Mat-Su Regional Plan for Delivery of Senior Services

Prepared for a Collaboration of the Following Funders:

Alaska Mental Health Trust Authority

Denali Commission

Mat-Su Health Foundation

Rasmuson Foundation

United Way of Mat-Su

McDowell GROUP

Research-Based Consulting

Juneau
Anchorage

In Association With:

HEALTH DIMENSIONS GROUP

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Executive Summary

The Alaska Mental Health Trust Authority, Denali Commission, Mat-Su Health Foundation (MSHF), Rasmuson Foundation and United Way of Mat-Su share a concern for the senior citizens of Alaska. The rate of population growth among the 65 and older demographic in Alaska is one of the highest in the nation. The increase in senior citizens is putting a strain on the senior services delivery system, particularly in Matanuska-Susitna Borough (Mat-Su). To better understand the needs of Mat-Su's senior population and to match those needs with an efficient and productive delivery system that can be implemented on a regional level, these organizations contracted with McDowell Group, in association with Health Dimensions Group (HDG), to prepare a regional plan for delivery of senior services in the Mat-Su. The funders offer this as one template for regional planning that can be used by the State and local communities to engage in proactive planning for their aging populations.

The study includes a demographic analysis of seniors in the Mat-Su and an assessment of senior services infrastructure, such as senior centers, senior housing, home and community-based services, senior transportation, and skilled nursing care. The team also conducted a demand analysis for senior services and analyzed the current gap in services and into the future. Taking all of these analyses into consideration, McDowell Group and HDG assessed regional plans and models found elsewhere in the United States for relevance to the Mat-Su condition. Four overarching regional strategies were developed for the Mat-Su and were analyzed for their financial feasibility.

Below is a summary of the key elements of the recommended regional strategies.

Challenges

Each of following challenges was considered in the development of a regional plan:

- **Lack of service coordination among providers**. There is a degree of perceived "territoriality" among providers but there are no specific "boundaries" with respect to service delivery. In effect, there is considerable duplication of service (and administration) in some areas. By way of contrast, there are areas in the borough that receive little to no service. The creation of a centralized resource to both provide information and refer seniors to service options will be essential in helping improve overall coordination of services.

- **The geography offers substantial challenges to service delivery.** The sheer distribution of seniors over a wide area is an omnipresent issue. Challenges imposed by distances, and the remote location of many communities with small concentrations of seniors impose considerable restrictions on the development of more services. Improved networking and communication among providers, the development of a chronic disease management model and the application of appropriate technology to support care monitoring will be critical in serving seniors throughout the Mat-Su effectively.

- **State governmental infrastructure is inefficient in identifying and qualifying seniors for service.** Alaska's current infrastructure to support and manage services for seniors needs to be improved. While Alaska directs more dollars to home and community based services than most states in the nation (51 percent of senior services funding vs. 25 percent nationally), external reviews of the state's long-term care system have identified fractured, fragmented and inefficient delivery of services.

- **Current service provisions are not sufficient to support future demand.** With the projected rate of senior growth in the Mat-Su and the increased need for services and programs accessed by seniors, program offerings and opportunities must grow or evolve to support increased demand. By 2030, total population for the borough will grow by 63.3 percent – a net increase of 53,354 persons. Senior population, including individuals age 65 and older, will expand at an even more dynamic rate. The age 65-to-74 cohort will more than double (159.2 percent), while the age 75 to 84 cohort will triple (247.0 percent). While this issue is not unique to the Mat-Su, the projected rate of senior population growth in the Mat-Su is roughly five times that of the nation as a whole.

Plan Management

Given the fragmented nature of current senior services in the Mat-Su, there is no dedicated, high-level organization available to lead, guide or champion a regional plan for senior service delivery. Thus, some method of plan management must be established as a foundational component.

The study group recommends a two-fold approach. First, overall responsibility for the evolution and daily management of the plan should be vested in a single individual or organization that can "own" and lead the process, coordinate community providers and participants, gain stakeholder participation, foster collaboration with the state and serve as a central voice for the process. Secondly, a senior service task force should be formed that encompasses participants from various organizations and providers in the Mat-Su. This task force should be mutually distinct from the current Coalition of Mat-Su Senior Centers (CMSSC) and should establish an appropriate scope to accomplish the recommended plan strategies, determine an appropriate meeting calendar, and elect officers.

Regional Plan Steps

The study team envisions a senior service plan for the Mat-Su evolving over the next two to three years and encompassing four primary steps:

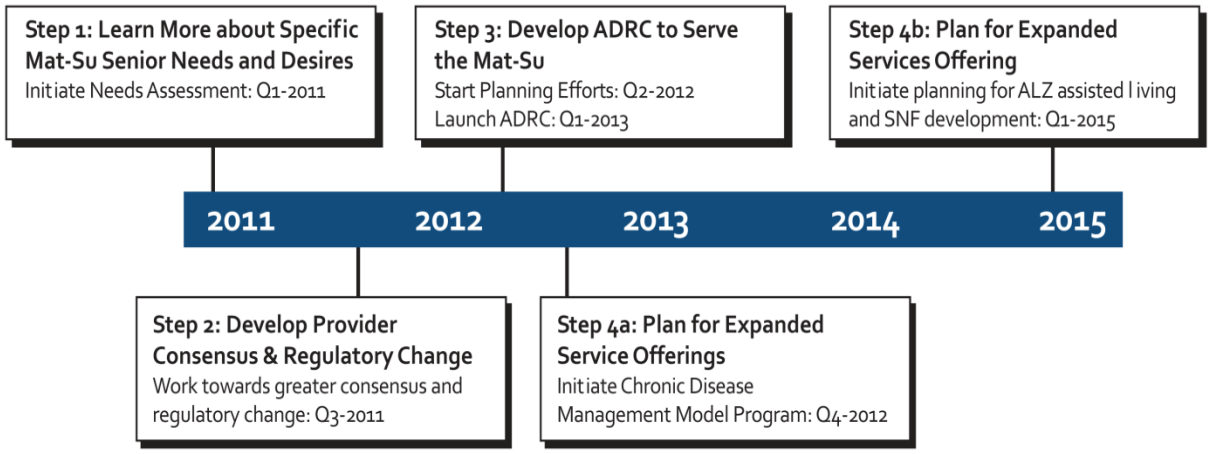
Step 1: Learn more about specific Mat-Su senior needs and desires

Step 2: Develop provider consensus about service areas and accomplish regulatory change

Step 3: Develop an Aging Disability and Resource Center (ADRC) to serve the Mat-Su

Step 4: Plan for expanded service offerings and new service development

Suggested Timeline For Mat-Su Regional Plan Next Steps, 2011 - 2015



Step 1: Learn More about Specific Mat-Su Senior Needs and Desires

To identify specific services, it will be critical to hear directly from consumers and seniors about their experiences in the Mat-Su area, opportunities for expansion or improvement of services, and general perceptions regarding living conditions, service availability, housing, transportation, and other areas.

Strategy 1a: Comprehensive Needs Assessment

A comprehensive needs assessment regarding senior care and services in the Mat-Su should be conducted. The needs assessment is foundational to the regional plan evolution and will provide both qualitative and quantitative information. The outcome of this assessment should serve to refine findings and issues identified by the regional plan and provide greater detail with respect to senior needs by location, age, gender, and other potential cross-tabulations.

The process should also both stimulate interest in senior services in the borough and provide "real world" senior experiences to help develop shared consensus and support a subsequent campaign for regulatory change at the state level.

Step 2: Develop Provider Consensus about Service Areas and Accomplish Regulatory Change

Step 2 will involve a sequential process that first requires shared consensus within the borough to, in turn, accomplish regulatory change.

Strategy 2a. Consensus about Service Areas

Providers, stakeholders, funders and the community at large must develop a shared consensus about how the coordination and delivery of senior services can be improved and what steps must be taken to achieve those improvements through better coordinated and consolidation at the local level. In addition, a collective effort must be set forth to help articulate and guide change at the state level. While establishing memoranda of understanding among the centers is an important first step, an inevitable future step may require or evolve into consolidation of all Mat-Su senior centers into one corporate entity with regional satellites or service sites in Palmer, Wasilla, Houston, and Talkeetna.

Strategy 2b. Regulatory Change

The goal of regulatory change will be to improve the overall quantity and quality of services delivered to seniors. To that end, three areas of action for change have been identified:

- **Create a distinct Mat-Su coverage area under the Alaska Department of Health and Social Services' senior service area assignments** – The Department's Coverage Area V currently encompasses the Mat-Su, Kenai Peninsula, and Valdez-Cordova. The state's current ADRC plan allows for one ADRC per administrative coverage area. Thus, the present regulatory structure precludes development of a new ADRC in the Mat-Su. Ungrouping Mat-Su from Region V is the first priority towards establishing an ADRC in the Mat-Su (*see Step 3*).

- **Secure an enhanced State commitment to evolve the ADRC model** – While some federal grant monies were secured to expand ADRC offerings for improved hospital coordination and Medicare beneficiary counseling, the state must dramatically increase ADRC funding to both achieve a fully-functioning model at the existing three sites and expand to other areas of need in Alaska. These efforts will likely require legislative support and planning efforts for FY2013 and should begin in late 2011.

- **Revise the State's Medicaid requirements to support individuals with Alzheimer's Disease and Related Disorders (ADRD)** – At present, participants in the Older Alaskans state waiver program must meet a requirement for nursing home level of care to qualify for Medicaid support. Most individuals who have been diagnosed with ADRD do not meet or require this level of care, and as such, they do not qualify for this support. This magnifies an already challenging issue, which is lack of service statewide (and in the Mat-Su) to manage people with ADRD. The state's current Medicaid plan can be revised to accomplish this change, which could result in increased Medicaid matching funds for the state. This change would benefit the development of an assisted living facility in the Mat-Su to support those patients with Alzheimer's disease, dementia and cognitive impairment. Absent some sort of change, current challenges with this population will persist and the state will face an increasing challenge to serve individuals with ADRD.

Beyond these three specifics, the study team also recommends that senior service stakeholders in the Mat-Su consider efforts in the following four areas:

- Support the consolidation of payment mechanisms in Division of Senior and Disability Services (DSDS) into a unified payment structure. At present, the DSDS manages 10 different funding authorities for long-term care services. This lack of integration requires that DSDS manage each program as a separate effort and creates a maze for consumers to navigate.
- Encourage the Division of Senior and Disability Services to seek more federal grant dollars through participation in new programs resulting from the Patient Protection and Affordable Care Act, including increased appropriations for ADRCs, service delivery models to be tested under the Center for Medicare and Medicaid Innovation, the Independence at Home demonstration program and grants for the creation of community health teams to develop medical homes by increasing access to comprehensive, community-based coordinated care.
- Create a financial incentive at either the state or borough level to support development of long-term care/skilled nursing facility in the Mat-Su. An incentive might take the form of tax-increment financing, property tax rebates or labor incentives for a developing organization.
- Revise the state funding formula for senior services accordingly to reflect population growth in the Mat-Su. At present, the Mat-Su is grouped with Kenai and Valdez Cordova as an administrative region with the DSDS. The state's funding formula for Older Americans Act Title III dollars is based on a series of factors, including the total number of seniors age 60+ in a given area, seniors age 80+, minority population 60+, 65+ seniors in poverty, and the number of rural seniors age 60+. Of these factors, poverty and rural account for half of the total formula. While Mat-Su accounts for only 49 percent of the total age 60+ senior population in the Area V administrative region, 58 percent of the rural component is vested in the Mat-Su. As such, the formula skews additional dollars for the region overall because of Mat-Su's rural contribution. Revisions to the state formula should reflect the Mat-Su as its own region.

Step 3: Develop an Aging Disability and Resource Center (ADRC) to Serve the Mat-Su

The third step of the regional plan would be focused on improving the overall coordination of services provided to seniors in the borough by both tribal and non-tribal providers, and offer expanded information about services. These tasks would be accomplished through two primary strategies:

1. Development of a fully functional ADRC to serve aging and disabled clients in the Mat-Su.
2. Creation of an on-line, senior navigator resource tool.

Strategy 3a: ADRC

An ADRC is an evolving model of service coordination, sponsored by both the US Administration on Aging (AOA) and the Centers for Medicare and Medicaid Services (CMS). ADRCs serve as single points of entry into the long-term supports and services system for older adults and people with disabilities. The primary goals of a Mat-Su ADRC would be to simplify and streamline access to long-term living services and supports; assist consumers who are seeking services and making long-term living decisions; and increase awareness of and provide access to reliable information.

Other specific outcomes would include:

- Creation of "One Stop Shop" where consumers can access long-term living and related services.
- Development of a seamless system that would eventually include eligibility screening, counseling, a single application, quicker functional and financial eligibility determinations, and personalized referrals.
- Make available comprehensive and consumer friendly information on long-term living services and benefits so that consumers can make informed decisions.
- Identify and intervene with individuals at risk of entering an institution with the goal of providing them with information and counseling that will allow them to make informed choices about the long term supports they receive.
- Link consumers who are not eligible for waiver or Medicaid-supported home and community based services with other community resources or opportunities.

The ADRC financial analysis presented in this report assumes a range of different funding supports for a Mat-Su ADRC, including federal grant monies, Older Americans Act funds, Medicaid support, an Alaska self-funded initiative for ADRCs, a one-time legislative allocation for the Mat-Su, and potential third-party grant support.

Strategy 3b: Senior Navigator Program

As a concurrent development with the ADRC, a web-based "Senior Navigator" or similar program is recommended that offers a centralized, on-line information portal regarding aging and disability resources in the Mat-Su. This portal would be publicly accessible from any computer and offer a searchable database of information, including health and aging, financial concerns, legal questions, health facilities, assisted living and housing, exercise programs, support groups and more. Information would be usable for seniors, adult children, caregivers, and providers alike. An on-line portal would serve as an adjunct to "211" services currently deployed in Alaska.

Initial funding for development of the portal could be secured through third-party grant support or contributions from commercial insurance organizations and Alaska corporations.

Step 4: Plan for Expanded Service Offerings and New Service Development

The evolution of new and currently unavailable services to meet future need should be anticipated. The volume of home and community-based providers currently present may be sufficient to serve seniors in the five to seven year timeframe. Into the future, however, these organizations must inevitably expand their capacity. Given that they are already operating in the Mat-Su and will likely continue into the future, the study team focused its discussion to new service offerings:

1. Implementing a model for Chronic Disease Management (CDM)

2. Developing facility-based services for Alzheimer's or dementia care and/or a long-term care nursing facility.

Strategy 4a: Chronic Disease Management

CDM is focused on the senior, not the venue. Thus, it is not tied to a building and is not necessarily limited by geography. In this sense, it is ideal for the Mat-Su. (It is important to note that the study team considered the Program for All-Inclusive Care for the Elderly – PACE – as a potential model for Mat-Su but determined that it would not be feasible, given the limited number of qualified dual-eligible persons in the area and the transportation challenges imposed by the geography.) An alternative model (GRACE) was considered instead that is highly similar to the Nuka Model currently deployed and in use by the Southcentral Foundation.

A CDM program for the Mat-Su would be grounded in first identifying potential candidates who might benefit from the program. This will require the development of specific characteristics for participation and might include individuals living independently at home who are "at risk" for institutionalization of expanded care management services, or it might include patients already enrolled in some degree of home and community-based service.

An initial assessment process would identify both the social and medical needs of a potential program participant and serve as the springboard for the development of an individualized service plan. Those individuals requiring specific medical or primary care services could be enrolled in an enhanced clinically-based component that includes nurse practitioner support, which might offer in-home visits to support seniors with multiple medical issues, medications, or compliance with doctor's orders.

The interdisciplinary team would meet on a regular basis to monitor and review program participants, identify opportunities for improvement or revision and guide participant care appropriately. Non-invasive, electronic (wireless) monitoring technology could be integrated into the program, thereby enabling the monitoring of a client's daily living activities and detection of possible deviations in behavior.

Beyond the funding opportunity found in the Independence at Home Demonstration Program (set forth in Patient Protection and Affordable Care Act), primary care services, including the physician and nurse extender, are covered by a participant's Medicare Part B benefit. Funding to support the interdisciplinary team component and wireless monitoring option could be potentially secured from commercial insurance and/or managed care organizations. Preventative models of senior care that encourage senior independence and quality of life are also of particular interest to major gifting organizations.

Strategy 4b: Facility-Based Services

The study team projected two areas of greatest demand: Alzheimer's or dementia care in a secure setting and long-term skilled nursing care.

MEMORY CARE (ALZHEIMER'S) ASSISTED LIVING

Dementia-care assisted living is a highly specialized supportive living environment for individuals with cognitive impairment or Alzheimer's disease. Servicing seniors and other disabled adults with these disorders in the Mat-Su already presents significant challenges. Placement for individuals who require this service typically involves admission to mental health facility via an acute hospital emergency room admission. Hospitals are, in turn, additionally challenged to find an appropriate placement.

The determination of need/demand for memory-care assisted living is not only based on affordability/income levels but also by need as measured by age and physical capabilities. Financial analysis was performed for the potential development of a 32-unit memory care assisted living facility, located ideally in the core Palmer-Wasilla area.

Development of a memory-care assisted living involving a private development effort is anticipated.

LONG-TERM/SKILLED NURSING CARE

While the State of Alaska has been historically adverse to the development of institutional-based skilled nursing care, the sheer volume of seniors requiring some form of institutional long-term care in the Mat-Su in the future cannot be ignored. A local service option will be essential in supporting Mat-Su seniors and should lessen the impact to providers in Anchorage and elsewhere.

Development of a Mat-Su long-term/skilled nursing care facility will require compliance with the State of Alaska's certificate of need (CON) process. A review of recent CON approvals in Alaska indicates favorable outcomes for additional long-term care bed development across the state. It is important to note, however, that these approvals have been for small bed additions to existing operations. A new facility CON has not transpired for long-term/skilled nursing care in recent history.

The development of a long-term/skilled nursing care facility will likely involve a private development effort, most likely by a proprietary operator of such facilities. Despite national trends strongly favoring home and community-based services, nursing home development nationwide continues at a steady pace.

The study team performed a financial analysis regarding the potential development of a 76-bed long-term/skilled nursing care facility. As with a memory-care assisted living facility, a long-term/skilled nursing care development would be ideally situated in the core Palmer-Wasilla area.

Detailed financial analyses assumptions and findings for each of the regional plan steps are presented in the financial analysis section of the report.

Methodology

To better understand the needs of Mat-Su's senior population and to match those needs with an efficient and productive delivery system that can be implemented on a regional level, the Alaska Mental Health Trust Authority, Denali Commission, Mat-Su Health Foundation, Rasmuson Foundation and United Way of Mat-Su contracted with McDowell Group, an Alaska consulting firm, in association with Health Dimensions Group (HDG), a nationally experienced senior services consulting firm, to prepare a regional plan for delivery of senior services in the Mat-Su. The study team employed a five-phased approach, detailed below.

Pre-Planning and Information Gathering

The study team began the project by conducting an initial conference call with the MSHF in mid-June 2010 and initiated data gathering regarding current providers in the Mat-Su. The study team additionally scheduled interviews and contacts for an on-site visit in July. During the site visit, two senior members of the study team conducted a range of interviews with Mat-Su area providers and funding partners to gather initial impressions and begin formulating potential plan strategies. The site visits resulted in additional information requests, which were submitted directly to area providers.

Demographic Analysis, Market Research, Infrastructure Assessment, Gap Analysis and Funding Streams

Concurrent with the site visit and initial information steps, the study team examined current service delivery in the Mat-Su, senior trends in the area, and opportunities for enhancement and expansion. The study team completed demographic analysis regarding the borough for both the near-term and future and examined potential need for a variety of senior services. Current service infrastructure was also reviewed and mapped to support an analysis of potential gaps in the senior service continuum. Throughout this process, the study team maintained an ongoing dialogue with the coalition support consultant engaged by the health foundation. More than 40 interviews were completed during the second phase to characterize research findings and gather additional information.

Strategy Development

Given the findings of the first two phases, the study team undertook initial strategy development for a regional senior service plan. This process involved the application of a senior services development and deployment model to the Mat-Su, examining a variety of different service types and options. As part of the development process, the study team reviewed senior service plans and models used elsewhere in the nation. This step resulted in the development of a conceptual report regarding the study team's findings to date and four potential strategies for consideration. The report was forwarded to the Mat-Su Health Foundation for consideration and review among the participating funders. Members of the study team presented the findings to a meeting of the funding organizations in early November.

High-Level Financial Analysis

The study team completed high-level financial analysis regarding four potential service options, which evolved from the plan strategies. The analysis involved a combination of assumptions and findings, based on specific research for the project as well as the experience of the study team in financial analysis.

Final Report and Summary Recommendations

In the final phase of the project, the study team summarized all information into a final written report that encompassed all data, findings and conclusions from the proceeding project phases.

A list of stakeholders interviewed for this study can be found in Appendix A.

Demographic Analysis

As a foundational step in developing a regional plan for senior service delivery, the study team conducted research on demographic trends in the borough, the current infrastructure to support senior services, and potential gaps in service.

Demographics

Following are demographic and economic characteristics of the population in the Mat-Su Borough based on actual, estimated, and projected data from the US Census and the State of Alaska.

