I. Purpose of This Report

This report summarizes the status of long-term care[1] for older persons in Minnesota in 2003. It is the first of a required legislative report (M.S. 144A.351) that combines two previously separate reports, one that dealt with nursing home capacity and the other that dealt with home and community-based services.

In 2001, the Minnesota Legislature enacted a comprehensive set of historic long-term care reform provisions prepared by the state's long-term care task force. Several key provisions sought to reduce reliance on the institutional model and expand the availability of home and community-based options for older persons. This report provides information on progress toward achieving the reform recommended by the state task force in 2000.[2]

As required by the legislation, this report includes demographic trends, estimates of the need for long-term care among older persons in the state, and the status of home and community-based services, senior housing and nursing homes serving older persons at the state, regional and county levels. Also discussed are the issues of chronic care management for older persons, access and information for long-term care decision-making, and other issues that will affect long-term care in the future. The report includes five long-term care benchmarks that measure the progress made on key elements of long-term care reform in Minnesota. Finally, the report draws some conclusions from the information included here, and describes achievements in long-term care reform, future challenges and goals, and needed policy changes and resource needs.

This report also addresses the feasibility of offering government or private sector loans to families of the elderly for the purchase of long-term care services, as required by the legislative language covering this report.

The Minnesota Department of Health contributed data and other information necessary for the completion of this report. Counties and Area Agencies on Aging/Eldercare Development Partnerships also contributed data and comments on the changes that have occurred in the availability of services over the past two years. The cost to prepare this report was approximately $5,000.

II. Demographic Trends and Need for Long-Term Care

Minnesota's population is aging and along with that change, the need for long-term care is increasing. The state's large baby boom generation begins to turn 65 in just seven years (2011), and many predict that providing long-term care for this large group of older people will quickly become one of the state's most critical issues. Demographic changes will reduce the number of

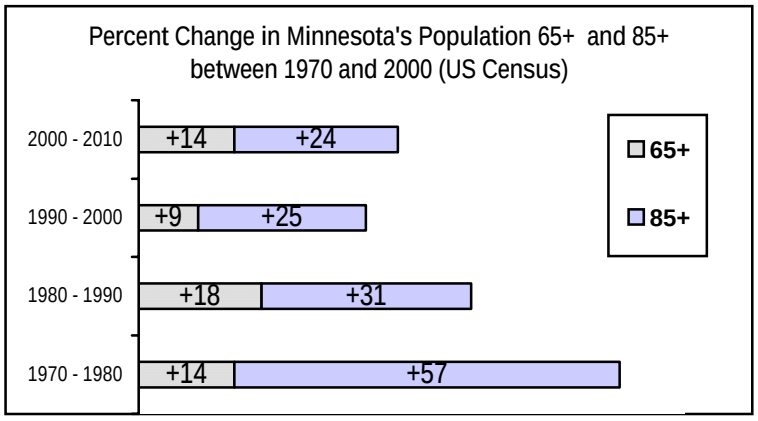
[1] Long-term care is defined as "assistance given over a sustained period of time to people who are experiencing long-term care inabilities in functioning because of a disability." *(Ladd, Kane, Kane, 2000.* For purposes of this report, long-term care refers to care provided in all settings, including homes, apartments, residential settings and nursing homes.

[2] For the sake of brevity, data sources and other references are not included in this summary report. The expanded version of this report includes additional data at the state, regional and county levels, additional narrative, and complete data sources and references. That report is available at www.dhs.state.mn.us/agingint/ltctaskforce/reports.

family members and workers available to provide care at the very time when the need for long-term care will be at an all-time high.

A. Demographic Changes

Between 1990 and 2000, Minnesota's population 65+ increased from 550,000 to 600,000, an 8.7 percent increase. This was a slower growth rate for the older population than the state experienced during the previous 20 years. The current slow growth is due to the lower birth rates in the years around the Depression. That smaller generation is now in its 60s and 70s.



Looking ahead, the older population 65+ is expected to grow by about 14 percent in the next ten years, not quite double the growth during the previous decade. Then, beginning in 2011, the first wave of the baby boom generation, born between 1946 and 1964, begins to turn 65, and for the next 50 years, the aging of this large generation will dominate the demographic landscape. Between 2010 and 2020, the population 65+ will grow by 40 percent, and between 2020 and 2030, it will grow by another 36 percent.

The highest rate of growth in the state is occurring within Minnesota's population 85+. Between 1990 and 2000, this group grew by about 25 percent, from 69,000 to 86,000. The elderly over 90 grew even faster, increasing by 28 percent. The 85+ group will grow 25 percent in the next ten years, 14 percent between 2010 and 2020, 34 percent between 2020 and 2030, and 58 percent between 2030 and 2040. By 2060, the overall numbers decline slightly because nearly all the baby boom generation will have died, and the next generation will not be as large. However, an older society will be a permanent fixture of the state's demographic profile into the foreseeable future.

B. Need for Long-Term Care

The current and future demand for long-term care in Minnesota is tied to the state's demographic characteristics. Minnesota's population is aging, and age is related to increased disability. As the number of older people in Minnesota grows, the number with disabilities that need long-term care will also grow. However, there is evidence that the age-specific disability rates in the United States are decreasing. Disability rates among the elderly have declined by 1% or more per year for the past several decades. Experts say that these declines are the result of advances in health and medical care widely utilized by older people, e.g., hip or knee replacements, prescription drugs that increase the ability to function and be independent.

While it is difficult to predict whether (and at what rate) disability rates might continue to decline, most experts agree that the number of disabled elderly needing long-term care will continue to rise even while disability rates decrease, because of the large *increases* in the overall

numbers of elderly. Without the declines in disability rates, the number and proportion of elderly needing long-term care would skyrocket.

Given these many complex factors, it is difficult to project the actual numbers of older Minnesotans that will need long-term care in the future. One way is to use national estimates of the utilization of or need for community vs. institutional care among the elderly, and apply those factors to our population. The most recent National Long-Term Care Survey completed by the National Center for Health Statistics found that about 15.6 percent of the 65+ population needs long-term care that can be provided in the community, and about 4.2 percent needs the intensive long-term care provided in a nursing home. (It should be noted that Minnesota's utilization of nursing home care is higher than this national estimate, but our utilization includes both short post-acute and long-term care stays).

Using these national estimates, the total number of older persons in Minnesota estimated to need long-term care in 2000 was about 118,000: 93,000 needed community care, and about 25,000 needed care in a nursing home. By 2010, these figures will rise to an estimated 135,000, with 106,000 needing community care and 28,500 needing institutional care. Because of the relatively slow growth in the older population from now to 2010, the need for long-term care will also grow relatively slowly.

III. Home and Community-based Services

The central theme of the reform recommended by the state's Long-Term Care Task Force is to reduce our reliance on the institutional model of care for older persons, and expand the supply of home and community-based options. These reforms reflect the state's attempt to "rebalance" its long-term care system after years of excessive reliance on the institutional model of care. In the past, the relative availability of nursing home beds made the development of services that helped older persons remain in their original homes less urgent, and fostered an acceptance of the nursing home as "the place" where elderly moved when they needed assistance.

Older persons today want to stay in their own homes and apartments either with no help, with help from family or with hired help. This demand for more control is expected to accelerate as baby boomers, the first real "consumer" generation, grow old and need care. Given this fact, it is critical that we develop cost-effective home-based options and provide consumer-friendly access to services. These system changes must start now to be ready when the boomers begin to need long-term care services.

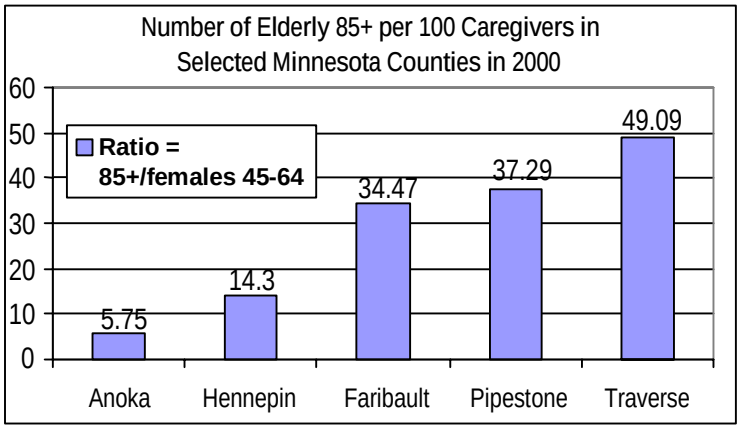
A. Informal Care

When an older person begins to need long-term care, they turn first to their family and close circle of friends and neighbors. Family members—mostly spouses and daughters and daughters-in-law—have historically provided the vast majority of help to older persons who need assistance with daily activities.

While the family continues to be the predominant source of care, there have been significant changes in this pattern over the past 15 years, as reported in the Survey of Older Minnesotans. Between 1988 and 2001, there was a decrease in the amount of personal care that spouses, other

relatives, friends or neighbors provided. In 1988 and 1995, family members provided 97 percent and 95 percent, respectively, of all assistance needed by older persons living in the community. By 2001, the percent of personal care and assistance provided by spouse and/or adult child had declined to 91 percent, as reported by older persons.

