Legislative Services Agency

HANDOUTS

Long-Term Care System Task Force

September 16, 2004

Vision for Iowa's Long-Term Living Materials

Proposed Vision for Iowa's Long-Term Living System

- The general assembly finds and declares that the vision for Iowa's long-term living system is to:
    - ensure all Iowans access to an extensive range of high-quality long-term care options that
    - maximize independence, choice, and dignity
    - through the development of a comprehensive, multiple services system in home, community-based, and residential long-term care settings that
    - provide consumers with affordable, high-quality, cost-effective services and other supports by a well trained, motivated workforce
    - delivered in the most integrated, life-enhancing setting.
- The general assembly finds and declares that informal care systems including family, friends and volunteers and community resources will not be eroded, that
    - the innovation through new delivery and financing models, and through use of technology will be encouraged and that
    - incentives to consumers for private financing of long-term care will be offered so that
    - Iowans live independently as long as they desire.
- The general assembly finds and declares that information regarding all components of the long-term living system must be effectively communicated to all those potentially impacted by the need for long-term care in order to empower consumers to plan, evaluate, and make decisions about how best to meet their own long-term living needs.

Goals and benchmarks of Iowa's Long-term Care system from SF 2190

GOAL OF IOWA'S LONG=TERM CARE SYSTEM.

- The general assembly finds and declares that the goal of Iowa's long=term care system is to:
  - ensure residents access to an extensive range of high=quality long=term care options that
  - maximize independence, choice, and dignity
  - through the development of a comprehensive system of community=based and institutional long=term care options that
  - provide affordable, high=quality, cost=effective services and other supports
  - delivered in the most integrated, life=enhancing setting.
- The general assembly finds and declares that information regarding all components of the long=term care system must be effectively communicated to all those potentially impacted by the need for long=term care in order to empower consumers to make decisions about how best to meet their own long=term care needs.

BENCHMARKS. The following benchmarks shall be used in measuring the state's progress in realizing its goal for the long=term care system:

o Reducing the number of nursing home beds from the current ninety=one per one thousand persons for individuals sixty=five years of age or older.

o Increasing the percentage of Medicaid long=term care dollars expended on community=based services.

o Increasing the proportion of Medicaid long=term care dollars expended on consumer=directed care.

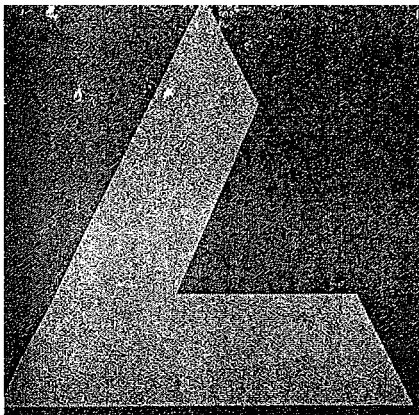
o Increasing the percent of providers having and using consumer satisfaction surveys.

o Reducing the use of nursing homes for individuals sixty=five years of age and older who have relatively few disabilities.

o Improving satisfaction with the long=term care system by both providers and consumers.

o Increasing the proportion of frail elders receiving assistance from family caregivers.

o Increasing the proportion of Iowans with private long=term care insurance coverage.



Reshaping Long-Term Care in Minnesota

State of Minnesota
Long-Term Care Task Force
Final Report

January 2001

For additional information on this report, contact:
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Long-Term Care Task Force Membership

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4. Edward Oliver (Deephaven)
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4. Kevin Goodno (Moorhead)
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1. Kit Hadley (Minnesota Housing Finance Agency)
2. Jan Malcolm (Minnesota Department of Health)
3. Michael O'Keefe (Minnesota Department of Human Services)*

*Commissioner O'Keefe served as chair of the task force.

Introduction

This report is a summary of the work of a long-term care task force composed of Minnesota legislators and state agency commissioners that met during the second half of 2000 to address the state's long-term care issues and develop strategies for dealing with them.

This report includes: 1) the task force vision for long-term care in the future; 2) a summary of the critical long-term care issues facing Minnesota; and 3) the recommendations of the task force. The recommendations support the reshaping of the state's long-term care system to address immediate issues, and help prepare the state for significant future long-term care pressures. More information on the task force is available on its website, http://www.dhs.state.mn.us/agingint/ltctaskforce.

The task force recommendations included in this report represent general consensus among the task force members. There was a great deal of agreement among the task force members—cutting across party lines and government agencies—about the problems within the existing system and the general strategies that should be pursued. There was also a shared recognition that there were many more deserving strategies than there were resources to implement them (both in terms of staff time and budgets). As a result, the task force went through a priority-setting process, with input from stakeholders, to narrow the set of strategies to those presented in this report.

The task force acknowledges and is very appreciative of the resource people who shared their long-term care expertise with members. The task force also appreciates consumer representatives, counties, providers, unions and members of the general public who took the time to attend focus groups, public meetings, or send written comments. Without these contributions, the task force would not have had as rich an understanding of how long-term care affects the everyday lives of individuals and families, nor as many ideas for improving the long-term care system in Minnesota. The task force especially appreciates the active participation of the many stakeholder groups that helped identify and analyze various strategies for change. If we all continue to work together on these issues, the task force believes that Minnesota can accomplish the necessary reshaping of its long-term care system, and can offer the kind of long-term care each of us wants for ourselves, our families and our communities.

The task force sees the implementation of the recommendations in this report as a multi-year effort of significant scope. Reshaping long-term care, especially expanding the capacity of community care options and reducing capacity on the institutional side, is not quickly done, but the effort must begin. Out of its final list of 48 strategies for reshaping long-term care, the task force prioritized 15 strategies for action in the upcoming legislative session. The task force also directed staff to begin work immediately on recommendations that do not require legislative or budgetary authority. The remaining recommendations can be implemented as future opportunities present themselves. Over time, these incremental steps will achieve the task force vision.

Vision for Long-Term Care

The task force developed an overall vision statement for long-term care in Minnesota to guide its discussion of issues and development of recommendations.

We envision a long-term care system serving older Minnesotans that:

Supports self-determination.
Such a system:

1. Empowers consumers and creates incentives for them to make decisions about their long-term care that balance cost, access and quality, when they are capable of doing so.
2. Provides consumers with useful information about long-term care options and provider performance.
3. Is sensitive to consumer preferences and desires.
4. Involves consumers in the planning, evaluation and decision-making for long-term care, so that service design is driven at all levels by consumer needs and preferences.

Provides services that meet consumer needs.
Such a system:

5. Makes multiple service options available in a wide variety of settings for all consumers, and supports older persons to live independently as long as they desire and are able.
6. Supports development of culturally acceptable, alternative long-term care programs for elders in ethnic, immigrant and tribal communities.
7. Responds to consumer desire for delivery of long-term care in residential settings.
8. Supports innovation through new delivery and financing models, and through use of technology.
9. Supports social and physical wellness by keeping people functional and connected with their communities.

Provides high quality care.
Such a system:

10. Ensures reasonable access, high quality and affordable care.
11. Rewards good outcomes, both in terms of excellent performance and improvements in performance.
12. Supports a motivated, stable work force through adequate compensation, work force training and career development opportunities.
13. Provides protections for the vulnerable, including those lacking in family and other informal supports, and those who are unable to make decisions.
14. Ensures quality through objective performance assessment, timely and appropriate response to consumer complaints and care deficiencies, and protection of consumer rights.

Ensures efficiency and affordability.
Such a system:

15. Supports the informal care system, including family, friends, volunteers, and existing community resources, and takes no action that erodes it.
16. Encourages efficiencies and productivity, including use of labor-saving technology, among both public and private long-term care providers.
17. Offers incentives to consumers for private financing of long-term care.