Overall Population Distributions

Summary of Population Trends by Age Cohort for the Mat-Su Borough

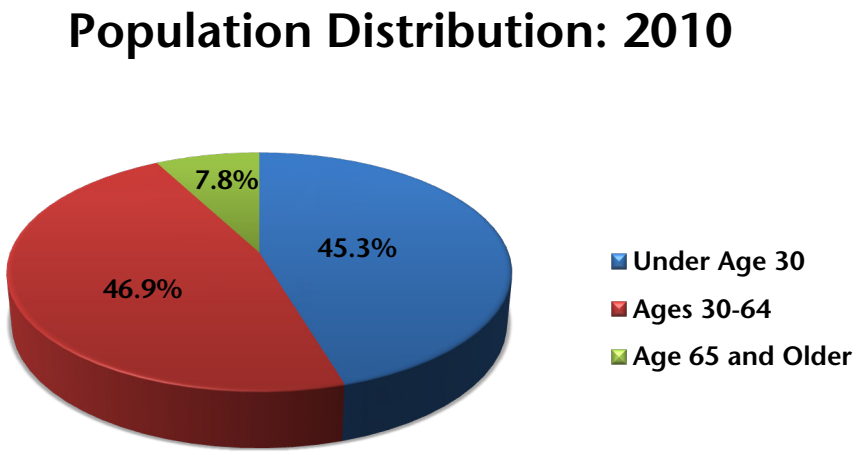
Age Cohort	2010	2015	2020	2025	2030	Change 2010-2030	% Change 2010-2030
0-9	13,191	15,777	17,993	19,891	22,255	+9,064	+68.7%
10-19	13,296	14,363	16,791	19,868	22,693	+9,397	+70.7
20-29	11,726	13,745	13,994	14,910	16,914	+5,188	+44.2
30-39	10,892	13,823	17,689	19,343	19,146	+8,254	+75.8
40-49	12,224	12,696	14,414	16,463	19,040	+6,816	+55.8
50-54	6,624	6,430	5,762	6,261	7,269	+645	+9.7
55-64	9,794	11,957	12,315	11,508	11,459	+1,665	+17.0
65-74	4,152	5,964	8,451	10,330	10,762	+6,610	+159.2
75-84	1,852	2,290	3,088	4,470	6,426	+4,574	+247.0
85+	577	798	1,004	1,255	1,718	+1,141	+197.7
Total	**84,328**	**97,843**	**111,501**	**124,299**	**137,682**	**+53,354**	**+63.3%**

Source: Alaska Department of Labor and Workforce Development.

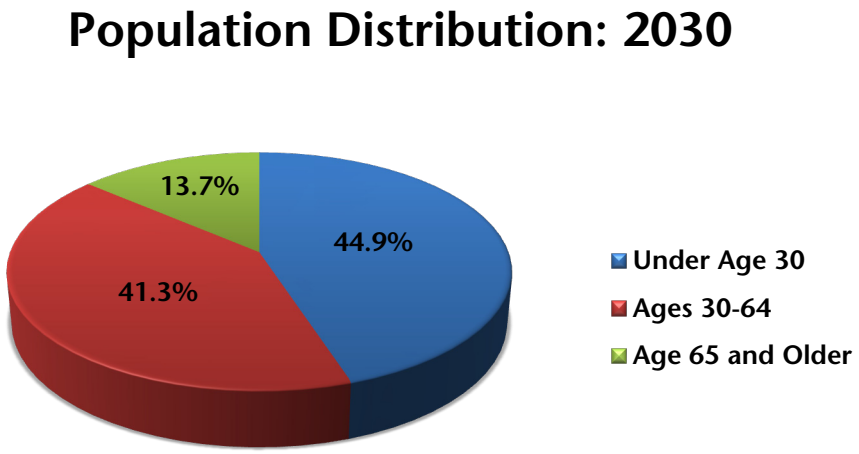
By 2030, total population for the borough will grow by 63.3 percent – a net increase of 53,354 persons. Compared to other state and national trends, this is an explosive degree of growth. Senior population, including individuals age 65 and older, will expand at an even more dynamic rate. The age 65-to-74 cohort will more than double (159.2 percent), while the age 75 to 84 cohort will triple (247.0 percent). Senior population will account for 23.1 percent of the total population growth by 2030.

Senior (Age 65+) Population

In 2010, seniors accounted for 7.8 percent of the Mat-Su's population (6,581 persons). By 2030, they will comprise 13.7 percent of the total population (18,906 persons). The age 30 to 64 cohort, which accounts for available workforce, will experience an overall percentage reduction by 2030, but the total size of this group will grow from 39,534 to 56,914 persons – a net increase of 43.9 percent. The pie charts below demonstrate how the age brackets will shift over time.



Source: Alaska Department of Labor and Workforce Development



Source: Alaska Department of Labor and Workforce Development

The Mat-Su Borough comprises six US Postal ZIP codes, which represents the most appropriate data segmentation when analyzing the senior market. As indicated in the table below, future growth among those age 65 and older is projected to be most pronounced in Wasilla and Talkeetna.

Age 65 and Older Growth by Zip Code, 2010 - 2015

Zip Code – City	2010	2015	Change	% Change
99654 – Wasilla	3,731	5,512	+1,781	+47.7%
99645 – Palmer	2,344	3,330	+986	+42.1
99688 – Willow	624	880	+256	+41.0
99676 – Talkeetna	295	434	+139	+47.1
99667 – Skwentna	7	7	0	0.0
99683 – Trapper Creek	-	-	-	0.0
Mat-Su Zip Code Total	**7,001**	**10,163**	**+3,162**	**+45.2%**

Source: Claritas, Inc.

Socioeconomic Characteristics

Socioeconomic characteristics include household income and the availability of personal financial means to purchase or secure senior services. In considering this data, the study team examined a range of different income categories.

Median incomes are the generally accepted analysis metric when considering affluence in a given area. Median incomes for senior households in the Mat-Su are generally comparable to the rest of Alaska, but outpace the national figure, as indicated in the table below. Incomes are projected to increase by 2015.

Senior Household Median Incomes, Age 65 and Over, 2010 & 2015

	Median Household Income		
Age Cohort	Mat-Su	Alaska	National
2010			
64 – 74 years	$52,840	$54,756	$39,819
75 – 84 years	47,857	45,701	29,848
85+ years	38,837	34,470	24,044
2015			
64 – 74 years	$58,333	$60,543	$43,615
75 – 84 years	55,844	51,152	32,629
85+ years	45,636	39,678	26,521

Source: Claritas, Inc. Note: Projections account for predicted inflation growth.

Medicaid Qualification

In 2010, the qualification threshold for Medicaid services typically utilized by seniors (i.e., nursing home care and waiver-supported services) in Alaska was $19,872. As indicated in the table below, 17.6 percent of senior households in the Mat-Su would qualify for Medicaid, slightly lower than the statewide figure of 17.9 percent.

While the percentage of households qualified for Medicaid statewide will decrease by 2015 (from 17.9 to 17.7 percent), the actual number will increase by 3,379, or 34.0 percent. This growth in the short-term will have dramatic financial consequences for the state. Growth of Medicaid-qualified households in the Mat-Su by 2015 is projected to be slightly over 38.0 percent.

Projections for Medicaid qualification and growth beyond 2015 are difficult because of the high potential for change in qualifying criteria.

Medicaid Qualification and Growth, 2010 & 2015

Age Cohort	% Mat-Su Senior Households Qualifying for Medicaid	Mat-Su Population Qualifying for Medicaid	% Alaska Senior Households Qualifying for Medicaid	State Population Qualifying for Medicaid
2010				
64 – 74 years	17.7%	735	16.3%	5,706
75 – 84 years	15.8	292	18.6	2,774
85+ years	22.3	128	27.0	1,437
Total 65+ years	**17.6%**	**1,155**	**17.9%**	**9,917**
2015				
64 – 74 years	17.7%	1,056	16.3%	8,279
75 – 84 years	15.8	361	18.6	3,277
85+ years	22.3	178	27.0	1,740
Total 65+ years	**17.6%**	**1,594**	**17.7%**	**13,296**

Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section, Demographics Unit, Nielsen, Claritas, Inc.

Gap Population

The "gap population" encompasses those households above the Medicaid threshold but below the median income. These individuals are typically at greatest risk because they do not qualify for state support but likely lack sufficient income to pay privately for senior services. While Alaska does offer a range of grant-supported programs to service this population, the projected rate of growth for this cohort in the Mat-Su is alarming. As the table below shows, this population encompasses 1,351 age 65-and-older households in the Mat-Su and will encompass 2,174 households by 2015 – an increase of 60.9 percent.

"Gap Population" Households Growth, 2010 & 2015

Age Cohort	Median Income	Mat-Su Households <Median; >$20,000
2010		
64 – 74 years	$52,840	832
75 – 84 years	47,857	443
85+ years	38,837	75
Total 65+ years		**1,351**
2015		
64 – 74 years	$58,333	1,425
75 – 84 years	55,844	632
85+ years	45,636	117
Total 65+ years		**2,174**

Source: Claritas, Inc.

Senior Services Infrastructure Assessment

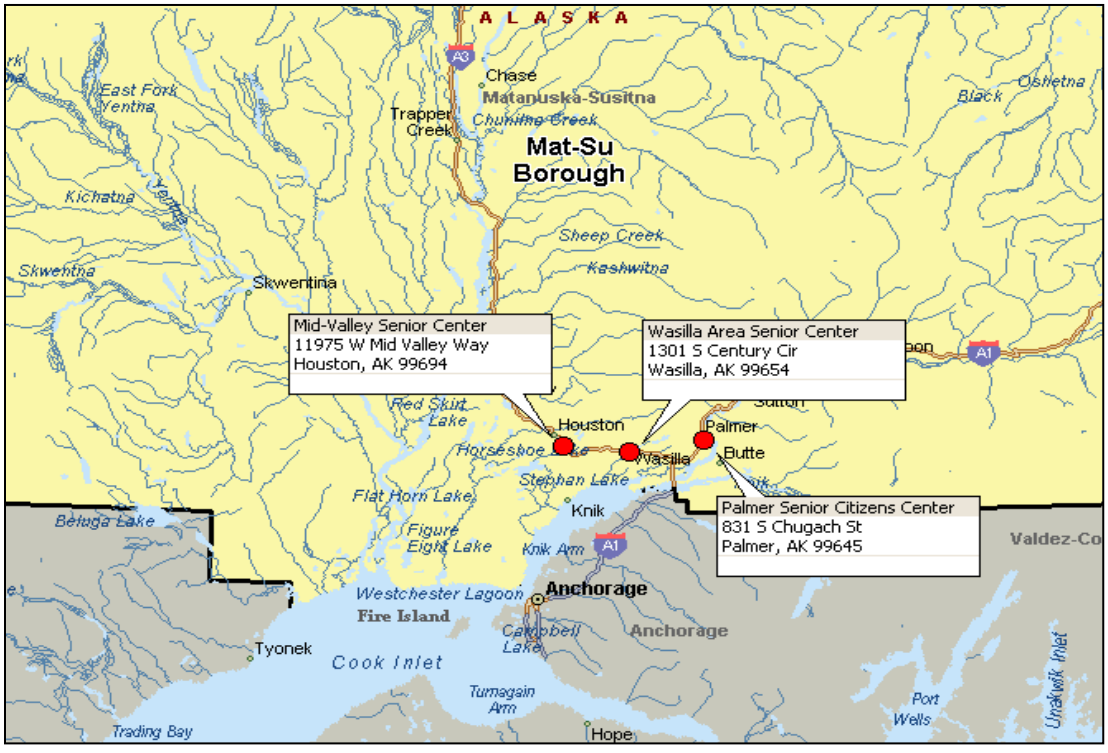
To better understand the Mat-Su senior service area and identify perceived service needs in developing a regional plan for senior service delivery, the study team conducted an informal assessment of existing senior service providers and services in the borough. This assessment involved on-site reviews of select providers, in-person and telephone interviews, on-line research, and reviews of provider data requested by the study team. In total, over 40 interviews were completed. (A list of individual and organization interviews is presented in Appendix A of this report.) Service providers were highly cooperative in providing requested data. Detailed requested operational data was received from the Palmer Seniors Center, Wasilla Seniors Campus, and the Mid-Valley Senior Center.

Current senior service infrastructure in the borough is available through a web of different providers, including senior centers, small and medium-sized assisted living facilities, a range of home care and chore providers (including personal care providers), and one Medicare-certified home health agency.

Senior Centers

Senior centers comprise the predominant "hubs" of senior-related services in the borough. There are three standalone senior centers in the borough, as indicated in the map below. The Chickaloon tribe, while not offering a senior center per se, does offer comparable services to those of other centers in the borough, including meals, assistance and service navigation.

Mat-Su Senior Center Locations



Of the three senior centers, Palmer is the largest and offers the widest range of services, including information and referral, meals, adult day services, housing, transportation, and care coordination services. The Wasilla center offers a smaller suite of services, including information and referral, meals and housing. Mid-Valley, located in Houston, offers meals and a limited amount of housing. Mid-Valley is additionally developing a transportation program. It is important to note that the bulk of senior meals (i.e., congregate meals and home-delivered) served throughout the borough are provided by the senior centers.

Summary information regarding these centers is presented in the tables on the following page.

Senior Center Service Offering Summary

	Services Offered							
Name	Info. & Referral	On-Site Meals	Home Delivered Meals	Transp.	Adult Day Services	Housing	Care Coord.	Chore Services
Mid-Valley Senior Center	X	X	X	X	-	X	-	-
Wasilla Area Senior Center	X	X	X	-	-	X	-	-
Palmer Senior Citizens Center	X	X	X	X	X	X	X	X

Source: Information provided by various senior centers.

Senior Center Service Utilization Counts

Name	Registered Members	Daily On-Site Meals	Daily Home Delivered Meals	Adult Day Participants (Avg. Daily)	Housing Units	Care Coord. Clients (Annual)
Mid-Valley Senior Center	250	30 – 80	60	n/a	18	n/a
Wasilla Area Senior Center	415	40	92	n/a	129	n/a
Palmer Senior Citizens Center	350	100 - 125	150	20	55	434

Source: Information provided by various senior centers.

There is considerable overlap with respect to service delivery among the three centers, especially between Palmer and Wasilla. Both organizations cite membership figures outside their own communities, as indicated in the table below.

Senior Center Membership Distribution

Name	Palmer	Wasilla	Willow/Houston/ Trapper Creek/ Talkeetna	Sutton/ Glacier View	Elsewhere
Mid-Valley Senior Center	30	40	150	0	30
Wasilla Area Senior Center	24	352	11	0	10
Palmer Senior Citizens Center	284	41	3	4	18

Source: Information provided by various senior centers.

All programs offer meals and meal-delivery services, and meals from one center (i.e., Palmer) will be delivered to residents in another (i.e., Wasilla). In some instances, meals are delivered by the Palmer center to residents living in Wasilla-center sponsored housing. There is no clear division or definition of "service area" for any of the centers, which has contributed to considerable competition among the centers and fractured relations.

The centers maintain a loose affiliation through the Coalition of Mat-Su Senior Centers. Mat-Su Health Foundation is currently assisting the group with a coalition building and support effort that is facilitated by an external consultant.

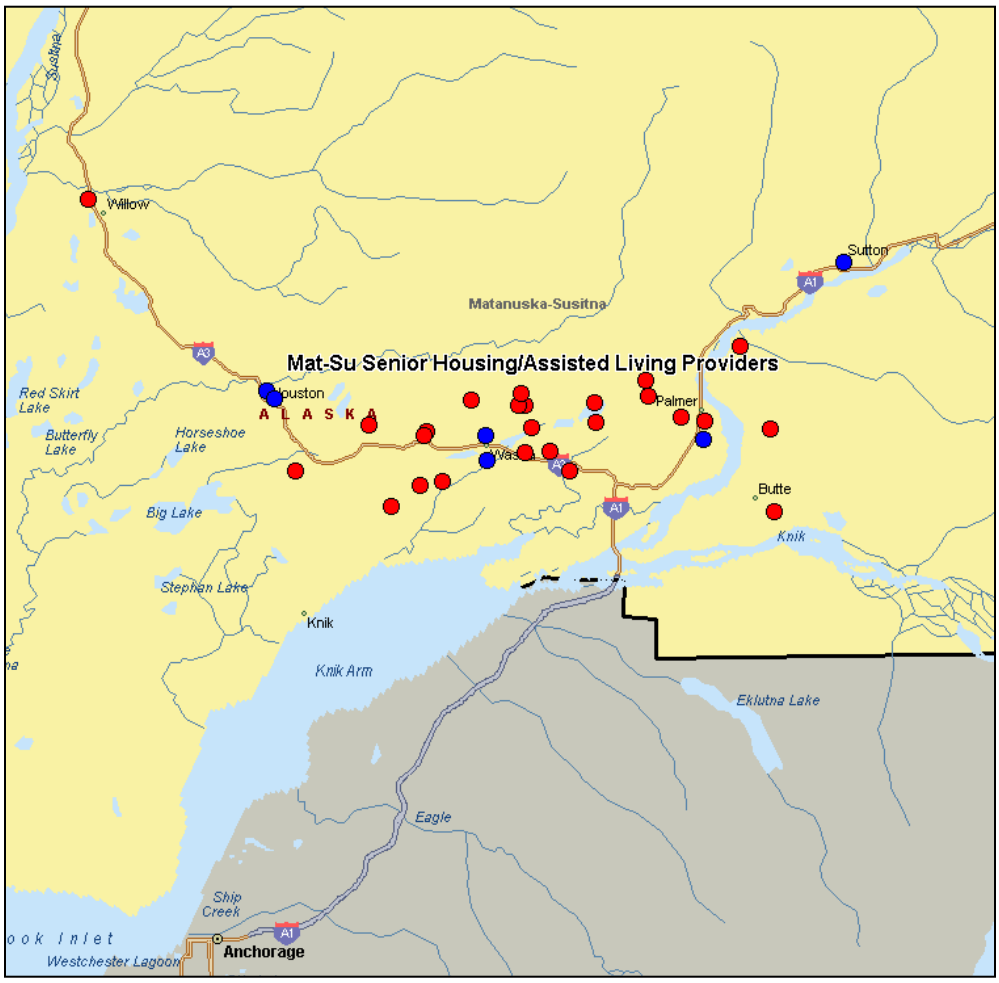
Services to Support Native Seniors

The Chickaloon tribe, while not offering a senior center per se, does offer comparable services to those of other centers in the borough, including meals, assistance and service navigation. According to staff with the US Administration on Aging, $85,000 granted under Title Vi of the Older Americans Act was awarded to Chickaloon for nutrition programs, information and referral and transportation.

Senior Housing

The study team identified over 30 senior housing options in the borough, including market-rate and subsidized independent living (IL) and assisted living (AL). Each of these options is mapped out below. Assisted living facilities are indicated in red; independent living in blue.

Mat-Su Senior Housing Locations



Most licensed assisted living facilities in the borough are smaller, home-based providers (typically five or less clients). It is important to note that there is no specific provision in the area for dementia or Alzheimer's clients. A summary of these senior housing options is presented in the table below. The location of these housing options is found in the map above.

Mat-Su Senior Housing Options

Name	City	Type	Units	Comment
Alaska Veterans and Pioneers Home	Palmer	AL	79 AL	
Among Friends ALH	Palmer	AL	4 AL	
Bald Mountain View ALH	Wasilla	AL	5 AL	
Blueberry Pointe	Houston	IL	8 IL	IR
Care, Inc.	Wasilla	AL	12 AL	
Chugach Estates	Palmer	IL	31 IL	MR/IR
Colony Estates	Palmer	IL	24 IL	MR/IR
Colony Manor	Wasilla	AL	5 AL	
Colony Manor at Creekside	Wasilla	AL	5 AL	
Colony Manor at Village Park	Wasilla	AL	5 AL	
Cranberry Ridge	Houston	IL	5 IL	IR
Creekside Assisted Living	Palmer	AL	5 AL	
Elvie's Home Care	Wasilla	AL	5 AL	
Golden Pond ALH	Houston	AL	5 AL	
Granny's Down Home Care Center	Wasilla	AL	4 AL	
Granny's Log Cabin Care Center	Wasilla	AL	5 AL	
Harbor View Manor	Wasilla	AL	16 AL	
Heidi's Place	Wasilla	AL	5 AL	
Jenny's Home	Wasilla	AL	5 AL	
Knik Manor Senior Housing	Wasilla	IL/AL	129 IL/12AL	MR/IR
Mid Valley Manor	Houston	IL	5 IL	IR
Northern Comfort	Wasilla	AL	16 AL	
Northern Living Centers	Wasilla	AL	12 AL	
Northstar Assisted Living	Palmer	AL	17 AL	
Palmer Manor	Palmer	IL	4 IL	IR
Primrose Retirement Community	Wasilla	IL/AL	38 AL	
Sunrise House	Wasilla	AL	10 AL	
Sunrise Manor ALH	Palmer	AL	5 AL	
Sutton Manor/Annex	Sutton	IL	8 IL	IR
The Homestead ALH	Palmer	AL	5 AL	
Tranquility Manor	Palmer	AL	5 AL	
Wickersham House	Wasilla	AL	5 AL	
Willow Creek ALH	Willow	AL	4 AL	

Source: Alaska, Alaska Housing Finance Corporation, State of Alaska, HUD, and on-line research.
Note: AL = Assisted Living; IL = Independent Living; IR = Income-Restricted; MR = Market-Rate.

