

Alaska Commission on Aging
PLANNING COMMITTEE/STATE PLAN ADVISORY COMMITTEE
Meeting Minutes
Friday, March 10, 2006

Planning Committee Members: Banarsi Lal, Chair; Frank Appel; Ed Zastrow. Additional ACoA Member: Sharon Howerton-Clark; State Plan Advisory Committee Members: Kay Branch (ANTHC); Cyndee Sugar (DSDS); Patrick Sidmore (DSDS). ACoA Staff Members: Linda Gohl, MaryAnn VandeCastle, Joanne Schmidt, and Sherrie Stears. Absent: Myllie Thomas, Pat Branson, Lisa Morley, Jeff Kemp.

Agenda was approved.

Overview. Linda Gohl spoke briefly about plan requirements. We'll submit a draft to staff at Region X (Seattle) U.S. Administration on Aging (AoA) office, who will review and recommend revisions, we will revise. The Plan includes 40 pages or more of assurances (terms/conditions) in addition to how Alaska intends to utilize approximately \$6 to 7 million in federal funds. An approved plan must be on file in order to receive funding from the federal government. The final document needs to be approved by Josefina Carbonell, Secretary of the AoA, before the expiration date of the current plan (which has been extended until June 13, 2008). Our aim is to have the new plan approved before June 30, 2007 so that it reflects new effective dates July 1, 2007 through June 30, 2011. (The current Plan expires June 13, 2008 and these dates are out of sync with the State's fiscal year, and is the only state Plan in the U.S. with an odd date.) The Department of Health & Social Services commissioner and the ACoA chair will also have to sign the final document.

Title III funds are utilized for pass-thru grants based on specific federal allocations for congregate meals, home-delivered meals, support services, preventative health, and the national family caregiver support program. The state decides how much funding will be utilized from the total allotment to pay for the Long Term Care Ombudsman position and towards support staffing (\$238,000 currently), and also \$500,000 is deducted from the total funds for administration which is based on a formula in the Older Americans Act (OAA). (A portion of the ACoA's operating budget is paid for from the Administration funds and is transferred from DSDS each year to ACoA.) Included in the total award, is approximately \$300,000 for the Nutrition Support Incentive Program which is allocated only to those grantees who provide meals.

The State indicates in the Plan what specific services will be funded utilizing the Title III 'Support Services' allocation. The OAA under Title III, includes a large list of allowable services in which to select from. The State is also required to utilize Support Services funding for legal services, and, there is a formula for minimum funding which must be allocated for legal, support and information and assistance services.

Title VII funds consist of two small allocations, one for the Long Term Care Ombudsman office (operations) and a small amount for Elder Protection utilized by DSDS for their Adult Protective Services program. DSDS transfers the LTC Ombudsman funding via a Reimbursable Services Agreement negotiated each year between DSDS and the Dept. of Revenue/Mental Health Trust Authority. It is critical that the contract amount be in sync with what the approved Plan reflects. (See page 81 of the current Plan, Title III Resource Allocation Plan for the Administration and Ombudsman Funds.)

Title V funds are provided directly from the U.S. Department of Labor for the Senior Community Service Employment Program, which is administered in Alaska by the Dept. of Labor's Mature Alaskans Seeking Skills Training (MAAST) program. The State must coordinate with the ADOL for the SCSEP program, which has a separate Plan from the OAA programs.

Federal funds are allocated based on an OAA formula which considers the number of people age 60 and over in each state's population.

Rod Moline has delegated DSDS' participatory role to Lisa Morley.

Continuum of Care for Seniors in Alaska. Cyndee Sugar gave a summary of the programs that Alaska provides using OAA funding. We can select from a list of programs in Title of the Older Americans Act. At the present time, much of Alaska's services are based at its senior centers. The senior centers provide information and referral services, and may coordinate other services such as chore services and coordinated transportation for the disabled and homebound. The centers provide a variety of activities for socialization, health promotion, and disease prevention such as exercise classes and blood pressure checks. Needs vary by community, and a survey of senior center needs may be a good idea in conjunction with this planning process.

In addition to the senior centers, independent living centers (ILCs) have traditionally provided information and assistance to disabled, blind, and hearing-impaired seniors. They have lending closets of equipment for loan to those who may need it. In the past couple of years, the ILCs have also been the focal point of the Aging and Disabilities Resource Centers (ADRC) project. As such, they have attempted to expand their services to seniors in general. They have provided benefits counseling to seniors in conjunction with the federal change-over to Medicare Part D. There is some overlap in the information and assistance services provided by the senior centers and the ILCs, creating a multitude of different information outlets to coordinate.