Critical Long-Term Care Issues Facing the State

Many experts feel that long-term care of the elderly will be one of the greatest challenges of the 21st century. Fueled by the aging of the large baby boom generation, increased life expectancies and reduced fertility rates, a much larger proportion of the population than ever before will be over age 85 and in need of long-term care beginning in 2030. These demographic realities will come together to create an aging society with increasing long-term care needs at a time when the necessary family and work force resources will be in very short supply. These challenges will be particularly acute for states because they are the major payers and regulators of long-term care.

To better understand these challenges, Minnesota's long-term care task force undertook a number of activities. It heard presentations by noted long-term care experts, spent time discussing the long-term care system in Minnesota, and developed a vision statement and gaps analysis based on these discussions. It also sponsored several consumer focus groups and held eight public meetings to obtain input on the issues from citizens and organizations throughout the state. Based upon all of this information, the task force identified several critical issues within long-term care and developed its recommendations. (See Appendix A for additional information on the work of the task force.)

Definition of Long-Term Care

For purposes of its work, the task force used the following definition of long-term care. Long-term care is defined as the "assistance given over a sustained period of time to people who are experiencing long-term inabilities or difficulties in functioning because of a disability."[1] Long-term care can be provided in a variety of settings, not just nursing homes, and most long-term care is provided by family members in the home of the individual who needs the assistance. People of all ages have the physical and mental disabilities that require long-term care, but the work of the task force focused only on the *elderly* who need long-term care.

What's Included in Long-Term Care?

Services

- Assistance with basic activities of daily living, e.g., bathing, dressing, eating, personal care.
- Assistance with instrumental activities of daily living, e.g., meal preparation, cleaning, shopping, money management, transportation.
- Assistive devices such as canes or walkers.
- Technology such as computerized medication reminders and emergency response systems.
- Home modifications like ramps, grab bars or easy-to-use door handles.

Housing or Settings

- Own home/apartment.
- Adult day health centers.
- Retirement housing.
- Assisted living facilities.
- Adult foster care, board and lodging, board and care homes.
- Nursing homes.

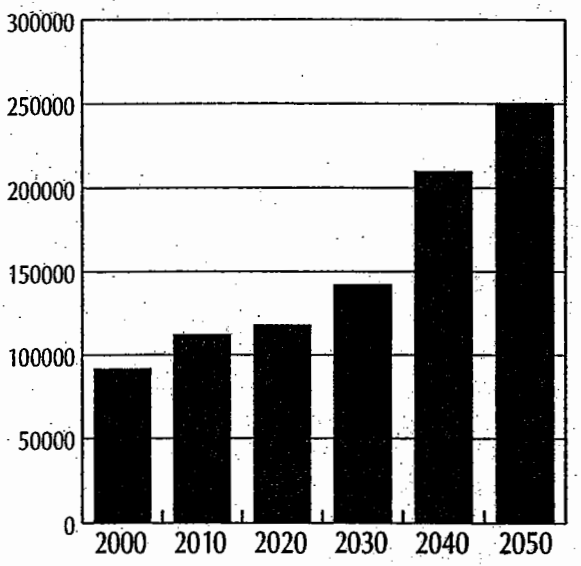
[1]Kane, Rosalie, Kane, Robert, and Ladd, Richard. (1998). *The Heart of Long-Term Care*. New York: Oxford University Press. p. 4.

Increasing Need for Long-Term Care

Minnesota faces unique challenges in long-term care. Not only do we have the second longest life expectancy in the United States (surpassed only by Hawaii), we also have one of the highest proportions of persons age 85 and over in the country. Both of these facts signal a current and future high need for long-term care.

Figure 1

Minnesota's 85+ Population 2000-2050



The need for long-term care will begin a steep rise in 2030, as the first of the large baby boom generation reaches old age. Minnesota will have 1.6 million persons age 65 and over by 2030, representing one out of every four Minnesotans, compared to one out of every eight today. By 2050, about 250,000 of these persons will be age 85 and over, about triple the number in 2000.

Even assuming that future elderly will be healthier, Minnesota will have twice the number of elderly with long-term care needs in 2030 (about 265,000 persons) than it had in 2000.

Just as they have throughout their lives, baby boomers will demand options, flexibility and control into old age, and this will extend to how they want long-term care provided.

Needs of Family Caregivers

Another unique part of Minnesota's long-term care system is the profile of our family caregivers. Minnesota has one of the highest labor force participation rates for women in the country (67.7 percent).[2] Since women are the primary caregivers for frail elderly, we have a high demand for the supplemental assistance that working women need in order to provide care to frail relatives.

The task force heard from consumers, families and providers that more options are needed to support caregivers, including better, more accessible information about services; education and training so they can do a better job of caring for older relatives; and various forms of respite services in order to supplement what they are able to do. Research has shown that family caregivers who receive training and respite services are able to provide care to frail relatives for longer periods of time, and delay nursing home placement.

Current and Future Worker Shortages

Minnesota is currently experiencing a severe shortage of workers in health and long-term care, especially nurses and "direct support" workers, such as nursing assistants, personal care attendants and home health aides. There are currently 4,000 direct support job openings throughout the state, compared to 17,000 direct support positions needed.[3] This shortage is expected to get worse in the future.

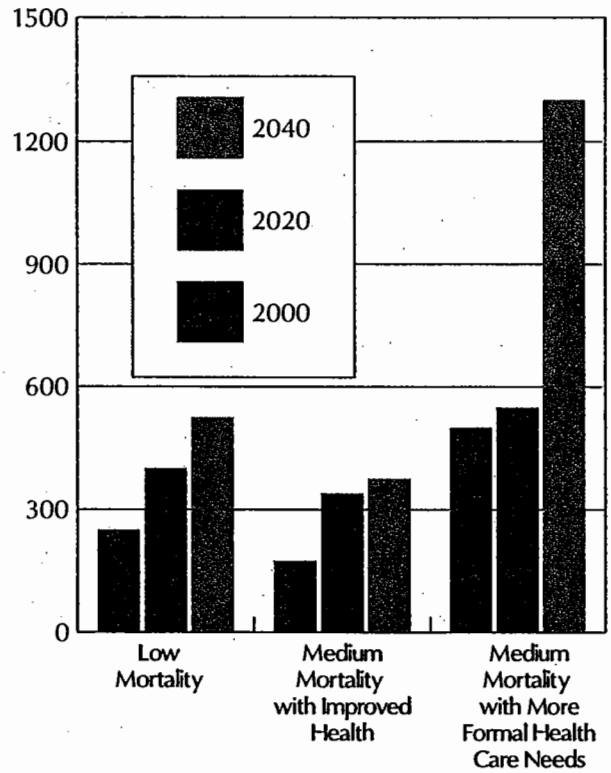
Minnesota faces labor shortages across all industries as a result of very low unemployment rates and high labor force participation rates. Shortages in long-term care are made more acute by the intense competition for low-wage workers between long-term care and retail, restaurant and other low-wage

[2]Available at www.des.state.mn.us
[3]Available at www.des.state.mn.us

sectors. In addition to low wages, the general lack of benefits is another barrier to the competitiveness of long-term care jobs. A recent study found that Minnesota's lower income workers were less likely than higher income workers to be offered health insurance coverage.[4] Another difficulty facing the long-term care industry is the current perception that "high tech" jobs are more attractive than "high touch" jobs such as those in long-term care.

Figure 2

Projection of FTE Home Health Aides Needed in Long-Term Care (U.S.) 2000-2040



Source: R. Suzman and K. Manton, "Forecasting Health and Functioning in Ageing Societies," in chapter 5 of *Aging, Health and Behavior*, eds., M. Ory and R. Ables (Sage Publications, 1991).