Thus, even though the elderly overwhelmingly prefer family care, this pattern is changing due to decline in availability of spouse, reduced family size, increased labor force participation by women, and geographic mobility. There is a growing use of paid services to supplement what families do. For example, the proportion of older Minnesotans (and their caregivers) that purchased services available "for hire," such as cleaning services, paid transportation and personal care, increased dramatically over the past 15 years, from about 4 percent in 1988 to 20 percent in 2001.



The lack of family members to provide assistance to older relatives is a growing issue in Greater Minnesota. Because of many years of out-migration, the western and southwestern tiers of Minnesota counties have high proportions of older residents and few younger family members to provide help.

B. Voluntary Services

As the intensity and scope of an older person's long-term care needs increase, the older person and their family often seek additional help from local sources such as church-sponsored services and volunteer-based programs to supplement what they (and any hired help) are able to do. These networks of primarily nonprofit agencies offer a wide range of social supportive services, depend heavily on volunteers to provide their services, and usually do not charge for their services. Examples include the Red Cross that provides volunteer driver services, ecumenical groups of churches that offer home delivered meals, the Block Nurse program that provides health and social support services to older residents in the neighborhood.

There has been a steady increase in these types of voluntary programs that serve older persons and their families. While there is no comprehensive inventory of such community- and faith-based programs across the state, it is estimated that there are now between 500 and 700 such groups organized and operating in virtually all of Minnesota's communities. Much of the long-term care reform effort to expand the home and community-based services has focused on developing the capacity of these types of services. These programs are available to older persons of all income levels, they provide important support services to older persons who are not frail or financially needy enough to be eligible for the publicly funded services, and are perceived as acceptable (and affordable) sources of assistance by both seniors and their families.

An important role of this system is the provision of social supportive services that help individuals remain independent in their homes as they begin to experience some physical limitations. Many of the agencies that provide these services are funded through the Minnesota

Board on Aging and its network of Area Agencies on Aging (AAAs)[3] using the federal Older Americans Act and related state funds. Since the 1970s, Minnesota's AAA network has worked to develop more home and community services, including senior nutrition programs, senior centers, transportation, chore, respite, information and advocacy, and health promotion programs.

In 2003, nearly 240,000 persons 60+ were served through one or more of these programs. Over 90,000 were served by the senior nutrition programs alone. While these services are available to persons 60+ regardless of income, close to 20 percent of those served have poverty level incomes (defined in 2003 as an annual income of $9,000 for a one-person elderly household and $12,100 for a two-person elderly household). The expenditures for these services in 2002 totaled $21 million in federal and state funds. (This figure does not include local match and client donations.)

C. Formal Services

When an older person's family can no longer handle their relative's needs, when confusion or incontinence become unmanageable, the family looks for a formal long-term care provider. This is often a turning point, when the older person moves from their original home to assisted living or a nursing home. This may also be the point when older people and their families call on their physician for advice. Some turn to their county for a more complete assessment of the older person's situation and help setting up service plans. If they are eligible, the older person may begin to receive publicly funded home and community-based services.

These more "formal" long-term care services are offered to older persons by proprietary, nonprofit and public agencies that include home health care agencies, assisted living facilities or nursing homes. Home health agencies usually accept both Medicare and Medicaid reimbursement, and these dollars comprise the majority of their budgets, although about 25 percent of home health agency budgets are private dollars. In assisted living, this is reversed, with the majority of the costs paid privately, and with Medicaid or insurance reimbursement a smaller proportion of overall budgets.

The number of licensed and Medicare certified home care agencies in Minnesota peaked at 252 agencies in 1998 and has remained relatively constant since that time. This is despite occasional media coverage and concern when an agency ceases operation in a rural part of the state. Labor shortages, however, are a concern for these agencies (and all formal service providers in long-term care).

D. Building Community Capacity

In order to rebalance Minnesota's long-term care system, the informal, voluntary and formal components of the home and community-based services need to be expanded so that more elderly can remain in their homes and communities longer. The 2001 long-term care reform included a number of efforts to expand the availability of home and community-based services

[3] Area Agencies on Aging are regional entities designated by the Minnesota Board on Aging under the federal Older Americans Act that provide information and assistance services, work with local providers and funders to improve aging services, and administer grants to agencies that provide nutrition or supportive services to older persons in their areas.

across the state—an assessment of gaps, a grant program to fill those gaps and technical assistance to develop the necessary organizational capacity.

1. Gaps Analysis

In October 2001, all counties and Area Agencies on Aging (AAAs) were required to complete a gaps analysis for their areas. They were to assess the supply of aging services, senior housing, and nursing home beds, and identify general trends in the system of services for older persons. In October 2003, counties were asked to update their 2001 gaps analysis in order to measure the effects of the intervening activities to expand home and community-based options. Although the follow-up was voluntary, surveys were returned from 72 of 87 counties (two surveys covered multiple counties).

These 2003 gaps analyses indicate that between 2001 and 2003, home and community-based services were developed or expanded in nearly all counties. A total of 93 percent of counties reported that there were more home and community care options in their county in 2003 than in 2001, and 60 percent of Minnesota's counties described their supply of home and community-based long-term care services as "adequate." The counties also reported that the long-term care services that had been developed addressed the priority gaps they identified in 2001.

Service Gaps in 2001 and 2003 as Reported by Minnesota Counties

2001 Service Gaps			New Services Developed			2003 Service Gaps		
Type of Service	**Rank**	**Percent of counties ***	**Type of Service**	**Rank**	**Percent of counties ***	**Type of Service**	**Rank**	**Percent of counties ***
Transportation	1	66	Transportation	3	25	Transportation	1	42
Respite/ companion	2	57	Respite/ companion	4	22	Respite/ companion	3	22
Chore service	3	48	Chore service	5	21	Chore service	2	28
LTC consultation	4	39	---			---		
Information and assistance	5	5	**			**		
--			Adult day service	2	27	Adult day service	4	21
--			--			Home delivered meals	4	21
--			Assisted living	1	39	--		

**All 87 counties responded to the 2001 gaps survey; 72 counties responded in 2003.*

***Senior LinkAge Line® and Minnesotahelp.info were developed and promoted by the state (in conjunction with Area Agencies on Aging).*

In terms of the top three service gaps in 2001 (transportation, respite/companion and chore), some progress was made in expanding the availability of all three. For example, the percentage of counties reporting that transportation was a critical service gap fell from 66 percent in 2001 to 42 percent in 2003, and 25 percent of counties developed new transportation resources in the

interim. Nonetheless, transportation was the biggest service gap in 2001 and remained the biggest gap in 2003.

2. Community Service/Service Development (CS/SD) Grant Program

The CS/SD state grant program was established in 2001 as part of long-term care reform. It provides seed money to develop new capacity within the home and community-based service system. To date, about $8.6 million in grant funds have been awarded to nearly 200 CS/SD projects in 46 counties across Minnesota. So far, these projects have expanded services to nearly 20,000 older persons.

Community Service/Service Development Projects Funded 2001 – 2003

Type of CS/SD Project	Number	People Served
Converting nursing home units to apartments	6	65
Creating new "assisted living" by making a service package available in low-income senior housing	19	1,350
New models of adult day care	8	177
New volunteer-based community support services: additional Living at Home/Block Nurse sites, faith-in-action programs, new services provided by existing volunteer programs	29	5,524
New transportation projects using volunteers or implementing more efficient methods of operation	7	5,286
Tele-home care in rural areas to support family caregivers and reduce emergency medical trips	3	22
Medication management to help elderly remain at home	1	143
Expanded "formal" in-home services, including new culturally competent home care for Asian, American Indian, Hispanic elders	12	426
Caregiver support, caregiver coach, caregiver respite services	4	367
Grocery/pharmacy delivery	2	144
Nurse-managed care	1	NA
Home modification services, e.g., accessibility, air conditioning, safety	5	NA

3. Targeted Technical Assistance for Community Development

The state's Eldercare Development Partnerships (EDPs, previously known as SAIL) and the AAAs in counties that do not have an EDP are required to provide targeted technical assistance to counties, local communities and service providers. This technical assistance is focused on creating or expanding the "infrastructure" necessary to support home and community-based options for seniors. Some examples of these efforts include:

1. Helping local communities set up programs that recruit, screen and train neighbors and friends to expand the supports available to older residents.
2. Facilitating the acceptance and use of new telecommunications technologies for home monitoring of frail elderly.
3. Providing technical assistance to nursing homes interested in transitioning from an institution-based model of care to a more integrated community care model.
4. Bringing together the major long-term care providers in each community—both the health and social service providers—to work together in ways that benefit their older clients.

E. Publicly funded Home and Community-based Services

As the preference of older people for home and community-based services (HCBS) has grown, so too has the utilization of home and community-based services within publicly funded

programs. These services include those provided through the Elderly Waiver (EW), Alternative Care (AC) and Medical Assistance (MA) home care programs.

1. Growth in Service Use and Expenditures

In the past three years (2001 – 2003), the overall number of persons 65+ served through the EW, AC and MA home care programs has grown from 23,000 to nearly 30,000, a 25 percent increase. The expenditures for HCBS have grown from $130 million to nearly $200 million, an increase of 50 percent. It is important to note that while these figures have increased, the older persons served and dollars expended for *nursing home care* have declined during this same period, consistent with the goals of the long-term care reform, to increase the percent of older persons served in their home and other community settings and reduce utilization of nursing homes.