The Home and Community-Based (HCB) grants program (state/Mental Health Trust funds), provide services on the basis of a sliding fee scale for those not eligible for the Older Alaskans Medicaid waiver program (federal/state funds), and locally-funded programs, round out the continuum of care for seniors. The aim is to help people remain in their homes avoiding institutionalization for as long as possible. The HCB grants include funds for care coordination, respite, adult day care, caregiver support (Title III OAA), and programs for grandparents raising grandchildren.

Assisted living homes, including the Pioneer Homes, and two senior residential centers (in Kotzebue and Tanana) provide care for those who are unable to remain at home. Most assisted living homes are funded by private pay as well as Medicaid. Pioneer Homes also get substantial revenue from the General Fund. Some homes receive General Relief room and board payments for very low-income clients as well. The Indian Health Service pays for no long-term care at all. Frank added that there are about 300 assisted living homes in Anchorage, though not all of them include seniors. Hospitals and nursing homes round out the continuum of care for seniors in Alaska.

The gaps in services that we are aware of include mental health services for seniors; substance abuse services; and specific services for those with Alzheimer's Disease and Related Disorders (ADRD). We also need to work on coordinating health promotion and disease prevention activities with other State and local entities.

Sherrie noted that Marilee Fletcher of the Division of Behavioral Health has been asked to take on senior issues, including the mental health and substance abuse problems of seniors.

Other services available through OAA funding include media activities (e.g., a grant to the Senior Voice newspaper), legal services, RSVP (Retired Senior Volunteer Program), Foster Grandparents, and senior companion program, and a senior employment program (MASST).

Joanne asked whether the 12 Native regional corporations could create some funding streams for long-term care, even though they are structured as profit-making corporations to benefit their shareholders. Kay noted that in some areas of the Lower 48, tribes are using casino earnings to pay for long-term care services.

New Since Last Plan: Linda summarized some of the plan requirements that are new since the last plan was written. These include the need to include sustaining the ADRC (Aging and Disabilities Resource Centers) project, the need to address health promotion and disease prevention, and the need to address compliance with the Medicare Modernization Act. Kay added that the role of the ACoA and the shift of grant programs to DSDS are huge changes that make this plan very different from the previous one. Also, the old plan is strictly focused on OAA services. With ACoA focusing more on its advocacy role, it may want to adopt a broader focus in this plan. Banarsi agreed that the new plan should talk about unmet need more generally.

Linda suggested we address the gaps and barriers in the current long-term care system and offer our vision and recommendations for a strategic long-term care plan. This plan could be a springboard to a more comprehensive long-term care plan. Somehow we should tie the national programs to the State's responsibilities overall. The State of Alaska could contribute much more money to OAA programs and services for seniors, as many other states do. (Alaska utilized 21% in General Funds towards the 15% minimum cash match for the Title III programs FY03 and prior.) DSDS is still mired in the growing-pains of bringing senior and disabilities services together.

Joanne observed that the old plan has “no people” in it. She suggested we aim to “give a face to” the information we present in the new plan. Ed agreed and proposed that we adopt a particular focus on the “donut hole people” – those lower middle income folks whose incomes are too high to qualify for Medicaid but too low to afford to pay for services on their own. “They’re the ones in trouble out there,” Ed stated. Cyndee, who previously worked in the senior services field, verified that people needed to be very poor, very wealthy, or very ill to get services. Those who need intermediate care – more than just regular in-home services, but not quite rising to nursing home level of care – really suffer as they can’t afford the nursing services they need. Even PCA (personal care attendant) services cost \$30 an hour for private-pay clients. [It is a requirement under the OAA that services be targeted to those who are lowest income, socially isolated and who are a minority.]

Frank said that we can advocate for programs that benefit the middle income group but are not necessarily costly – we can promote healthy lifestyles, nutrition, disease prevention, financial training to help people save money and plan for the future, etc. Ed noted that there are major changes on the horizon, with the impending end of pensions and health insurance for retirees.

It was agreed that the plan needs to be an advocacy tool. It should also emphasize the future needs of the boomers and younger generations .