The task force heard many comments on the worker shortages at the focus groups and public meetings. In some regions, worker shortages have caused nursing homes to close off admissions. This, in turn, has meant that some elderly patients have remained longer in hospitals, waiting for nursing homes to have staff and space available.

Shortages in home health care have also been growing. There are several counties in the state where clients are on waiting lists for personal care attendants because no staff is available to provide the service. Assisted living facilities in the state face similar problems in recruiting and retaining workers.

Over-Reliance on Institutional Model

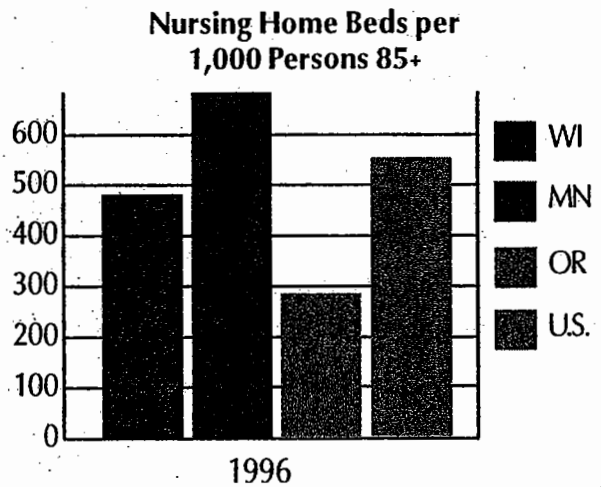
Minnesota has relied extensively on the institutional model of long-term care since the 1960s when the passage of Medicaid first made federal funds available for nursing home care, and spurred dramatic growth in the nursing home industry. Because these dollars were intended to pay for medical care, federal and state officials envisioned the emerging nursing homes as "miniature hospitals" and thus the regulations put in place emphasized life safety and nursing care. This meant that nursing homes were required to provide a more medical model of care than many elderly needed or wanted. However, these nursing homes often were the only options available to the elderly who needed some assistance with day-to-day tasks.

By 1980, Minnesota's nursing home utilization rate was the highest in the nation, 8.8 percent of persons age 65 and over, and double-digit increases in nursing home costs were straining the state budget. Expenditures rose from $129 million to $441 million between 1976 and 1985. In 1983, in response to this situation, the state tightened nursing home reimbursement and placed a moratorium on the construction of new nursing home beds. In addition, the state established several programs intended to divert elderly at risk of institutionalization from nursing homes into more cost-effective home and community-based services whenever feasible.

[4]Minnesota Department of Health, Health Economics Program. (February 2000). *Employer-based Health Insurance in Minnesota*. St. Paul, MN: same.

In 1983, Minnesota began providing home and community-based services (a wide range of long-term care services that can be provided in one's own home to assist with day-to-day tasks, e.g., help with personal care, household chores) for Medicaid-eligible older persons at risk of institutionalization through the Elderly Waiver program, a federally approved waiver from Medicaid financing requirements. The state also established a parallel state-funded Alternative Care program for older persons who were within the 180 days of eligibility for Medicaid and at risk of institutionalization. Another component put in place at this time was the Pre-Admission Screening program, a required screening of anyone going to a nursing home, in order to identify the level of care required.

Figure 3



Even with these efforts to provide community-based care, Minnesota's high nursing home utilization rates continued. In 1996, Minnesota spent 92.6 percent of its Medicaid long-term care dollars on nursing homes, ranking 7th out of 50 states in the proportion of Medicaid long-term dollars spent on nursing home care vs. community care, and 6th out of 50 in the number of nursing home beds per 1,000 persons age 85 and over (587.0)[5]

At the focus groups and public meetings, consumers said they wanted help to stay in their own homes and apartments as long as possible, and saw nursing homes as necessary only when the type or level of care they need can no longer be provided at home, e.g., when mental impairments became severe, for medically complex conditions, for end-of-life care.

Need for More Community-based Options

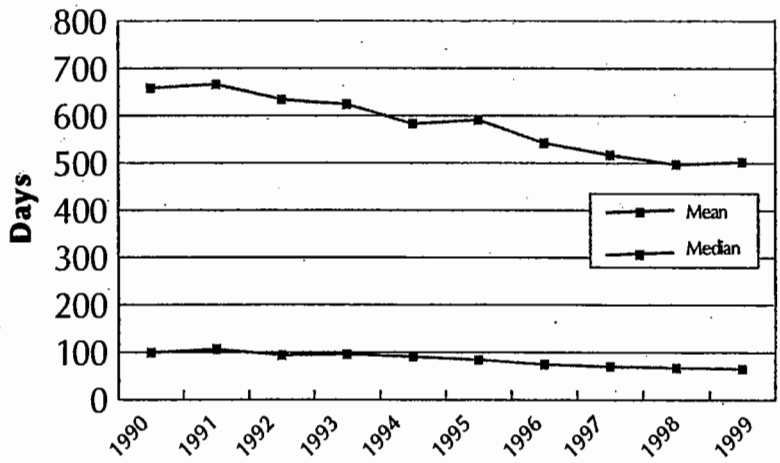
Probably the most significant issue identified by the task force is the dramatic change occurring in consumer preferences in long-term care. Consumers no longer see nursing homes as the first or only long-term care option. New options are developing rapidly and use of nursing homes is declining for the first time.

The average length of stay in Minnesota's nursing homes declined from 99 days in 1990 to 65.5 in 1999. This decline accelerated in the mid-90s when Medicare changes gave hospitals additional incentives to discharge their elderly patients as quickly as possible, very often to a nursing home for a short recuperative or rehabilitative stay before returning home. The overall occupancy rate in Minnesota's nursing homes has also been steadily dropping for the past five years, and now stands at 92 percent, down from 97 percent in 1992.[6] Between 1993 and 1998, the percent of the elderly using nursing homes (under Medicaid) declined from 7.6 percent to 6.1 percent, and the percent using home and community-based services increased from 1.5 percent to 3.7 percent. In just over two years, the number of facilities registered with the Minnesota Department of Health as "housing with service establishments," which includes assisted living facilities, increased from 400 to 628, and the number of apartments/units within these facilities grew from 13,000 in 1997 to 27,000 in 1999. (Statistics available at http://www.health.state.mn.us)

[5] Ladd, Richard, Kane, Robert, and Kane, Rosalie. (1999). *State LTC Profiles 1996.* Washington, D.C.: Administration on Aging. p. 123.
[6] Minnesota Department of Human Services and Minnesota Department of Health. (January 2000). *The 1999 Distribution of Nursing Home Beds in Minnesota.* St. Paul, MN: same.

Figure 4

Mean and Median Length of Stay in Minnesota Nursing Homes 1990-1999



Even though the supply of home care and housing options has grown, there are still many counties and regions of the state where an adequate array of long-term care services and housing options does not exist. This is especially true in the rural areas of Minnesota.

Many consumers, family members and providers at the focus groups and public meetings described the need for more choices and options in long-term care. This need is particularly acute for ethnic elders. Many individuals described the need for additional affordable supportive housing options, more options for people who want to stay in their homes, and the need for these options to be available on a sliding fee scale so that all elderly can access the services and pay for them based upon their income.

Need to Empower Consumers and Communities

Much of the emphasis in long-term care at the state level has been on developing and paying for traditional formal services, whether nursing home care or home and community-based programs. These programs and services are essential, and Minnesota spends over $1 billion per year to provide long-term care services to low-income frail elderly who need assistance. However, in order to meet sharp increases in future needs, the state must also support efforts that help people meet their own long-term care needs and help communities support their older residents.

