow Manor	314 Anchorage
Barrow	7	0
Bristol Bay	15 Dillingham	0
Southeast	15 Petersburg 5 Wrangell 5 Juneau 48 Juneau Pioneer Home 75 Sitka Pioneer Home 48 Ketchikan Pioneer Home	15 Petersburg 14 Wrangell 49 Juneau 15 Sitka 29 Ketchikan
Fairbanks/Interior	75 Fairbanks in small homes 93 Fairbanks Pioneer Home 14 Tanana	90 Fairbanks
Kodiak	10	19
Kenai	19 Kenai in small homes 45 Soldotna in small homes 66 Homer (Friendship Terrace & small homes)	60 Soldotna 25 Homer 43 Seward
Valdez/Cordova	0	10 Cordova 10 Valdez
Totals	20 Tribal 1,695 Non-Tribal	15 Tribal 693 Non-Tribal

(Source: "LTC Needs of Alaska Native Elders, 2005" - *information non-tribal unless otherwise indicated)

TABLE 9: Estimate of Assisted Living & Nursing Home Need Statewide for Alaska Native Elders and Persons with Disabilities						
Service Area	2004 Base Assisted Living Need	2004 Base Nursing Home Need	2004 Base Total Bed Need	2020 Base Assisted Living Need	2020 Base Nursing Home Need	2020 Base Total Bed Need
Kotzebue	10	8	18	18	14	32
Norton Sound	15	11	26	27	20	47
Yukon/Kuskokwim	37	28	65	66	50	116
Anchorage/Mat-Su	35	29	64	59	52	111
Barrow	9	7	16	16	13	29
Bristol Bay	11	9	20	20	15	35
Southeast	38	30	68	67	53	120
Interior	26	20	46	46	35	81
Kodiak	5	4	9	9	7	16
Kenai	9	7	16	16	12	28
Valdez/Cordova	4	3	7	8	6	14
Aleutians	4	2	6	6	4	10
Total	203	158	361	358	281	639

(Source: 2008 Alaska Department of Labor estimates)

Methodology

More specific information regarding the demand for assisted living and nursing homes is presented in the tables in *Appendix C* of this document. The following methodology was used to develop those tables:

- The demand for assisted living was calculated by applying activities of daily living percentages that are used nationally to estimate the number of people with disability needs to the Alaska Native population as follows: 65 – 74 age group – 9.3% disabled; 75 - 84 age group – 25.9% disabled; 85+ age group – 34.9%. Of this total, a penetration rate of 15% was used, assuming that the remainder would receive care at home or in a nursing home. An additional 20% of beds were added to account for the population under age 65. ANMC discharge data indicates that there are a significant number of younger adults discharged to assisted living (2005 ANTHC report).
- The nursing home demand was estimated according to the current utilization rate for Alaska Native people, which is 1.92%, rounded down to 1.9% of the over 65 population. As with assisted living, an additional 20% of beds were added to account for the population under age 65.

It is important to note that the estimates presented here pertaining to facility-based service development are population based only, and do not consider in-state migration, discharge patterns, sub acute or other transitional care needs. Each tribal health organization will need to conduct a more thorough demand analysis for their population and service area, taking into consideration the desired package of services for both assisted living and nursing homes. These estimates are also based on the assumption of the consistent availability of home and community based services for Alaska Native elders and persons with disabilities, as outlined in the “Home & Community Based LTC Service Delivery Planning Tool” included in this document. If those services are not routinely available, more people would likely need nursing home and assisted living home care.

Section 2: Barriers to Facility Development and Sustainability

Financial Barriers

A number of financial barriers to facility development and sustainability will need to be overcome by tribal health organizations considering this new service line:

- Construction costs: The cost of construction for new nursing homes and assisted living facilities are not likely to be supportable by tribal health organizations, and the federal funding process for new tribal health facilities through the Indian Health Services can take many years (generally a decade or longer).
- Medicaid reimbursement: The current rate of reimbursement does not cover the cost of operating an assisted living facility, as the room and board related costs are not included.
- Variability of Medicare eligibility: Eligibility for Medicare is based on an individual's, or their spouse's, work history and payments to Social Security. Because of the lack of formal employment over their life time, some Alaska Native elders do not qualify for Medicare. Medicare pays for time limited nursing home stays that are transitional and rehabilitative in

nature. Medicare will also cover time limited home health services if registered nurse oversight is required and the services are therapeutic in nature.

- Long term care services are not historically funded by IHS: Tribal health organizations have a commitment to providing services for all Alaska Natives, not just those who are Medicaid eligible, however funding for this service for non-Medicaid beneficiaries is not included in IHS funding agreements.

A variety of solutions will be required to address the needs for financing construction costs, and for ensuring sustainability through appropriate reimbursement that covers operational costs.

- Tribal health organizations will need to work with a variety of statewide and community partners for construction financing. Capital construction grants will most likely be required for these projects.
- Medicaid rate setting cycles for nursing homes should be shortened to more adequately support nursing home operations.
- The methodology for determining assisted living home rates must be fixed to prevent pressure in the system that forces nursing home development where less costly assisted living is the preferred and more appropriate level of care.
- Tribal health organizations must be prepared to consider and answer some challenging policy questions, such as how they will include the service in their funding agreement with IHS, whether their new facility will accept non-IHS beneficiaries, will they require self-pay/cost-sharing, will they impose a limit on non-reimbursable days, and how will they pay for non-reimbursable residents.