Home-Based Services

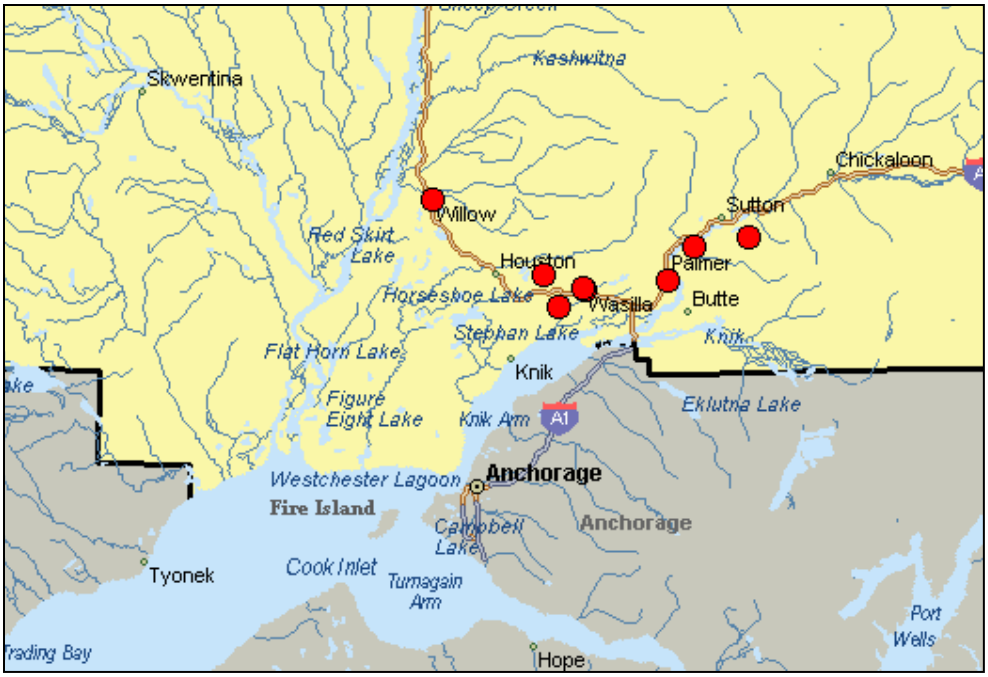
Home-based services encompass a range of different options, including home health or home care, chore services, personal care services, care or case management and training/support for family members seeking assistance with in-home care or respite care support. Several organizations in the Mat-Su offer these services for private-pay, Medicaid and grant-supported clients. A summary of home-based service providers is presented in the table below. The location of these home-based services is found in the map that follows.

Mat-Su Home-Based Service Providers

Name	City	Type	Comment
ABC Care Coordination	Wasilla	GCM	Care management/coordination
Acacia Personal Care Services	Wasilla	GCM/PCA/CS	Personal care assistance (CDPCA), chore services, respite services
Access Alaska	Wasilla	PCA/CS	ADL assistance, home management, daily and overtime. Respite day time
Alaska Home Care	Wasilla	PCA/CS	ADL assistance, home management, daily and overtime. Respite day time
Amedisys Home Health Care	Wasilla	HHA	Medicare-certified home health care and hospice
Care Connections	Palmer	GCM/PCA/CS	Care coordination, personal care assistance (CDPCA), chore services
Comfort Keepers	Wasilla	CS	ADL assistance, home management, daily and overtime. Respite day time
DM Care Coordination	Palmer	GCM	Care management/coordination
Home Instead Senior Care	Wasilla	CS	ADL assistance, home management, daily and overtime. Respite day time
Mat-Su Regional Home Care	Wasilla	HHA/HOS	Medicare-certified home health care and hospice
Palmer Senior Citizens Center	Palmer	GCM/CS	Chore services for those eligible for Medicaid Waiver (CHOICES)
ProCare PC	Wasilla	PCA	Care management/coordination
Ready Care	Wasilla		ADL assistance and home management. Day time respite care
Red Mountain Care Coordination	Palmer	GCM	Care management/coordination
Starfish Cares	Wasilla	GCM/PCA	Care management/coordination
Trinion Quality Care Services	Wasilla	PCA	ADL assistance, home management
Upper Susitna Valley Care Coordination	Willow	GCM	Care management/coordination
Willow Personal Care Assistants	Willow	PCA	Personal care assistance (CDPCA)

Source: State of Alaska, telephone interviews, and on-line research.
GCM: Geriatric Care Management; PCA: Personal Care Assistant; CS: Chore Services; HOS: Hospice; HHA: Home Health Aide.

Mat-Su Home-Based Service Providers



Adult Day Services

Adult day services programs provide a coordinated program of professional and compassionate services for adults in a community-based group setting. Services are designed to provide social and some health services to adults who need supervised care in a safe place outside the home during the day.

The study team identified three adult day services programs in the borough, which are summarized in the table below. The location of these adult day services is found in the map that follows.

Mat-Su Adult Day Services Providers

Program	Location	Avg. Daily Census	Details
Palmer Senior Citizens Center	Palmer	20	Accepts Medicaid waiver and private pay clients. Private pay fee is based on sliding scale, which provides services to non-Medicaid individuals below a certain annual income. Full private pay rate is $106.70 per day.
Respect Your Elders	Palmer	4-6	Accepts private pay only. Private pay rate is $98.12 per day.
Hearts & Hands	Palmer	6	Accepts Medicaid waiver and private pay. Private pay rate is $60 for full day, including transportation.

Source: State of Alaska, telephone interviews, and on-line research.

Mat-Su Adult Day Services Providers

Senior Transportation

Transportation is a critical service for seniors desiring to remain independent in their own homes or the community. Of particular importance is "door-to-door" service, which involves meeting a senior at their front door, transporting them to the desired destination and escorting them to the door of the destination. This level of service is key for seniors, given challenges in self-ambulation and decreased function. "Curb-to-curb" service, in comparison, is oftentimes not sufficient for many senior clients.

In the Mat-Su, coordinated transportation services are primarily available in the core population area. Three providers comprise the bulk of transportation services for seniors:

- Matanuska-Susitna Community Transit (MASCOT) maintains several dedicated routes and provides deviated service on request. The service is primarily curb-to-curb. Transport to Anchorage is also available.
- Palmer Senior Citizens Center (PSCC) offers dedicated routes but additionally provides individual transportation on demand throughout the borough. The service is typically door-to-door.
- Valley Mover is a new, non-profit organization operating year-round transportation between Wasilla and Anchorage.

Skilled Nursing/Long-Term Care

There is no option for skilled nursing or long-term institutional care in the borough. Interview participants cited this absence as a challenge for many individuals and families who must seek such services elsewhere, most commonly in Anchorage.

Senior Service Demand Analyses

To better understand future service needs with respect to senior population growth in the Mat-Su, the study team completed a range of high-level demand analyses regarding services typically used by seniors and their family caregivers. While these analyses were focused primarily in the area of community-based services, the study team additionally examined demand for services currently not present in the borough but typically found in markets elsewhere in the nation.

Analyses were completed by applying industry-accepted study methodologies to the predicted population changes in the Mat-Su through 2030. It is important to note that long-range demographic forecasts cannot account for potential changes in delivery and payment systems (i.e., Medicare and Medicaid). Thus, the analyses assume that current rates of utilization of a service will remain static over the projection period.

Medicare-Certified Home Health Care Demand

Medicare-certified home health care involves the provision of a skilled nursing care and certain other health care services (i.e., therapy services) that are provided in a client's home for the treatment of an illness or injury. All Medicare beneficiaries can receive home health care benefits if they meet skilled need as certified by a physician.

The study team completed a high-level demand analysis for Medicare-certified home health potential in the Mat-Su Borough for age 65 and older Medicare beneficiaries only. (Home health may often time serve individuals under age 65 and sometimes those individuals with a non-Medicare payor.) Based on Medicare beneficiary home health utilization for Alaska of 3.5 percent and other industry-relevant benchmarks regarding average number of episodes per beneficiary, episodes per admission, and average length of stay, the market area had a projected demand for an average daily census (ADC) of 33 home health clients in 2010. The projected ADC will climb to 95 clients by 2030.

Medicare Certified Home Health Demand, Mat-Su Borough
2010, 2010, and 2030

Year	Senior Population	3.5% Utilization	1.9 Avg. Episodes	1.7 Episodes per Admission	47 Days ALOS	Avg. Daily Census
2010	6,581	230	438	257	12,099	**33**
2020	12,543	439	834	491	23,061	**63**
2030	18,906	662	1,257	740	34,759	**95**

Long-Term Nursing Home Bed Demand

The demand for nursing home beds was calculated using the utilization of nursing home beds in Alaska by age cohort. It is assumed the utilization will remain consistent into the future, given the limited number of nursing home beds in Alaska. It is important to note the following:

- Utilization of nursing home beds in Alaska is the lowest in the nation.
- There are currently no nursing homes in the Mat-Su.

The tables below summarize the demand for nursing home beds in Mat-Su in 2010, 2020, and 2030. This demand only concerns the population 65 years and older.

Nursing Home Bed Demand for the Mat-Su, 2010, 2020, and 2030

2010	Population	Utilization	Bed Demand
Age 65-74 years	4,152	0.0043007	18
Age 75-84 years	1,852	0.0145029	27
Age 85+ years	577	0.0356557	21
Bed Demand	**6,581**		**66**
Existing Beds in Market Area			0
Unmet Demand (Excess)			**66**
2020			
Age 65-74 years	8,451	0.0043007	36
Age 75-84 years	3,088	0.0145029	45
Age 85+ years	1,004	0.0356557	36
Bed Demand	**12,543**		**117**
Existing Beds in Market Area			0
Unmet Demand (Excess)			**117**
2030			
Age 65-74 years	10,762	0.0043007	46
Age 75-84 years	6,426	0.0145029	93
Age 85+ years	1,718	0.0356557	61
Bed Demand	**18,906**		**201**
Existing Beds in Market Area			0
Unmet Demand (Excess)			**201**

Source: PMD Advisory Services, Claritas, Inc., Cowles Research Group's 2008 Nursing Home Statistical Yearbook, 2008 Nursing Home Compendium, and HDG Methodology.
Note: Due to rounding, columns may not add up to the total.

Based on the nursing home bed demand, there was an undersupply of 66 beds in the Mat-Si in 2010. By 2030, the undersupply will rise to 201 beds.

Geriatric Care Management Demand

Geriatric care management programs typically involve the services of a social worker or human services professional who provide case management services in a preventative model of care. Geriatric care managers (GCMs) offer typical case management services as well as assessment, care planning, service coordination, and ongoing monitoring. The demand for geriatric care management was calculated by analyzing the population by age cohort and sex for seniors 75 to 84 and 85 years of age and older living in the Mat-Su.

Persons age 75 and over are selected as these individuals have typically reached an age at which they might benefit from assistance or service. The number of persons living alone in 2000, the most recent data available, was then applied to the demographics by age cohort and sex to determine how many persons were living alone in 2010 and into the future. Those individuals living alone, and lacking the support of a spouse or other living partner, are those most likely to consider the services of a geriatric care manager. Age cohort and sex are important because household size varies tremendously by gender and age.

After determining the number of persons living alone, income qualification is applied to determine who can afford the service. Households with incomes of $75,000 or more were used in this analysis. Age cohort is important in this calculation since household income decreases by age cohort.

All age cohorts are then added to determine the estimated number of seniors that meet the age, living situation, and income targets for geriatric care management.

Geriatric Care Management Demand Analysis, Age and Household-Qualified
2010, 2020, and 2030

	2010	2020	2030
75 to 84 Year Cohort			
Female Population	953	1,503	3,272
Female Non-Family Household	51.5%	51.5%	51.5%
Est. Female Non-Family Household	491	775	1,686
Male Population	899	1,585	3,154
Male Non-Family Household	29.6%	29.6%	29.6%
Est. Male Non-Family Household	266	470	935
75 to 84 Year Cohort Total Non-Family Households	**758**	**1,244**	**2,621**

Table continued, next page

Geriatric Care Management Demand Analysis, Age and Household-Qualified (Cont'd)
2010, 2020, and 2030

	2010	2020	2030
85+ Year Cohort			
Female Population	344	551	897
Female Non-Family Household	51.5%	51.5%	51.5%
Est. Female Non-Family Household	177	284	462
Male Population	233	453	821
Male Non-Family Household	29.6%	29.6%	29.6%
Est. Male Non-Family Household	69	134	243
85+ Year Cohort Total Non-Family Households	**246**	**418**	**706**

Source: Claritas, Inc., HDG Methodology.
Note: Due to rounding, columns may not add up to the total.

Geriatric Care Management Demand Analysis, Income-Qualified, 2010, 2020 and 2030

	2010	2020	2030
75-84 Year Cohort Total Non-Family Households, $75K+	206	339	714
85+ Year Total Non-Family Households, $75K+	54	92	155
Total, 75+ Year Cohort Non-Family Households, 75K+	**260**	**431**	**869**

Source: Claritas, Inc., HDG Methodology.
Note: Due to rounding, columns may not add up to the total.

In 2010, the demand study identified 260 total households that were age, income, and household-qualified to be considered likely candidates for a geriatric care management program. Given projected population increases, this total pool should grow to 869 households. This analysis accounts only for those individuals who could pay privately for such services. An analysis for Medicaid-qualified individuals (those making less than $20,000 per year) ranges from 95 participants in 2010 to 311 individuals by 2030.

Traditional Assisted Living Demand

The senior market for assisted living includes the moderately dependent resident who requires supervised living. This person is typically over age 75 and needs regular assistance with activities of daily living (ADLs) but does not have to be placed in a nursing home. Services included would consist of three daily meals, flat linen and personal laundry, assistance with ADLs as needed, medication supervision, daily housekeeping, scheduled transportation, and all utilities. The demand analysis is based on age and physical capabilities.

The demand for traditional assisted living was calculated by analyzing the population by age cohort: seniors age 75-to-84 and 85-and-older living in the Mat-Su. This population is in turn segmented by those individuals who have need for assistance from a formal caregiver for activities of daily living.

The age 75-to-84 cohort accounts for 9.2 percent of the population in need of assisted living, while the 85-and-older cohort accounts for 25.6 percent.

Traditional Assisted Living (AL) Need-Qualified, 2010, 2020, and 2030

	2010		2020		2030	
Age Cohort	Population	AL Need	Population	AL Need	Population	AL Need
75-84 years	1,852	170	3,088	284	6,426	591
85+ years	577	148	1,004	257	1,718	440
Total 75+ Years	**2,429**	**318**	**4,092**	**541**	**8,144**	**1,031**

Source: PMD Advisory Services, Inc., Claritas, Inc., HDG Methodology.

Based on the analysis, there was an overall need in the Mat-Su of 318 assisted living units in 2010. This number rises to more than 1,000 units by 2030. It is important to note that this analysis projects need only; ability to afford is not accounted for. Also, there are approximately 220 units of assisted living currently operating in the borough. Thus, current supply likely accommodates a large portion of the presently stated need. The projected increase, however, will far exceed the current capacity.

Alzheimer's/Dementia Assisted Living Demand

The senior market for this alternative senior housing includes the moderately dependent resident who has some form of memory loss and requires supervised living. The demand analysis is based on age and physical capabilities.

The demand for Alzheimer's assisted living was calculated by analyzing the population by age cohort: seniors age 65-to-74, 75-to-84, and 85-and-older living in the Mat-Su. Younger cohorts are considered for memory-care assisted living because dementia-related illnesses do not discriminate on the basis of age. These cohorts are in turn segmented by those individuals who likely have a memory-related illness and need assistance from a formal caregiver for ADLs. For the age 65-to-74 cohort, this accounts for 0.3 percent of the population in need of Alzheimer's/dementia assisted living; the 75-to-84 cohort accounts for 3.4 percent; and the 85-and-older cohort accounts for 20.0 percent.

Memory-Care Assisted Living Need-Qualified, 2010, 2020, and 2030

	2010		2020		2030	
Age Cohort	Population	ALZ Need	Population	ALZ Need	Population	ALZ Need
65-74 year	4,152	12	8,451	25	10,762	32
75-84 year	1,852	62	3,088	103	6,426	215
85+ year	577	112	1,004	200	1,718	343
Total 65+ year	**6,581**	**190**	**12,543**	**329**	**18,906**	**590**

Source: PMD Advisory Services, Inc., Claritas, Inc., HDG Methodology.

Based on the analysis, there is an overall need for memory-care assisted living in the Mat-Su in 2010 of 190 units. This number rises to nearly 600 units by 2030. It is important to note that this analysis projects need only; ability to afford is not accounted for. At present, the only service provision for individuals with memory-related disorders in the Mat-Su is offered through the Alaska Veterans and Pioneers Homes in Palmer, which is typically full with a waiting list. It is important to also note that the Alaska Veterans and Pioneers Home in Palmer is a designated Veteran's Administration facility, and by default, demonstrates a preference for VA beneficiaries.

Hospice

Hospice service provides comfort care to persons at end-of-life who are no longer receiving medical treatment. The hospice benefit is available to all persons enrolled into Medicare, and is often provided in the patient's home, skilled nursing home, or hospital.

The study team completed a high-level demand analysis for Medicare hospice potential in the Mat-Su. The data is based on projecting the number of deaths, by age cohort and sex. The historical utilization of hospice services by seniors living in Alaska, as well as the state average length of stay, were applied to estimate how many persons would be cared for in hospice. In 2010, it was estimated that 11 persons would be cared for in hospice at any given time. The projected ADC will climb to 32 clients by 2030.

Medicare Hospice Demand, 2010, 2020, and 2030

Year	Age 65+ Population	Projected Deaths	Annual Hospice Admissions (w/30% utilization)	Total Hospice Days	Average Daily Census
2010	6,581	259	78	3,891	11
2020	12,543	468	140	7,044	19
2030	18,906	789	237	11,836	32

Summary of Demand for Services

A summary of projected need for studied services in the Mat-Su is presented in the table below.

Consolidated Senior Service Need Projections in the Mat-Su Borough, 2010, 2020, and 2030

	Current Beds/Service	2010	2020	2030
Assisted Living	245	318	541	1,031
Alzheimer's Assisted Living	26	190	329	590
Private pay Geriatric Chronic Management $75k+	n/a	130	266	341
Skilled Nursing Facility Bed Need	0	66	117	201
Adult Day Services	35-45	49	94	142
Medicare Certified Home Health ADC	n/a	33	63	95
Hospice Beds	n/a	11	19	32

Note: n/a denotes "not applicable."6

As evidenced above, service needs will increase across the board by 2030. While the borough currently offers a range of services to address some of these needs, other programs are lacking. For example, there are 26 licensed assisted living providers currently operating in the borough with a total capacity of approximately 245 units. Need for assisted living in 2010, regardless of income, was 318 units. The need will more than triple to 1,031 by 2030.

At present, the assisted living memory care setting in the market area is limited to the Alaska Veterans and Pioneers Home (which is at capacity with 79 beds and an extensive waiting list). By 2020, the total need for this service will exceed 300 units. With regard to a skilled nursing facility, demand for SNF beds will reach 117 beds by 2020 and exceed 200 by 2030. At present, there is no skilled nursing facility in the Mat-Su.

Gap Analysis

As part of the information gathering and review phase, the study team conducted an informal analysis of apparent gaps in the senior service continuum in the Mat-Su. This analysis was conducted in light of the summary demand analysis findings and with respect to Health Dimensions Group's model for senior services development, which is summarized in the table below.

Model for Planning for a Senior Services Continuum

Geriatric Institutional	Community-Based, Medically Oriented	Community-Based, Socially Oriented	Financially-Based
Hospice and Respite	Home Health Agency/ Hospice/ Home Care-Private Duty	Senior Membership Programs	Annuities
LTCH	Outpatient and Ambulatory Services	Senior Information and Referral/Senior Navigators	Financial Planning
Subacute Unit	Geriatric Assessment Clinic	Health/Wellness Education and Senior Fitness Programs	Money Management – Bill Pay
Transitional Rehab All But Hospital (TRABH)	Geriatric Physician Panel: Nursing Home Medical Directors; Physician House Calls	Community Case Management	Trust Accounts
Skilled Nursing/Nursing Facility	Geropsychiatric Clinics/Services	Transportation	Long Term Care Insurance
Assisted Living/Continuing Care Retirement Communities	Adult Day Services	Outreach Services: Lifeline, Meals, Nursing coordination in Houses of Worship, Friendly Visitor, Home Maintenance, etc.	Medicare Supplement Insurance
Dementia/Alzheimer's Facilities	PACE, Chronic Care Program	Housing, including low income	Life Insurance

Source: Health Dimensions Group

The analysis was particularly focused on community-based services, both medically and socially oriented (the middle two columns above). These two groupings often encompass the greatest need areas for senior services and offer a reasonable mix with broad appeal to a wide array of consumers. The study team's analysis additionally considered institutional service provision and the informal input of service providers and organizations in the study area, who were consistently asked about their perception of gaps or perceived needs in the Mat-Su.

An assessment by individual services is summarized over the following pages. Those services highlighted in light blue represent critical gaps or key areas for improvement in the Mat-Su's senior service continuum.