Consumers are demanding more control over how and where services are provided. They want a better fit between their needs and preferences and services. For this to happen, individuals need better information about long-term care, more information on how they can use their personal financial resources, and information on the availability of other resources that help them meet their own needs.

Communities are also taking more responsibility for building the supports necessary to help older residents remain a part of their community. Examples of these efforts include Block Nurse programs, volunteer driver and chore programs, availability of supportive and affordable housing, and businesses that are sensitive to the needs of older customers.

Consumers and others at the focus groups and public meetings talked about the need for more approaches that give the consumer control and choice in how long-term care needs are met, and more incentives, such as tax credits, to prepare for and meet their own needs. Many also described the ongoing need for accurate, comprehensive information about long-term care options and the quality and track record of specific providers. In addition, community representatives described the importance of supporting local programs that help the elderly stay independent and integrated. They

described the proven ability of communities to harness significant volunteer unpaid resources to meet many of the day-to-day needs of older residents, often at much lower costs than formal programs.

Need for New Regulation and Reimbursement Systems

The types of changes needed in Minnesota's long-term care system have many regulatory and funding implications.

As long-term care moves away from a medical model of care to a nonmedical, supportive model, the current highly prescribed regulatory approach that focuses on clinical standards will not work. This new model requires more flexibility in meeting the outcomes important to individual consumers as opposed to a "one-size-fits-all" approach. As more long-term care is provided in the home and in residential settings, the way that quality is defined and measured needs to change.

It was clear at the focus groups and public meetings that there is a high level of dissatisfaction with the way that long-term care is now regulated and reimbursed. Consumers, families and providers described levels of paperwork and documentation required by regulators and funders in both nursing homes and home care programs that are overwhelming and ineffective, from their point of view. Many stated that too much paperwork impedes the provision of direct care, and reduces the productivity of staff already stretched because of worker shortages.

On the other hand, consumer advocates indicated that the current regulatory system is not always enforced effectively enough to protect vulnerable elderly. This issue will become even more critical as increasing levels of care are provided in home and community settings.

Since most if not all regulations in this area are federal, any change will require change in, or waivers from, current federal rules. Thus, the task force believes that the state must approach the federal government regarding any needed changes.

In addition to new regulatory approaches, a reshaped long-term care system needs a reimbursement system that effectively supports the new array of services and programs. As the state's nursing home capacity is rebalanced, adequate reimbursement is a key ingredient to strengthening the remaining nursing home industry so it can provide services in the new system. Reimbursement rates for nursing homes have relied on outdated cost data, include inequities and disparities that are worsening, and have made it difficult for facilities to complete necessary maintenance and facility improvements.

Reimbursement rates for home and community-based services are also problematic. Geographic disparities exist as do disparities between similar services within different programs. Another issue is the degree to which the current reimbursement system encourages consumer directed care options. Many counties and home health agencies testified at the public meetings that low or inflexible reimbursement rates have forced some agencies to close their doors. Disparities in rates between the Elderly Waiver and Alternative Care programs and across counties have caused access and equity problems in many areas.

Reimbursement issues in housing revolve around the degree to which the state pays for housing separately from long-term care services, how that payment is made and what type of funding is used. These issues will grow as more and more consumers choose home and residential settings for the provision of their long-term care, but need financial assistance, or affordable housing options, in order to remain in these settings.

Task Force Recommendations

To respond to immediate concerns, prepare for future pressures on the state's long-term care system, and achieve its vision, the task force concluded that a major reshaping of Minnesota's long-term care system is necessary. The framework for this reshaping includes six major policy directions, each of which addresses a theme from the vision statement. To move forward on these policy directions, the task force is recommending 48 strategies. A complete list of these policy directions and strategies is included in Appendix B.

Policy Direction #1

Maximize peoples' ability to meet their own long-term care needs.

Any redesign of long-term care needs to put primary emphasis on empowering individuals to meet their own long-term care needs to the extent possible. Consumer control over decision-making must be a key feature of new long-term care approaches.

Policy Direction #2

Expand capacity of community long-term care system.

In order to expand the home and community-based options that consumers prefer, much work is needed to develop these services and housing options in all parts of the state so they are truly available to all elderly. In addition, communities need assistance to further develop their capacity to support older residents.

Policy Direction #3

Reduce Minnesota's reliance on the institutional model of long-term care.

In order to provide services that are more responsive to consumer needs, we must reduce our reliance on nursing homes, and transform and strengthen the remaining nursing homes to serve those consumers who will need the services best provided in the type of protected setting that nursing homes can provide.

Policy Direction #4

Align systems to support high quality and good outcomes.

The current emphasis on paperwork and documentation must be refocused to ensure achievement of good outcomes for the consumer. More quality data needs to be collected and made accessible to consumers and providers.

Policy Direction #5

Support the informal network of families, friends and neighbors.

Because of smaller families and increasing labor force participation rates among women, family caregivers need more support than they have received in the past to manage continued provision of large amounts of assistance to older, frail relatives.

Policy Direction #6

Recruit and retain a stable long-term care work force.

Because future increases in the numbers of elderly needing long-term care will occur at the same time that the pool of entry level workers is shrinking, it is essential that steps are taken to support a motivated and stable work force in long-term care. While there is no one single strategy that achieves a solution, a number of actions can be taken to more adequately compensate workers and improve recruitment, retention and training of workers.

Task Force Priorities for 2001 Legislative Session

The task force identified 15 strategies as priorities for action in the 2001 legislative session. (The wording included here may be condensed. See Appendix B for complete wording for all strategies.)

1. Expand consumer information and assistance services; redesign case management services into a broker model; develop a single point of access for all elderly in a local area; make information more accessible to elders in ethnic, immigrant and tribal communities, and to family caregivers.
2. Encourage development of the long-term care insurance market, through continuing the current state tax credit for long-term care insurance, promoting long-term care insurance with employers, and beefing up consumer protection measures for long-term care insurance products.
3. Ensure adequate funding for the Elderly Waiver and Alternative Care programs to serve elderly diverted from nursing homes, and equalize the rate limits between these programs and across all Minnesota counties.
4. Create an inter-agency competitive capital fund to develop new or retrofit existing buildings to provide assisted living, supportive housing, and to help nursing homes improve their physical plants.
5. Develop a process for the voluntary closure of nursing homes, that includes incentives for nursing homes to close, a method for determining excess capacity and gaps, a regional planning process, a state level RFP process, and a nursing home planning and transition grant program for rural nursing homes.
6. Explore different standards for subacute and long-term care.
7. Study and identify a new method for setting rates for nursing homes in the context of the changes in their customers and services, and other changes in the long-term care system.
8. Identify and apply valid measures of quality of life across long-term care settings, and disseminate these and other data to consumers, providers and the general public.
9. Develop a cohesive strategy for approaching the Health Care Financing Administration (HCFA) to obtain more state flexibility in the regulation of long-term care.
10. Provide a greater menu of respite services to caregivers in all parts of the state, and make services more affordable to caregivers using a sliding fee scale.
11. Add a Cost-of-Living-Adjustment (COLA) to the rates of all long-term care providers, and design mechanisms for long-term care employer buy-in to group health insurance for workers and their families.
12. Require state registration of pool agencies, criminal background checks for all pool staff, and set a maximum rate paid to pool agencies.

13. Create strong intergenerational programs within schools, and encourage middle and high school students to work and volunteer in health and long-term care settings.

14. Expand tuition credits and loan forgiveness options, and develop a "GI bill" for health and long-term care workers.

15. Require the Minnesota State Colleges and Universities (MNSCU) and the Higher Education Industry Partnership (HEIP) work force partnerships to improve recruitment, training, retraining, on-the-job-training, certification process, and develop career ladders for direct support workers in health and long-term care. In these efforts, special emphasis should be placed on: a) the needs of immigrant workers; and b) development of Internet-based curricula and other technology-based learning tools.