Regulatory Barriers

Potential regulatory barriers to facility development and operations include:

- Certain state Medicaid regulations and policies, such as those regarding assessments and in-person reviews by an individual not part of the provider agency, will be problematic for assisted living projects.
- Coordination of State licensure regulations and policies, such as those regarding environmental and fire safety inspections, could pose problems for facility projects in rural areas.
- Criminal history background check regulations and policies are complicated and require research to determine the best way to apply the rules so as to not prevent workforce development, while at the same time ensuring safety of residents and workers and protecting individual rights.

Overcoming regulatory barriers will require thorough review of applicable state reimbursement and licensure laws and regulations, and technical assistance with application of the rules from state agencies. For example, AHS Phase I planning has included technical assistance sessions between tribal health organization project staff and DHSS Certification and Licensing, Certificate of Need, and Office of Rate Review staff. The process has been mutually beneficial in learning about requirements, procedures and timing, and informing state staff about the AHS facility planning efforts.

Certain regulations have been identified which require advocacy for change to alleviate an undue burden placed on providers, such as the criminal history background check and barrier crimes regulations. A plan for conducting a legal analysis and identifying specific changes required for these regulations is identified in the comprehensive action plan in Part III, Section 3 of this report.

Workforce Barriers

There is general difficulty with workforce recruitment and retention in the long term care industry, which will be compounded in rural areas of Alaska. Tribal health organizations developing long term care facilities will face the same workforce challenges as described in the Home and Community Based Services part of this report (Part II, Section 4.B).

The need for a workforce development plan is identified and included in the timeline of the comprehensive action plan in Part III, Section 3 of this report. The workforce development plan will include identification of positions and qualifications needed, assessment of the availability of in-state training from a variety of sources and modalities (Tribal, University and private; in-person and audio/web-based), and recommended recruitment and retention strategies. In addition, organizations' individual business planning efforts for facility development must include a facility-specific plan for workforce development based on the strengths, challenges and resources of the community and region.

Organizational Capacity Barriers

Tribal health organizations must have sufficient capacity within their organization to meet the challenge of adding a new service line and building and operating a new care facility, including:

- Executive leadership support, with an understanding of and commitment to the time required for themselves and their senior managers, project planners, and program staff to ensure the success of the new program.
- Sound revenue cycle operations, including systems for client enrollment, registration, documentation, billing for services, and cost accounting and reporting, in order to maximize reimbursement and ensure financial viability.
- Information technology systems that support the data collection and management requirements of the new program.
- Standardized policies and processes that will ensure the quality of care and provide measurable outcomes of successful service delivery.

Strategies for strengthening revenue cycle operations, meeting IT needs, and achieving other system and infrastructure improvements and administrative efficiencies are addressed through other components of the Tribal Medicaid Reform and additional AHTS initiatives. Financially sustainable facility projects will be an indicator of THO willingness to move forward with development. The AHTS LTC plan includes a process for building capacity of organizations through sharing of standardized policies and procedure manuals, technical assistance and mentoring. As facilities mature through the development process and procedures are created, information will be compiled and shared.

Section 3: Sustainable Business Planning Guidelines

Sound business planning is required to ensure the success and financial sustainability of a new long term care facility. Tribal health organizations are advised to utilize the guidelines outlined in the material for the Alaska Coming Home project developed in 2004, revised February 2008, which is available on the Alaska Housing Finance Corporation and DHSS Senior and Disabilities Services, Rural Long Term Care web sties. The following elements must be included in the business plan for each proposed facility development project:

- Project description
- Project site information
- Documentation of community and regional support
- Market analysis and needs assessment
- Architectural plans
- Capacity of lead development team and organization responsible
- Operational management and staffing plan
- Match and leverage contributions
- Development cost estimates
- Operational financial feasibility analysis
- Risk analysis

The tools available from the Alaska Coming Home project include a spreadsheet for determining financial feasibility for assisted living. In addition, business planning tools created by individual tribal health organizations involved in Phase I long term care facility project development (see Section 5) may be modified and utilized in other areas of the state.

Section 4: 18-Month Action Plan (January 2008 – June 2009)

Planning for development of new tribal long term care facilities began system wide within the ATHS at the Tribal Medicaid Reform Summit in January 2008. Following is the action plan that begins with the identification of Phase I projects at the Summit, and continues through the life of the SB 61-funded project (June 2009).

Action Item	Lead Organization(s)	Timeframe
<i>Phase I Facility Projects identified</i>	Association of Tribal Health Directors	By 01/31/08 done
<i>SFY 09 Capital project funding requests for Phase I submitted to State DHSS and Legislature</i>	ANTHC, YKHC, NSHC, Maniilaq	By 02/15/08 done
<i>Statewide Tribal Long Term Care Facility Plan developed</i>	ANTHC	By 11/30/08 done
<i>Phase II Facility Projects identified</i>	ATHS	By 11/30/08 done
<i>Develop planning tool for tribal health organizations to guide decisions regarding level and model of facility-based care that is the best fit for their community(ies)</i>	ANTHC Incorporate Alaska Coming Home materials	By 11/30/08 done
<i>SFY 10 Capital project funding requests for Phase I submitted to State DHSS and Legislature</i>	ATHS	By 12/31/08 done
<i>Facility business planning for Phase I Projects</i>	ANTHC, YKHC, Maniilaq	By 1/31/09
<i>Tribal long term care facility workforce development planning</i>	ATHD Long Term Care Committee	By 06/30/09