Geriatric Institutional Services, Mat-Su Borough

Service	Status	Comment
Hospice and Respite	Present	Services available through multiple providers in the Mat-Su.
Long-Term Acute Care Hospital	Not Present	LTACH services are not available in the Mat-Su but are available in Anchorage.
Subacute Unit	Not Present	Subacute services are typically offered in a skilled nursing facility or hospital-based skilled nursing unit. Subacute services are available in Anchorage but represent an important component of the local senior service continuum.
Transitional Rehab All But Hospital (TRABH)	Not Present	TRABH is a highly specialized subacute program. The Mat-Su does not offer sufficient patient volume to support a TRABH facility.
Skilled Nursing/ Nursing Facility	**Not Present**	**A skilled nursing or long-term care facility is a critical component of a mature senior service continuum. This likely represents a development priority in the borough.**
Assisted Living/ Continuing Care Retirement Communities	Present	While the borough does not offer a continuing care retirement community, there are ample assisted living providers in the area.
Dementia/ Alzheimer's Facilities	**Present but Limited**	**A specialized facility to care for those individuals with memory-related illnesses is a critical component of a mature senior services continuum. This likely represents a development priority in the borough as current offerings at the Alaska Veterans and Pioneers Home in Palmer are insufficient to meet the need.**

Community-Based, Medically-Orientated Services, Mat-Su Borough

Service	Status	Comment
Home Health Agency/ Hospice/ Home Care-Private Duty	Present	Services available through multiple providers in the Mat-Su.
Outpatient and Ambulatory Services	Present	Services available through providers in the Mat-Su.
Geriatric Assessment Clinic	Not Present	Assessment clinics serve an important role in a mature senior continuum. The volume of seniors in the Mat-Su, however, is not likely sufficient to support such a service. Thus, geriatric assessment is a likely service opportunity for existing primary care physicians.
Geriatric Physician Panel: Nursing Home Medical Directors; Physician House Calls	**Not Present**	
Geropsychiatric Clinics/Services	Not Present	Geriatric psychiatric services are an important part of the aging services continuum. The total volume of patients in the Mat-Su area might support a smal program developed by existing healthcare infrastructure.
Adult Day Services	Present	Services available through multiple providers in the Mat-Su.
PACE, Chronic Care Program	**Not Present**	**While the Mat-Su does not offer sufficient population to support a PACE program, there is likely opportunity for a chronic care or chronic disease management program, which would offer care and services to promote senior independence.**

Community-Based, Socially-Orientated Services, Mat-Su Borough

Service	Status	Comment
Senior Membership Programs	Present	Services currently available through providers in the Mat-Su.
Senior Information and Referral/Senior Navigators	Present	While information and referral services are presently available in the borough, the service is offered in an uncoordinated manner among multiple providers. Thus, there are redundant structures in place to serve seniors. A web-based navigator service is not currently available and represents an important tool in serving geographically distant seniors and communities.
Health/Wellness Education and Senior Fitness Programs	Present	Services currently available through providers in the Mat-Su.
Community Case Management	**Present**	**Services currently available through providers in the Mat-Su.**
Transportation	Present	While some transportation services are present in the Mat-Su, several organizations and interviewees cited transportation as consistent challenge for seniors.
Outreach Services: Lifeline, Meals, Nursing coordination in Houses of Worship, Friendly Visitor, Home Maintenance, etc.	Present	Services currently available through providers in the Mat-Su.
Housing, including low income	**Present**	**Services currently available through providers in the Mat-Su.**

Summary

The range of services offered in the Mat-Su is fairly broad, and there are likely sufficient service offerings to support the population in the short-term – especially for information and referral, care coordination and case management, home health, hospice, and adult day services. In many instances, however, there is considerable duplication of service among different providers (i.e., the senior centers). Lack of service coordination or an over-arching coordinating element must evolve in the Mat-Su to support seniors in the future.

In addition, there is limited capacity for assisted living into the future and limited service available to support memory-care assisted living or skilled nursing care. Transportation services are available but limited, and beyond the state's self-directed disease management program, this is no formal or physician-led program in place for management of chronic illness to promote independence.

The study team's analysis, in combination with anecdotal observations offered by service providers and stakeholders both in and outside the borough, point to several areas of concern in the current infrastructure. These should be addressed in a regional plan that maximizes service to seniors in cost-effective and efficient manner.

These areas include:

- Unnecessary and cost-ineffective duplication of service
- Lack of sufficient service offerings to support seniors with dementia, cognitive impairment or Alzheimer's disease and related disorders
- Insufficient coordinated transportation services
- Absence of institutional long-term care or skilled nursing beds
- No formal program to manage chronic illness and support independence
- Limited service provision outside borough "urban" centers

It is important to note that the infrastructure gap analysis is based on the opinions of area providers, related stakeholders, and observations from the study team. A thorough needs assessment effort, focused on senior perceptions, will likely identify other areas of opportunity.

A Review of Regional Plans and Models

Senior service delivery throughout the United States involves a complex web of organizations, providers, and payor systems. Traditional bricks-and-mortar based providers (such as nursing homes and senior living communities) and home and community-based services (such as care management and home health) offer a range of different service options for older adults and their family caregivers alike. The industry has seen considerable evolution during the last two decades, given the increasing demands of consumers and the desire of payors, especially the state and federal government, to drive down costs. Thus, alternative service offerings have evolved. Assisted living, by way of example, gained a foothold as an "alternative" option for placement in a more traditional, long-term care institutional setting. Assisted living was originally conceived as a "residential" model of care, as opposed to the institutional "medical" model of a nursing home. As consumers have expressed increasing desire to remain in their homes, movements around "aging in place" have launched new forms of senior service delivery, including expansions of home care and chore-based service businesses, evolving case management services and the coming wave of technology solutions for the senior at home.

Evolution of our senior service systems cannot come soon enough, given the coming wave of baby boomers. While the brunt of the baby boomers will not impact residential and institutional settings until the mid 2020s, their impact on community-based providers, stay-at-home solutions, and models for chronic disease management will be felt much sooner.

At the core of changing how we manage and deliver healthcare in this country is a paradigmatic shift from "reactive" to "preventative" care. How we manage disease before it happens will be key to managing the sheer volume of people who will require care in the future. We cannot, as a nation, manage the number of seniors who might impact the current infrastructure, should boomers approach it in the same manner as their parents. It is generally safe to assume, however, that they will not approach it in the same way. They will expect to be treated at home in a manner that is conducive to their lifestyle and timetable – not that of a provider.

In developing key strategies for a regional plan for senior service delivery, the study team reviewed a range of other plans and service models at work throughout the nation. It is difficult to approximate plans for geographic areas that are similar in size and scope to the Mat-Su Borough. While its overall physical reach is dramatic (25,260 square miles), its total population of seniors age 65 and older (7,093 in 2010) is roughly comparable to that of a mid-size American city, like Boulder, Colorado (7,415 seniors in 25 square miles) or Columbia, Missouri (8,338 seniors in 60 square miles). Thus, the Mat-Su does not lend itself readily to an easy comparison with other parts of the country.

Senior Service Plans

Senior service plans or regional plans are often developed by a state's aging administration or an area agency on aging, depending on the state. By statute, every state must submit a plan regarding aging programs or services to the US Administration on Aging as a condition of participation in receiving federal monies to support aging services. These plans are typically highly strategic in nature and commonly spell out broad goals and objectives related to aging and senior issues that will involve the participation of various agencies, organizations, and providers. (The state plan on aging for West Virginia, which is summarized as an example in our analysis below, is one such example.) Given the "networked" nature of serving seniors, this is common around the country. In many states, senior service providers that may be somewhat similar in clientele (say, nursing homes and assisted living) may be regulated by two entirely different state agencies. Thus, cooperation among entities is a key facet of any strategic plan for aging or senior services.

In crafting a regional plan for senior services for the Mat-Su, the study team has opted to develop a plan that embraces both strategy and specific tactical recommendations. From the team's perspective, this approach is critical, given the unique characteristics of the Mat-Su and the current state of senior provision in the borough. In addition to a review of plans, we have also provided summary information regarding specific senior service delivery models that may be directly applicable to the expansion of senior services in the Mat-Su.

State Plan Review: West Virginia Older Americans Act State Plan on Aging | FY07-FY10

West Virginia is approximately 24,000 square miles in size and has a population just under 2 million. Despite this figure and its location in the eastern United States, West Virginia is considered one of the most rural states in the country. Per the plan, 15 percent of the state's population is age 65 or older. By 2025, people age 60 and older will account for 30 percent of the state's population.

West Virginia, like all states who receive monies from the Older Americans Act, must submit a four-year state plan for aging. These plans are designed specifically to assure that preference is given to older individuals with the greatest economic and social needs, especially those who are minorities or living in a rural area. The current plan encompasses the FY2007 through FY2010 timeframe and is developed and implemented by the West Virginia Bureau of Senior Services, which is an executive branch department. West Virginia is further divided into four area aging agencies (AAAs), which are the designated planning and service areas. Each of these agencies is responsible for developing a specific plan that indicates types and levels of service that will be provided to meet the unique needs of the elderly in each region, based on area and community needs assessments. Area plans in West Virginia are designed to additionally emphasize coordination among public and private resources to avert duplication and overlap in programming. These area plans are coordinated in development with the overall state plan.

The state plan outlines four broad goals:

1. Increase the number of older people who have access to an integrated array of health and social supports.

2. Increase the number of older persons who are active and healthy.

3. Increase the number of families who are supported in their efforts to care for their loved ones at home and in the community.

4. Increase the number of older people who benefit from programs that protect their rights and prevent elder abuse, neglect, and exploitation.

Each goal is in turn expanded through more specific objectives and even more specific strategies "to accomplish the objective." This is a fairly typical approach for state plans across the country, offering high-level direction to more local organizations (like the area aging agencies) which will employ specific tactics to deploy or actualize the plan, working in cooperation with local providers and aging service organizations. For West Virginia's first goal, there are 12 specific objectives, and each objective includes three to six strategies. For instance:

> ***Objective 1.8 – Strengthen the capacity to provide information to older individuals utilizing the Aging and Disabled Resource Center (ADRC) concept through the continuation of programs developed via the ADRC Grant and state/county funding.***
>
> *Strategies to Accomplish Objective:*
>
> - *Educate the public about the services the ADRCs offer to assist individuals in making health and social support decisions.*
> - *Educate individuals who utilize ADRS services of health and social supports available to meet their needs.*
> - *Assist individuals with program eligibility screening to expedite access to services.*

West Virginia's plan additionally addresses the financial distribution of Title III monies to the four AAAs, based on weighting factors (for population age 60+, low income distribution, and minorities) and population. The plan also provides a summary of funding sources for FY2007. Of the $52.5 million cited in the funding summary, $38.7 million (73.7 percent) comes from West Virginia's state lottery. Title III monies account for only $8.6 million of the total.

West Virginia's state plan, including full citations from the Older Americans Act and related state statutes, encompasses approximately 40 pages.

APPLICABILITY FOR THE MAT-SU

State plans, like West Virginia's, typically offer higher-level perspectives about aging issues and address areas of concern about seniors that are common or universal – for example, desire for healthy aging, access to appropriate services, and decreasing abuse and exploitation of seniors. While these are extremely important issues, they are not specific or endemic to West Virginia or any other specific state, for that matter. The "generality" or macro nature of state plans cannot address specific issues in a region (like the Mat-Su) or propose an option that is desirable or applicable at a micro level.

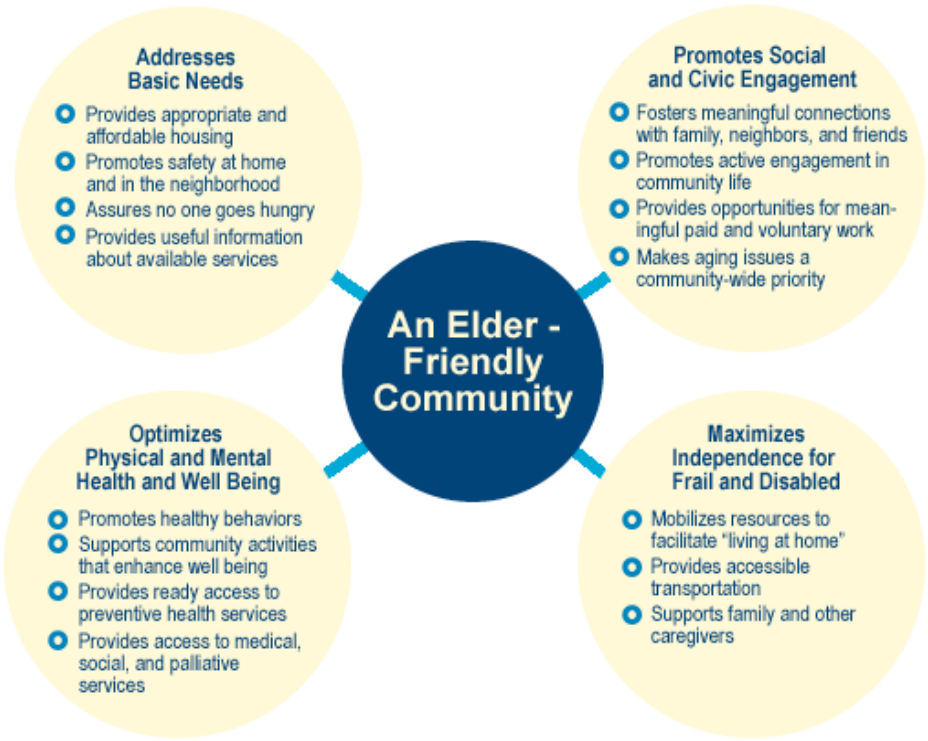
Local Plan Review: Boulder County, Colorado

Boulder County, Colorado is located in north central Colorado along the front range of the Rocky Mountains – about 50 minutes north of metropolitan Denver. The county encompasses just over 750 square miles and had an estimated 2006 population of 282,304. Only 7.8 percent of the population (approximately 22,000 people) is over age 65. In 2006, the Boulder County Aging Services Division undertook a strategic visioning process in conjunction with local municipalities and community members. A coordinating team of 50 individuals employed an "appreciative inquiry" process. They conducted more than 150 interviews, held 23 community meetings, and integrated the findings of a 2004 needs assessment to develop a strategic plan document titled "Creating Vibrant Communities in Which We All Age Well."

Boulder County's plan for "aging well" is crafted on the essential elements of an "elder-friendly" community, which were developed by the AdvantAge Initiative in New York in the early 2000s. By their own definition, the AdvantAge Initiative is "a community-building effort focused on creating vibrant and elder-friendly, or AdvantAged, communities that are prepared to meet the needs and nurture the aspirations of older adults." The four essential elements of an elderly friendly community and supportive explanations are presented in the figure below.

See figure, next page.

Elder-Friendly Community Elements



Source: AdvantAge

The formal AdvantAge initiative engaged 10 pilot communities throughout the nation and involved a comprehensive survey of community-residing older adults to provide a data snapshot of "how well seniors are currently faring in their communities." This data was used in turn to build awareness about aging, inform planning efforts and stimulate community-wide action.

Boulder County did not employ the AdvantAge survey approach. Rather, it combined the findings of its interviews, community meetings and need assessment process to examine each elder-friendly element and identify related strengths and concerns. These findings were, in turn, used to develop specific goals that are grouped by the bullet points displayed under each element in the figure above. Each goal includes several strategies. By way of example, goals and strategies for the first elder-friendly element (Addresses Basic Needs) are presented in the table below.

Strategies for Addressing Basic Needs, Boulder County Aging Plan

Goal 1: Housing is affordable, appropriate, and accessible.

1.1 Increase the amount of affordable, appropriate, and accessible housing.
1.2 Create affordable, livable, sustainable communities.
1.3 Change zoning ordinances and housing regulations to encourage "visitability," multi-occupancy, accessory apartments, and to encourage community services and businesses to co-locate in neighborhoods.
1.4 Expand housing options to include cohousing communities.

Goal 2: Neighborhoods are safe and livable.

2.1 Identify, develop, and strengthen neighborhood connections.
2.2 Educate residents, service providers, and first responders to watch for, and report, changes in everyday patterns in the neighborhood.
2.3 Develop a corps of neighborhood volunteers to promote safety, convey information, and provide assistance.

Goal 3: Everyone has enough to eat.

3.1 Establish a countywide food distribution network.
3.2 Make senior meal programs available countywide, focusing efforts on those in greatest need.
3.3 Educate people of all ages about healthy food choices.
3.4 Integrate congregate and home-delivered meal programs.
3.5 Create more choices for residents of long-term care facilities.

Goal 4: Access to essential services is seamless, barrier-free, affordable, and welcoming – *One Call Does It All!*

4.1 Develop and maintain one accurate, comprehensive database with Web access.
4.2 Organize a network of information and assistance providers, and coordinate access to the services that people need – One Call Does It All!
4.3 Establish a multidisciplinary team to triage calls and link callers with the right person or place.
4.4 Establish and market one central phone number for people to call for assistance.
4.5 Assist people to secure essential services, when needed.
4.6 Increase the availability and affordability of care coordination services.
4.7 Create a "preferred provider network" of agencies that agree to:
- Use a single application form;
- Use a common release of information form;
- Agree upon common definitions and use a common language;
- Use a single identifier code for each individual;
- Use a sliding fee scale for services.

4.8 Improve, expand, and market the resources of "211."
4.9 Increase community awareness of available services

Source: Boulder County Aging Services Division

The Boulder County plan additionally provides a discussion about the importance of measuring progress through future needs assessment efforts and other data sources, like the US Census. While the plan does not spell out specific benchmarks or targets to be achieved, this aspect of the plan is unlike many state plans, which do not spell out expectations with respect to outcomes.

APPLICABILITY FOR THE MAT-SU

The Boulder County plan offers an interesting alternative to state aging plans and provides an effective plan development tool (the elder-friendly community rubric) for guiding the process. Several elements of the Boulder plan may be applicable to the Mat-Su in future planning efforts. It is important to note that this approach involves considerable community involvement and generally reliable data from some form of needs assessment to guide the goal setting and strategy development process.

Coordination and Delivery Models

Models for the coordination and delivery of senior service are wide and varied, depending on the market, the types of seniors to be served and the funding or payor mechanisms available to support them. Beyond the more traditional models of service, like a nursing home or senior living community, the industry has been rapidly evolving alternative forms of service that are community or home-based. These programs represent the current "cutting edge" in aging service delivery because most are designed to keep seniors both independent and at home – a universal preference expressed by seniors and many of their family caregivers across the nation.

The Olmstead Decision

Expanded development of home and community-based supports across our nation over the last decade is also attributable, in large part, to a key judgment handed down by US Supreme Court in 1999. In Olmstead v. L.C., a case was brought against the Georgia State Commissioner of Human Resources (Tommy Olmstead) on behalf of two women with developmental disabilities (known as L.C. and E.W.) who were diagnosed with mental illness. They were voluntarily admitted to Georgia Regional Hospital for treatment in a psychiatric unit and later indicated a preference for discharge. Reviews by healthcare professionals determined that they were ready to move into a community setting with appropriate support. The discharge, however, never occurred. In 1995 the Atlanta Legal Aid Society filed a lawsuit that was eventually heard by the Supreme Court. The Supreme Court ruled that, under Title II of the Americans with Disabilities Act, the women had the right to receive care in the most integrated setting appropriate and that their unnecessary institutionalization was discriminatory and violated the ADA.

The ruling provided an important clarification about how states should comply with Title II of the ADA. The ADA applies to all public bodies and to the use of public funds. As a result, it had profound implications for Medicaid services for people with disabilities. The Olmstead decision confirmed that states must ensure that Medicaid-eligible persons do not experience discrimination by being institutionalized when they could be served in a more integrated (i.e., community) setting. As a result, states were recommended, by the court, to make "reasonable accommodations" to long-term care systems. This has, in turn, led to initiatives nationwide regarding reduced institutionalization and increased available of community-based options, particularly in the area of Medicaid-waiver program growth.

The study team examined three coordination and delivery models that have been considered both viable and successful in expanding care and service to seniors:

- ADRC – The Aging and Disability Resource Center (coordination of services model)
- PACE – The Program for All-Inclusive Care for the Elderly (delivery of services model)
- GRACE – Geriatric Resources for Assessment and Care of Elders (delivery of services model)

A summary of these models is presented below.

The Aging and Disability Resource Center

The Aging and Disability Resource Center (ADRC) is an evolving model of service coordination, sponsored by both the US Administration on Aging (AOA) and the Centers for Medicare and Medicaid Services (CMS). As summarized by the ADRC's technical assistance exchange:

> *ADRCs serve as single points of entry into the long-term supports and services system for older adults and people with disabilities. Sometimes referred to as a "one stop shop" or "no wrong door" system, ADRCs address many of the frustrations consumers and their families experience when trying to find needed information, services, and supports. Through integration or coordination of existing aging and disability service systems, ADRC programs raise visibility about the full range of options that are available, provide objective information, advice, counseling and assistance, empower people to make informed decisions about their long term supports, and help people more easily access public and private long term support and service programs.*

Funding was first made available for ADRCs in 2003. Since that time, 45 states and territories have implemented more than 200 ADRC programs nationwide, reaching approximately 40 percent of the US population. Programs have assisted states and communities in optimizing the use of financial resources under state and federal programs and in creating state and local partnerships to streamline access to care and services. In September 2009, $11 million in grants were awarded to 49 states and territories to implement or expand the Aging and Disability Resource Center Program.

Primary Functions of ADRCs

Awareness & Information	Assistance	Access
• Public Education • Information on Options	• Referral • Crisis Intervention • Options Counseling • Benefits Counseling • Planning for Future Needs • Employment Options Counseling	• Eligibility Screening • Private Pay Services • Comprehensive Assessment • Programmatic Eligibility Determination • Medicaid Financial Eligibility Determination • One Stop Access to all Public Programs

ADRCs are viewed as a key element in the process of expanding access to services for older adults and disability populations for a variety of reasons, as cited by the US Department of Health Human Services.

- State budgets will not be able to support the current system of Medicaid long-term care and spend-down without creating a plan to slow the rate of its growth and expenditures.
- The *Olmstead* decision supports and upholds citizens' rights to have the broadest access to home and community-based supports and be free of publicly funded systems that have an institutional bias.

- An inefficient and overburdened system is not a good use of resources and results in consumer dissatisfaction with a state's publicly funded services.
- Consumers would like a person-centered, self-directed system that assists them with identifying and accessing a range of home and community-based resources that support and maintain their independence.

ADRCs have been deemed a successful model by the AOA, CMS, and aging service professionals and providers from around the nation. As indicated by the ADRC technical assistance center in 2009, "ADRCs play an active role in helping consumers access public benefits for long term services and supports, making the application process less onerous, less bureaucratic, less administratively burdensome for Medicaid agencies, and more seamless for consumers."

Among the 43 states awarded grants in 2003 through 2005:

- All assist consumers with completing financial applications for Medicaid.
- 40 percent have functional eligibility assessors co-located with the ADRC.
- Over 25 percent have financial eligibility assessors co-located, and over three-quarters can track the eligibility status of applicants as they move through the system.
- 25 states have statewide long-term supports and services resource directories accessible to the public and professionals via the internet (17 of them new since ADRC and another six significantly enhanced through the ADRC project) and another 13 are in the process of developing similar statewide capability.
- 34 of the 43 original ADRC states have Medicaid applications available on the internet with seven of these (and another four in process) allowing consumers to complete the application online and submit it electronically.
- 16 ADRCs have online consumer decision tools and another 15 are in the process of developing such capability.
- ADRC pilot sites developed information exchange protocols across partners so consumers only have to tell their story once.
- Several ADRCs use portable technology for data entry and scanning documents; eight states use laptops in the field and three employ portable scanning or photography

APPLICABILITY FOR THE MAT-SU

ADRC is a viable model of service coordination for the Mat-Su and could ideally consolidate information and referral services in one setting. (At present, information and referral is offered by three senior centers in the Mat-Su, inviting three redundant administrative structures and related operating costs.)