Rationale for Priority Strategies

Listed below are the rationales for the task force selection of these 15 strategies as priorities for the 2001 legislative session. The estimated overall cost of these strategies is approximately $113 million. Major expenditures include the provision of a COLA for long-term care providers, ensuring adequate funding for the Elderly Waiver and Alternative Care programs and creation of a capital housing fund (which may be more appropriately considered in the 2002 session bonding bill). Major savings result from the closure of excess capacity in the nursing home system. Several of the other individual strategies have minimal costs. In addition, staff work on some strategies can begin immediately without legislative or budgetary action.

1. Expand and improve consumer information and assistance, and improve case management services.
   - Older consumers and their families want to find and obtain their own long-term care but need accurate, timely information and trained professionals to assist them in making these critical decisions.
   - Case management services need to take a more comprehensive approach to long-term care assessment, and refer elderly to a broad range of services, not just publicly-funded services.
2. Encourage development of the long-term care insurance market.
   - There are many middle-income individuals who now pay out-of-pocket for long-term care services.
   - If these individuals were covered by insurance, their chances of becoming impoverished and qualifying for Medicaid would be greatly reduced.
3. Ensure Elderly Waiver and Alternative Care program adequacy.
   - As nursing homes close or downsize, there must be adequate community-based services to meet the demand for long-term care.
   - In order to maintain client access to services, historic rate disparities between these programs and differences in rates across counties must be eliminated.
4. Create an inter-agency competitive housing fund.
   - Stable, affordable and appropriate housing is vital for the provision of services to frail elderly.
   - As nursing home capacity is reduced, additional affordable housing options will be needed in many communities.
   - Physical plants of remaining nursing homes may need upgrading.

5. Develop a process for the voluntary closure of nursing homes.
   - Minnesota has growing excess nursing home capacity because older people who need long-term care prefer to stay in their homes and other housing options, supported by families and communities, and home and community-based services.
   - A voluntary process for closure of nursing homes provides incentives to homes to close, and involves relevant community interests in determining how long-term care needs should be met in local areas.
6. Explore different standards for subacute and long-term care.
   - Current regulations for long-term care follow a medical model for staffing and services.
   - As long-term care changes, current regulations may not fit the changing nature of the elderly served in the programs.
7. Study and identify a new method for setting nursing home rates.
   - Nursing home rates should be sufficient to provide for the needs of a quality facility operated in an economic manner.
   - Providers report that current rates do not cover actual costs and many are experiencing losses.
   - A study needs to be completed and recommendations developed for rate setting options.
8. Identify and apply valid measures of quality of life, and disseminate the resulting information.
   - Quality of life measures, including those contained in consumer satisfaction surveys, are essential to assess the performance of providers in delivering satisfactory services to consumers.
   - This information would empower consumers and their families to make informed decisions when selecting long-term care providers, and would provide comparison data to providers so they can assess the results of their efforts.
9. Develop a cohesive strategy for approaching the Health Care Financing Administration (HCFA) to obtain more state flexibility in regulation of long-term care.
   - There is growing concern among states about the regulatory burden placed on them and providers by federal long-term care regulations.
   - Methods must be found to reduce the amount of paperwork, so that more staff time can be focused on direct care and achieving better outcomes.
10. Improve respite services for caregivers in all parts of the state.
    - Respite services are a key ingredient in greater support of caregivers. Respite is the most frequently mentioned service when caregivers are asked what they need to keep providing services.
    - Many Minnesota communities do not yet have a full range of respite services to meet the needs of their caregivers.
11. Add a COLA to rates of all long-term care providers, and design mechanisms for long-term care employer buy-in to group health insurance for workers and their families.
    - It is increasingly difficult for long-term care providers to attract and retain direct support workers, in part because of low wages and lack of benefits.
    - Provision of better wages and benefits is essential for long-term care jobs to have some degree of competitiveness in the current labor market.

12. Require state registration of pool agencies, criminal background checks for all pool staff, and set a maximum rate paid to pool agencies.
    - The use of staff from pool agencies has risen in the past few years as a result of worker shortages and the need to cover staffing requirements.
    - In order to ensure a more level playing field, there needs to be some additional regulation of how pool agencies providing staff to long-term care providers operate in the state.
13. Encourage middle and high school students to volunteer and work in health and long-term care settings.
    - In order to overcome the negative public image of work in long-term care, efforts are needed to introduce young people to the positive aspects of long-term care.
    - Internship programs for students in health care settings have experienced 50 percent retention rates after five years. It appears that early exposure to these jobs is an effective method of recruiting and retaining workers.
14. Expand tuition credits and loan forgiveness options, and develop a "GI bill" for health and long-term care workers.
    - The costs of obtaining the required training for long-term care jobs can be a barrier to some potential workers.
    - Finding ways to remove these barriers and making training accessible are important parts of a larger work force strategy.
15. Require MNSCU and HEIP work force partnerships to focus on the needs of direct support workers.
    - It is essential that the state's higher education and work force systems address the urgent need for direct support workers in health and long-term care.
    - Even though these jobs are not "high wage" jobs, the functions they perform in caring for children, disabled and elderly individuals (many of whom are clients of publicly funded programs) are functions essential to the state.

Immediate Steps to be Taken

The task force asked staff to identify any of the recommended strategies where work could be begin immediately without legislative or budgetary authority.

The staff identified the following strategies where work can begin immediately.

1. Promote greater use of Elderly Waiver and Alternative Care programs to obtain and pay for assistive devices and home modifications.
2. Implement the Bush Foundation demonstration to create affordable assisted living.
3. Identify and collect data on actual costs of long-term care across all settings.
4. Provide more and better information on assisted living for consumers and families.
5. Promote greater use of existing hardship waivers to pay family caregivers.
6. Explore ways to make better use of staff, e.g., more flexible hours and more use of the universal worker concept.

Keeping the Vision

Next Steps

The work of the task force has engendered a great deal of enthusiasm and optimism that long overdue reforms in the long-term care system will begin. Consumers, providers and policymakers support these changes. Many stakeholders are hopeful that they can continue to be involved in the changes, and to build on the momentum generated by the work of the task force.

The work of the task force has engendered a great deal of enthusiasm and optimism that long overdue reforms in the long-term care system will begin.

The first step in this reform, will be to enact the task force's high priority strategies in the 2001 legislative session. The task force intends to reconvene after the 2001 legislative session and take stock of what was accomplished, hear progress reports on the strategies that staff has been working on, and discuss what next steps might be necessary.

Another step the task force has taken is to set benchmarks to measure the state's progress in rebalancing the long-term care system, improving information and quality, supporting family caregivers, helping people take care of their own needs as much as possible, and making jobs in long-term care more competitive.

Benchmarks

Listed below are several benchmarks that will be used to measure change in Minnesota's long-term care system over time.

1. Nursing home beds per 1,000 persons age 85 and older.
2. Percent of Medicaid long-term care dollars spent on community-based services.
3. Proportion of Medicaid long-term care dollars spent on consumer-directed care.
4. Percent of providers having and using consumer satisfaction surveys.
5. Reduction in disability rates in the elderly population.
6. Reduced use of nursing homes for less disabled elderly.
7. Improved satisfaction with long-term care by both providers and consumers.
8. Reduced use of pool staff in long-term care.
9. Lower staff turnover rates in long-term care settings.
10. Increased availability of quality profiles for all long-term care settings.
11. Proportion of frail elderly receiving assistance from family caregivers.
12. Increased proportion of the population having private long-term care insurance coverage.