Section 5: Phase I & Phase II ATHS Long Term Care Facility Projects

Phase I

The Tribal Health Directors identified the Phase I projects at their February 2008 meeting. These projects were identified based both on known need, and organizational readiness. Capital funding was requested from the state legislature to support the first year of Phase I development. The following projects received funding appropriated by the legislature for the state 2009 fiscal year (beginning July 2008):

- Kotzebue – 18 Bed Nursing Home: The Maniilaq Association received \$7 million to support roughly half the estimated construction cost for building an 18-bed skilled nursing facility wing onto the existing hospital in Kotzebue.
- Bethel – 18 Bed Nursing Home and/or Assisted Living Facility: The Yukon Kuskokwim Health Corporation received \$8 million to support roughly half the estimated construction cost for building a stand-alone nursing home or assisted living facility in Bethel. The exact bed-type mix will be determined based on business plans under development by the corporation.¹
- Anchorage – 100 Bed Nursing Home and Assisted Living Complex: The Alaska Native Tribal Health Consortium received \$7.5 million to support planning for a 100 bed nursing home and assisted living complex in Anchorage.

A fourth project, \$250,000 for Norton Sound Health Corporation to incorporate planning for an 18-bed skilled nursing facility wing into planning for the new hospital in Nome, was requested under the Phase I development plan but was not funded.

As of the publication of this report, projects funded for Bethel and Anchorage are completing business plans, and the Kotzebue project has completed business and construction plans and is ready to award a construction contract pending completion of the construction financing package. All three projects have requested additional state funding for the 2010 state fiscal year. Funding for the Nome project has also been requested for 2010. In addition, federal funds have been requested through the economic stimulus package opportunity, and business planning efforts are evaluating the possibility of debt funding for supporting a portion of construction costs.

Phase II

Projects for Phase II for ATHS long term care facility development focus on regional and community planning for assisted living facilities, and have been identified by individual tribal health organizations based on need and organizational readiness.

- Prince of Wales Island Assisted Living Facility Planning: The Southeast Alaska Regional Health Corporation has requested \$150,000 for project planning for a 6 to 10 bed Green House style assisted living home in Klawock, Alaska for the residents of Prince of Wales Island.

¹ YKHC, ANTHC and APIA are considering the Green House model of long term care facility. A brief description of this model is included as Appendix D.

- Upper Tanana Assisted Living Community Planning: Tanana Chiefs Conference has requested \$50,000 for community planning for a 6 to 10 bed Green House style assisted living home in Northway, Alaska for the residents of the Upper Tanana Subregion.
- Aleutian Region/Anchorage Assisted Living Facility Planning: The Aleutian/Pribilof Islands Association has requested \$150,000 for project planning for a 6 to 10 bed Green House style assisted living home located in Anchorage for the residents of the Aleutian Region.

Appendix A

Definitions

1. *ADL – Activities of Daily Living:* The activities of daily living is the measure of the functional status most frequently used in determining an individual's need for long term care services. The six primary ADL are bathing, dressing, grooming, eating, moving around and toileting. Increasing disability can affect an individual's ability to perform these tasks independently.
2. *Administrative Wait Beds:* Beds designated by a hospital for use as nursing home beds when needed are called administrative wait beds. These beds do not have to meet complex federal admission requirements and reporting standards in order to bill Medicaid for those services. This type of bed exists solely in Alaska.
3. *ANTHC – Alaska Native Tribal Health Consortium:* ANTHC is part of the Alaska Tribal Health System, a network of tribes linked by common goals and objectives. ANTHC provides specialty medical care, community health services, construction of clean-water and sanitation facilities, information technology, training and educational support, and a host of other health services. ANTHC is the largest and most comprehensive tribal health organization in the country. ANTHC was formed in December 1997 to manage statewide health services for Alaska Natives. All Alaska Natives, through their tribal governments and through their regional nonprofit organizations, own the Consortium. ANTHC employs approximately 1,800 people and has an operating budget of more than \$300 million.
4. *ATHS – Alaska Tribal Health System:* A voluntary affiliation of over 30 Alaskan tribes and tribal organizations providing health services to Alaska Natives and American Indians. Each tribe or tribal health organization serves a specific geographical area. The entire Alaska Tribal Health System serves approximately 130,000 Alaska Natives.
5. *CHA/P – Community Health Aide/Practitioner Program:* This program of the Alaska Tribal Health System trains and manages paraprofessional workers, known as Community Health Aides and Community Health Practitioners, to provide primary health care in rural Alaska villages. There are approximately 176 Community Health Aide Clinics across rural Alaska employing over 500 Community Health Aide Practitioners.
6. *CON - Certificate of Need:* The Certificate of Need is a certification and licensing standards process within the Department of Health and Social Services that regulates the development of new nursing home beds in Alaska and throughout the nation.
7. *CMS - Center for Medicare & Medicaid Services:* The federal agency with a mandate to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries.
8. *DHSS – State of Alaska, Department of Health and Social Services:* This is the State department that manages and oversees all health and social services in the state, including long term care.
9. *DOL - State of Alaska, Department of Labor:* The State department that manages, regulates and oversees all issues pertaining to employment, including wage and hour laws, employment security, etc.