Utilization and Expenditures for Publicly Funded HCBS for Persons 65+
Minnesota - 2001 - 2003

SF Year	Alternative Care		Elderly Waiver		Non Waiver MA Home Care		Total HCBS	
	Clients	Cost	Clients	Cost	Clients	Cost	Clients*	Cost
2001	11,787	$56,346,000	10,978	$69,112,000	695	$4,057,000	23,460	$129,515,000
2002	12,233	$66,969,000	12,050	$84,024,000	1,847	$5,471,000	26,130	$156,464,000
2003	11,709	$76,445,000	13,561	$104,267,000	4,129	$14,483,000	29,399	$195,195,000

*Numbers may include duplicated count, since some clients use more than one program over a year's time.
Source: Minnesota Department of Human Services Data Warehouse 02/26/04, and Hennepin County Social Services for Hennepin County AC figures. Does not include some services paid for under managed care; does not include MSHO clients and cost.

Twice a year, DHS prepares a five-year forecast of the expected utilization and expenditures for persons served by publicly funded health programs. The February 2004 forecast for long-term care services for persons 65+ estimates that community care will continue growing, increasing from 19,000 persons served monthly in 2000 to 27,000 in 2007. The demand for nursing home care will continue to decline, decreasing from 25,000 persons served monthly in 2000 to 22,000 in 2007.

2. Impact of 2003 Changes in Alternative Care Program

The 2003 legislature enacted major policy changes in the Alternative Care (AC) program effective July 1, 2003. The changes included tightening eligibility criteria, expanding monthly fees, and imposing state recovery provisions (liens). The goal of these changes was to reduce the overall program expenditures. As expected, these changes have had an impact on the program's current clients as well as potential clients. DHS has been monitoring the impact of these changes, and has some early results.

The number of clients on the program dropped from 7,100 in June 2003 to 5,900 in December 2003. According to a survey of counties (75 or 86 percent of counties responded to the survey), 824 clients left the program due to the changes, 377 applicants discontinued their program application due to the changes, and 806 elders remained on the program in spite of the changes. It appears the primary reason for clients' decisions to leave the program is the state's recovery provisions and the imposing of liens on the property of AC clients. For those elderly applying to

the AC program who decided to cancel their application, the reason was also related to the liens. Thus far, of those who left the program, 77 percent have remained in the community, either with help from family or informal sources (25 percent), with help from Elderly Waiver services (21 percent), with help from other voluntary or formal services (18 percent) or with no outside help (12 percent). About 10 percent have moved to a nursing home. DHS will continue to monitor these changes especially use of institutional care by those who would have otherwise been served through the AC program.

3. Consumer-directed Services

In long-term care, consumer-directed services are service options—usually publicly funded--that allow consumers to hire, supervise and fire the workers who provide personal and other types of care for them.

Up to now, these service options have been strongly supported and advocated for by younger disabled individuals, for whom the ability to hire and fire personal care attendants is a critical part of being independent and in control of their own lives. Now, the concept is increasingly an element of service design for older persons, as a way to offer more choice and flexibility in who provides services, and how and when they are provided.

In early 2004, CMS approved new services within Minnesota's Elderly Waiver (and all the other HCBS waivers operated by the state), one of which was consumer-directed community supports (CDCS). This option will be available to EW, Minnesota Senior Health Options (MSHO) and MA home care clients beginning in April 2005. The option will allow eligible clients to use public funds to hire workers to provide needed personal care services, including hiring family members, friends, neighbors or others. While these changes relate to those on public programs, the concept is already having an impact on aging services, as providers begin to redesign services to participate in the CDCS services but also begin to rethink their services for all clients.

Aging services have long been dominated by assessments done by professionals, care plans written by professionals, and concerns about professional liability to ensure health and safety for clients. Consumer direction is changing these assumptions, and will accelerate as baby boomers begin to need long-term care services. Many observers see the boomers as savvy shoppers who will expect and demand more control, more options and more flexibility in services than previous generations. Because the consumer-directed approach offers the opportunity to "unbundle" services and reduce costs, it also has the potential to make long-term care services more affordable.

4. Quality Assurance

Most of our collective experience in quality assurance in long-term care has been in the institutional area, where formal regulations and rules dominate. As the state reshapes long-term care and encourages older consumers to "age in place" in their current home and community, we need to develop a quality assurance system that is responsive to the unique challenges of services provided in non-regulated environments.

A framework of quality assurance for community-based long-term care was developed by a work group of the long-term care task force in 2002. It included seven essential elements.

- Accurate and timely consumer information about options in a variety of formats.
- Supports to help consumers and families use consumer-directed services.
- Building a community presence in local long-term care services through volunteers, community integration, ongoing communication between community and provider, etc.
- Continuous quality improvement, including regular use of consumer feedback.
- Consumers that understand their rights and have access to the means to exercise their rights.
- Consumer protection and access to complaint offices and ombudsman services.
- Rules and regulations that are responsive to the consumer and to the special program integrity issues faced by home and community-based options.

a. Current Efforts in Quality Assurance

DHS and MBA have a number of efforts underway that address the seven elements of a quality assurance system. Examples include expansion of consumer information, development of ways to integrate consumer satisfaction and other feedback loops into programs, provision of easy-to-understand booklets on consumer rights and how to exercise those rights, and expansion of the use of ombudsman volunteer advocates to more residential long-term care settings.

b. Federal Grant Awarded

DHS recently received a federal grant to improve quality assurance in its home and community-based waiver services. The project will expand the department's capacity to manage, assess and make improvements in home and community-based services and programs; incorporate client definitions of quality of care and quality of life into quality improvement strategies; and enhance the capacity of the state and counties to address the health and safety of clients by improving the Vulnerable Adults report tracking system.

Developing and implementing all the components of a community-based quality assurance system will continue to be a key component of long-term care reform as increasing numbers of long-term care consumers are served in their homes and community settings.

IV. Senior Housing

Senior housing is a broad term that encompasses everything from active adult communities to memory care facilities. One of the issues in senior housing is the lack of commonly accepted definitions and categories. Maxfield Research, a market research company that tracks the senior housing market in the Twin Cities Metro Area, uses the following categories:

- Active adult communities – restricted to persons over age 55 or 62, offer a variety of ownership or rental housing types, but provide no health or support services.
- Congregate housing developments – offer support services such as transportation, meals and housekeeping.
- Assisted living facilities – offer a package of services, usually two daily meals, transportation, housekeeping, personal care, and 24-hour staffing and emergency response services.

- Memory care facilities - a specialized type of assisted living designed for persons with Alzheimers or other dementias; provide all the services available in assisted living as well as additional safety and supervision services.

According to Maxfield Research, there are an estimated 80,000 units of senior housing in Minnesota, and 9,500 board and care/adult foster care units, some of which serve elderly. Of these 80,000 units, about one-half are assisted living units. For purposes of this report, assisted living facilities are referred to as assisted living residences, and are of increasing interest because of the key role they have begun to play in long-term care.

A. Assisted Living Residences

Assisted living is a concept and an option whose popularity is increasing among older people and their families. By combining an apartment type of living unit with services available as needed, it offers a package of housing and related services that is more preferred than traditional nursing homes. It is especially attractive to families because it combines housing and services and relieves them of the oversight and coordination of housing and services necessary to help an older relative remain in their single family home.

Assisted living in Minnesota is considered to be a type of "housing with service establishment" where the housing provider or another agency provides services to the residents as a part of a housing and service package. These establishments must register with the Minnesota Department of Health (MDH) and the service provider must be appropriately licensed to provide the advertised services. Nearly all of these establishments are assisted living residences and most of the residents are elderly.

1. Growth in Assisted Living

There are now 907 assisted living residences registered in Minnesota. These residences include 40,086 units that serve an estimated 35,000 older people. Between 1997 and 2004, the numbers of residences doubled (426 to 907) and the number of available units tripled, rising from 13,000 units to 40,086 units. Minnesota now has more assisted living residences and units than it has nursing homes and nursing home beds. There are 432 nursing facilities compared to 907 assisted living residences, with 39,530 nursing home beds compared to 40,086 assisted living units.

The typical assisted living resident is an 81-year old woman who is mobile but needs assistance with two activities of daily living (ADLs). The typical resident stays in assisted living for an average of 28 months, and when residents move, most do so because they need a higher level of medical care. About 33 percent move to a nursing home, 25 percent move to a hospital or another assisted living facility, 12 percent return to their home, and 28 percent die in the residence. The average annual income of assisted living residents is $25,000, and 40 percent supplement their income with interest from savings or other assets. About 16 percent receive financial assistance from family members in order to pay for the assisted living. Nationally, the average length of stay for assisted living residents receiving public assistance is twice as long (4.1 years) as private pay residents (2.1 years). Over 90 percent of the residents report that someone besides themselves was very involved in the decision to move to assisted living, usually an adult child.

The growth in assisted living represents a major shift in the type of congregate settings available to serve the elderly. It has shifted much of the "congregate capacity" from an institutional model to a residential/social model. Some of the assisted living in Minnesota includes nursing homes that have closed beds and converted wings or buildings to assisted living.