Appendix A

Background on Task Force Work

What Led to the Task Force?

The changing market forces in long-term care, increasing financial instability within the state's nursing home industry, and a severe labor shortage in long-term care came to a head during the 2000 legislative session. Many nursing homes faced the possibility of closure. Labor shortages were exacerbating the occupancy problems for nursing homes, and also posed a problem for home care providers. There was also a great deal of concern about the actual effectiveness of the regulations and paperwork required by the federal government in both nursing homes and home health programs.

Leadership from the legislative and executive branch of state government agreed that these critical issues should be dealt with outside the hectic schedule of the legislative session, at a time when members could focus on these complex issues, and develop solutions for specific long-term care problems in the context of all long-term care.

Work of the Task Force

In May 2000, the task force convened to address the emerging issues in long-term care in Minnesota. The task force members included 12 legislators, six senators and six representatives, named by the leadership in the Senate and House, with bipartisan representation. Members also included the three commissioners of state agencies most involved in long-term care issues: the Minnesota Department of Human Services, Minnesota Department of Health and the Minnesota Housing Finance Agency. The Commissioner of Human Services convened the task force and chaired the meetings.

The goal of the task force was to develop a common understanding of needs and issues in long-term care for older citizens of Minnesota, and reach as much agreement as possible on the best strategies for addressing these issues. Based upon this work, the task force members developed proposals for the 2001 legislative session.

The task force retained a consultant, Bailit Health Purchasing of Boston, Massachusetts, to provide support to the staff of the task force, participate in public meetings, facilitate consumer focus groups, and maintain ongoing communication with an extensive list of "stakeholders" in long-term care, including consumer organizations, unions, providers, local government representatives, and provider associations.

The task force met 12 times between May and December 2000. At the first three meetings in May and June, the task force reviewed current information about the long-term care system and the issues facing the state, developed a working draft of a vision statement, and heard responses to the draft vision statement from stakeholders. During July, the task force consultant held a series of consumer focus groups around the state, and the task force discussed gaps between its vision and the current system. In August, the task force held a series of eight public meetings to obtain input from citizens and stakeholders around the state on long-term care issues. It then formed five work groups made up of task force members, counties, stakeholders and agency and legislative staff to review all of the input received, and to identify and analyze a broad range of strategies for achieving the vision.

Following this intensive process, the task force identified six major policy directions necessary to achieve its vision, and reviewed over 90 strategies for implementing these policy directions. After further discussion and analysis, the task force directed staff to prepare more detailed proposals for a subset of these strategies. At its last three meetings, the task force reviewed these proposals along with the associated costs of implementation, agreed on a set of 48 strategies and related budgetary estimates for both short- and long-term legislative and administrative action. It then chose 15 strategies as priorities for action during the 2001 legislative session. The task force also recommended that staff continue work already begun or begin work immediately on strategies where legislative or budgetary action is not immediately required.

Stakeholder Input Into Task Force

The task force placed great emphasis on hearing from "stakeholders," including individuals and organizations with a particular stake in the long-term care system, such as consumers, their families, providers, local government, advocacy organizations, and general citizens, about the changes underway in long-term care. To do this, the task force sponsored several consumer focus groups and a series of public meetings throughout the state.

Consumer Focus Groups

The task force particularly wanted to hear from consumers and their families about their needs and preferences in long-term care. The task force consultant held seven focus groups with a broad range of consumers and family members. Area Agencies on Aging and advocacy organizations provided assistance with the arrangements for the focus groups. The focus groups were held in July, and the consultant facilitated the discussion using a common instrument for all groups.

In addition to these consumer focus groups, the task force also requested additional meetings with elders from the minority and immigrant communities who have special difficulties finding and using available long-term care services. Staff provided the task force with summaries of a number of other recent focus groups held with elders in minority and immigrant communities. In addition, staff from the Department of Human Services held five focus groups with elders from the Cambodian, Hmong, and Korean communities during August.

The most common themes that emerged from these focus groups are summarized below. A summary of each focus group is available on the task force web site at http://www.dhs.state.mn.us/agingint/ltctaskforce.

Service Gaps in Community

- There is a lack of affordable services for moderate-income seniors.
- The elderly, especially immigrant elders, have difficulty finding and coordinating services.
- There is a great need for additional support and respite for family caregivers.

Nursing Homes

- Staffing problems are increasing in nursing homes.
- Homes need to do a better job of communicating with family members.
- Staff training, especially how to deal with dementia patients, must be improved.
- More funding is needed for state ombudsman services for older Minnesotans.

Special Problems for Ethnic and Immigrant Elders

- There are not enough interpreter services and brochures and applications in non-English languages.
- Staff at county and home health agencies often do not speak the language of the elders, and may not be sensitive to cultural differences.
- Families of elders carry heavy responsibilities for providing assistance to older relatives who need long-term care.
- Elders face high levels of depression, isolation and sense of loss due to their immigration.
- There are some community agencies that have tailored services to meet the needs of ethnic elders.

Public Meetings

In order to hear from citizens across the state on the current situation in long-term care, the task force sponsored a series of eight public meetings during August. The purpose of the meetings was to ask Minnesotans for their input on the following questions:

1. In what way does the current long-term care system meet your needs and the needs of your family?
2. In what ways does it not?
3. Does the vision of a long-term care system as stated by the task force make sense to you?
4. How can policymakers improve long-term care right now and for the future?

Meetings were held in St. Paul, Rochester, Minneapolis, Mankato, Moorhead, Willmar, Duluth, and Brainerd. Approximately 800 persons attended the meetings, and 150 provided testimony. Task force members chaired six of the meetings, and local legislators chaired two of the meetings. In addition, legislators who were members of the health and human services committees and whose district included the community where the public meetings were held were invited to attend, and many did so, giving them an opportunity to hear first hand about the long-term care issues in their areas. The meetings also received substantial media coverage. The public was encouraged to follow-up with written comments through use of the task force web site and related e-mail. Over 75 additional comments were received through the web site.

Several themes emerged at the public meetings, and some of the most commonly voiced concerns are listed below. A summary of each meeting is available on the task force web site.

Information and Consumer Support

- The elderly and their families need more and better information about services.
- The need for timely, useful information and help with decision-making is particularly acute when the elderly are discharged from the hospital, and available information and assistance is currently inadequate.
- The elderly and their families want one-stop shopping for information and services.

Nursing Homes and Community Services

- Nursing facilities should be downsized, and emphasis placed on helping the elderly stay at home as long as possible.
- Affordable housing options, including housing that provides supportive services, and home-based and community services, need to be more available, especially in rural areas.
- Rates paid to nursing homes, and in the Elderly Waiver and Alternative Care programs from one county or region to the next are insufficient and unequal.

- The savings from nursing home closures need to be reinvested into community services.
- Community services need to be expanded and strengthened in order to support additional individuals diverted from nursing homes.
- There is a lack of services, including nursing homes, on Indian reservations.

Administrative Requirements/Quality

- Too much paperwork detracts from time available to provide direct care.
- Staff turnover and the use of pool staff means less attention to and inadequate care for nursing home residents.
- Staffing problems in assisted living facilities are growing.
- Regulations should not be eliminated—they are needed to ensure that resident and consumer safety is protected.

Informal Caregiving

- Families need much better access to a full menu of respite services.
- It should be possible to pay caregivers or give them vouchers.
- Tax breaks or similar incentives should be available to caregivers.
- Families of elders from ethnic, immigrant and tribal communities carry heavy responsibilities for meeting long-term care needs of older relatives.