In addition, an ADRC could provide service eligibility screening at a local level, improving response time and, ultimately, service delivery.

The State of Alaska has endorsed the ADRC model with a stated intention of operating at least six ADRCs. At present, there are three operating ADRCs in Alaska – one serving Southeast, one in the Kenai and a final within the Anchorage municipality. A fourth ADRC is just starting in Dillingham.

PACE – The Program for All-Inclusive Care for the Elderly

The Program of All-inclusive Care for the Elderly (PACE) model is centered around the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. The program provides access to the full continuum of preventive, primary, acute, and long-term care services. PACE programs take many familiar elements of the traditional health care system and reorganize them in a way that makes sense to families, health care providers, and the government programs and others that pay for care.

PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and live in a PACE service area. Although all PACE participants must be certified to need nursing home care, only about 7 percent of PACE participants nationally reside in a nursing home. If a PACE enrollee does need nursing home care, the PACE program pays for it and continues to coordinate the enrollee's care. It is important to note that a PACE participant must be eligible for both Medicaid and Medicare ("dually eligible"). Enrollment in PACE is voluntary.

The typical PACE participant is 80+ years of age, has seven medical conditions, and at least three ADLs. Currently, there are 79 PACE programs located in 30 states.

PACE has been generally accepted as a successful model of chronic care for older adults. It has been universally appealing to participants, healthcare providers and payors – each for different reasons, as summarized in the table below.

The Appeal of PACE

For Participants	For Healthcare Providers	For Payors
• Caregivers who listen to and can respond to their individualized care needs • The option to continue living in the community as long as possible • One-stop shopping for all health care services	• Capitated funding arrangement that rewards providers that are flexible and creative in providing the best care possible • Ability to coordinate care for the individuals across settings and medical disciplines • Ability to meet increasing consumer demands for individualized care and supportive services arrangements	• Cost savings and predictable expenditures • Comprehensive service package emphasizing preventive care that is usually less expensive and more effective than acute care • A model of choice for older individuals focused on keeping them at home and out of institutional settings

Source: National Pace Association, www.npaonline.org

Services

Delivering all needed medical and supportive services, the PACE program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. Care and services include:

- Adult day services that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care
- Medical care provided by a PACE physician familiar with the history, needs and preferences of each participant
- Home health care and personal care
- All necessary prescription drugs
- Social services
- Medical specialists such as audiology, dentistry, optometry, podiatry, and speech therapy
- Respite care
- Hospital and nursing home care when necessary

Model

PACE operates as a "capitated" model, in which the PACE provider is at risk to provide all services to its participants.[1] In this model, the provider receives a monthly, lump-sum payment from Medicare combined with Medicaid or a participant's private pay resources to furnish all services. Thus, the provider is motivated to keep people healthy and independent at home for as long as possible. Care services are tailored to the needs of each PACE participant to help him or her avoid hospital or nursing home placement to the greatest extent possible. The program is designed to monitor participants closely for even subtle changes in needs which, left unattended, could lead to costly acute care episodes. The Center for Medicare Education's "Pace Model" Issue Brief (Vol. 2, No.10 – 2001) offers an excellent example of how the process works:

> *...a Medicare beneficiary shows up at the emergency room every month to be treated for skin infections caused by flea bites. The traditional, fragmented care delivery system would have trouble addressing the root cause of her condition and might just keep treating the patient's flea bites. For a PACE enrollee, the team, with input from social workers, home health aides and drivers who have been in her home, may decide to fumigate her home and provide a flea dip for her pet. This flexibility can produce more cost-effective solutions and a higher quality of life than prescribing costly medications or continually hospitalizing an individual.*

[1] In a capitated model, a provider organization (i.e., the PACE provider) is paid a set amount for each enrolled person regardless of the services provided or utilized by the enrollee.

Hallmarks of PACE

There are three essential hallmarks of the PACE program: an interdisciplinary team approach to chronic disease management, the adult day health center, and transportation.

- **Interdisciplinary Teams:** Teams comprised of physicians, nurse practitioners, nurses, social workers, therapists, van drivers, aides and others meet regularly to exchange information and solve problems as the conditions and needs of PACE participants change. Through interdisciplinary teams, the viewpoints of different disciplines are brought together, and information gained through interaction with the PACE participant over time and in different settings is shared. This approach empowers those involved and allows more information to be available at the critical points when decisions are being made.

- **Adult Day Centers**: PACE participants regularly attend an adult day center—on average, three days a week. This center typically includes a health clinic with an on-site physician and nurse practitioner, physical and occupational therapy facilities, and at least one common room for social and recreational activities. Because PACE participants have regular contact with primary care professionals who know them well, slight changes in their health status or mood can be addressed immediately.

- **Transportation:** Transportation for PACE participants is another covered benefit. Transportation is critical to the implementation of the care plan. It is a key way PACE supports families who are providing care for their loved ones. Transportation is not only to and from the day center, but also to other appointments. Providing transportation also places a driver who has been trained to observe cues in the home of the PACE participant. Drivers can then report these cues that may signal a change in health status or other changes that should be monitored.

Disadvantages of PACE

As a viable business model, PACE is dependent on a sufficient volume of potential participants within a specifically defined geography. Thus, it is ideally suited to high-population, urban environments with sufficient dually eligible prospects. Of the 79 programs currently operating, less than a handful are located in rural settings. While a "rural PACE" model has evolved over the last several years, rural operators have struggled to achieve financial viability given limited participants and the distance involved.

APPLICABILITY FOR THE MAT-SU

As a "turnkey" option, PACE is likely unworkable for the Mat-Su, given the geography involved and population density. (Quantitative analysis indicates insufficient dual-eligible prospects in the borough to support a program. While sufficient population may develop by 2030, the geographic implications are unavoidable.) Elements of the model, including an interdisciplinary team approach for chronic disease

management, tools to support this management and the adult day center, however, may have application as part of a senior service delivery plan for the Mat-Su.

GRACE Model

Similar to PACE, the Geriatric Resources for Assessment and Care of Elders (GRACE) utilizes an interdisciplinary team, but focuses on a pre-PACE population of seniors – those who are frail and potentially vulnerable, but not nursing home-eligible. Development of GRACE was funded by the National Institute on Aging, the Nina Mason Pulliam Charitable Trust and Wishard Health Services.

GRACE was developed to coordinate care to low-income seniors with chronic needs through supplemental assistance to their primary care physicians. The goal of the GRACE model is to improve the quality of geriatric care to optimize health and functional status and prevent long-term nursing home placement.

The key GRACE team members are the nurse practitioner and social worker support team. This team works closely with the community physician to continually coordinate care and manage emergent situations.

- Upon enrollment, the patient receives a comprehensive geriatric assessment that includes a home visit.
- Then, the GRACE interdisciplinary team that may include a geriatrician, pharmacist, physical therapist, mental health social worker, and a community-based services liaison will develop an individualized plan of care. The plan of care is based upon GRACE clinical protocols with best practices for treating common geriatric conditions. This approach is similar in many ways to the NUKA model developed and deployed by the Southcentral Foundation.
- The GRACE support team meets with the primary care physician to discuss and modify the plan as needed.
- The GRACE program is typically supported by an electronic medical record.

The GRACE support team provides ongoing care management and coordination of care across multiple providers and sites of care to improve the management of multiple geriatric syndromes.

Results of the GRACE clinical trial funded by the National Institute on Aging in the table below show proven results for best practices as compared to usual care.

See table, next page

GRACE Clinical Trial Results

	Usual Care	GRACE
Preventive Care		
Newly reporting having a flu shot	35.2%	48.5%
Reported at 12 months having a flu shot in the past year	66.8	73.6
Pneumococcal vaccination received in those on record as not having previously had pneumococcal vaccination	10.7	17.6
Continuity of Care		
Newly identified a primary care doctor	63.2%	81.1%
Follow-up primary care visit occurred within six weeks of first hospital discharge in those having one or more hospitalization	53.9	83.3
Medication Use		
Newly reported having a medication list	38.2%	58.1%
Not prescribed a medication with strong anti-cholinergic effects in months 6 -12	82.8	87.6
End-of-Life Care		
Newly reported having a health care representative or living will	17.0%	44.3%

Source: IU Geriatrics, Indianapolis, IN, 2007

GRACE has been nationally recognized for its effective approach and cost-saving benefits in the Journal of the American Medical Association as one of three models with the greatest potential to improve the effectiveness and efficiency of the complex primary health care of older adults. In a large clinical study, GRACE improved health and quality of life, decreased emergency room visits, and lowered hospital admission rates in a group at high risk for hospital admission.

GRACE has been additionally determined to be cost-effective. By its second year, GRACE saved money for the sickest (those with three to four chronic diseases), and in the third year, a year after the home-based intervention ended, it saved even more.

APPLICABILITY FOR THE MAT-SU

GRACE is potentially viable option in improving care and services for older adults in the Mat-Su. The model addresses both physical and social well-being through a combination medical/social service support team, which is not immediately impacted by geographic challenges. The program is typically vested in a primary care physician clinic, and as such, it requires the leadership and involvement of a primary care physician or physician group. This can sometimes be a challenge for seniors who lack a PCP or are resistant to physician interaction. The integration of the support team, however, is seen as beneficial for both physician and patient, which may decrease physician resistance to some older patients.

Regional Plan Strategies

A strategic plan for senior service delivery in the Mat-Su must encompass a wide range of seniors with varying backgrounds, financial means, and social, psychological and physical needs. Thus, there is no particular emphasis on serving a specific senior cohort or financial segment.

Plan Challenges

Based on the study team's analysis and opinion, challenges in the Mat-Su are fourfold:

1. **Lack of service coordination among all senior service providers**. There is a degree of perceived "territoriality" among providers, but there are no specific "boundaries" with respect to service delivery. Thus, an entity in one community may serve clients in an adjacent community, which may already have a similar service available. In effect, there is considerable duplication of service (and administration) in some areas. By way of contrast, there are areas in the borough that receive little to no service. The creation of a centralized resource to both provide information and refer seniors to service options will be key in helping improve overall coordination of services. Additionally, major providers must establish or develop some shared agreement or consensus about competing in a healthy and non-duplicative manner. This might take the form of understood service boundaries or specific service provisions by each provider.

2. **The geography offers substantial challenges to service delivery.** The sheer distribution of seniors over a wide area is an omnipresent issue. Interviewees consistently cited challenges imposed by distances, and the remote location of many communities with small concentrations of seniors impose considerable restrictions on the development of more services. Improved networking and communication among providers, the development of a chronic disease management model, and the application of appropriate technology to support care monitoring will be critical in serving seniors throughout the Mat-Su effectively.

3. **State governmental infrastructure is inefficient in identifying and qualifying seniors for service.** Alaska's current infrastructure to support and manage services for seniors could benefit from improvement. While Alaska directs more dollars to home and community-based services than most states in the nation (51 percent of senior services funding vs. 25 percent nationally), external reviews of the state's long-term care system have identified several problems.

   One study noted that the system "remains fragmented and without an over-arching infrastructure." As a result, Alaska "suffers from parallel systems of care, ineffective rates, and continuum of LTC that does not provide complete and consistent delivery of services." Work completed by HCBS Resources, Inc. in 2008 noted several recommendations for improvement, most notably that the state "restructure the process for matching people with funding sources."

HCBS additionally comments on access processes for the Pioneers Homes and ten different funding authorities for long-term care services operated by the Division of Senior and Disability Services:

> *In addition to having separate access processes, most of the programs use different assessment tools and have eligibility criteria that may potentially overlap. This lack of integration creates challenges for the State in that it must manage each program as a separate effort, thus preventing it from managing the delivery system as a whole. Trying to contain costs for one funding stream will inevitably create pressure for cost increases on other funding streams. The lack of integration also creates a maze that consumers in need of services must navigate.*

As an example, Alaska's assessment practices for financial qualification and service need require state intervention, which is lengthy. Thus, seniors oftentimes wait two to five months before receiving services. Also, the state's current assessment process rewards for the volume of applications, regardless of likely qualification. Per some interview contacts, nearly half of all applicants do not remotely qualify for services.

4. **Current service provisions are not sufficient to support future demand.** Based on the study team's demographic and service analyses, the projected rate of senior growth in the borough will result in increased need for services and programs accessed by seniors. Thus, program offerings and opportunities must grow or evolve to support increased demand. While this issue is not unique to the Mat-Su (markets across the country will be challenged to support an aging population), the projected rate of growth in the borough's senior population is roughly five times that of the nation as a whole.

Plan Strategies

Addressing these challenges will require a deliberate and organized approach, involving providers, community stakeholders, healthcare organizations, and senior customers and their adult children. The study team envisions a senior service plan for the Mat-Su evolving over a two to three-year timeframe and encompassing four primary steps:

1. Learn more about specific Mat-Su senior needs and desires
2. Develop provider consensus about service areas and accomplish regulatory change
3. Develop an Aging Disability and Resource Center (ADRC) to serve the Mat-Su
4. Plan for expanded service offerings and new service development

These steps are expanded in greater detail and with corresponding recommended action plans over the following pages. It is important to note that the steps are presented in sequential format, understanding that information and accomplishments secured in one step will be essential in implementing subsequent steps.

Plan Management

Given the fragmented nature of current senior services in the borough, there is no dedicated, high-level organization available to lead, guide, or champion a regional plan for senior service delivery. Thus, some method of plan management must be established as a foundational component.

The study group recommends a two-fold approach. First, overall responsibility for the evolution and daily management of the plan should be vested in a single individual or organization that can "own" and lead the process, coordinate community providers and participants, gain stakeholder participation, foster collaboration with the state and serve as a central voice for the process. Given the importance and urgency of senior services, it may be advisable that these responsibilities rest with an established organization that has far-reaching understanding of both the borough and the implications discussed herein.

Secondly, a senior service task force should be created that includes participants from various organizations and providers in the Mat-Su. This task force should be distinct from the current Coalition of Mat-Su Senior Centers (CMSSC). While the coalition is an important element of local service provision, its focus is too narrow to support a plan of this scope. The coalition may also be hampered by self-interest in achieving certain plan elements.

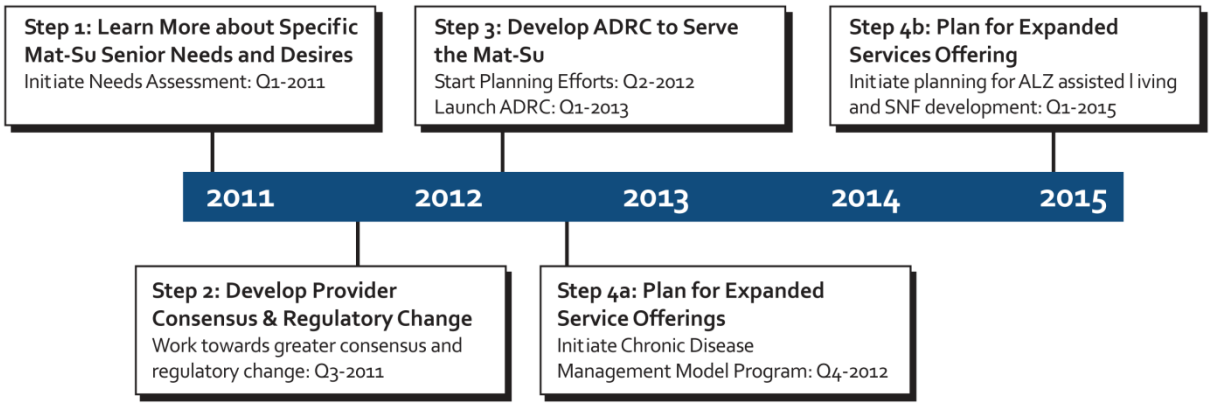
A task force of eight to 12 members is recommended that includes the following individuals:

- Two representatives from current funders (i.e., MSHF, AMHT, United Way, etc.)
- Two representatives from the general senior community
- One representative from the CMSSC
- One representative from MASCOT
- One representative from case management/home care providers
- One representative from Mat-Su borough government (ideally an elected official)
- One representative from the local physician community
- One representative from senior housing providers
- One or two representatives from the community-at-large (TBD)

The task force should establish an appropriate scope to accomplish the recommended plan strategies, determine an appropriate meeting calendar, and elect officers.

Suggested Implementation Timeline

A suggested implementation timeline for major steps, which are explained over the following pages, is presented below.



Step 1: Learn More about Specific Mat-Su Senior Needs and Desires

Outcome: Increased understanding of senior needs, service gaps and prioritization of efforts related to regulatory change and future development.

At this time, the study team's understanding of senior needs is based primarily on feedback from Mat-Su area providers, our familiarity with senior-related trends in the area, and our experience elsewhere. To identify specific services, it will be critical to hear directly from consumers and seniors about their experiences in the Mat-Su area, opportunities for expansion or improvement of services, and general perceptions regarding living conditions, service availability, housing, transportation, and other areas.

The task force should engage with a third-party organization to conduct a comprehensive needs assessment regarding senior care and services in the Mat-Su. The needs assessment process usually employs some combination of the following research techniques:

- **Existing Data** -- Statistical data such as census data, health data and hospital information is analyzed and a report prepared for the community.
- **Attitude Survey** -- Information about senior well-being is collected by surveys. A telephone survey of randomly selected households would be the preferred approach to ensure statistically useful data.

- **Key Informant Input** -- Key informants, such as community leaders or others knowledgeable about senior services, complete a questionnaire or are interviewed to obtain their impressions of senior needs.

- **Community Forum** -- A public meeting(s) is held during which the participants discuss the needs and priorities of seniors in the community and what can be done to address them.

- **Focus/Discussion Groups** -- A group of people selected for their particular skills, experience, views, or position are asked a series of questions about senior service and support issues to gather their opinions. Group interaction is used to obtain detailed information about senior needs.

The needs assessment is foundational to the regional plan evolution and will provide senior-specific data and anecdotes. The needs assessment outcomes should serve to refine findings and issues identified by the study team and provide greater detail with respect to senior needs by location, age, gender, and other potential cross-tabulations.

The process should also both stimulate interest in senior services in the borough and provide "real world" senior experiences to help develop shared consensus and support a subsequent campaign for regulatory change at the state level.

Step 2: Develop Provider Consensus about Service Areas and Accomplish Regulatory Change

During Step 2 of the regional plan process, providers, stakeholders, funders and the community at large must develop a shared consensus about how the coordination and delivery of senior services can be improved and what steps must be taken to achieve those improvements through better coordinated and consolidation at the local level. In addition, a collective effort must be set forth to help articulate and guide change at the state level.

The findings of this current study, in concert with the needs assessment outcome, will help frame a specific outline of how service delivery and coordination must change. Shared consensus will be essential if the borough is to be successful at articulating and accomplishing regulatory change at the state level. In addition, local service providers (i.e., the senior centers) will better understand how their operations and service efforts must be coordinated and integrated to serve the greatest volume of seniors possible. It is important to underscore that the status quo is not tenable into the future, given projected population growth and limited funding.

STRATEGY 2A: DEVELOPING PROVIDER CONSENSUS

There are two potential steps in approaching provider consensus – developing expanded memoranda of understanding among providers and growing towards consolidation.

Memoranda of Understanding

Under this approach, dominant providers in the market area (i.e., senior centers) must establish a broad set of shared understandings about services to be provided, the geographic limitations of each provider's service area, and the anticipated number of seniors to be served by each provider.

This approach is used successfully by Southeast Senior Services, a network of 14 senior centers sponsored by Catholic Community Services (CCS) in Southeast Alaska. As explained on CCS' website:

> *In 1974, Southeast Senior Services was organized in 1974 under the sponsorship of Catholic Community Service, a non-profit corporation dedicated to the delivery of quality human services. When Southeast Senior Services began that year as Southeast Nutrition Program for the Elderly, it opened senior centers in Angoon, Juneau, Ketchikan and Sitka. Between 1974 and 1983, SESS developed the four centers into a network of fourteen senior centers throughout Southeast Alaska. These centers offer congregate and home-delivered meals and transportation, along with various support services for seniors in these communities. Seven of these senior centers are designated as a networked system of Aging and Disability Resource Centers, and as such, serve people with disabilities in their community by providing information, assistance and referral services.*

Under the CCS model, funding is secured en masse for all 14 centers and divided appropriately, based on specific needs of each center. By way of comparison, centers in the Mat-Su approach funding sources separately and individually, which has led to unhealthy competition and considerable duplication of service. If the centers could derive expanded memoranda of understanding in a similar manner, they could approach the state and funding entities in a unified way, so that funding streams could be divided appropriately based on definitions of service, geographic scope, and demographics.

Working Toward Consensus

Recognizing the challenges inherent in the current status quo and an inevitable need for change, the Mat-Su Health Foundation engaged Kennedy & Associates and Rider Consulting to support the Coalition of Mat-Su Senior Centers' efforts to help build trusting relationships amongst the members, assess the current environment, explore collaboration opportunities, and clarify their strategic vision. This engagement was secured as a corollary effort to regional plan development effort, which has resulted in this study.

Gwen Kennedy, Ph.D., provided group facilitation and organizational development support and Mary Elizabeth Rider assembled existing regional data on the Mat-Su seniors for group discussion and analysis. The coalition-building consultants have maintained an ongoing dialogue and discussion with the McDowell Group/HDG study team throughout the evolution of both engagements.

Coalition members have included representatives from five centers in the borough, as indicated in the table on the next page.