10. *DSDS - State of Alaska, Division of Senior and Disability Services*: This State agency regulates and manages services for the aging population, adults with physical disabilities, and persons with developmental disabilities. The Medicaid waivers are managed by this agency.
11. *FMAP - Federal Medical Assistance Percentage*: The Federal Government pays a share of the medical assistance expenditures under each state's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. The current FMAP for Alaska is 50%. The FMAP for services provided by the IHS and 638 Tribal organizations is 100%; the facility from which services are provided must be included on the facility list compiled by the IHS.
12. *HCBS - Home and Community Based Services*: Services provided in a person's home or in a community facility. Types of services include respite care, environmental modifications, adult day care, transportation, specialized medical equipment, chore services, assisted living, private duty nursing and congregate or home-delivered meals.
13. *Home Health*: Home health is a federally controlled Medicare and Medicaid service that provides skilled nursing and therapy services to eligible individuals at home. Home health agencies must be certified by the Section of Certification and Licensing in the Division of Public Health. Home health services are intended to be part-time or intermittent, and there are strict criteria for the service to be covered by Medicare and Medicaid.
14. *Hospice and Palliative Care*: Palliative care is the active total care of the body, mind and spirit of the patient and family. The purpose of palliative care is to prevent or lessen the severity of pain and other symptoms and to achieve the best quality of life for people dying or suffering from a long-term disease. Comfort is the goal of palliative care. Comfort is also the goal for those patients still receiving potentially curative therapy. Hospice is a program that delivers palliative care to people who are dying and need treatment to prevent or manage pain and other symptoms even when cure is no longer possible. Hospice programs can be certified to bill Medicare, or provide services on a volunteer basis.
15. *IADL – Instrumental Activities of Daily Living*: : The instrumental activities of daily living is a secondary measure of the functional status most frequently used in determining an individual's need for long term care services. Being unable to do these tasks may compromise an individual's ability to live independently. IADL includes the ancillary activities, such as housekeeping, meal preparation, shopping, using the telephone and managing money and medications.
16. *IHS – Indian Health Service*: The Indian Health Service is the federal government agency that manages and oversees all health care services and programs serving Alaska Natives and American Indians.
17. *LTC – Long Term Care*: Long term care refers to the provision of services, including health care, personal care, social services and economic assistance, delivered over a sustained period of time in a variety of settings, ranging from a client's own home to institutional settings, to ensure quality of life and maximum independence.

18. *Medicaid*: A federal and State financed program that provides health care coverage for eligible children, families, disabled adults, the elderly and pregnant women. Medicaid eligibility is based on financial need, and both income and assets are considered in determining eligibility (except for pregnant women and children who have no asset standard). Regular Medicaid is the primary payment source for nursing home care and home and community based services in Alaska and the lower 48. Medicaid also pays for in home personal care services.
19. *Medicaid Waivers*: Instituted in Alaska in 1995, Medicaid Waivers (Project CHOICE) provide people who are eligible for nursing home admission services in their home or another less restrictive community setting such as an assisted living home. To be eligible a person must meet the financial eligibility guidelines from the State Division of Public Assistance and meet nursing home level of care.
20. *Medicare*: Medicare is a federally-funded health insurance program available to U.S. citizens age 65 and older and certain disabled people. Medicare pays for very limited long term care services. Eligibility for Medicare is based on an individual's or their spouse's work history and payments to Social Security. Because of the lack of formal employment over their life time, some Alaska Native elders do not qualify for Medicare. Medicare pays for time limited nursing home stays that are transitional and rehabilitative in nature; and it will pay for limited home health services if there is registered nurse oversight and the services are therapeutic in nature.
21. *Nursing Home*: Skilled care facilities operated independently or collocated with a hospital. Nursing homes are licensed by the State following national certification and licensing standards. The Certificate of Need (CON) process within the Department of Health and Social Services regulates the development of new nursing home beds in Alaska.
22. *OA - Older Alaskans Waiver*: One of the Medicaid waivers that allows people who are eligible for nursing home admission to receive services in their home or another, less restrictive, community setting such as an assisted living home.
23. *OAA - Older Americans Act*: The federal act regulating funding for nutrition, transportation and supportive services to seniors. Funds from Title III of the OAA pass through the State Department of Health & Social Services to non-profit agencies and governments around the state to provide these services. Title VI is grants to Indian Tribes for similar services. Funding for Title VI flows directly from the federal government to Tribes. Services are typically congregate and home delivered meals, transportation and information and referral.
24. *PACE - Program for the All-Inclusive Care for the Elderly*: PACE is a planned approach to chronic care that serves individuals 55 and over who meet nursing home level of care. It is a risk-based, capitated, managed care program that includes all medical and supportive services, including nursing home, hospital care, case management and personal care in the home. PACE is reimbursable through both Medicaid and Medicare and requires sponsoring organizations to take full financial risk for all the care needs of their clients. There are no PACE programs in Alaska currently.
25. *PCA - Personal Care Assistance*: A Medicaid program where personal care assistants assist clients with the activities of daily living. There are two types of personal care programs in Alaska. The agency based program, in which a registered nurse oversees the services and the personal care assistants; and the consumer directed program, where the

consumer takes a more direct role in training and supervising their assistant, and an agency acts as a fiscal agent to bill for services and issue payroll.