Work Force Issues

- There is an insufficient supply of nursing aides and personal care attendants.
- Non-competitive wages and benefits in long-term care make these jobs less attractive to workers.
- Staff training is needed on how to work with those with dementia and to prepare staff for "reality" on the job.
- Long-term care workers need non-monetary rewards and incentives, e.g., child care, recognition ceremonies, awards for excellence.
- Increasing use of immigrant workers in long-term care presents special challenges, e.g., provision of responsive education and training, acceptance by consumers and their families.

Appendix B

Complete List of Strategies Recommended by Task Force

1. Maximize peoples' ability to meet their own long-term care needs.

Strategies

A. Provide consumers with objective, accessible and useful information on long-term care and preparation for retirement and old age.

1. Greatly expand and strengthen information about long-term care options for consumers and family caregivers.
   - Expand Senior Linkage Line services in ways that make it more accessible to family caregivers.
   - Provide basic information on all long-term care resources, and trained professionals to assist consumers and families in making decisions.
   - Redesign county-level case management to become a "service broker" model that provides universal access to long-term care services.
   - Develop a single point of access for all elderly in a given geographic area.
   - Encourage special efforts to make information about long-term care services and housing options accessible and useful to ethnic, immigrant and tribal elders and their families.

B. Expand the availability and use of mechanisms for private financing of long-term care.

1. Encourage the development of the long-term care insurance market in Minnesota.
   - Continue the current state tax credit for long-term care insurance.
   - Work with employers to promote the offering of long-term care insurance products to their employees.
   - Beef up consumer protection safeguards for long-term care insurance purchase.

C. Expand the use of assistive devices and home modifications that enable consumers to meet their own long-term care needs.

1. Simplify and expand information about, and funding for, home modifications, energy modifications, general repairs and personal adaptive equipment for older persons wanting to stay in their homes.
2. Promote greater use of available reimbursement for assistive devices and home modifications through the Elderly Waiver and Alternative Care programs.

D. Retool the long-term care system and redesign key components.

1. Expand efforts to test the applicability of consumer-budgeted and directed care, e.g., vouchers.

2. Set up a pilot to test a redesign of the system that incorporates a single point of access for all elderly within a given geographic area, combines multiple public funding streams, and establishes a sliding fee scale for private pay consumers.

3. Implement a process to track long-term care investments across state agencies to allow more integrated long-term care budgeting and spending, and the potential of reinvesting savings from one part of the system to another.

4. Explore separating payment for housing from payment for services, to allow consumers to "buy" housing they desire with their income and assets, and receive services regardless of location.

2. Expand capacity of the community long-term care system.

Strategies

A. Expand capacity of Elderly Waiver (EW) and Alternative Care (AC) programs, through reinvestment of savings from nursing home downsizing

1. Strengthen the Elderly Waiver and Alternative Care programs.
   - Ensure adequate funding in these programs to meet increased demand due to elderly being diverted from nursing homes.
   - Equalize the rate limits between these programs.
   - Equalize these programs' rate limits across all Minnesota counties.

B. Expand the availability of affordable assisted living and other supportive housing options.

1. Create an inter-agency competitive capital fund to develop new, or retrofit existing, buildings into affordable assisted living or other supportive housing, and to help nursing facilities improve their physical plants.

2. Implement the Bush Foundation demonstration project recently funded at the Department of Human Services to create affordable assisted living, using *existing* affordable senior housing linked to Elderly Waiver, Alternative Care, and Older Americans Act services.

C. Make communities more "age-sensitive," with more supports for older residents.

1. Expand Seniors' Agenda for Independent Living (SAIL) statewide to bring communities and providers together to shape long-term care services and housing options that meet community needs, and facilitate the planning process for voluntary nursing home closures.

D. Provide long-term care that is responsive to the special needs of elders in ethnic, immigrant and tribal communities.[7]

1. Ensure that the strategies described in this report are responsive to the needs of elders in ethnic, immigrant and tribal communities as they are implemented.

2. Develop long-term care services and housing options that address the special needs of elders in ethnic, immigrant and tribal communities and their families, as part of the strategies in this report.

[7]These communities include African American, Asian American, American Indian, Hispanic, and a variety of immigrant and other ethnic communities.

3. Reduce Minnesota's reliance on the institutional model of long-term care.

Strategies

A. Reduce the size and capacity of Minnesota's nursing home system.

1. Develop a process for voluntary closure of nursing homes that provides incentives to homes that close. Savings should be reinvested into capital funding for renovations, increased rates, and expansion of community service options.

   This process needs to include:
   - A method for determining the current and future need for nursing home beds, assisted living and home care services at the state and regional/local level.
   - A regional/local planning process that considers the community's long-term care needs and resources now and in the future, so that adequate supplies of long-term care services and housing options (including nursing homes) are available. The state should provide any available data on local long-term care needs and resources to regional/local entities completing the planning process.
   - A state level RFP process for soliciting and approving closure proposals. The RFP should encourage nursing homes in areas of excess supply to close some or all of their capacity and retrofit for other uses that meet local long-term care or community needs.
   - A nursing home planning and transition grants program that would provide planning support to nursing homes in rural areas to assess their situations and their environments, and plan appropriate changes in services, including development of facility renovation plans.

B. Transform remaining nursing homes to address specialized long-term care needs.

1. Explore the possibility of different standards for subacute and long-term care facilities, with a more medical model required in subacute facilities serving rehab clients, and a more residential model in programs serving longer stay residents with specialized needs, e.g., end-of-life care, mental impairments, medically complex needs.
   - The inter-agency capital fund included in section 2B above would be available to help nursing homes retrofit or improve their physical plants to serve more specialized needs.
   - The nursing home planning and transition grants program in section 3A above would provide planning support to nursing homes in rural areas to assess their situations and plan appropriate changes in services.

C. Provide adequate and competitive rates for nursing home providers.

1. Implement targeted rate increases for nursing homes, especially to diminish existing geographic rate disparities.
2. Study and identify a new method for setting rates for nursing homes in the context of ongoing changes in the customers and services, and other changes in the long-term care system.
3. Identify and collect accurate data on the actual costs of providing long-term care in all settings, including nursing homes. These data include wages, case mix of clients served, labor market competitiveness, geographic disparities, etc.

4. Align systems to support quality and good outcomes.

Strategies

A. Collect consumer-focused quality data across all long-term care settings, and utilize this data (together with other approaches) to improve quality.

1. Identify and apply valid measures for "quality of life" across all long-term care settings, with stakeholder participation, and phase them in over time.
   - Clinical measures should be developed after quality of life measures are in place.
   - Develop separate quality measures for subacute care and long-term care.
   - Publish consumer reports that include this qualify information.
   - Disseminate information to consumers, providers and the public, using hard copy and the Internet, and through the media, consumer advocacy and other organizations.

B. Improve the efficiency and effectiveness of the state's regulatory process.

1. Revise the current survey process for nursing homes to incorporate more consultation and technical assistance. Develop and fund a technical assistance team within the Department of Health to consult with and provide training to nursing homes.
2. Establish an ongoing mechanism to explore alternative regulatory strategies and regulatory relief, in order to decrease or make regulations more flexible, and to reduce paperwork across all long-term care settings.
3. Explore the creation of a standardized assessment instrument to use across all care settings.
4. Implement the case mix revisions now being developed to eliminate duplicate assessment systems in nursing homes.
5. Provide more and better information to consumers and their families about assisted living options, and identify methods to help consumers compare service packages across different assisted living providers.
6. Foster greater community involvement in quality oversight through community councils that can monitor quality across care settings within a geographic area. To begin, develop a pilot project using the Region 10 quality assurance model and apply that approach to long-term care for the elderly. Apply for waivers if necessary to implement the project.
7. Develop a cohesive strategy for approaching the Health Care Financing Administration (HCFA) to obtain more state flexibility in the regulation of long-term care in the state, and in how high quality is achieved and monitored. Work in collaboration with the Council of State Governments and the National Council of State Legislatures on this strategy.