With such a large supply available, the growing preference for this option and the state's current policy to reduce institutional capacity, there has been increased pressure on the EW and AC programs to support assisted living (see below). The data on typical residents illustrate that many are middle income and may spend down their resources during their stay in assisted living, and either become EW/AC clients, be discharged from the residence because of inability to pay, or move to a nursing home where they would quickly become eligible for MA-funded care.

Another issue in assisted living is the appropriate level and type of regulatory oversight that should exist for this residential option where services are being provided to (some would say) quite vulnerable elderly. Concerns are growing as the number of elderly living in assisted living continues to increase. Right now, Minnesota's quality assurance approach for assisted living requires that the "establishment" register with the state, that the services be provided by appropriately licensed providers, and that a contract including state-specified provisions be signed by the resident and the facility. The residences must also comply with any applicable housing codes or laws. This approach is very unique in the country. Many states license and inspect assisted living residences in a manner similar to nursing homes. Minnesota took this direction explicitly to avoid the problems inherent in the facility licensing approach used for nursing homes, and to avoid making assisted living into "the new" nursing home.

As consumers and providers have had more experience with this approach, some gaps have come to light, e.g., need for more clarification on how and when services are provided, continuing stay criteria, definition of "supervision." We are still in the early stages of developing all the elements of an overall quality assurance framework for home and community-based services, and the gaps in the framework likely show up in some of the issues identified in assisted living. Providers in cooperation with other stakeholders have already begun to design and implement more elements within the current framework that they hope will address the concerns of their residents, the general public and others.

2. Publicly funded Assisted Living

The number of EW and AC clients receiving "congregate residential care," of which the vast majority is assisted living, has grown from 4,285 clients in 2000 to 7,403 in 2003, a 73 percent increase. Nearly all of these clients are in assisted living "plus" settings that provide 24-hour supervision.

The growth in publicly funded assisted living has been spurred by the state's long-term care reform efforts and incentives such as the Bush Foundation grants for affordable assisted living and the community service/service development grants. Both have provided start-up funds to develop affordable assisted living. (It should be noted that some publicly-funded assisted living services are provided in already existing affordable senior housing, and some are provided in market-rate "purpose-built" assisted living.)

An issue that has been raised by some is the degree to which EW and AC clients served in assisted living are more disabled than those served in their own homes or apartments. To

determine this, the characteristics of clients in assisted living were analyzed and compared to all other clients. This analysis showed that clients in congregate residential care are higher case mix and have more dependencies than EW/AC clients overall. A lower proportion is case mix A, a higher proportion is case mix B or E, and a greater proportion is dependent in self-preservation and medication management. Thus, clients served in assisted living are more dependent and not able to live safely in their own homes. For these individuals, the assisted living service is a true alternative to a nursing home.

As the number of clients served in assisted living plus settings has increased, the proportion of the overall EW and AC expenditures for assisted living and other congregate residential care has risen. In 2000, about 37 percent of total EW/AC expenditures was spent on congregate residential services. By 2003, this percent had increased to 54 percent of total EW/AC expenditures.

While it appears that the expenditures on assisted living are allowing more disabled elderly to remain in the community and out of nursing homes, DHS is monitoring the use of assisted living within the EW and AC programs. This setting is an important option for many elderly, especially those who need oversight and supervision.

However, we must continue to improve the services and supports that help older people remain in their *original homes*, so that as many as possible are able to remain in their home for as long as possible. From a policy standpoint, this is a more affordable setting for most elderly and the state, it makes use of an already existing affordable resource, and informal supports are more available to older people who remain in their own homes and communities.

B. Housing Gaps Analysis

The 2001 gaps analysis completed by all counties included a section on the adequacy of the senior housing supply from the counties' perspective. In 2001, 50 counties identified affordable senior housing as the biggest gap in their areas, followed by adult foster care, assisted living and market rate rental. By 2003, counties reported that much additional housing had been developed, with 27 counties reporting subsidized or affordable housing developments, 17 reporting development of adult foster care, and 16 reporting development of assisted living. Because of these developments, assisted living was no longer considered a gap by 2003, with most counties reporting it as a lower priority.

C. Family Payment Plan

A new program to help families pay for eldercare has begun in parts of the United States, and legislation was introduced in 2003 to establish a version of that program in Minnesota. This program provides personal loans of up to $50,000 for creditworthy family members to pay for long-term care for their older relatives. The concept is said to be similar to the student loan program but for elders. Legislation passed in 2003 required that this report provide a discussion of the feasibility of such a program in Minnesota.

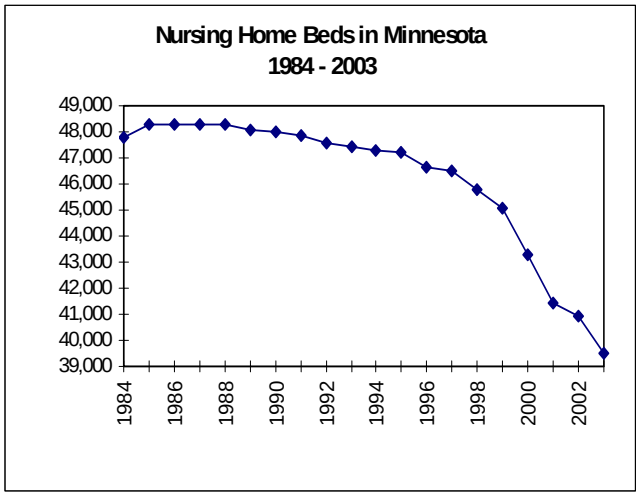
Now operating in five states (Tennessee, Kansas, Massachusetts, Virginia, and Maryland), this loan program has served about 400 families, and the loans are primarily used to pay for assisted living services. Typically, the assisted living facilities refer families to this program that offers

loans to facilitate quick moves into facilities when necessary. No states currently offer financial support to this program, but proponents of this concept in Minnesota have sought state support to reduce the interest rate and provide default protection for banks that give these loans, in order to make these loans more available to moderate income families.

DHS has begun a detailed analysis of all available private long-term care financing options, including the family payment plan, to meet the requirements of a legislative study due January 2005. The result of this analysis will be the ranking of options from strongest to weakest in achieving state policy goals of maximizing private dollars for long-term care and minimizing future Medicaid liabilities. Because this analysis has not yet been completed, we are not able at this time to make specific recommendations on the option, but will do so as part of the broader analysis and full report on private financing options due to the legislature in January 2005.

VI. Nursing Homes

In addition to expanding the capacity of the home and community-based system of services for older people, the 2001 long-term care reform called for a reduction in the state's reliance on nursing homes. The size of the nursing home bed supply was already declining due to market changes, and the state wanted to encourage that trend while ensuring that adequate numbers of nursing home beds were available to serve those who required nursing home care.



A. Number of Nursing Home Beds

In the last two years the state's supply of nursing home beds has decreased, continuing a long decline that began over 10 years ago. The number of nursing home beds peaked in 1987 at 48,307 beds, and as of September 30, 2003, the number of beds had decreased to 39,530, a decrease of 8,777 beds. A total of 1,470 of those beds are on layaway. Minnesota's nursing home bed supply is now 18 percent smaller than it was at its height in 1987.

1. Nursing Home Beds Per 1000

Minnesota's beds per 1000 rates have been declining for several years for both the 65+ and 85+ age groups. The beds per 1000 for persons 65+ dropped from 83.9 in 1993 to 65.7 in 2002. During that same 10-year period, the beds per 1000 for persons 85+ dropped dramatically from 643.2 to 431.4. The national average beds per 1000 for persons 65+ dropped somewhat between 1993 and 2002, from 53.7 to 49.7, but dropped significantly for persons 85+, declining from 491.2 in 1993 to 453.0 in 2001. Minnesota had the fifth highest ratios in the country in 1998, but dropped to the tenth highest in 2002. In addition, our beds per 1000 for the 85+ age group dipped below the national average (431.4 compared to 453.0).

2. Extreme Hardship Counties

The decline in beds has led to a few areas where the reduced supply may trigger an extreme hardship situation. There are five counties--Chisago, Isanti, Sherburne, Washington and Goodhue--where an exception to the moratorium on nursing home beds might be considered due to the potential for an "extreme hardship" situation because of the low number of beds in their contiguous county groups.

By definition, two criteria must be met for an extreme hardship situation to exist:

1. A county must have a beds per 1000 average for people age 65 and over (in that county and contiguous counties) that is less than the national average plus 10% (54.7 beds/1000 in 2001).
2. An extreme hardship situation can only be found after the county documents the existence of unmet medical needs that cannot be addressed by any other alternatives.