26. *Swing Beds*: Rural hospitals with less than 100 beds that are more than 50 miles from a skilled nursing home and are Medicare and Medicaid certified may apply to operate swing beds. These beds allow for the provision of nursing home care in empty hospital beds in rural areas.

Appendix B

ATHS Long Term Care Committee Charter & Membership Roster

ALASKA TRIBAL HEALTH DIRECTORS LONG TERM CARE COMMITTEE CHARTER

February 11, 2008

I. Vision

Alaska Native elders and those with disabilities have access to the long term care services necessary to keep them as close to home as possible, as healthy and safe as possible, and that affords them as much independence as possible.

II. Purpose

To create a system which provides the full continuum of long term care services at the appropriate level of care in each community across the state.

III. Objectives

Strengthen the Alaska Tribal Health System's capacity to meet the long term care needs of elders and persons with disabilities by 1) ongoing identification of service development and delivery issues, 2) partnering with stakeholders to develop and implement improvement strategies, and 3) advocating for an effective long term care system.

IV. Guiding Principles

- All elders and persons with disabilities deserve access to the full range of long term care services within their home region.
- All elders and persons with disabilities deserve to be served by an appropriately trained, culturally competent and compassionate workforce.
- All elders and persons with disabilities deserve access to services that are delivered in their community by local service providers to help them stay in their own homes and/or communities as long as possible.
- All elders and persons with disabilities, and their families, deserve to know which services could help them and where they could receive those services.
- All elders and persons with disabilities have the right to choose their own care and to be actively involved in the development of their service plan.
- All elders and persons with disabilities deserve to be served by a tribal health organization that takes a customer-centered approach to long term care service development.
- All elders and persons with disabilities deserve to be served by a tribal health organization that delivers services that are financially feasible and sustainable over time.

V. Definition

Long term care is the care of an elder or individual with a disability who requires on-going assistance with daily living activities such as bathing, dressing, eating, shopping & cooking. Long term care services support elders and their families with medical, personal, and social services delivered in a variety of settings, ranging from a person's own home to institutional settings, to ensure quality of life, maximum independence and dignity.

VI. Membership

There will be one primary representative from each of the tribal health organizations; other or alternate members may also attend meetings.

VII. Process

- The committee will select a chair and co-chair
- The group will meet regularly (approximately once per month) by teleconference
- In-person meetings will be planned when needed and as resources allow.

- All primary representatives will participate on an equal basis
- Meetings will be organized and staffed by the Alaska Native Tribal Health Consortium
- Advance notice and materials will be provided for all meetings

VIII. Meeting Ground Rules

- Be willing to support our vision and purpose.
- Listen actively and respectfully, and acknowledge whatever is being communicated as true for the speaker at that moment. Active listening guidelines:
 - No interrupting
 - No side conversations
 - Cell phones on mute or vibrate
 - Focus on the speaker
 - Encourage active participation of all present
 - Do not criticize or make judgments of the speaker
- Always tell your truth with compassion for others

**Alaska Tribal Health Directors
Long Term Care Committee**

Committee Membership Roster

Updated: 09-25-08

Tribal Health Organization	Official Representative
Alaska Native Tribal Health Consortium	Kay Branch
Aleutian Pribilof Islands Association	Paul Allis
Arctic Slope Native Association	
Council of Athabascan Tribal Gov'ts	
Bristol Bay Area Health Corporation	Rose Heyano
Chugachmiut	Taren Klingler
Copper River Native Association	Crystal Talyat
Eastern Aleutian Tribes	Katherine Cart
Native Village of Eklutna	
Native Village of Eyak	Joan Domnick
Karluck IRA Tribal Council	
Kenaitze Indian Tribe, IRA	Jaylene Peterson-Nyren
Ketchikan Indian community	Sue Pickrell
Kodiak Area Native Association	Mary Hogan-Rijos
Maniilaq Association	Kellie Haas
Metlakatla Indian Community	Opal Hudson
Mt. Sanford Tribal Council	Wilson Justin
Ninilchik Village Traditional Council	
Norton Sound Health Corporation	Angela Gorn
Seldovia Village Tribe	
SE Alaska Regional Health Corporation	Nancy Jo Bleier
Southcentral Foundation	Kim Thorp
Tanana Chiefs Conference	Cyndi Nation
Native Village of Tyonek	
Valdez Native Tribe	
Yukon Kuskokwim Health Corporation	Liz Lee*

Additional Committee Participants

Alaska Native Tribal Health Consortium

Aleutian Pribilof Islands Association

Bristol Bay Area Health Corporation

Bristol Bay Native Association

Kenaitze Indian Tribe, IRA

Maniilaq Association

Norton Sound Health Corporation

SE Alaska Regional Health Coproration

Southcentral Foundation

Tanana Chiefs Conference

Yukon Kuskokwim Health Corporation

*** Committee Chairperson**

Valerie Davidson, Garvin Federenko, Charles Fagerstrom, Tim Gilbert, Gwen Obermiller, Susan Cook, Paul Sherry, Deb Erickson

Carolyn Crowder, Michelle Klass, Renee Kochuten, Tina Woods, Diana Mack (Gundersen)