Coalition Members

Senior Center	Location	Members
Palmer Senior Citizen's Center	Palmer	Richard Tubbs, Chair Rachel Greenberg
Wasilla Area Senior	Wasilla	Sondra Kaplan Shelia Walker
Upper Susitna Seniors	Talkeetna	Herman Thompson Larry Dearman
Mid-Valley Seniors	Houston	Lorie Rounds, Vice-Chair
Meadow Lakes	Meadow Lake	Julie Starr Sherri Rusher
Willow Area Seniors	Willow	B.J. Eldred

Source: Kennedy and Associates

The result of Dr. Kennedy's and Ms. Rider's work with the coalition members has resulted in a strategic action plan for the next year, and the Coalition has begun conversations to explore opportunities for collaboration. They share a vision of keeping seniors living as independently as possible and a goal of ensuring the availability of coalition services to all seniors in the Mat-Su.

Four specific goals have been identified to date:

1. Organization development
2. Needs assessment
3. Advocacy
4. Business plan

Further work is needed on the strategic action plan to ensure group alignment, identification of leads and support resources, and establishment of timelines. Dr. Kennedy will continue to serve as a consultant/facilitator to help the group build trust amongst them and address territorial, monetary and other issues that may challenge the group's effort to achieve their vision. She will work with the group to explore:

- Collaborative opportunities within key programs and service areas: 1) congregate meals, 2) home delivery meals, 3) transportation, 4) employment, 5) assisted living, 6) nutrition education and 7) housing management.
- Business models of collaboration including Southeast Senior Services, Aging & Disability Resource Center, and Meals on Wheels Association of America.
- Additional ways to advocate for both immediate and long-term needs including current priorities and changes in state funding formulas.

Evolving to Consolidation

While establishing memoranda of understanding among the centers may be seen as a first step, an inevitable future step may involve the consolidation of all Mat-Su senior centers into one corporate entity as a borough-wide senior center with regional satellites or service sites in primary communities, including Palmer, Wasilla, Houston, and Talkeetna.

A consolidated approach would eliminate redundancies in administrative and management structures, decrease issues regarding "territoriality," and resolve potential service duplication issues. It might also serve to deploy expanded service capacity in areas that are currently underserved, especially with respect to meal services and transportation. A consolidated administrative structure would also simplify funding and grant applications, streamline board recruitment and participation, and minimize potential consumer confusion. Singularity of voice will also be crucial in advocating regulatory change to support increased services for seniors throughout the Mat-Su.

The study team recognizes that this approach represents a potentially unwelcome suggestion and would impact the degree of local control retained by each currently operating senior center. It is important to understand that a "recommendation" to consolidate is not stated here. The reality, however, of potential decreased funding in the future and the inherent duplication of services, especially in management and administrative functions, may rapidly outpace the centers' desire to remain independent and distinct in the future.

STRATEGY 2B: REGULATORY CHANGE

As indicated previously in this report, regulatory change must figure prominently as part of a regional plan that improves senior services and service delivery, not only in the Mat-Su but also statewide. It is the recommendation of the study group that efforts to accomplish such change encompass a broad swath of individuals and organizations in the borough, including the Coalition of Senior Centers, other senior service providers, community leaders, senior consumers, funding organizations and other advocacy organizations.

The goal of regulatory change will be to improve the overall quantity and quality of services delivered to seniors. To that end, the study group has identified three areas of action for change:

- **Ungrouping Mat-Su from the Alaska Department of Health Services' current Coverage Area V assignment and creating a distinct Mat-Su region** – The Department's Coverage Area V currently encompasses the Mat-Su, the Kenai Peninsula, and Valdez-Cordova. The state's current ADRC plan allows for one ADRC per administrative coverage area, and the ADRC based in the Kenai Peninsula Living Center is the designated ADRC for Mat-Su. Thus, the present regulatory structure precludes development of a new ADRC in the Mat-Su. Staff from the Kenai ADRC have indicated that they have been challenged to serve the Mat-Su appropriately, given the size of the borough and its distance from Kenai. They did consider placing an ADRC specialist in the Mat-Su to address information and referral issues, but it was eventually determined unfeasible. Staff from

Kenai also indicated that they have made little promotion of their services in the Mat-Su because of the inherent service challenges. Seniors in the Mat-Su, as a result, have little to no ADRC resource at their immediate disposal. Ungrouping Mat-Su from Region V is the first priority towards establishing an ADRC in the Mat-Su.

- **Securing Enhanced State Commitment to Evolving the Fully-Functional ADRC Model** – As explained earlier, the state's current commitment for ADRC support is vested in three sites through FY2012. While some federal grant monies were secured in 2008 and 2009 to expand ADRC offerings for improved hospital coordination and Medicare beneficiary counseling, the state must dramatically increase ADRC funding to both achieve the fully-functioning model at existing sites and expand to other areas of need in Alaska. Projected growth of senior population in the Mat-Su should position the borough accordingly to be considered for an ADRC. Representatives from the state's Division of Senior and Disability Services indicated potential consideration of an ADRC in the Mat-Su, if 2010 Census results confirm the predicted growth and the Mat-Su could be "split" from Coverage Area V. Staff implied that both efforts would likely require legislative support and that planning efforts for the FY2013 period would begin in late 2011. This would represent the ideal time to initiate lobbying efforts. A fully functioning ADRC would encompass all three primary functions of the program and would increase the volume of senior services and assessments that could be completed at the local level. This would benefit seniors and service providers alike.

- **Revising State Medicaid Requirements to Support Individuals with Alzheimer's Disease and Related Disorders** – At present, participants in the Older Alaskans state waiver program must meet a requirement for nursing home level of care to qualify for Medicaid support. Most individuals who have been diagnosed with ADRD do not meet this level of care, and as such, they do not qualify for this support. This magnifies an already challenging issue, which is lack of service statewide (and in the Mat-Su) to manage people with ADRD. The state's current Medicaid plan can be revised to accomplish this change, which could result in increased Medicaid matching funds for the state. This change would benefit the development of an assisted living facility in the Mat-Su to support those patients with Alzheimer's disease, dementia and cognitive impairment.

Beyond these three specifics, the study team also recommends that senior service stakeholders in the Mat-Su consider efforts in the following four areas:

- Support the consolidation of payment mechanisms in Division of Senior and Disability Services (DSDS) into a unified payment structure. At present, the DSDS manages 10 different funding authorities for long-term care services. This lack of integration requires that DSDS manage each program as a separate effort and creates a maze for consumers to navigate.

- Encourage the Division of Senior and Disability Services to seek more federal grant dollars through participation in new programs resulting from the Patient Protection and Affordable Care Act, including increased appropriations for ADRCs, service delivery models to be tested under the Center for Medicare and Medicaid Innovation, the Independence at Home demonstration program and grants for the creation of community health teams to develop medical homes by increasing access to comprehensive, community-based coordinated care.
- Create a financial incentive at either the state or borough level to support development of long-term care/skilled nursing facility in the Mat-Su. An incentive might take the form of tax-increment financing, property tax rebates or labor incentives for a developing organization.
- Revise the state funding formula for senior services accordingly to reflect population growth in the Mat-Su. At present, the Mat-Su is grouped with Kenai and Valdez Cordova as an administrative region with the DSDS. The state's funding formula for Older Americans Act Title III dollars is based on a series of factors, including the total number of seniors age 60+ in a given area, seniors age 80+, minority population 60+, 65+ seniors in poverty, and the number of rural seniors age 60+. Of these factors, poverty and rural account for half of the total formula. While Mat-Su accounts for only 49 percent of the total age 60+ senior population in the Area V administrative region, 58 percent of the rural component is vested in the Mat-Su. As such, the formula skews additional dollars for the region overall because of Mat-Su's rural contribution. Revisions to the state formula should reflect the Mat-Su as its own region.

Step 3: Develop an Aging Disability and Resource Center (ADRC) to Serve the Mat-Su

Outcomes: Increased senior knowledge about service offerings and improved coordination of services.

The third step of the regional plan would be focused on improving the overall coordination of services provided to seniors in the borough and offer expanded information about services. These tasks would be accomplished through two primary strategies:

1. Development of a fully-functional Aging and Disability Resource Center to serve aging and disabled clients in the Mat-Su.

2. Creation of an on-line, senior navigator resource tool.

STRATEGY 3A: ADRC: OVERVIEW, SERVICES AND CLIENTELE

As explained earlier in this report, an Aging and Disability Resource Center (ADRC) is an evolving model of service coordination, sponsored by both the US Administration on Aging (AOA) and the Centers for Medicare and Medicaid Services (CMS). ADRCs serve as single points of entry into the long-term supports and services system for older adults and people with disabilities.

The primary goals of a Mat-Su ADRC would be to simplify and streamline access to long-term living services and supports; assist consumers who are seeking services and making long-term living decisions; and increase awareness of and provide access to reliable information. Other specific outcomes would include:

- Creation of "One Stop Shop" where consumers can access long-term living and related services
- Development of a seamless system that would eventually include eligibility screening, counseling, a single application, quicker functional and financial eligibility determinations, and personalized referrals
- Making available comprehensive and consumer-friendly information on long-term living services and benefits so that consumers can make informed decisions
- Identifying and intervening with individuals at risk of entering an institution with the goal of providing them with information and counseling that will allow them to make informed choices about the long-term supports they receive
- Linking consumers who are not eligible for waiver or Medicaid-supported home and community based services with other community resources or opportunities.

A Mat-Su ADRC will serve everyone needing long-term living services, without regard to age or disability, including older persons, persons with disabilities, persons with mental illness and mental retardation. This includes those persons who may need long-term living services in the future and want to begin planning now, family members seeking information for immediate or future long-term living services, as well as professionals who work with people needing long-term living services. It also includes both those who are private pay and those who are eligible for public services.

Development

As explained earlier, current state infrastructure precludes the immediate development of an ADRC in the Mat-Su. Thus, it is anticipated that an ADRC would evolve during the second or third year of a regional senior services plan implementation process. This evolution is naturally contingent upon revisions to state regulatory issues cited earlier in this report:

- Redefinition of state geographic divisions by the Department of Health
- Increased state appropriations to support ADRC deployment and evolution in Alaska
- Revisions to the state funding formula for aging services to include ADRCs as part of the service mix

Assuming that these changes can be facilitated in the first or second year of the regional plan implementation, ADRC development can proceed.

The State of Alaska has established an operational guide related to the design, development, and operation of ADRCs in Alaska. The guide sets forth specific requirements for ADRCs, which are summarized below:

- **Target Groups** - the ADRCs serve seniors, caregivers, and individuals with disabilities.
- **Streamlining Access** - The ADRCs must serve as an entry point to access all public programs for home and community-based services and institutional long-term support services administered by the state under Medicaid and those portions of the Older Americans Act program that are devoted to long-term support services, and any other publicly funded service related to long-term care.
- **Public and Private Pay Clients** - the ADRC will be a resource for private-pay individuals, those eligible for publicly funded services, and health and long-term support professionals and others who provide services to seniors, caregivers, and individuals with disabilities.
- **Critical Pathways** - the ADRC will create formal linkages between and among the critical pathways to long-term support (hospitals, nursing homes, CLTC, etc.).
- **Management Information Systems/Information Technology** - the ADRC program will have MIS/IT that supports the functions of the program including tracking client demographics, referrals, screenings, care plans, follow-up, service utilization, and costs. MiCIL and DS3 will be used for this function.
- **Evaluation Activities** - the ADRC must establish measurable performance objectives including objectives related to visibility, consumer trust, ease of access to services, responsiveness to consumer needs, efficiency of operations and effectiveness of the ADRC. The ADRCs will use the Logic Model, Customer Satisfaction Surveys, and Site Reviews.
- **Staffing and Resources** - the ADRCs will have a designated AIRS certified, ADRC Specialist to provide services, and a Director to oversee the overall ADRC project. ADRCs will communicate with SDS to assure adequate capacity to assist consumers in a timely manner and SDS and ADRCs will seek both private and public funding opportunities to maintain sustainable programs.

The operational guide additionally provides checklists, suggested program structures, community outreach options and key descriptions of services to be provided. ADRC development would additionally involve interaction and linkage with current operating ADRCs to gain best-practices information and learn from other operators.

ADRC Business Plan

As an initial development step, the ADRC should develop a business plan that specifies functions of the ADRC, services to be offered, business processes, potential customers and so on. The ADRC Technical Assistance Exchange (http://www.adrc-tae.org) offers a comprehensive library of information regarding ADRC operational and business plan development as well as an ADRC business plan template which can serve as a useful resource for guiding initial development of an ADRC in the Mat-Su. At minimum, a business plan for the Mat-Su ADRC should include the following sections:

- General Description
- Services
- Marketing Plan
- Service Forecast
- Operational Plan
- Management and Organization
- Financial Plan

Functions

While a fully evolved ADRC model involves three primary functions, Alaska has, to date, engaged primarily in only the first function of awareness and information. It is anticipated that a Mat-Su ADRC would evolve in a similar fashion. During the first one to two years of operation, the ADRC would be focused on offering information and referral services as well as community outreach, education, and marketing regarding the program and its offerings. As Alaska's commitment to the ADRC model evolves, so would the Mat-Su ADRC, inevitably including assistance and access services to support options and benefit counseling and assessment/eligibility screening.

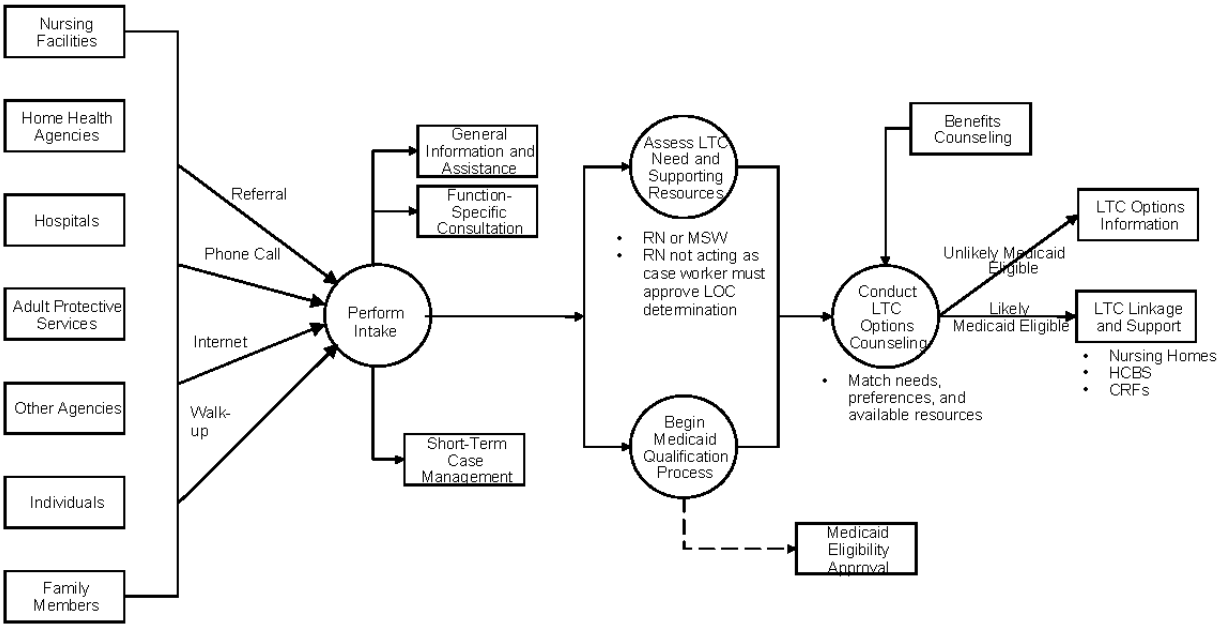
Generally speaking, a fully-functioning ADRC must typically fulfill the following functions:

- Intake
- Information and Referral
- Short term stabilization and/or care management
- Assessment and eligibility determinations
- Long-term care options counseling
- Interaction with Medicaid eligibility approval processes

- Linkage to long term supports
- Benefits counseling

A flowchart that details ADRC operational process and the interrelationship of these functions is presented in the figure below.

ADRC Operational Process and Functional Interrelationships



Source: ADRC Technical Assistance Exchange (http://www.adrc-tae.org).

Funding Support

As cited earlier in this report, state support of ADRCs has been fairly limited to available federal grant supports. Improving support for ADRCs statewide, as well as in the Mat-Su, will require changes in current state funding practices for aging services and may potentially require specific legislative action to establish a permanent funding mechanism to support ADRCs or create some form of interim support as a permanent mechanism is established. The ADRC financial analysis presented in this report assumes a range of different funding supports for a Mat-Su ADRC, including federal grant monies, Older Americans Act funds, Medicaid support, an Alaska self-funded initiative for ADRCs, a one-time legislative allocation for the Mat-Su, and potential third-party grant support.

Impact to Current Providers

For current providers in the borough, the ADRC would assume the primary role of "information and assistance" (I&A) or "information and referral" (I&R). This would provide a singular resource for this function and eliminate duplication of I&A and I&R services currently vested in the borough's senior centers. An ADRC would additionally provide an unbiased referring organization that would not be inclined to self-direct individuals. Eventually the ADRC would also evolve as a local resource for programmatic and eligibility determinations, which would facilitate improved response to prospective client needs.

STRATEGY 3B: SENIOR NAVIGATOR PROGRAM

As a concurrent development with the ADRC, the regional plan should include development of a web-based "Senior Navigator" or similar program that offers a centralized, on-line information portal regarding aging and disability resources in the Mat-Su. This portal would be publicly accessible from any computer and offer a searchable database of information, including health and aging, financial concerns, legal questions, health facilities, assisted living and housing, exercise programs, support groups and more. Information would be usable for seniors, adult children, caregivers and providers alike. An on-line portal could be use to supplement current services offered through Alaska's statewide 211 program.

A Mat-Su information web portal would be modeled after the highly successful SeniorNavigator® system developed by the State of Virginia. The program has been recognized as a national model for aging and disability resources, and provides free information about the health and aging resources available to Virginians. It is considered by many to be the benchmark for similar programs nationwide.

Given the geographic diversity of the Mat-Su, an online portal will offer essential centralized access to information about where and how seniors can get services and support.

Portal Offerings

To support a high-degree of usability and user interaction, the portal should offer a range of services and features, which are suggested below.

Search Engines

Ultimately, seniors, adult children, and caregivers desire to know more about certain services or offerings that are accessible to them. The portal should be designed with an easy-to-use function that automates the search for services by service types, ZIP code, or Boolean input.

Learn About Features

In order to assist in the search for the most optimal services, understandable and accessible information should be provided to users through the specific, functional features:

- Learn about features would include a library of downloadable articles, links, podcasts, and video. Users could access articles on every type of disease and chronic care condition, prevention and wellness techniques, financial management, end of life issues, and literally hundreds of other topics of interest.

- Ask the expert feature where responses to questions could be provided by experts; depending upon the question, a geriatrician, attorney, pharmacist, social worker, or nurse could be consulted and the answer combined. Answers could be emailed or posted on the Web site.

- Calendar of events, which could be continually updated for participating providers and sources.

- Chat rooms, blogs, other user-directed options and interfaces with social media could be included, depending on potential interest.

- Personalized Information after Log-In/Registration

The portal could be customized for a user in many different ways and offers access to a personal section through a log-in. After logging in, a user might have access to:

- An on-line needs assessment: by completing a very simple needs assessment, the senior/caregiver could be directed to suggested services based upon their needs assessment. Other assessments could include health risk assessments such as calculation of Body Mass Index, etc.

- Creation of a personal life plan, such as a step-by-step process to complete the living will, health care power of attorney, etc.

- Benefits checkup to determine eligibility for available benefits and on-line completion of forms for benefits.

- Retain personal forms, such as a medications list or a living will, in a secure, personal "file drawer."

HELP!

Finally, the portal should include clear directions about how to receive additional assistance or guidance, which would provide a direct linkage to the Mat-Su ADRC.

Providers

Providers and vendors would be able to log in to complete applications to be completed on-line for inclusion in the provider/vendor services search engine; attach scanned qualifications by email; update information on their services (spontaneously or in response to semi-annual update requests); add information to the Calendar of Events on the main Web site; or provide feedback to user questions or inquiries.

Development

Initial development of the portal would likely require a nine to 15 month timeframe and involve a third-party provider to manage programming and implementation support. Once the initial portal is developed and populated with appropriate content and provider information, it is anticipated that ongoing maintenance and upkeep would be managed as support function of the Mat-Su ADRC.

Funding

Initial funding for development of the portal could be secured through third-party grant support or contributions from commercial insurance organizations and Alaska corporations.

Step 4: Plan for Expanded Service Offerings and New Service Development

Outcome: Increased capacity to serve seniors and improved senior quality of life

In the regional plan's final step, the borough must anticipate the evolution of new and currently unavailable services to meet future need. As indicated the infrastructure assessment, the volume of home and community-based providers currently present may be sufficient to serve seniors in the five to seven year timeframe. Into the future, however, these organizations must inevitably expand their capacity. Given that they are already operating in the Mat-Su and will likely continue to do into the future, the study team has focused our discussion in this step with respect to new service offerings.