C. Ensure that consumer protection mechanisms are adequate to address the needs of vulnerable elders across all long-term care settings.

1. Assure that the ombudsman program for older Minnesotans has adequate program capacity to meet current mandates.
2. Assure that state and county agencies have the resources they need to fulfill the mandates of the Vulnerable Adults Act.

5. Support the informal network of families, friends and neighbors.

Strategies

A. Provide training, education and information about long-term care resources to caregivers.

1. Develop a cohesive program for training and education of caregivers to help them in their caregiving role. This should include written formats, videos, classes, and use of the Internet to make the information as accessible as possible.
2. Encourage families to include children in the care and support of older relatives.

B. Strengthen and expand workplace support of eldercare.

1. Work with employers and groups such as the Chambers of Commerce, Minnesota Business Partnership, and the Minnesota Employers Association to promote eldercare benefits and policies.

C. Pay targeted family caregivers to provide care.

1. Promote greater use of existing hardship waivers and other exceptions in public programs to pay family caregivers in specific cases:
   - if the family provides Personal Care Attendant (PCA) services.
   - if the family is the provider chosen under the cash option within the Alternative Care program.
   - in cases where culturally competent staff is not available to care for an elder in an ethnic, immigrant or tribal community.

D. Provide a wide variety of respite services for caregivers.

1. Provide a greater menu of respite services to family caregivers in all parts of the state, including such services as adult day health, in-home respite (either volunteer or paid), out-of-home respite (either foster care or nursing home care), and other types of assistance that can serve as respite.
2. Allow reimbursement for transportation costs in state-reimbursed adult day health services.
3. Make respite services more accessible and affordable to all caregivers, including the use of sliding fee scales.

6. Recruit and retain a stable long-term care work force.

Strategies

A. Provide competitive wages and benefits for all workers in long-term care.

1. Add a cost-of-living adjustment (COLA) to the reimbursement rates for all long-term care providers, and design a mechanism to facilitate long-term care employer buy-in to group health insurance for workers and their families.
2. Require state registration of pool agencies, require criminal background checks of employees of registered pool agencies, and have the state set a maximum rate for payments to pool agencies.

B. Change the way that work is done in all long-term care settings to optimize labor resources.

1. Reduce the amount of paperwork in all long-term care settings by:

- Reducing paperwork requirements.
- Fostering innovation and improved efficiencies through application of technology, including a capital fund to promote technology improvements, and greater use of telemedicine.

2. Explore ways to make better use of staff, e.g., more flexible hours, more use of the universal worker concept.

C. Cultivate creative recruitment of direct support workers.

1. Create strong intergenerational programs within schools in order to provide interaction between all generations, and encourage middle and high school students to volunteer and work in long-term care settings.

2. Develop non-monetary rewards for long-term care workers, e.g., a well-publicized and regular recognition or award to workers who exemplify excellence and commitment to the elderly they serve.

D. Make training more responsive to the needs of long-term care workers.

1. Expand tuition credits and loan forgiveness programs, and develop a "GI bill" for long-term care workers.

2. Require the Minnesota State Colleges and Universities (MNSCU) and the Higher Education Industry Partnership (HEIP) work force partnerships to improve recruitment, training, retraining, on-the-job training, certification process, and develop career ladders for direct support workers in health and long-term care. In this effort, special emphasis should be placed on: a) the needs of immigrant workers; and b) development of Internet-based curricula, and other technology-based learning tools.

3. Provide resources to regions of the state that need help (or require existing higher education or work force resources to be used) to address regional health and long-term care work force issues and develop concrete strategies.

E. Prepare health and long-term care workers to meet the changing needs of their customers.

1. Increase the competence of all health and long-term care workers in the areas of disability and aging.

2. Develop a cultural training and awareness module for current long-term care workers and incorporate it into the required certified nursing assistant (CNA) curriculum and in-service training.

3. Incorporate training on dementia care into the required curriculum and in-service training for current long-term care workers in all long-term care settings who provide care to those with dementia.

Iowa's Olmstead Real Choices Consumer Task Force

September 13, 2004

Dear Long Term Care System Task Force Members:

I am writing as chair of the Olmstead Real Choices Consumer Taskforce to thank you for your commitment to the work you are doing to help Iowa plan wisely for a long term care system that meets the needs and preferences of elderly Iowans and Iowans with disabilities. As you know, Iowa's Real Choices System Change project is funded by the Centers for Medicare and Medicaid Services to help Iowa implement the Olmstead Supreme Court decision in our state. Olmstead underscored a citizen's right to community supports and said that inappropriate institutionalization is discrimination under the Americans with Disabilities Act. Both President Bush's New Freedom Initiative and Governor Vilsack's Executive Order 27 strongly reaffirm this policy direction.

Last winter, the Olmstead Real Choices Taskforce held a legislative breakfast where the attached checklist on Olmstead implementation was distributed. As you are about to undertake your important charge, we thought it would be appropriate to send the checklist to you again.

If there is anything the Olmstead Real Choices Taskforce can do to support your efforts, please do not hesitate to contact me at holdimal@yahoo.com.

Sincerely yours,

Alice Holdiman, Chair
Olmstead Real Choices Consumer Taskforce

A Checklist for Designing Legislation that Meets the Mandates of the Olmstead Decision

Olmstead V. L. C. (98-536) 527 U.S. 581 (1999)

This legislative checklist can help you determine whether proposed legislation will be in compliance with the Olmstead Decision. As you prepare or review draft legislation, ask yourself:

Does this legislation:

☐ **Move Iowa toward a system of community-based services?** *Does it modify Iowa's existing programs for the elderly and for people with disabilities, and develop a more effective range of services in the community?*

☐ **Ensure choice?** *Does it avoid forcing elderly Iowans and Iowans with disabilities to live in an institution or a nursing home in order to get essential care or services?*

☐ **Protect basic human rights?** *Does it respect the rights of elderly Iowans and people with disabilities to choose where they will live, what services they will use, and from whom they will get these services?*

☐ **Avoid inappropriate institutionalization?** *Does it call for screening immediately before and regularly after placement of all people considered for or residents of nursing homes and other institutions, to determine whether a person could be more appropriately served in the community?*

☐ **Help people return to their communities?** *Does it move people off waiting lists and into community-based services at a reasonable pace, one that is not set by the state's desire to keep its institutions full?*

☐ **Make optimal use of available funding?** *Does it seek out and tap federal and other funding opportunities for home and community-based services?*

☐ **Fight institutional bias?** *Does it fund community-based services and institution-based services equally?*

☐ **Fund existing programs that support community-based services?** *Does it call for adequate funding of existing Medicaid programs that encourage integrated, community-based services?*

☐ **Avoid caps that compel institutional bias?** *Does it avoid arbitrary expenditure caps on covered home and community services, so that caps can neither force institutionalization nor lead to the denial of community care?*

☐ **Simplify eligibility?** *Does it create a single, consistent set of eligibility requirements for Iowa Medicaid waiver programs?*

☐ **Eliminate discrimination?** *Does it use program, activity, and service eligibility criteria that do not discriminate against older people or people with disabilities?*

☐ **Reinforce natural support systems?** *Does it permit funding to pay for natural supports as well as community-based services?*

☐ **Fund people, not programs?** *Does it let funding flow to the individuals who will then determine their own goals, and spend funds in their own communities as they work to reach these goals? Does it allow local market forces to directly shape more efficient, effective services?*

To learn more about the Olmstead Decision and its implementation in Iowa, please contact:

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