Robert Clark, Sue Mulkeit, Bob Swope

Carolyn Smith

Dave Segura

Paul Hansen, Mary Shaeffer, Kevin Smalley

Nat Palaniappan

Frank Sutton, Patricia Atkinson, Sara Beaber-Fjioka, Norma Perkins

Doug Eby, Fred Kopacz, Dave Morgan, Chris Bragg

Lisa Donat, Victor Joseph

Tommy Tompkins, Fran Buckley, Nancy Weller

Appendix C

Tables: Projected HCB Service Needs by Region

The following 13 tables present projections of the number of Alaska Native people in need of home and community based services beginning in 2004 and projected to 2020. The estimates were calculated by applying nationally accepted activities of daily living percentages to determine the number of people with disability needs to the Alaska Native population as follows: 65–74 age group = 9.3% disabled; 75 - 84 age group = 25.9% disabled; 85+ age group = 34.9%. An additional 20% of this total was added to account for the under 65 population who would likely be eligible for an Adults with Physical Disabilities Waiver or Personal Care Services. From this total, the number of people predicted to be in a nursing or assisted living home was subtracted, resulting in the total estimate needing home and community based services. It is important to note that these estimates are based solely on population figures, and there have been changes in population between 2004 and today. However, current information on population by ethnicity, age group and region are not available. These figures also do not consider any in-state migration patterns.

1. Anchorage Service Unit			
Age	Total #	% at risk	Demand
65-74	735	9.3%	68
75-84	272	25.9%	70
85+	47	34.9%	16
<i>Total</i>	<i>1,054</i>		<i>155</i>
20% of total for under 65			31
Total disability estimate			186
less assisted living demand			29
less nursing home demand			24
<i>Total HCB need 2004</i>			<i>133</i>
2020 plus 77% pop growth			275
20% of total for under 65			55
Total disability estimate			330
less assisted living demand			51
less nursing home demand			43
<i>Total HCB need 2020</i>			<i>236</i>

2. Barrow Service Area			
Age	Total #	% at risk	Demand
65-74	215	9.3%	20
75-84	88	25.9%	23
85+	23	34.9%	8
<i>Total</i>	<i>326</i>		<i>51</i>
20% of total for under 65			10
Total disability estimate			61
less assisted living demand			9
less nursing home demand			7
<i>Total HCB need 2004</i>			<i>45</i>
2020 plus 77% pop growth			90
20% of total for under 65			18
Total disability estimate			108
less assisted living demand			16
less nursing home demand			13
<i>Total HCB need 2020</i>			<i>79</i>

3. Kotzebue Service Area			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	223	9.3%	21
75-84	110	25.9%	28
85+	23	34.9%	8
<i>Total</i>	<i>356</i>		<i>57</i>
20% of total for under 65			20
Total disability estimate			78
less assisted living demand			10
less nursing home demand			8
<i>Total HCB need 2004</i>			<i>60</i>
2020 plus 77% pop growth			101
20% of total for under 65			20
Total disability estimate			122
less assisted living demand			18
less nursing home demand			14
<i>Total HCB need 2020</i>			<i>90</i>

4. Norton Sound Service Area			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	292	9.3%	27
75-84	147	25.9%	38
85+	55	34.9%	19
<i>Total</i>	<i>494</i>		<i>84</i>
20% of total for under 65			17
Total disability estimate			101
less assisted living demand			15
less nursing home demand			11
<i>Total HCB need 2004</i>			<i>75</i>
2020 plus 77% pop growth			149
20% of total for under 65			30
Total disability estimate			179
less assisted living demand			27
less nursing home demand			20
<i>Total HCB need 2020</i>			<i>132</i>

5. Yukon Kuskokwim Delta			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	757	9.3%	70
75-84	361	25.9%	93
85+	126	34.9%	44
<i>Total</i>	<i>1,244</i>		<i>208</i>
20% of total for under 65			42
Total disability estimate			249
less assisted living demand			37
less nursing home demand			28
<i>Total HCB need 2004</i>			<i>184</i>
2020 plus 77% pop growth			368
20% of total for under 65			74
Total disability estimate			442
less assisted living demand			66
less nursing home demand			50
<i>Total HCB need 2020</i>			<i>326</i>

6. Bristol Bay Service Area			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	237	9.3%	22
75-84	111	25.9%	29
85+	30	34.9%	10
<i>Total</i>	<i>378</i>		<i>61</i>
20% of total for under 65			12
Total disability estimate			74
less assisted living demand			11
less nursing home demand			9
<i>Total HCB need 2004</i>			<i>54</i>
2020 plus 77% pop growth			108
20% of total for under 65			22
Total disability estimate			130
less assisted living demand			20
less nursing home demand			15
<i>Total HCB need 2020</i>			<i>95</i>

7. Rural Service Unit - Aleutians			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	80	9.3%	7
75-84	36	25.9%	9
85+	8	34.9%	3
<i>Total</i>	<i>124</i>		<i>20</i>
20% of total for under 65			4
Total disability estimate			23
less assisted living demand			4
less nursing home demand			2
<i>Total HCB need 2004</i>			<i>17</i>
2020 plus 77% pop growth			35
20% of total for under 65			7
Total disability estimate			42
less assisted living demand			6
less nursing home demand			4
<i>Total HCB need 2020</i>			<i>32</i>

8. Rural Service Unit - Kodiak			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	110	9.3%	10
75-84	40	25.9%	10
85+	26	34.9%	9
<i>Total</i>	<i>176</i>		<i>30</i>
20% of total for under 65			6
Total disability estimate			36
less assisted living demand			5
less nursing home demand			4
<i>Total HCB need 2004</i>			<i>27</i>
2020 plus 77% pop growth			53
20% of total for under 65			11
Total disability estimate			64
less assisted living demand			9
less nursing home demand			7
<i>Total HCB need 2020</i>			<i>48</i>