Two key strategies to expand service offerings and capacity include the following:

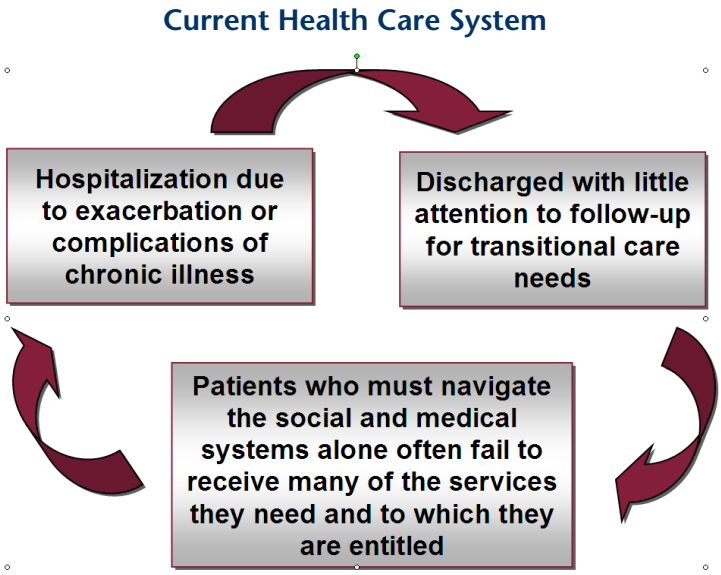
1. Implementing a model for Chronic Disease Management
2. Developing facility-based services for Alzheimer's or dementia care and/or a long-term care nursing facility.

Each of these strategies is discussed below.

STRATEGY 4A: CHRONIC DISEASE MANAGEMENT

Developing and deploying a model for chronic disease management (CDM) represents a pivotal strategy for expanding senior service delivery in the borough. CDM is focused on the senior, not the venue. Thus, it is not tied to a building and is not necessarily limited by geography. In this sense, it is ideal for Mat-Su.

In our national model of health care, seniors are especially challenged to navigate the multitude of services and systems necessary to remain healthy and, most importantly, remain at home. The figure on the next page provides a summative example of the health care cycle for many seniors.



Source: HDG.

From a national perspective, seniors comprise 12 percent of the population but account for 26 percent of physician office visits, 35 percent of all hospital stays, and 38 percent of all emergency room visits. Longer life expectancies and improved medical care have fostered a national culture of chronic disease. In fact, the average person in this country over age 65 has at least one chronic illness—diabetes, high blood pressure, or heart disease. As individuals age, the incidence of chronic disease for each individual increases.

A chronic-disease management model for the Mat-Su should focus on providing necessary resources to seniors to navigate social and medical systems with the goal of maintaining independence, thereby keeping seniors at home and out of acute or post-acute health care venues.

A Model for the Mat-Su

Over the last 15 years, several models have evolved to support chronic-disease management in senior populations. Both PACE and GRACE, which were presented and discussed earlier in this report, are excellent examples of a model that manages illness and promotes independence. Both models focus on interdisciplinary team management and coordinate care across the entire continuum of care, rather than in segmented systems or venues.

Identification

A CDM program for the Mat-Su would be grounded in first identifying potential candidates who might benefit from the program. This will require the development of specific characteristics for participation and might include individuals living independently at home who are "at risk" for institutionalization of expanded care management services, or it might include patients already enrolled in some degree of home and community-based service. Participants could be referred to the program via the ADRC, as a result of a physician referral or recommendation, a care coordinator, a housing provider or even a home health or chore-provider organization.

Initial Assessment

Once identified, an initial assessment process would identify both the social and medical needs of a potential program participant and serve as the springboard for the development of an individualized service plan. CDM programs are most commonly oriented toward physical and social care and may involve the primary care physician or mid-level practitioner and a supporting interdisciplinary care team, including social worker, pharmacist, and/or a community-based services liaison.

Service Plan Development

Developed in the conjunction with the participant, the service plan would establish specific goals and in turn identify potential need for various services, which could be provided by local providers, personal care attendants, family members or other community members. Those individuals requiring specific medical or primary care services could be enrolled in an enhanced clinically based component that includes nurse practitioner support, which might offer in-home visits to support seniors with multiple medical issues, medications, or compliance with doctor's orders.

Monitoring

The interdisciplinary team would meet on a regular basis to monitor and review program participants, identify opportunities for improvement or revision and guide participant care appropriately.

Integrating Technology

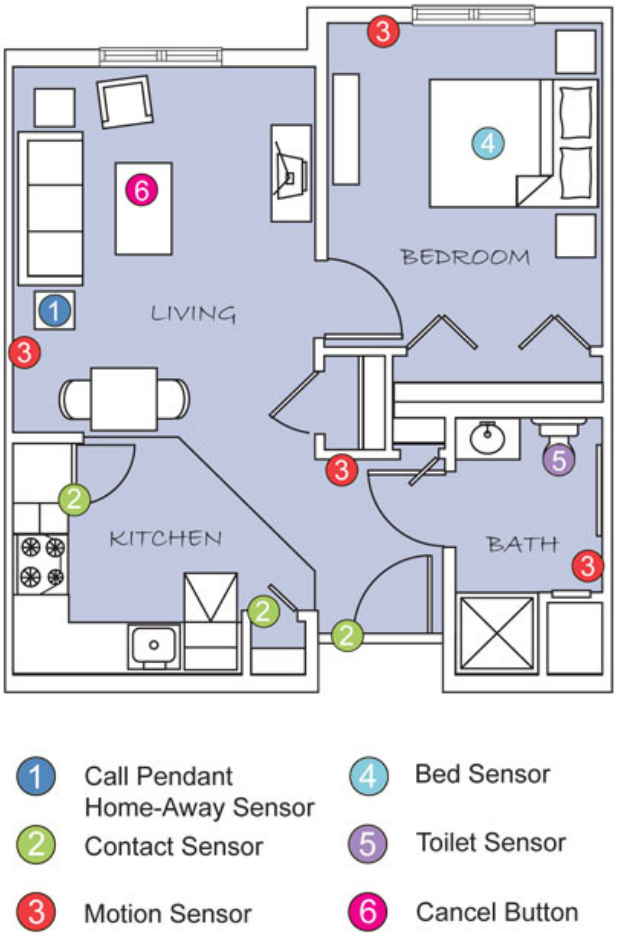
A Mat-Su CDM model could also be integrated with a non-invasive, electronic-monitoring system that monitors clients' daily living activities to detect possible deviations in behavior. These systems extend the ability to provide care for elder persons living alone or those with chronic illness. One specific example is the eNeighbor platform developed by Healthsense, Inc.

Per their description:

> *eNeighbor is a truly automated personal emergency response system. A traditional call button requires that the senior is alert, can reach the button, and is able to activate it. This is often not possible. The eNeighbor system has an emergency call button too, but in addition it uses small, wireless sensors placed throughout the residence to automatically call for help if the senior cannot. The eNeighbor system provides safe coverage of the entire residence 24 hours per day even if the senior cannot activate a call button. The eNeighbor system also provides valuable information on the health of the senior that call buttons alone cannot provide.*

The figure on the next page indicates the placement of non-invasive sensors in a senior's home to provide around the clock monitoring.

Wireless Monitoring Sensor Placement



Source: Healthsense, www.healthsense.com.

Studies have demonstrated that these technologies improve the well-being and independence of older adults, the segment of our population that has the greatest demand for health and long-term care services. The software and monitoring algorithms for these systems have evolved to include mathematical modeling systems that can predict or detect problems before a critical event occurs. Electronic monitoring systems are also scalable to meet specific client needs up to and including medical or clinical monitoring components. Thus, as a patient ages and his or her health deteriorates, the system can be augmented to support a range of different devices.

Platforms like eNeighbor are also an ideal solution for servicing populations spread over a wide terrain. Thus, they may be particularly appropriate for deployment in the Mat-Su.

Funding Support

A Mat-Su CDM program could be a candidate participant for the Independence at Home Demonstration Program set forth in Patient Protection and Affordable Care Act legislation passed in the spring of 2010. The program requires the Secretary of Health and Human Services to conduct a demonstration program to test a payment incentive and service delivery model using physician- and nurse practitioner-directed home-based primary care teams designed to reduce expenditures and improve health outcomes for frail, at risk chronic disease seniors in the community.

Beyond this demonstration funding opportunity, primary care services, including the physician and nurse extender, are covered by a participant's Medicare Part B benefit. Funding to support the interdisciplinary team component and wireless monitoring option could be potentially secured from commercial insurance and/or managed care organizations that would benefit from decreased patient care costs associated with fewer hospitalizations and potential emergency room visits. Preventative models of senior care that encourage senior independence and quality of life are also of particular interest to major gifting organizations like the Atlantic Philanthropies, which has elected to spend itself out of existence by gifting $300 to $350 million per year through approximately 2017.

Program Evolution

A CDM model for the Mat-Su should be developed along an evolutionary path, in which the program is first piloted in specific areas to establish practices and procedures, demonstrate potential outcomes, and establish positive participant perceptions. A potential pilot would operate for 12 to 18 months. Once a pilot phase is completed, the program could be expanded to a broader service area.

STRATEGY 4B: FACILITY-BASED SERVICES

Even with an emphasis on home-based chronic disease management and other home-based services, projected senior growth in the Mat-Su will likely require the future development of some facility-based services.

The study team projected two areas of greatest demand: Alzheimer's or dementia care in a secure setting and long-term skilled nursing care. At present, a secure dementia care setting is available at the Alaska Veterans and Pioneers Home. This facility, however, is typically full with a long waiting list. The Alaska Veterans and Pioneers Home also gives preference to veterans in the admissions process. There is no skilled nursing option available in the borough.

Facility Based Services Need Projections, 2010 - 2030

	2010	2020	2030
Alzheimer's Assisted Living	190	329	590
Skilled Nursing Facility Bed Need	66	117	201

MEMORY CARE (ALZHEIMER'S) ASSISTED LIVING

Dementia-care assisted living is a highly-specialized supportive living environment for individuals with cognitive impairment or Alzheimer's disease. This component of the senior living continuum has experienced dramatic growth nationwide over the last 10 years resulting from increasing incidence of memory-related illnesses (as populations grow older) and consumer willingness to utilize the setting when it is available. Interviews with Mat-Su area providers revealed that servicing seniors and other disabled adults with these disorders already presents significant challenges. Placement for individuals who require this service typically involves admission to mental health facility via an acute hospital emergency room admission. Hospitals are, in turn, additionally challenged to find an appropriate placement.

The target market for this service includes the moderately dependent resident who has some form of memory loss and requires supervised living. This person is typically over age 65, needs regular assistance with ADLs, and/or needs continuous supervision in the form of a locked or monitored unit but does not have to be placed in a nursing home. Services included would consist of three daily meals, flat linen and personal laundry, assistance with ADLs as needed, medication supervision, daily housekeeping, scheduled transportation, and all utilities. The determination of need/demand for memory-care assisted living is not only based on affordability/income levels but also by need as measured by age and physical capabilities.

The study team performed financial analysis regarding the potential development of a 32-unit memory care assisted living facility. Such a development would be ideally situated in the core urban area of the Mat-Su (i.e., Houston-Wasilla-Palmer).

Development Funding

The study team anticipates that development of a memory-care assisted living will involve a private development effort, most likely by a proprietary operator of such facilities. Several development organizations across the nation have been pursuing such facilities, given increased need for the service in many markets around the country. Given this fact, the Mat-Su should explore such opportunities through dialog with potential providers. Major providers of memory-care assisted living include:

- Emeritus Senior Living – Seattle, Washington: 450 senior living communities in 44 states
- Sunrise Senior Living – McClean, Virginia: 300+ senior living communities nationwide
- Brookdale Senior Living – Chicago, Illinois: 565 senior living communities in 35 states

LONG-TERM/SKILLED NURSING CARE

While the State of Alaska has been historically adverse to the development of institutional-based skilled nursing care, the sheer volume of seniors requiring some form of institutional long-term care in the Mat-Su in the future cannot be ignored. Currently, skilled nursing or long-term care is available mainly in Anchorage, which serves a wide range of skilled nursing residents from throughout Alaska. Given predicted senior growth in the Mat-Su and elsewhere in Alaska, it is likely that the Anchorage facilities will

be severely overburdened in the future. A local service option will be essential in supporting Mat-Su seniors and should lessen the impact to providers in Anchorage and elsewhere.

Skilled nursing facilities, or "nursing homes," provide two primary kinds of service:

- Long-term care involves the provision of services and supports to meet health or personal care needs over an extended period of time. In a nursing home setting, these services are provided for individuals who require either 24-hour supervision in a safe environment or have a chronic or long-term illness that may require the intervention of registered nurse. Nationally, long-term care accounts for approximately 65 percent of the individuals residing in nursing homes. Long-term care is typically funded for an individual through their own means or assets (private-pay) or through government support (Medicaid).

- Short-term care involves the provision of medical and therapeutic care for a short timeframe (typically less than 45 days) for individuals after surgery or other medical treatment. Short-term care is provided with the expectation that a person's condition will gradually improve over time, which will facilitate an eventual discharge from the facility to return home or to a lesser level of care. Short-term care is often referred to as "rehabilitative care" or "subacute care." The most predominant payor for short-term skilled nursing care is Medicare, or in some instances, a commercial insurance organization.

A facility developed for the Mat-Su would offer both short-term and long-term care.

Certificate of Need

Development of a Mat-Su long-term/skilled nursing care facility will require compliance with the State of Alaska's certificate of need (CON) process. CON is a review process used by the state to "promote responsive health facility and service development, rational health planning, health care quality, access to health care, and health care cost containment." In Alaska, CON applies to hospitals, nursing homes, psychiatric facilities and a range of outpatient medical services.

CON processes exist in many states nationwide and ensures that healthcare development projects meet a public need while preventing excessive, unnecessary, or duplicative development of facilities or services. Like many states, Alaska is cautious about new health care construction projects and equipment purchases because of the large amount of money states expend for Medicaid.

A review of recent CON approvals in Alaska indicated favorable outcomes for additional long-term care bed development across the state. It is important to note, however, that these approvals have been for small bed additions to existing operations. A new facility CON has not transpired for long-term/skilled nursing care in recent history.

With respect to potential development in Alaska, it is interesting to consider a 2006 study completed by the Public Consulting Group for the Alaska Department of Health and Social Services. PCG cited historical data regarding the growth of nursing home beds in Alaska from 1967 through 2005. While licensed bed growth generally leveled off in the early 1990s,

> *PCG found little data to support a near term increase in the number of licensed beds, based on our review of current nursing home utilization (detailed in the System Analysis section within this report), national trends, our recommendations for the state's log term care programs, as well as the continuation of current licensing and program practices within the state.*

The PCG report goes on to state, however, that "because there is expected to be a doubling of potential long term care users over the next 20 years, it is implied that the state will need some expansion of its nursing beds…within 10 years of this report, additional nursing home capacity will be needed in the state." PCG, writing in 2005, stated that "the needs for more nursing capacity should be revisited in 2010."

Development Funding

The study team anticipates that development of a long-term/skilled nursing care facility will involve a private development effort, most likely by a proprietary operator of such facilities. Despite national trends strongly favoring home and community-based services, nursing home development nationwide continues at a steady pace. Small, mid-sized and large nursing home operating organizations are pursuing development. Thus, the range of potential developers is fairly broad.

The study team performed financial analysis regarding the potential development of a 76-bed long-term/skilled nursing care facility. As with a memory-care assisted living facility, a long-term/skilled nursing care development would be ideally situated in the core urban area of the Mat-Su (i.e., Houston-Wasilla-Palmer).

Financial Analysis

The study team performed financial analysis with respect to four potential options in a regional plan:

1. Development of an ADRC
2. Creation of a Model for Chronic-Disease Management
3. Construction and Operation of a Memory-Care Assisted Living Community
4. Construction and Operation of Long-Term Care/Skilled Nursing Facility

Analysis assumptions and summary findings for each of these options are presented in this section of the report.

Development of an ADRC

Financial analysis of the ADRC was based on population characteristics of the Mat-Su and ADRC cost model assumptions developed by the Wisconsin Department of Health and Family Services' Division of Long-Term Care. The ADRC concept is widely deployed in Wisconsin, and financial reporting data has supported the development of a detailed cost budgeting model. This information has been instrumental in developing an ADRC financial model for the Mat-Su.

Population and Initial Contacts

While ADRCs are designed primarily to support aging and disability populations, total utilization is based on initial contact from the age 18 and older population, encompassing seniors, those with disabilities, family members, and informal and formal caregivers. The utilization benchmark is based on the number of contacts per 1,000 population for a given region. Historical utilization for Wisconsin varies from 10.7 per 1,000 (1.07 percent) to 24.9 per 1,000 (2.49 percent). The mean value is 16.32, or 1.63 percent. For the Mat-Su, the study team has assumed a starting year utilization of 1.55 percent, increasing annually by 0.05 percent over the five-year projection timeframe. The increase is applied, given the assumption that ADRC utilization will increase as more Mat-Su residents become aware of the offering.

The table below offers a summary of initial contacts for the five-year projection period.

ADRC Utilization and Initial Contact Volume

	2012	2013	2014	2015	2016
Mat-Su Population	69,415	71,466	73,517	75,568	77,619
Utilization	1.55%	1.60%	1.65%	1.70%	1.75%
Initial ADRC Contacts	1,076	1,143	1,213	1,285	1,358

Source: WI ADRC Cost Model Budgeting Tool, HDG Analysis.

Volumes

Volume of services provided by the ADRC are based on the initial contact and are extrapolated from the Wisconsin cost model. Each service type encompasses a staff time assumption for performance of the service. The table below offers a summary of services, volume of initial contacts requiring that service and the staff time required to perform each service.

Service Volume and Staff Time Assumptions

	Initial contact requiring service (%)	Staff time required per service (hours)
Information and Assistance - Process	100%	0.50
Information and Assistance - Respond	40.0	1.25
Information and Assistance – Follow-Up	5.8	0.25
LTC Options Counseling	24.5	2.50
Elderly Benefits Counseling	15.7	2.50
Immediate Services/Short Term Care Coordination	3.6	7.50
Functional Screening (Medicaid/Program Eligibility)	4.5	5.70

Source: WI ADRC Cost Model Budgeting Tool, HDG Analysis.

ADRC service volume by area and required staff time, based on population is summarized in the table below.

Service Volume and Staff Time Summary

	2012	2013	2014	2015	2016
Information and Assistance - Respond	**1,076**	**1,143**	**1,213**	**1,285**	**1,358**
Licensed Social Worker (LSW) Time (Annual Hours)	*538*	*572*	*607*	*642*	*679*
Information and Assistance - Process	**430**	**457**	**485**	**514**	**543**
LSW Time (Annual Hours)	*538*	*572*	*607*	*642*	*679*
Information and Assistance – Follow-Up	**63**	**67**	**71**	**75**	**79**
LSW Time (Annual Hours)	*16*	*17*	*18*	*19*	*20*
LTC Options Counseling	**263**	**280**	**297**	**314**	**332**
LSW Time (Annual Hours)	*658*	*699*	*742*	*786*	*831*
Elderly Benefits Counseling	**169**	**179**	**190**	**201**	**213**
LSW Time (Annual Hours)	*422*	*448*	*476*	*504*	*532*
Immediate Services/Short Term Care Coordination	**36**	**38**	**41**	**43**	**46**
LSW Time (Annual Hours)	*271*	*288*	*305*	*323*	*342*
Functional Screening (Registered Nurse RN)			**313**	**331**	**350**
LSW Time (Annual Hours)					
Total Social Worker Hours	**2,442**	**2,595**	**2,753**	**2,916**	**3,083**
Total Registered Nurse Hours			**313**	**331**	**350**

Source: WI ADRC Cost Model Budgeting Tool, HDG Analysis

Staffing and Salary Costs

Staffing is based on the total hours of service required to support the potential volume of client inquiries and related tasks. The staffing summary by operational year is presented in the table below.

ADRC Staffing

	2012	2013	2014	2015	2016
Total LSW Hours	**2,442**	**2,595**	**2,753**	**2,916**	**3,083**
Total RN Hours			**313**	**331**	**350**
Staff FTEs					
Director (ADRC Specialist)	0.50	0.75	0.75	0.75	0.75
LSW (ADRC Specialist)	1.00	1.00	1.00	1.25	1.50
Administrative Assistant	0.25	0.25	0.50	0.50	0.50
RN			0.15	0.17	0.19
Total FTE's	**1.75**	**2.00**	**2.40**	**2.67**	**2.94**

In the first year of operation, the ADRC would require:

- A half-time director and full time ADRC specialist, per Alaska state requirements.
- A quarter time administrative assistant is included to support the director and full-time specialist. ADRC specialist volume increases as the service demand increases into future operational years.
- An RN is added in Year 3, assuming the evolution of the ADRC into a fully-functioning model to perform functional screening and eligibility assessment determinations.
- Benefit costs are assumed 28 percent of salary.

Total staffing costs are summarized in the table below.

ADRC Staffing & Salary Costs

	2012	2013	2014	2015	2016
Hourly					
Director (ADRC Specialist)	$38.25	$39.02	$39.80	$40.59	$41.40
LSW (ADRC Specialist)	33.50	34.17	34.85	35.55	36.26
Administrative Assistant	18.50	18.87	19.25	19.63	20.02
RN	46.00	46.92	47.86	48.82	49.79
Annual Salary					
Director (ADRC Specialist)	$39,780	$60,863	$62,081	$63,322	$64,589
LSW (ADRC Specialist)	69,680	71,074	72,495	92,431	113,136
Administrative Assistant	7,215	9,812	20,017	20,418	20,826
RN			14,932	17,261	19,678
Subtotal	***$116,675***	***$141,749***	***$169,525***	***$193,432***	***$218,228***
Benefits	28%				
Total (Staffing)	**$149,344**	**$181,439**	**$216,992**	**$247,593**	**$279,332**

Non-Salary Expenses

Non-salary expenses are based on the Wisconsin cost model assumptions as follows:

- Non-client specific services, including marketing, outreach and public education, client advocacy, are based on 15 percent of the total direct service hours for the functions indicated.
- Other direct expenses, including telephone, rent, supplies and services, are based on 20 percent of salaries.
- Indirect expenses, including agency management support overhead and administrative expenses, are based on 10 percent of salaries and other direct expenses.

The table below offers a summary of non-salary expenses.