Guiding Principles and Focal Points for the Plan. The group engaged in a brainstorming exercise in which everyone jotted down the values, guiding principles, and focal points they wanted to see embodied in the plan and the way seniors are served. Those ideas were then sorted by theme, which revealed the following areas of interest:

- ***Independence, dignity, respect:*** personal empowerment, ability to stay in own home, remain close to and involve family and culture and traditional values and practices, person-centered care, get help with home repairs, have services for modifying home for easier access, continue to be able to drive, have their value acknowledged and contributions recognized, dispel fears of future needs, offer consumer choice.
- ***Community connection:*** interaction with all generations, participation in life, community engagement, reach those who are isolated, increase visibility in the community, more social involvement, continued productivity, peer-to-peer support, variety of activities, share knowledge with young people and families, reduce dependency on government programs by offering innovative alternative programs at the community level, provide services at convenient locations.
- ***Safety and security:*** prevention and protection from abuse/neglect/scams/fraud, personal safety, financial security, adequate income, safe transportation, affordable housing for lower middle income people, stronger action by communities in dealing with elder abuse.
- ***Affordable health care:*** access to high-quality, affordable health care, prescription drugs, and long-term care.
- ***Prevention and early intervention:*** access to health promotion/maintenance information, activities, support, and equipment to reduce the incidence and progression of chronic diseases and lessen the need for costly institutional care.
- ***Education and assistance:*** keep seniors informed of what's happening, provide easy access to sources of information on available services, make paperwork (forms) simple to complete, help seniors share knowledge and skills.
- ***Improved coordination of resources*** by the various programs and levels of government in order to make more money available for actual services to seniors.
- ***Equitable service provision*** between rural and urban areas of the state.
- ***The most efficient services*** consistent with a high level of quality care.

The group discussed the “community center” model and the “one-stop service center” model. Senior centers could expand to be more than just a senior center – the entire community could be brought in to the senior center. Perhaps there could be outreach to the schools, with kids receiving credit for coming in to help or socialize with seniors. Senior centers could partner with other programs and coordinated activities could be planned with other segments of the community. Joanne noted that while adolescents can greatly benefit from connecting with elders, we’d need to plan carefully so as not to alienate some seniors, who might withdraw from the young people.

We should keep in mind that State and federal funds are usually only a small portion of a senior center’s budget. We also need to address the boomers’ desire for redesigned senior centers – they will want a different kind of facility with different capacities.

As for the one-stop shop model, many seniors may prefer to be able to access services at the most convenient location for them, rather than a centralized location. Some people won’t go to a senior center at all (60% of Alaskan seniors, according to the ACoA’s 2005 survey of senior concerns), for a number of reasons, but often because they don’t want to associate just with other seniors, aren’t interested in the activities offered, or are homebound due to health problems or disabilities. We will need to make sure we plan to serve the needs of this group of people as well.

Tanana Chiefs Conference and other Native groups in the state keep track of their elders and visit them on a regular basis. Patrick stated that even Anchorage is developing a list of vulnerable people within the community. Faith-based communities can help with this kind of personalized monitoring. We

should make sure to discuss senior housing needs in the plan as well. We can invite Jim McCall of AHFC to participate in that session of the advisory committee. We also need to address homelessness in the senior population. We can get data on this – there is a report available, developed by a consortium of the DHSS, the Governor’s Office, the Mental Health Trust Authority and other stateholder. Our aim should be to develop collaborative partnerships wherever possible – with AHFC, Behavioral Health, schools and youth groups, faith-based communities, etc.

Other issues mentioned include whether the chore or homemaker program is a good use of these limited funds; we will need input from consumers, providers, DSDS staff. Patrick pointed out that currently it is left to the providers to propose how much funding they want to apply to which programs. It might be that we want to ask that local advisory committees prioritize the services for their areas, though that would be a complex process. Generally the senior centers get funded first, and those who don’t go there for services get whatever is left.

We’ll also have to integrate the ADRC model (for providing information and assistance) into our service delivery system, while minimizing the duplication of information and referral services to the extent possible. DSDS will be picking up the ADRC project after the 3-year grant runs out (6/30/07). Our state plan is required to address ADRC services, but no additional or separate OAA funding is anticipated to be available when the grant ends. We will need to determine how and how much we should channel resources to the ADRC system. There will be a class for ACoA members and staff and DSDS staff on June 26th in Anchorage, facilitated by the Lewin Group, consultant for states awarded the ADRC grant, and Steve Lutzky, a long-term care consultant with particular expertise on the ADRC issue.

The group expressed the desire to schedule further dialogue on the one-stop service center model and ADRC process at a later time.