9. Anchorage Service Unit - Mat-Su			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	156	9.3%	15
75-84	57	25.9%	15
85+	10	34.9%	3
<i>Total</i>	<i>223</i>		<i>33</i>
20% of total for under 65			7
Total disability estimate			39
less assisted living demand			6
less nursing home demand			5
<i>Total HCB need 2004</i>			<i>28</i>
2020 plus 77% pop growth			58
20% of total for under 65			12
Total disability estimate			70
less assisted living demand			10
less nursing home demand			9
<i>Total HCB need 2020</i>			<i>51</i>

10. Rural Service Unit - Kenai Peninsula			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	195	9.3%	18
75-84	87	25.9%	23
85+	26	34.9%	9
<i>Total</i>	<i>308</i>		<i>50</i>
20% of total for under 65			10
Total disability estimate			60
less assisted living demand			9
less nursing home demand			7
<i>Total HCB need 2004</i>			<i>44</i>
2020 plus 77% pop growth			88
20% of total for under 65			18
Total disability estimate			106
less assisted living demand			16
less nursing home demand			12
<i>Total HCB need 2020</i>			<i>78</i>

11. Rural Service Unit - Valdez & Cordova			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	83	9.3%	8
75-84	49	25.9%	13
85+	12	34.9%	4
<i>Total</i>	<i>144</i>		<i>25</i>
20% of total for under 65			5
Total disability estimate			30
less assisted living demand			4
less nursing home demand			3
<i>Total HCB need 2004</i>			<i>30</i>
2020 plus 77% pop growth			44
20% of total for under 65			9
Total disability estimate			52
less assisted living demand			8
less nursing home demand			6
<i>Total HCB need 2020</i>			<i>38</i>

12. Mt. Edgecumbe & Annette Island			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	828	9.3%	77
75-84	372	25.9%	96
85+	110	34.9%	38
<i>Total</i>	<i>1,310</i>		<i>212</i>
20% of total for under 65			42
Total disability estimate			254
less assisted living demand			38
less nursing home demand			2630
<i>Total HCB need 2004</i>			<i>186</i>
2020 plus 77% pop growth			375
20% of total for under 65			75
Total disability estimate			450
less assisted living demand			67
less nursing home demand			53
<i>Total HCB need 2020</i>			<i>330</i>

13. Interior Service Unit			
<i>Age</i>	<i>Total #</i>	<i>% at risk</i>	<i>Demand</i>
65-74	533	9.3%	50
75-84	250	25.9%	65
85+	84	34.9%	29
<i>Total</i>	<i>867</i>		<i>144</i>
20% of total for under 65			29
Total disability estimate			172
less assisted living demand			26
less nursing home demand			20
<i>Total HCB need 2004</i>			<i>126</i>
2020 plus 77% pop growth			254
20% of total for under 65			51
Total disability estimate			305
less assisted living demand			46
less nursing home demand			35
<i>Total HCB need 2020</i>			<i>224</i>

Appendix D

Facility-Based Care Model

Green House Model of Nursing or Assisted Living Care

Green House is a model of care for facility-based long term care services that focuses on creating a home-like environment for residents. It represents a shift from the more traditional institutional, medical model of care, to a social model of care that fosters an atmosphere of greater autonomy, privacy and choice for residents.

The model features a series of 10-unit homes with a staffing plan that increases the responsibilities of the direct care provider, and utilizes a clinical support team from a larger institution who visit the home at regular weekly intervals, providing nursing, physical and occupational therapy and other clinical services.

Basic Components:

- Architecture—structurally independent houses for up to 10 residents to include private bedrooms with baths, open living and kitchen areas, large dining table for family-style meals, ceiling lifts in all bedrooms, and outdoor area.
- Organizational structure—self-managed work team of direct care providers assigned to each house. Clinical support team itinerant to home. Administrator oversees all self-managed work teams and clinical support teams.
- Philosophy—the Green House is the elders' home. It serves as a place where elders can receive assistance and support with activities of daily living and clinical care, without the assistance and care becoming the focus of their existence.

Other Considerations:

- Need an umbrella organization to provide clinical services. The umbrella organization can be a hospital, nursing home or home health agency.
- The goal is to decrease face time of clinical staff, but increase the quality of that time.
- Rigorous training for direct staff includes housekeeping, cooking and menu planning, house management skills, etc. 120 hours of training in addition to formal Certified Nursing Assistant or Personal Care Assistant training.
- Ongoing educational process is needed to maintain the philosophy (emphasize that this is not a medical model of care).

Appendix E

Tribal HCB Services Pilot Project Plan Alaska Native Tribal Health Consortium October 2008

Purpose of Pilot Project

Expand and maintain HCB Services currently offered by YKHC, TCC & Maniilaq to demonstrate the tribal health system's ability to:

- Improve the quality and access to HCB services for clients in rural areas and to provide such services in a timely and effective manner in compliance with State rules and regulations
- Maintain and support the provision of HCB services to clients in rural areas to ensure the sustainability of tribal HCB programs

HCB services to be addressed by all 3 tribal health organizations in this pilot project:

- PCA
- Chore
- Respite
- Care Coordination

Pilot Project Timeline

The pilot project will be conducted over a period of two (2) to three (3) years - actual time period and start date to be determined.