Non-Salary Expenses

	2012	2013	2014	2015	2016
Non-Client Specific Services (Marketing/Outreach & Public Education/Client Advocacy)	$14,001	$17,010	$20,343	$23,212	$26,187
Other Direct Expenses (Telephone/Rent/Supplies & Services)	29,869	36,288	43,398	49,519	55,866
Indirect (Administrative/Overhead)	17,921	21,773	26,039	29,711	33,520
Total (Staffing)	**$81,791**	**$75,070**	**$89,780**	**$102,442**	**$115,574**

Source: WI ADRC Cost Model Budgeting Tool, HDG Analysis.

Revenue

Revenues to support a fully functioning ADRC will require a combination of funding streams, including an improved state support for ADRCs, the potential reallocation of Older Americans Act Title III monies, a portion of state Medicaid dollars, third party foundation support, and federal Medicaid matching dollars. As indicated earlier in this report, developing an ADRC in the Mat-Su will require efforts to accommodate regulatory changes necessary to support the program.

For the purposes of analysis, the study team has employed a funding mix of the above-explained resources as a potential revenue distribution. The table below illustrates the funding breakdown for a five-year operational period.

See table, next page

ADRC Revenue and Funding

	2012	2013	2014	2015	2016
Re-authorized AK ADRC Support	$140,000	$110,000	$90,000		
Future Federal Grant Support (HCR)				$30,000	$20,000
Designated Legislative Allocation	50,000	25,000	25,000	40,000	40,000
Reassigned Title III (AOA) Monies		20,000	30,000	50,000	65,000
AK State Self-Funded ADRC Initiative		40,000	60,000	80,000	100,000
AK Medicaid (Diverted to Support ADRC)		40,000	55,000	85,000	100,000
Federal Medicaid Matching			27,000	42,000	50,000
Third-party Grant Support	25,000	25,000	25,000	25,000	25,000
Senior Navigator Grant	20,000				
Total Revenue	**$235,000**	**$260,000**	**$312,000**	**$352,000**	**$400,000**

Profit & Loss Summary

The table below presents the summary profit & loss operating statement for a Mat-Su ADRC over a five-year operating period.

ADRC Profit & Loss Summary, 2012 - 2016

	2012	2013	2014	2015	2016	Total
Total Revenue	**$235,000**	**$260,000**	**$312,000**	**$352,000**	**$400,000**	**$1,559,000**
Subtotal (Staffing)	$149,344	$181,439	$216,992	$247,593	$279,332	$1,074,701
Subtotal (Non-Salary)	81,791	75,070	89,780	102,442	115,574	464,657
Total Expenses	**$231,135**	**$256,510**	**$306,772**	**$350,035**	**$394,906**	**$1,539,358**
Net Remaining	$3,865	$3,490	$5,228	$1,965	$5,094	$19,642
Margin	*1.64%*	*1.34%*	*1.68%*	*0.56%*	*1.27%*	*1.26%*

Total revenue for the five-year period is $1.56 million with total expenses of $1.54 million.

Based on population and projected utilization, the ADRC would process 6,075 inquiries in that time at a projected cost of $253.38 per inquiry.

Chronic Disease Management

Financial analysis regarding the creation of a model for chronic disease management is based on HDG's financial modeling experience for home and community-based service development and relies on our research and analysis of such models nationwide. It is important to note that models of care for chronic disease and population health management are wide and varied. Thus, the assumptions for a Mat-Su program are based on best practices derived from similar models we have developed for other clients and from our research in this area. Medicare payment rates and salary assumptions were gathered from Alaska-specific resources.

Detailed assumptions regarding financial analysis for the memory-care assisted living community are explained below.

Model Format

The operational projection period is FY2012 through FY2015.

Program Volume, Visits, and Payment

- A program would begin with 20 clients in FY2012, growing to 120 clients by FY2015.
- The program would see a net incremental growth of 25 new clients per year; attrition is assumed to be 20 percent.
- Total visit volume is projected as a mix of one initial evaluation per new client and five follow-up visits per year per client.
- Payment for visits is based on the Medicare non-facility payment rate in Alaska for both initial evaluations and established follow-ups; rates are predicted to increase 2 percent per year through FY2015.
- An additional payment amount is included as an offset for the program's potential participation as a Medical Home or Independence at Home demonstration project.

Other Revenue

- The model additionally assumes third-party grant support for two program components: $80,000 over five years for expanded case management and $75,000 over five years to support the wireless technology monitoring component.

Staffing Assumptions

- The model will primarily require a clinical social worker functioning as a case manager. The role is half-time for the first two years and full-time thereafter.
- Other staffing includes a primary care physician, consulting pharmacist and nurse practitioner. Staffing volume for these positions is based on predicted visit schedule.
- The model assumes that 25 percent of clients will require some degree of home visit intervention, serviced by the nurse practitioner.
- Hourly rates for all staff were estimated using salary.com for Wasilla and inflated by 2 percent annually.
- Employee benefits expense is estimated to be 28 percent of salary expense.

Non-Salary Expense Assumptions

- Telephone, IT and computer expense is based on HDG experience with chronic disease and population health management models.
- Marketing expense is limited – $3,000 in FY2012 and $1,500 per year thereafter.
- Nursing, activities, dietary, laundry, and housekeeping costs are all derived from HDG's database of senior living operational expenses and adjusted appropriately to reflect higher costs in Alaska.
- Nurse practitioner travel expense is estimated at $35 per home visit.
- Administrative expense is projected at 5 percent of Medicare revenue per year.
- Wireless monitoring unit fees encompass the monthly lease fee for a third-party provided system that includes all installation, maintenance and monitoring costs. The model assumes that 20 percent of program clients would require or benefit from the wireless monitoring system.

Profit & Loss Summary

The summary profit & loss statement is presented in the table below.

Chronic Disease Management Profit & Loss Summary, 2012 – 2016

Summary P & L	Year 1 2012	Year 2 2013	Year 3 2014	Year 4 2015	Year 5 2016
New Clients	20	29	34	39	44
Total Clients	**20**	**45**	**70**	**95**	**120**
Subtotal Medicare Revenue	$27,260	$58,433	$89,789	$122,375	$156,230
Subtotal Grant Revenue (Case MGT Support)	30,000	15,000	15,000	10,000	10,000
Subtotal Grant Revenue (Wireless Monitoring)	15,000	15,000	15,000	15,000	15,000
Total Revenue	**$72,260**	**$88,433**	**$119,789**	**$147,375**	**$181,230**
Subtotal (Staffing)	$53,869	$73,457	$132,365	$153,691	$175,818
Subtotal (Non-Salary)	16,668	17,083	24,207	31,893	39,641
Total Expenses	**$70,537**	**$90,540**	**$156,572**	**$185,584**	**$215,459**
Net Cash Flow	*$1,723*	*-$2,107*	*-$36,783*	*-$38,208*	*-$34,229*

As the P&L summary indicates, a chronic-disease management model is challenged to achieve operational viability, absent additional third-party support or an expansion of Medicare payment rates to support population health management or increased preventative care for older adults. This disparity is what challenges many physician practices nationwide to embrace a case management model of care for chronic disease.

It is important to note that the physician offset payment for participation as a demonstration project is an estimated amount at this time. Most aging service professionals anticipate that the volume of dollars available to support chronic disease demonstration projects will increase dramatically in the next two to five years, given funding availability and enhancement resulting from the Patient Protection and Affordable Care Act (e.g., healthcare reform).

Industry watchers also anticipate that the evolving Center for Medicare and Medicaid Innovation will provide additional demonstration dollars for these types of programs. The Innovation Center has announced an opportunity for states to apply for contracts to support development of new models aimed at improving care quality, care coordination, cost-effectiveness and overall experience of beneficiaries who are eligible for both Medicare and Medicaid, also known as "dual eligibles." Up to $1 million in design contracts will be awarded to as many as 15 state programs.

Construction and Operation of a Memory-Care Assisted Living Community

Financial analysis regarding the construction and operation of a memory-care assisted living community is based on HDG's financial modeling experience in the development, construction, and operation of such a facility. In performing this analysis, the study team relied on industry-accepted benchmarks regarding staffing and operations of assisted living communities, projected labor and construction costs for the state of Alaska and HDG's internal database of operating and development assumptions.

Detailed assumptions regarding financial analysis for the memory-care assisted living community are explained below.

Model Format

- The construction and startup period is FY2011; construction is expected to take 12 months.
- The operational projection period is FY2012 through FY2015.

Census, Occupancy, and Payor Mix Assumptions

- The community would offer 32 one-bedroom assisted living units.
- Average daily census is projected to be 32, or 100.0 percent occupancy, with a six month ramp-up in FY2012.
- The payor mix is projected at 75 percent private pay residents (24 units) and 25 percent Older Alaskan waiver supported residents (8 units).

Revenue Assumptions

- Private pay revenues are projected $5,300 per month. This is an all-inclusive rate for memory-care assisted living service, offering three meals per day, assistance with activities of daily living, medication management and other supportive services typically found in a memory-care assisted living setting. A 3 percent annual inflation factor has been applied for FY2013 through FY2015.
- Medicaid waiver revenues are projected at $3,100 per month. A 1.5 percent annual inflation factor has been applied for FY2013 through FY2015.

Staffing Assumptions

- Certified nurse aide staffing to support residents is calculated at a ratio of 1 aide per every 6.33 residents.
- RN supervision, monitoring and management of resident service plans requires one full-time nurse.
- Other staffing is included per industry benchmarks for assisted living.
- Hourly rates for all staff were estimated using *www.salary.com* for Wasilla and inflated by 2.5 percent annually.
- Employee benefits expense is estimated to be 30 percent of salary expense.

Non-Salary Assumptions

- Nursing, activities, dietary, laundry and housekeeping costs are all derived from HDG's database of senior living operational expenses and adjusted appropriately to reflect higher costs in Alaska.
- Marketing expense is included for the first year at $40,000 and $10,000 per year thereafter.
- Insurance expense has been estimated based on other similar sized facilities and inflated by 3 percent annually; real estate taxes are included and estimated at $10,000 per year.
- Depreciation and interest expense is based on the projected capital costs described below.
- Management fees are projected to be $90,000 per year.

Capital Investment

- The capital investment is estimated to be $3.68 million which includes the following:
    - Construction: $3,200,000
    - Equipment: $96,000
    - Working Capital: $385,311

- The capital analysis assumes that property (land) for the project site is donated by a third party.
- Construction is estimated to be completed by the end of 2011.
- Interest expense is estimated based on a projected 30-year loan with an interest rate of 7.5 percent.

Profit & Loss Summary

The summary profit & loss statement is presented in the table below.

Summary Profit & Loss, Mat-Su Memory-Care Assisted Living

	Projected					5 Year
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	Total
Total Revenue	-	**$1,524,713**	**$1,979,132**	**$2,033,838**	**$2,090,116**	**$7,627,799**
Total Operating Expenses	**$213,984**	**$1,449,860**	**$1,594,706**	**$1,594,100**	**$1,622,990**	**$6,475,639**
Operating Income (Loss)	(213,984)	74,853	384,427	439,739	467,126	1,152,160
Non-Operating Income	-	-	-	-	-	-
Net Income	(213,984)	74,853	384,427	439,739	467,126	1,152,160
EBITDA	(209,643)	439,792	749,562	773,405	798,030	2,551,146
Operating Margin	*0%*	*5%*	*19%*	*22%*	*22%*	*15%*
EBITDA Margin	*0%*	*29%*	*38%*	*38%*	*38%*	*33%*

Cash Flow Summary

This project results in a stabilized operating margin of approximately $384,427 (19 percent) in Year 3 of the projection period. The stabilized Earnings before Interest, Depreciation, Taxes, and Amortization (EBITDA) are projected to be approximately $749,562 million (38 percent). As indicated in the table below, break-even cash flow is projected to occur in Year 2 of the projection period.

See table, next page

Summary Cash Flow, Mat-Su Memory-Care Assisted Living

		Projected			
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Operating Activities					
Increase (decrease) in net assets	$(213,984)	$74,853	$384,427	$439,739	$467,126
Add Back Non-Cash Items:					
Depreciation & Amortization	-	91,428	91,428	91,428	91,428
Changes in Operating Assets & Liabilities:					
Accounts Receivable	-	(158,297)	(4,371)	(4,496)	(4,626)
Accounts Payable	15,713	46,295	795	(1,569)	818
Cash from Operating Activities	**$(198,271)**	**$54,277**	**$472,287**	**$525,101**	**$554,746**
Investing Activities:					
Acquisition of Buildings, Equipment, and Vans	$(3,363,980)	-	-	-	-
Cash from Investing Activities	**$(3,363,980)**				
Financing Activities:					
Cash provided by (used in) Financing Activities	$3,562,251	$155,164	$(419,578)	$(36,837)	$(39,600)
Cash from Financing Activities	**$3,562,251**	**$155,164**	**$(419,578)**	**$(36,837)**	**$(39,600)**
Net Change in Cash	-	*$209,442*	*$52,700*	*$488,264*	*$515,146*
Cash, Beginning of Year	-	-	*209,442*	*262,142*	*750,406*
Cash, End of Year	-	*209,442*	*262,142*	*750,406*	*1,265,551*

Construction and Operation of Long-Term Care/Skilled Nursing Facility

Financial analysis regarding the construction and operation of a long-term care/skilled nursing facility is based on HDG's extensive financial modeling experience in the development, construction and operation of nursing homes. In performing this analysis, the study team relied on industry-accepted benchmarks regarding staffing, operations and ancillary costs, projected labor and construction costs for the state of Alaska and HDG's internal database of operating and development assumptions.

Detailed assumptions regarding long-term care/skilled nursing facility analysis are explained below.

Model Format

- The construction and startup period is FY2011.
- The operational projection period is FY2012 through FY2016.

Census, Occupancy, and Payor Mix Assumptions

- Total beds are 76.

- Average daily census is projected to be 70, or 92.1 percent occupancy with a 12 month ramp-up in FY2012.

Mat-Su Skilled Nursing Facility, Projected Average Daily Census

Payor	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Medicare	6	10	10	10	10
Medicaid	27	48	48	48	48
Private	4	8	8	8	8
Other	2	4	4	4	4
Total	**39**	**70**	**70**	**70**	**70**

Revenue Assumptions

- Medicare revenues are calculated based on the state of Alaska average RUG distribution using the most recent published FY2011 rates. A 2 percent annual inflation factor has been applied for FY2012 through FY2016.
- Medicaid and Hospice revenues are calculated using a projected FY2012 rate of $372.74. A 1.5 percent annual inflation factor has been applied for FY2012 through FY2016.
- Private pay revenues are calculated based on an estimated per diem rate of $460 inflated by 3 percent annually.
- Commercial revenues are calculated based on an estimated per diem rate of $382.38 inflated by 2 percent annually.
- Other revenues have been calculated based on an estimated rate of $1.50 per patient day inflated by 2 percent annually.

Staffing Assumptions

- Nurse staffing is calculated based on 3.6 hours per patient day (0.4 RN/0.6 LPN/2.6 CNA).
- Other non-nursing staffing is calculated based on a typical staffing model for a 76 bed skilled nursing facility.
- Hourly rates for all staff were estimated using salary.com for Wasilla, AK and inflated by 2.5 percent annually.
- Employee benefits expense is estimated to be 30 percent of salary expense.

Non-Salary Assumptions

- Purchased services cost includes ancillary and support services provided by outside companies. The cost per patient day and annual cost assumptions are based on our experience with other similar sized facilities with consideration for the location in rural Alaska and have been inflated by 2.5 percent annually.
- Medical supplies and pharmacy expenses were calculated based on estimated per patient day assumptions inflated by 2 and 3 percent annually respectively.
- Insurance expense has been estimated based on other similar sized facilities and inflated by 3 percent annually.
- Other non-salary expenses including administration, plant operations/maintenance, housekeeping/laundry, activities/social service, and utilities have been calculated based on estimated annual or per patient day cost assumptions inflated by 2 to 5 percent annually.
- Bad debt expense has been calculated based on an estimate of 1.5 percent of net patient revenues.
- Depreciation and interest expense is based on the projected capital costs described below.
- Management fees are based on 5 percent of net revenue.

Capital Investment

- The capital investment is estimated to be $18.9 million which includes the following:

  Construction: $15.0 million

  Equipment: $600,000

  Capitalized Interest: $321,750

  Working Capital: $3.0 million

- The capital analysis assumes that property for the project site is donated by a third party.
- Construction is estimated to be completed by the end of 2011.
- Interest expense is estimated based on a projected 40 year loan with an interest rate of 4.5 percent.

Profit & Loss Summary

The summary profit and loss statement is presented in the table below *(see next page).*

Summary Profit & Loss, Skilled Nursing Facility

	Startup Constr. 2011	Year 1 2012	Year 2 2013	Year 3 2014	Year 4 2015	Year 5 2016	Year 6 Total
Total Revenue	-	$5,630,360	$10,329,963	$10,515,334	$10,704,301	$10,896,941	$48,076,901
Total Operating Expenses	$444,756	6,669,074	9,386,261	9,559,117	9,736,705	9,919,143	45,715,056
Net Income	(444,756)	(1,038,714)	943,702	956,218	967,597	977,798	2,361,845
Margin Percent	*0.00%*	*-18.45%*	*9.14%*	*9.09%*	*9.04%*	*8.97%*	*4.91%*
EBITDA	(444,756)	245,809	2,206,938	2,198,166	2,188,258	2,177,172	8,571,587
EBITDA Margin	*0.00%*	*4.37%*	*21.36%*	*20.90%*	*20.44%*	*19.98%*	*17.83%*

Cash Flow Summary

This project results in a stabilized operating margin of approximately $943,702 (9.14 percent) in Year 2 of the projection period. The stabilized Earnings before Interest, Depreciation, Taxes, and Amortization (EBITDA) are projected to be approximately $2.2 million (21.4 percent). As indicated in the table below, break-even cash flow is projected to occur at the end of Year 2.

Summary Cash Flow, Skilled Nursing Facility

	Startup Constr. 2011	Year 1 2012	Year 2 2013	Year 3 2014	Year 4 2015	Year 5 2016
Operating Activities						
Increase (decrease) in net assets	$(444,756)	$(1,038,714)	$943,702	$956,218	$967,597	$977,798
Add Back Non-Cash Items:						
Depreciation & Amortization	-	433,044	433,044	433,044	433,044	433,044
Changes in Operating Assets & Liabilities:						
Accounts Receivable	-	(1,966,106)	(35,215)	(35,897)	(36,593)	(37,305)
Accounts Payable	64,398	262,738	2,358	4,137	4,276	4,418
Payroll Liabilities	66,689	105,034	19,879	4,790	4,910	5,033
Cash Provided by (used in) Operating Activities	**$(313,668)**	**$(2,204,005)**	**$1,363,767**	**$1,362,292**	**$1,373,232**	**$1,382,987**
Investing Activities:						
Acquisition of Buildings, Equipment, and Vans	$(15,921,750)	-	-	-	-	-
Cash used in Investing Activities						
Financing Activities:						
Proceeds from Financing	$18,921,750	-	-	-	-	-
Repayments of Long-Term Debt	-	(473,044)	(473,044)	(473,044)	(473,044)	(473,044)
Cash used in Financing Activities	**$18,921,750**	**(473,044)**	**(473,044)**	**(473,044)**	**(473,044)**	**(473,044)**
Net Increase (Decrease) in Cash and Cash Equivalents	$2,686,332	$(2,677,048)	$890,723	$889,248	$900,189	$909,944
Cash, Beginning of Year	-	2,686,332	9,284	900,007	1,789,255	2,689,444
Cash, End of Year	2,686,332	9,284	900,007	1,789,255	2,689,444	3,599,388

Appendix A: List of Agencies and Stakeholders Interviewed

Acacia Personal Care Service – Stephanie Tucker

Access Alaska – Linda Kiggins

Alaska Commission on Aging – Denise Daniello

Alaska Department of Health and Social Services, Division of Senior & Disability Services – Marcy Ryan and Lisa Morley

Alaska Home Care – Cheri Day

Alaska Housing and Finance Corporation – Jim McCall

Alaska Mental Health Trust Authority – Nancy Burke

Alaska Veterans and Pioneers Home – Lynda Garcia

Alzheimer's Disease Resource Agency of Alaska – Dulce Nobre

Amedisys Hospice – Angela Graham

Amedisys Home Health Care – Tina Schwager

Chickaloon Village Traditional Council – Lisa Wade

Denali Commission – Joel Neimeyer and Nancy Merriman

The Foraker Group – Chris Kowalczewski

Hearts and Hands – Jen Bergman

Home Instead Senior Care – Dawn Gagnon

Kennedy & Associates – Gwen Kennedy

Kenai Peninsula Independent Living Center (Kenai ADRC) – Joyanna Geisler

Mat Su Activity and Respite Center – Liza McCafferty

Mat Su Regional Hospital – Joy Heasley and Robin Thompson

Mat Su Regional Home Care – Mary Tilley

Mat Su Regional Hospice – Mary Tilley

Mid-Valley Senior Center – Lorie Rounds

Municipality of Anchorage ADRC – Lynda Meyer

Palmer Seniors Citizens' Center, Inc. – Richard Tubbs and Rachel Greenburg

Pro Care PC Inc – Cheryl Carrier

Rasmuson Foundation – Sammye Pokryfki

Ready Care – Amanda Zold

Respect your Elders – Angela Bailey-Peck

Senior Care of Alaska – Catherine Reese

Southcentral Foundation Valley Native Primary Care Center – Melissa Caswell

Starfish Cares – MaryK Diehl

Sunshine Community Health Center – Sharon Montagnino

United Way of Mat-Su – Stephanie Allen

Upper Su Senior Center – Herman Thompson

U.S. Administration on Aging – Terry Duffin

U.S. Department of Housing and Urban Development – Carma Reed

Wasilla Primrose – Kristen Woods

Wasilla Senior Campus – Sondra Kaplan and Sheila Walker

Willow PCA – Tom Dahlen