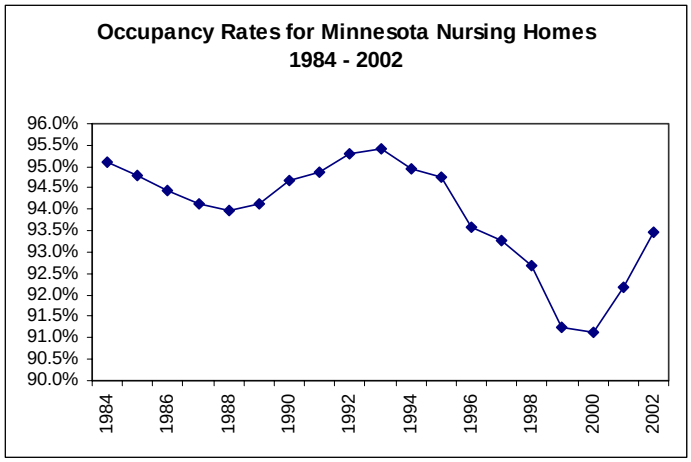
Many of the lowest beds per 1000 rates are found in and around the Twin Cities Metro Area. Chisago, Isanti, Washington, and Sherburne Counties all border Anoka County, which has the state's lowest beds per 1000 rate at 22.4, and these counties are affected by Anoka's low bed rate.

If we apply the statutory definition of "extreme hardship county" to the current bed per 1000 rates, we get some unusual results. For example, even though Isanti and Sherburne counties have high beds per 1000 rates age 65+ (ranking 23rd and 24th, respectively), they are potential extreme hardship counties, while Anoka (ranking 87th) is not. A similar phenomenon occurs with Goodhue County and its contiguous counties.

The objective of identifying potential hardship counties may be better met by using criteria that recognize either low beds per 1000 rates for both a county and its contiguous county group, or very low beds per 1000 for a county regardless of contiguous counties. (Sample legislative language to effect this change is included in the expanded version of this report on the web at www.dhs.state.mn.us/agingint/ltctaskforce/reports.)

B. Occupancy and Utilization Rates

Occupancy is defined as the percentage of days a nursing home bed is occupied during the year. Occupancy in Minnesota's nursing homes had been decreasing along with the number of beds since 1987. However, beginning in 2000, occupancy rates started to rise, most likely in response to the ongoing decrease in bed supply. The statewide occupancy rate in September 2002 was 93.5 percent.



Nursing home utilization rates for older persons in Minnesota have been declining for the past 20 years, and they continued to decrease over the past two years. In 1984, the utilization rate was

8.4 percent, and by 2002, it had declined to 5.5 percent, a 52 percent drop. The greatest reductions in the rates occurred between 1993 and 1994 and between 1996 and 1998, which were also the years that saw the largest reductions in beds per 1000.

Utilization rates do vary considerably throughout the state. For example, older people are more likely to use nursing home services in the regions along the western border of the state (regions 1, 4, 6W and 8) and least likely to use nursing homes in the Twin Cities Metro Area.

The nursing home utilization rate for persons under 65 has remained fairly stable over the past six years (1996 to 2001), at less than 1 percent of Minnesota's population ages 0 – 64. Major efforts have been underway since 2001 to relocate younger disabled persons from institutions to community settings, similar to the reform efforts for the elderly.

Nursing Home Utilization Rates in Selected Years from 1984 - 2002 for Persons 65+ and 85+ in Minnesota

			(Restated)*				(Restated)*	
Year	65+ Utilization	Annual Rate of Change	65+ Utilization	Annual Rate of Change	85+ Utilization	Annual Rate of Change	85+ Utilization	Annual Rate of Change
1984	8.4%				36.4%			
1987	8.1%	-1.2%			35.1%			
1989	7.8%	-1.9%			33.4%			
1993	7.6%	-0.6%			30.8%			
1994	7.1%	-6.6%			28.7%			
1996	6.9%	-1.4%			28.2%			
1998	6.1%	-5.8%			24.3%			
2000	6.1%	0.0%	5.84%		22.3%		22.8%	
2001	5.8%	-2.5%	5.59%	-2.1%	22.0%		21.3%	-3.3%
2002			5.52%	-0.6%			20.6%	-1.6%

Source: Residents – MDH and DHS; Population – US Census Bureau
*Beginning in 2002, it was necessary to restate the utilization rate because the data source used to compute this rate was no longer available. The case mix system was replaced with the RUGS system. It may take a few years to establish a new trend line because of this change.

C. Projections

One of the questions that must be addressed in this report is whether the state has an adequate supply of nursing home beds for the foreseeable future or if additional beds will be needed. To do this, DHS first looked at projected need based upon historic changes in the number of beds and then projected need based upon utilization of nursing home services.

1. Projections based on changes in the number of beds

As we have seen, the number of nursing home beds in Minnesota has been decreasing at an accelerating rate. To project the number of beds needed in the future, staff developed three different scenarios. These scenarios chart future bed supply based on the average change in the number of beds over the last twelve years, seven years and three years. The seven-year and three-year trends are progressively steeper, evidence of the accelerating rate of decline.
Using the twelve-year trend line, Minnesota will need 38,100 nursing home beds in 2005 and about 35,000 beds by 2010. The seven–year trend line projects the need for 37,500 beds in 2005 and 32,400 beds by 2010. Using the three-year trend line, the state will need 37,000 beds in

2005 and 30,800 in 2010. Using this method of calculation, even the highest projection is below our current number of beds (39,530).

Projecting Number of Nursing Home Beds Using Three Trend Lines

	12-year trend	7-year trend	3-year trend
2003	39,530	39,530	39,530
2005	38,156	37,502	37,044
2010	34,694	32,408	30,829
2015	31,233	27,315	24,614
2020	27,771	22,221	18,399
2025	24,309	17,127	12,184

(2003 = actual number of beds)

2. Projections based on changing utilization rate of nursing home services

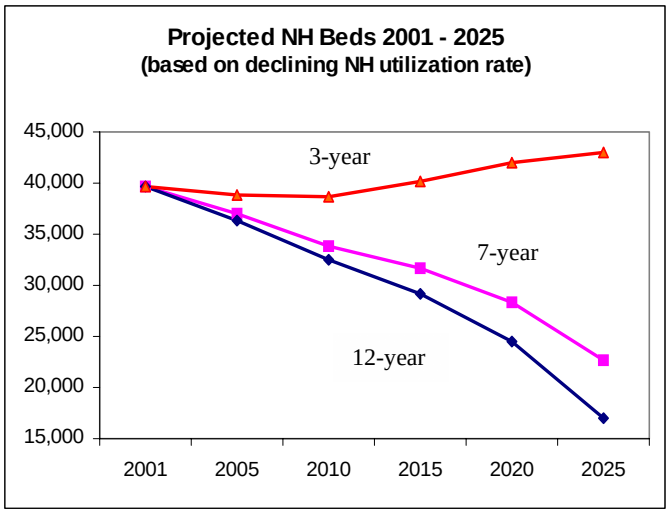
The change in the nursing home utilization rate is perhaps a better barometer of future demand than changes in the number of beds. Although occupancy levels have risen from a low of 91 percent in 2000 to 93.6 percent in 2002, they are still well below the high of 95.7 percent in 1993.

Utilization rates have been falling for many years. Nonetheless, if we were to assume that the rate of nursing home bed utilization would level off at the 2001 rate of 5.8 percent for the 65+ age group, the need for beds would increase steadily, surpassing current supply by about 2005, assuming occupancy does not exceed the record high of 95.68 percent in 1993. This is because of the increase in the older population that will occur during that time.

But, because of the decline in disability rates, shorter nursing home stays, and increasing utilization of alternatives to nursing home services, we expect that nursing home utilization rates will continue to decrease in the coming years, although at a slower rate than in the recent past.

Assuming then, that utilization rates will continue to decline, the question is, will the pattern of recent declines continue or will a longer-term average be more likely? And then, what does that mean for the number of nursing home beds that will be needed?

To answer these questions, DHS projected historic nursing home utilization rates for persons 65+ out to 2025 using three different rates of decline. The steepest rate of decline is the seven-year trend line, and the 12-year trend line is somewhat more gradual. The most shallow is the three-year trend line, because of the stable utilization rate between 1998 and 2000. The next step is to apply the three utilization rates to the population projections to determine various scenarios for the future nursing home bed need. (These projections of beds are based on US Census population projections, they assume that 91 percent of all nursing home residents are 65+, and they assume a constant occupancy rate of 95.68 percent.)



The assumptions about the rate of decline in nursing home utilization significantly change the projected need for nursing home beds. If the utilization rate stabilizes or declines very slowly, as it has in the last three years, the increase in the older population will begin to have the impact one would expect after 2010--an increase in bed need. However, if the utilization rate declines more rapidly, as it has in the past seven years and 12 years, it will be many years before additional beds will be needed. Utilization will most likely not decline at the steeper projected rate for the next 25 years, but even a modest decline will mean no beds will be needed for another 10 to 15 years, and that Minnesota will have an adequate supply of beds available to meet demand until at least 2015.

In previous analyses of bed need (1999 and 2001), the three-year trend line showed the steepest decline in number of beds needed. This is the first time that it suggests an eventual increase in bed need. Given the volatility of the three-year trend line, DHS recommends watching this and seeing if the trend persists. At this time no strategies to encourage further bed closures are being actively pursued.

D. Publicly Funded Nursing Home Care

Because the cost of nursing home care is expensive (the average daily cost of a nursing home in Minnesota is now $136.14 which adds up to $49,691 annually), many elderly in nursing homes spend down their assets and become eligible for MA within a few months. While utilization rates are declining, Minnesota still has relatively high utilization rates and higher numbers of beds per 1000 for persons 65+ than most other states, so expenditures for nursing home care are a major component of the state's MA program.