Goals & Objectives

Goal #1: Improve access to services for clients in rural areas

A. Improve assessment process

1. Streamline and standardize client screening process
2. Simplify process for referring client to State for assessment
3. Use same process and tools for all HCB services (PCA and waiver)
4. Revise process so THOs evaluate the client to determine needs and initiate some basic transitional services while waiting for State assessor to complete the assessment and the plan of care (POC)
5. Identify specific State Assessor to consistently serve each THO (to develop relationship and standardize process in order to optimize learning from the pilot project)

B. Support THOs in managing and delivering HCB services

1. Approve use of revised intake/screening tool and process for referral of client to the State
2. Research sources for "start-up" funding to support the pilot project (identify specific costs to be covered by "start-up" funds, including training; determine total amount for each THO)
3. Research development of transitional services package to provide service while client waits for final POC approval
4. Develop system to identify where problems or breakdowns exist in current system (evaluation/process improvement cycle)

Goal #2: Increase capacity of THOs to sustain HCB programs in rural areas

- A. Develop THO infrastructure to develop capacity to determine actual cost of service delivery (cost reports)
- B. Improve the THO billing systems to ensure all services are billed and reimbursed
- C. Increase coordination between program and billing staff so all costs pertaining to services are identified and reimbursed

Goal #3: Improve the quality and increase size of the workforce in rural areas

- A. Make regional PCA and CNA training available in rural areas
 - 1. Look at what can be adapted in the interim to get more workers trained and continue to develop longer term solutions
- B. Develop and implement expedited process for training and/or certification of workers
 - 1. RNs or HC Director sign-off options
 - 2. Scale down curriculum and make pertinent to actual client needs in rural areas
 - 3. Recognize current skills, past training and education of worker
 - 4. Allow alternate testing methods - such as skills and competency-based testing
- C. Support THOs to manage and provide worker training
 - 1. Provide interim funding to THOs to expedite training in rural areas (amount of funding to be included in "start-up" cost to be determined)

Goal #4: Improve effectiveness and efficiencies in HCB service delivery in rural areas

- A. Develop quality assurance and monitoring system for THOs in coordination with State
- B. Develop necessary tracking system and tools

Desired Outcomes

- 1. A more timely and efficient assessment process used by THOs resulting in quicker service delivery of appropriate services to clients
 - o Decrease in time between client intake and service delivery
- 2. Improved capacity of THOs to support and sustain HCB services in their regions
 - o Decrease in time between service delivery and billing
 - o Improved capture rate (reimbursement)
 - o THO infrastructure capable of identifying the actual cost of the service
 - o Better tracking system for determining success and identifying problems or needed changes in the system
- 3. A workforce in each region made up of certified workers adequate in numbers to meet the need
 - o Increase of HCB staff resources available in each region
 - o Increase in the education and/or experience levels of workers in each region
- 4. A functioning quality assurance program within each THO
 - o Increased communication between THO and State re: quality issues
 - o A viable data collection and tracking system that will result in quality monitoring

Tracking System

The tracking of identified data elements for this pilot project is critical in being able to quantitatively measure the success of the pilot project; identify needed changes in process and/or approach; understand how the system is working to know where to intervene as problems arise; and provide feedback to the THOs and the State. It is proposed that there will be tracking systems to capture programmatic information and billing and reimbursement issues. It is understood that there must be a process whereby all of the data collected by those systems is analyzed together in order to be able to quantitatively measure the success. The process for doing such analysis is yet to be determined; however, it will undoubtedly require increased communication and coordination between program and billing staff in each THO.

The specific tools to be used to track the data have yet to be finalized; however, a preliminary list of potential data elements and ideas has been proposed, including:

- Identify where service commencement timeline decreases (or perhaps acuity of patients or breadth of services) due to greater availability of trained workforce
- Track dates for each of the steps in the referral process through the billing process
 - Time between patient referral date and initial screening
 - Time between intake/screening and request for assessment
 - Time between request to State for assessment and completion of assessment
 - Time between assessment and POC returned to THO
 - Time between POC approval and beginning of services - track two time categories for workers available and workers not available
- Track worker availability at time of interim assessment
- Track and collect time-in and time-out vs. time approved on POC - can give State & THOs ideas for acuity levels and potential service packages
- Identify what services are reimbursed, which are not reimbursed, and why
- Client log, including: date of referral, date of requested additional info, date of approval, date of service commencement, type of service delivery
- Identify clearly the direct costs and track reimbursement directly back to the program
Identify services provided but not presently included in the list of Medicaid covered services to show the need
- Identify the actual costs of each service – could use Myers & Stauffer template or modified FQHC template
- Billing system data elements - from referral to service delivery & referral to billing & reimbursement

Referral to Service Delivery Process & Timeline

Action Step		Timeframe
1	Client and/or family contacts THO to request help	Start tracking
2	THO conducts intake and screening of client	2 working days to complete
3	THO completes paperwork and refers client to the State for assessment	1 working day to complete
4	State puts client in system; State assessor travels to client, completes assessment, determines eligibility and produces a Plan of Care; State distributes POC to THO	2 weeks to complete all
5	THO begins service delivery to the client	3 days if worker is available; if worker not available document & track; services begin as soon as a worker is available
6	THO billing department submits the billing for the services	Specific process & timelines TBD
7	THO receives payment	Specific process & timelines TBD