Expenditures for nursing home care in the state's MA program were nearly $1 billion in 2003. This represents about 20 percent of the total MA budget (federal and state combined). The numbers of elderly on MA receiving nursing home care has been declining for several years, which has affected the rate of increases in the expenditures. In 2001, 36,676 persons 65+ on MA were cared for in nursing homes, and by 2003, this number has declined to 33,430. MA expenditures for nursing home care during that same period grew from $900 million to $973 million. The department's forecast estimates that the number of persons receiving MA nursing home care will continue to decline and the expenditures will rise moderately from now to 2007.

E. 2001 Reform Provisions for Nursing Homes

The 2001 long-term care reform legislation contained a number of provisions to reduce nursing home bed supply and make improvements in Minnesota's nursing home system.

1. Voluntary Planned Closure

The voluntary planned closure provisions provided an incentive to nursing homes that closed beds by increasing their reimbursement rates for remaining beds. A goal of closing 5,140 beds was set under this provision. Between 2001 and 2003, when the planned closure provisions expired, a total of 4,925 beds had either been closed or approved for closure. This number includes active beds that were closed, layaway beds that were closed, both active and layaway beds that have been approved but not yet closed, and some beds that closed without taking advantage of the planned closure provisions.

2. Quality Profiles

DHS is developing quality profiles for consumers to use to make better decisions about their long-term care needs and to choose which providers would best meet their needs. The quality profiles will focus on nursing homes first, but are intended to eventually include all long-term care providers. Work has been done to identify key quality measures for nursing facilities that most stakeholders can agree on, and these will be refined and soon be available on the web. The first seven quality measures look at staffing level, staff turnover, staff retention, use of nursing pools, percent of beds in single bed rooms, quality indicators from the MDS and deficiencies from the certification survey. Measures addressing quality of life, consumer satisfaction and family satisfaction are to be developed next.

3. New Reimbursement System and Related Changes

DHS completed a report in March 2004 that recommended a new nursing facility reimbursement system. Using a value-based approach, the report recommends a system that is a hybrid of a price-based system, a cost-based system and a quality-based system. The report included bill language to enact the proposed system.

A new case mix system, based on a national model called Resource Utilization Groups (RUGs) was implemented on October 1, 2002. The RUGs model assigns each nursing facility resident to one of 34 groups, each of which has a weighting factor used to adjust payment for the case mix adjusted portion of the facility's costs. The weighting factors initially used were based on research done several years ago in seven other states, primarily for Medicare. A staff time measurement study is underway to establish new indices based on current data collected in Minnesota facilities for all residents. New indices should be implemented on October 1, 2004.

A small amount of money was made available to facilities to provide scholarships to lower wage employees who work at least 20 hours per week. The scholarships could be used for any educational program, outside of the facility's regular staff training, that would lead to advancement within the facility or to a career in long-term care. If a facility gave out more in scholarships than the rate component covered, the facility would be given a rate increase, and if they used less, then their rate would go down. In its first year, about 90% of facilities gave out scholarships to just over 3,000 employees. Over half of these employees took courses to become LPNs or RNs. In its second year, about 75% of facilities gave out over 2,400 scholarships.

F. Department of Health's Long-Term Care Initiative

In April 2003, the department of health began an initiative to address concerns surrounding long-term care regulations, the nursing home survey process and other issues affecting Minnesota's

nursing home industry. In August 2003 the commissioner formed a Long-Term Care Issues Ad Hoc Committee to advise the department on ways to address regulatory and other issues. The Committee includes providers, consumers and advocates, and statewide associations with interest in these issues. Since that time, several activities have been initiated.

Steps have been taken to evaluate and improve the licensing and certification efforts of the department's Facility and Provider Compliance division, responsible for the nursing home survey process. The goal is to identify the underlying causes of deficiencies within facilities, develop a process for analyzing identified trends, and focus on ways to enhance quality of care. Another area of work seeks to minimize tensions created by the survey and regulatory process. In this case, the committee is examining current communication processes and clarifying roles and responsibilities between the department and providers, in order to foster more productive communication.

Other work includes putting the most recent survey findings on the department's website for use by consumers and others, and creating a report card on nursing homes that can be used by consumers to evaluate the quality of care at each of Minnesota's nursing homes. This work is being coordinated with DHS work on nursing home quality profiles.

In summary, there has been major transformation in Minnesota's nursing home system over the past few years, and this process is likely to continue, spurred on by continuing changes in the market. The nursing home is evolving into one of the essential components within the long-term care continuum rather than the only long-term care option available to consumers in some parts of the state.

VII. Chronic Care Management

There is increasing interest in the issue of how long-term care and acute care interact, and how they can be better integrated, to improve the management of health and long-term care for older persons with chronic conditions. This integration is increasingly important because persons with multiple chronic conditions consume over 90 percent of all Medicare and Medicaid expenditures. Better management of their care could not only improve continuity of care and save money, but improve the individual's quality of life.

In order to bring these health care elements into a single system, Minnesota was the first state in the country to develop a model to provide primary, acute, and the full range of long-term care through a special federally approved demonstration program. Minnesota Senior Health Options (MSHO) delivers all needed Medicare and Medicaid benefits through an integrated care coordination model to a voluntarily enrolled group of older persons who are both Medicare and Medicaid eligible. Over 5,000 individuals in ten Minnesota counties receive their care through a provider network they select, contracted through one of three participating health plans. While enrollees live both in nursing homes and community settings, capitation payments are adjusted in order to keep individuals in the community as long as possible.

MSHO is an alternative to the Pre-Paid Medical Assistance Program (PMAP) for older persons who are eligible for MA and live in the counties where MSHO is offered. MSHO continues to

be the only one of its kind in the nation, although Massachusetts will soon have a similar program in operation. Many of the elements of the MSHO model, e.g., care coordination, new benefits, use of specialized nurses, could be adapted for use in the private care systems that serve Medicare beneficiaries.

Other models that offer greater integration of acute, primary and long-term care for older persons are now being looked at or developed in Minnesota. These include the Program of All-Inclusive Care for the Elderly (PACE) model of care and the legislatively mandated EW into PMAP demonstration. The 2003 legislature required DHS to move the EW program into PMAP, which would integrate the medical care and long-term care for elderly persons on Medical Assistance who are at risk of institutionalization.

VIII. Access to Information and Assistance

Older persons are seeking more home and community-based services instead of institutional models of care. They want to remain in their homes and choose the services they need to maintain independence. Because consumers generally don't seek out information about long-term care services until a crisis, the 2001 long-term care reform legislation included a multi-pronged approach to improve consumer information and assistance so that it can respond in real time to the need for information.

1. Information and Assistance Improvements

The Minnesota Board on Aging has provided information and assistance through the AAAs for several years. In response to the 2001 legislation, the MBA developed an easy-to-use website called MinnesotaHelp.info. It also improved the quality of service provided through its Senior LinkAge Line®, expanded a toll-free telephone information and assistance service available throughout the state, and improved linkages between the Senior LinkAge Line® and the assessment, screening and eligibility determination functions of the counties.

2. Long-Term Care Consultation Services

Changes were also mandated in the assessment and assistance services administered by the counties. The name of the Pre-Admission Screening program was changed to long-term care consultation (LTCC), and the responsibilities were revised to include provision of broader "consultation" services to older persons of all income levels faced with long-term care issues.

As a result, county LTCC staff provided screenings to about 8,000 more people in 2002 than in 2001, about 65,000 people 65+ and 22,000 persons under 65. About 89 percent of the screenings and about 60 percent of the community visits were provided to persons 65+. About 70 percent of the persons visited in institutions were under age 65, in part because of legislation that required early follow-up visits for people under 65 admitted to nursing facilities.

3. One-Stop Aging and Disability Resource Centers

A consortium of agencies including DHS, Hennepin County, the Metropolitan Center for Independent Living, the Metropolitan Area Agency on Aging, and the University of Minnesota Center for Aging received a federal grant in late 2003 to improve consumer access to services. Among other things, it included the creation of four resource centers in Hennepin County,

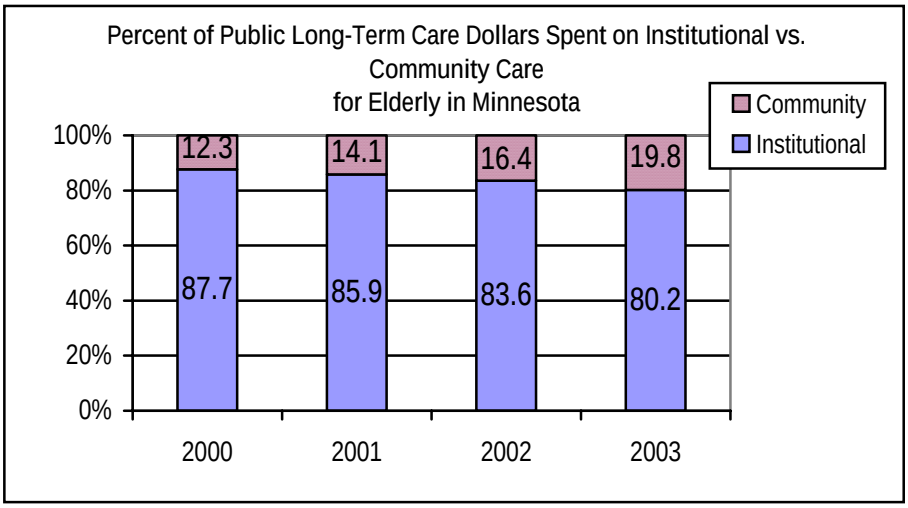
additional professional and consumer linkages with www.minnesotahelp.info, a management information system that links to county billing systems, and expanded access to screening options for caregivers and professional helpers.

These efforts will more closely coordinate the many components of Minnesota's highly regarded information and assistance system, improve consumer access to information about long-term care services and offer this information in a wide variety of formats. This work will move us closer to achieving Minnesota's goal of "no wrong door" for consumers desiring to find out about their options, obtain information about specific providers, and make their own decisions about long-term care services.

IX. Long-Term Care Benchmarks

In 2001, five benchmarks were identified to measure the state's progress toward rebalancing the long-term care system as called for in the state's long-term care reform. These benchmarks are described below, with the most recent measures included.

Benchmark #1
Percent of public long-term care dollars spent on institutional vs. community care for persons 65+.

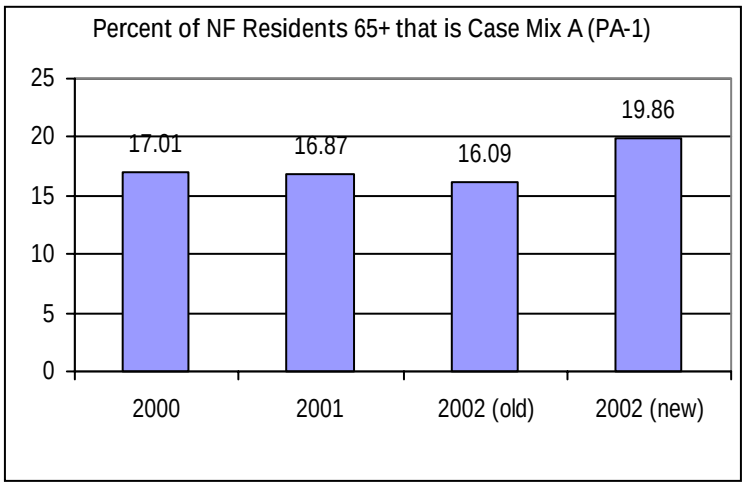


What does this benchmark measure? It measures the relative proportion of the state's and each county's total long-term care budget spent for nursing home care and community care for persons 65+. Community care includes expenditures in the Elderly Waiver, Alternative Care and the Medical Assistance home care programs, and institutional care includes MA expenditures for nursing facility care.

Why is this important? Minnesota's use of nursing home care is higher than the national average, and as we reduce our reliance on nursing homes, we will reduce the proportion of public long-term care dollars spent on nursing home care and increase the proportion spent on community care. This benchmark allows us to compare each county with statewide averages, and compare Minnesota to other states in the country.

Where do we stand? In 2003, our statewide proportion of expenditures on nursing home care vs. community care for older persons was 80/20 percent of the state's total long-term care expenditures for the elderly. The ratio has shifted since 2001, when it stood at 86/14. There is wide variation among the state's 87 counties in the ratio of institutional to community care expenditures, ranging from 67.2/32.8 in Crow Wing County to 96.5/3.5 in Cook County.

Benchmark #2
Percent of nursing home residents 65+ that is case mix A.

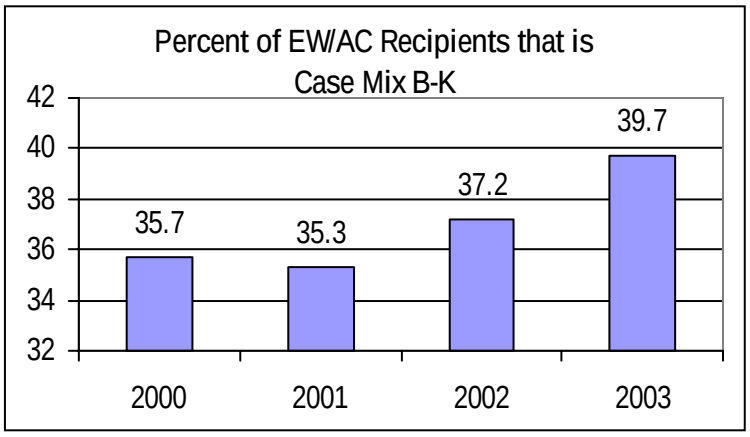


What does this benchmark measure? It measures the percent of the less disabled older people being served in nursing homes, i.e., those elderly with "case mix A" level of ADLs. Because the state's case mix system was replaced with the RUGS system in October 2002, this benchmark needs to be redefined using measures in the new system. Beginning in 2002, this measure will be called "PA-1" instead of "case mix A." It is defined as residents of nursing homes with no special conditions, no nursing rehab needs, and an ADL count of 4 – 5.

Why is this important? In order to reduce our reliance on nursing homes, we need to examine they way we use nursing homes, especially for older people with fewer needs who could be maintained in the community if proper support services were available.

Where do we stand? In 2002, the overall state proportion of nursing home residents that was case mix A/PA-1.was 16 percent (old) and 19.8 percent (new). We will need to measure this again next year using the new definition to determine the progress made on this benchmark.

Benchmark #3
Percent of Elderly Waiver and Alternative Care recipients that is case mix B – K.

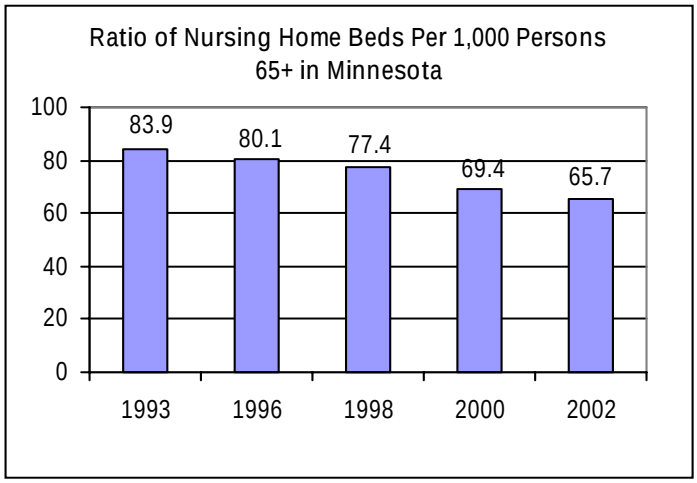


What does this benchmark measure? It measures the percent of the elderly served in Elderly Waiver and Alternative Care programs that is more disabled and need more intensive services because of greater difficulties with ADLs.

Why is this important? In order to reduce our reliance on nursing homes, we need home and community care options that can support more disabled frail elderly in their homes or apartments.

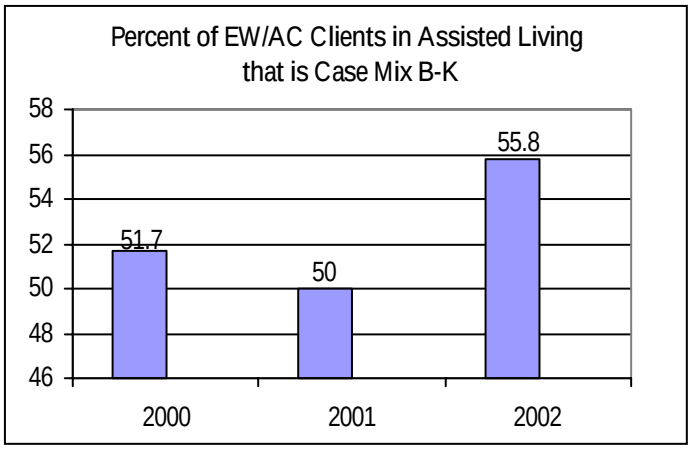
Where do we stand? In 2003, the statewide proportion of elderly served in the community care programs that had case mix scores of B - K was 39.7 percent. This is an increase from 2002 when 37.2 percent of clients was at higher case mix levels. Again, there is wide variation among counties in this measure, ranging from 6.8 percent in Big Stone County to 76.4 percent in Kandiyohi County.

Benchmark #4
Ratio of nursing home beds per 1000 persons 65+.



What does this benchmark measure? It measures the current number of nursing home beds and computes the ratio of nursing home beds to the current population 65+. It allows a consistent comparison of the relative supply of nursing home beds in a particular geographical area.
Why is this important? Minnesota's ratio of nursing home beds per 1000 is higher than the national average, and we are trying to reduce our reliance on nursing homes. This measure helps us compare the supply of beds to the population, and monitor how this changes over time, as more community options are put in place.
Where do we stand? In 2002, our statewide ratio of beds was 65.7 beds per 1000 persons 65+. The rate has been steadily declining since 1987. There is wide variation among counties, with the ratio ranging from 132.3 in Norman County to 22.4 in Anoka County.

Benchmark #5[4]
Percent of EW/AC recipients in assisted living that is case mix B – K.



What does this benchmark measure? It measures the proportion of disabled recipients in our community care programs served in assisted living settings. Assisted living services offer an important option especially for elderly who would otherwise need to move to a nursing home.
Why is this important? In order to reduce our reliance on nursing homes, we need an adequate supply of housing options that offer high levels of services including supervision and oversight. Monitoring the use of assisted living allows us to track the percent of more disabled elderly being served in this alternative.
***Where do we stand*?** In 2003, the statewide proportion of recipients receiving assisted living that had case mix scores of B – K was 54 percent. County level data is not available at this time.

[4] This benchmark was originally the ratio of senior housing units to persons 65+, similar to the nursing home bed ratio. Because of the difficulty of defining which senior housing expands the supply of service settings that serve the most at risk, the benchmark was refocused on assisted living and the use of public funds to serve those with the highest risk of institutionalization.

X. Conclusions

A. Progress on 2001 Long-Term Care Reform

This report represents the first time that the state has analyzed changes in both the institutional and community components of Minnesota's long-term care system for older people and compared these changes to an articulated vision, policy directions and benchmarks. This analysis makes it clear that much progress has been made on the long-term care reform set in motion in 2001.

1. Achievements on Benchmarks

The five long-term care benchmarks that measure the state's progress toward its rebalancing goals all indicate that the measures are changing in the direction called for in the 2001 reform. The percent of total public long-term care dollars spent on institutional care is declining, and the proportion spent on community care is increasing. The ratio of nursing home beds per 1000 has continued its downward trend, bringing us lower than the national average for the 85+ age group. The most dramatic changes in the last two years were in the increased percentage of more disabled clients supported in the community within the EW and AC programs.

2. System Change and Infrastructure Development

Key systems changes are being made that will support continued reform of long-term care.

- An information and assistance system is now available statewide, and more improvements are coming.
- Community and voluntary service providers have been strengthened and their scope of service broadened.
- Linkages among voluntary providers, counties and health systems have been created and expanded in several market areas of the state.
- A broader array of home and community-based services and housing options is now available in communities across the state.
- New ways of using technology to provide long-term care and reduce the need for staff are being demonstrated in both urban and rural parts of the state.
- The goal of voluntary closure of 5,140 nursing home beds during 2001 – 2003 has been substantially achieved.
- Nursing homes continue to transform their business to focus on specific target groups or services.
- The elements of a quality assurance system for home and community-based services are being put in place.
- A great deal of rethinking and new directions in services have begun within counties, AAAs, EDPs and providers. They are focused on how they can participate in achieving the goals of long-term care reform.
- The CS/SD grant program has provided the incentive needed for counties and communities to develop creative and sustainable supports for their older residents.

B. Future Challenges and Goals

While work has begun on many fronts, some of these areas present additional challenges and opportunities as we consider the upcoming increases in our older population.

1. Consumer- and family-directed Services

Developing consumer-directed services within the EW and AC programs is critical to further progress in long-term care reform. Consumer direction implements several policy goals—helping people help themselves, giving consumers more control, and putting in place more cost-effective ways of providing direct services, e.g., using more nontraditional sources of labor, such as family, friends and neighbors.

Moving in this direction requires a major infrastructure change in aging services: from an agency and professional focus, to a model where agencies help *the consumer* find and control their own long-term care workers and services. This will be a major market feature as the baby boomers begin to need long-term care and look around for what services are available. It is also a more affordable approach than the traditional professional service model. (Obviously there will continue to be the need for professional management and oversight for those elderly with more complex medical and personal care needs.)

As long-term care service providers redesign their services consistent with consumer direction, they may see other opportunities to develop coordinating functions for consumers and their families. Families are increasingly purchasing services to supplement what they are able to provide to their elderly relatives, and consumer-directed services that coordinate, arrange, package services may become popular and in demand.

Along with consumer-directed services, tangible support for family caregivers is another critical challenge for the future. If the current trend continues, family provision of eldercare will decline. Even though it now appears that families are hiring help to supplement their caregiving, it is likely that some families will also turn to public programs as a supplement or substitute. To help families extend their caregiving, the state should be intensifying efforts to provide the kinds of supports that caregivers want and need--"wraparound" supports, real time information and assistance, caregiver coaches, etc.

2. Chronic Care Management

A critical long-term care issue that has only recently emerged is chronic care management. For both cost and quality reasons, we need to more seriously address the challenges posed by the small portion of the older population with multiple chronic conditions that use the vast majority of the resources in both the acute and long-term care systems. This problem will become even more critical as baby boomers reach retirement age with chronic conditions that need to be managed effectively. Moving forward on this issue could include expansion of the successful MSHO model to additional counties in the state, demonstrating new models for how EW services can be integrated with PMAP services (now under consideration), and development of PACE sites within the state.

Some are concerned that this strategy will "medicalize" long-term care. However, the goal is to improve overall care for persons with chronic illness, and target non-medical supports more effectively. This is important for all elderly, not just those on Medicaid.

3. Expanding Community Capacity and Infrastructure

Continued development of the capacity of voluntary long-term care resources–churches, voluntary programs, community and local groups–is a critical issue. This system is the one most seniors and their families turn to when they need additional support, and it can be found in all communities, but it needs maintenance and nurturing to be as effective as it can be. The strategies now in place to expand this capacity should be continued, e.g., use of the CS/SD grant program to fund these efforts, continued use of technical assistance to these local groups to help them develop and connect to the more formal parts of the long-term care system.

The small towns scattered throughout Greater Minnesota are aging dramatically, and the challenge of maintaining sufficient community capacity to support an aging population is the same issue faced by all the residents of the community—how to keep the grocery store in town, how to provide transportation for the community, how to attract businesses and workers to the community, how to keep the schools open. We need to think broadly about building the capacity of these towns and how to help these communities "connect the dots" for these communities so they can have the economic vitality that retains or attracts business and workers. This, in turn, enables communities to maintain the service infrastructure that is important for all the residents including the older residents.

4. Technology and Labor Shortages

Many important demonstrations of new technology in long-term care have begun in the past two years, and there are several long-term care issues that technology can address.. One is the shortage of labor to provide long-term care. These shortages are predicted to reach almost crisis proportions at the time that the baby boomers reach old age and have the greatest need for health care. To the extent that technology is able to replace workers, make best use of limited staff or maximize an individual's ability to take care of their own needs, it will be an important tool for addressing the issue of labor shortages.

The other issue that technology can address is distance. With more people aging in place, technology can provide cost-effective monitoring of and communication with older people living in scattered sites throughout a geographic area. The technology to maintain frail elderly at home alone is already available with robotics and other electronic monitoring devices. It is hard to imagine what will become available in the future, but it will no doubt change our assumptions about what is possible in long-term care.

5. Assisted Living Challenges

Because of growing interaction between the private and public payment for assisted living, the state should monitor the growth of this option, and collect additional information on the characteristics of those using assisted living and the interaction between this use and the use of public payment for assisted living or subsequent nursing home stays. The goal of the state is that assisted living is available as an option for those who cannot stay at home alone safely and would otherwise need to move to a nursing home. However, because of the tremendous growth in the supply and the recent large growth in the use of this services and public expenditures for this option, we need to monitor developments in this market for changes that could affect future public expenditures and long-term care reform efforts.

6. Long-Term Care Financing Reform

Another major challenge in the future is to identify more options for individuals to use to pay for their own long-term care. Because of the large numbers of people who will need long-term care when the baby boomers grow old, government will not be able to sustain the current levels of public payment for long-term care. In order to keep the safety net programs strong for those who will have no other resources, we need to work now to help boomers identify and implement strategies for using their own personal resources to pay for long-term care whenever this is possible.

DHS is now actively collaborating with several other state agencies to determine the adequacy of the income and assets of future elderly (the boomers) in order to identify the extent of the problem in the future. DHS has a contract with the Milbank Memorial Fund and the Employee Benefits Research Institute (EBRI) to provide Minnesota-specific data on the issue of future retirement income and assets. This data is expected in June 2004, and will provide a picture of how many and who will be unable to pay for health and long-term care costs in the future, and suggest options for addressing the adequacy of income and assets. This information will also provide a good database for a legislatively mandated study of private financing options currently underway at DHS, to identify which of several options have the most potential to achieve the state's policy goals of maximizing private dollars in long-term care and minimizing future Medicaid liabilities.

C. Policy Changes and Resource Needs

The years since 2001 have seen major deficits at the state level, requiring shifts and reductions in expenditure levels for long-term care. These reductions have had an impact on the rate of progress toward achieving the state's rebalancing goals. As an example, the effects of the changes in the AC program may mean that increased numbers of elderly who would have used this program to remain in the community end up using nursing home care earlier than they might have.

It is unclear whether the rate of progress on reform efforts to date is adequate to prepare us for the upcoming challenges that the state will face as the baby boom generation begins to grow old and need long-term care. We may need to take bolder steps in the next two years in order to move forward more quickly as the retirement of the boomer generation draws closer. For example, we may need to beef up our efforts to support family caregivers, increase the capacity of communities and voluntary resources, and increase the use of private financing options for long-term care. At a minimum we need to monitor progress carefully in the next two years and determine if additional strategies and/or additional resources are needed in specific areas to intensify the reform efforts.

Summary

Much has been accomplished since the 2001 long-term care legislation was passed. Much remains to be done. The commitment and creativity that characterizes the elected officials, consumers, advocates and providers in Minnesota will surely continue to move us forward toward the kind of long-term care system that each of us wants for ourselves, our families and our communities.