Funding Formula Issues. After lunch, Patrick addressed some of the decisions we’d need to make with regard to a funding formula. [See page 15 allocation chart]. The old plan’s definition of “frail elder” was “those age 80 and older.” This definition was inadequate and even racist and sexist, as minorities and males tend to die at a younger age. He looked at using a formula that would be based on the place of death, but realized that was skewed by the location of hospitals and nursing homes. He then found that there is census data showing the number of people aged 65 and over with a disability, by census area, which could be the best available guideline to use. The percentages of those 65 and over with a disability ranged from 40% to 65% depending on the census area. We may be able to get the Census people to do a special run showing Alaskans age 60 and over with a disability, by census area.

Patrick also recommended using a cost of living adjustment based on census areas/location, which was not done in the old plan. He has developed a variety of spreadsheets that play out different scenarios. The group decided to use a cost of living adjustment in the new plan. The final amount allocated to each region would be adjusted by a cost of living multiplier for that region. If economic statistics should change markedly during the time period covered by the plan, we can amend the plan. [Or, the allocation plan may be implemented over a phase-in period.]

We should take another look at our definition of “rural” as used in the plan. The Trust defines as rural a community with a population of 10,000 or less that is not connected to Anchorage or Fairbanks by road, or a community with a population of 1600 or less that is connected to Anchorage or Fairbanks by road. [The current plan utilizes the same definition from the prior plan, which took nearly one-year to develop with a special committee devoted to this project. It is the AHFC’s statutory definition.]

Census data on minority populations has changed due to a new method of collecting race data which began with the 2000 census (where people were asked to “check all that apply” rather than selecting one race). Patrick suggested we may want to adopt the Census definition of minority status. Recent population data shows the Native population growing by leaps and bounds.

There was some discussion of the various categories and their allotted percentages for contribution to the funding formula. We are not obligated to keep the same percentages as last time. We should realize that some people will be in more than one group (e.g., minority, rural, frail, etc.). The cost of living adjustment would not constitute an additional weighting category, but would be a way to adjust the final numbers arrived at via the formula.

Some group members had questions about how the previous percentage weights were arrived at for the old plan. Nobody present had that information, though it was pointed out that such a decision is subjective and would not necessarily be supported by specific data. Staff was asked to contact Jon Sherwood and Alison Elgee to find out if they had any recollection of how the funding formula was arrived at. Patrick also suggested we look at how the populations of the various sub-groups had changed over time. [Per Linda there was no method to develop the weighting factors and was subjective.]

Assurances. MaryAnn reviewed a list of the many assurances that are required to be included in the plan. Some of the related comments and suggestions included:

We should mention that Native groups are doing well with health promotion and disease prevention, especially with regard to diabetes, etc. We should discuss the role of Native organizations in health care, long-term care, etc. as they are so prominent in Alaska. Discuss coordination, bringing the two systems together to save money.

Health services are so costly that there is little money left to support human services. We should address the health care issue and options in that context.

We currently don't have a program for elder abuse prevention. The Center for Human Development is training people in elder abuse prevention. We need a strategy for more in this area. Kay suggested changing the term “elder abuse” to “elder respect and disrespect” because it is a very sensitive topic and many elders will not self-identify as “abused.” The term can include, for example, things like poor quality care of a diabetic elder. She suggested looking at some reports available on the website of the National Resource Center for American Indian, Alaska Native, and Hawaiian Elders.

Data, Resources, Etc. The group liked some of the data presentation ideas used by Colorado in their state plan. We can use them as a guide. It was suggested we add appropriate data from the Lewin Group report, the PCG Long-term Care study, the ISER report on senior economic status, information from the Bristol Observatory data project, and other available data sources.

We may want to conduct an online survey of grantees and other stakeholders to find out if they have waiting lists for any of their services, and what kinds of services they feel are needed in addition to what is now available. Some programs provide Cyndee with their waiting list figures every quarter, but others don't.

We may also want to ask providers and provider organizations for figures on workforce shortages and also gather a consumer perspective on workforce difficulties. Some of the problems with the worker

shortage include lack of training, low salaries, and irregular schedules. In many areas, if they can't access distance education, they can't get training.

The plan should try to provide information on unmet needs overall, including health care and direct services gaps and barriers.

Plan reviewers should include Bill Hogan, Rod Moline, Rebecca Hilgendorf, and various other DSDS staff as well as the private sector – providers and the public. We may want to get the public involved at an earlier stage this time. We should ask AgeNet and the Senior Advocacy Coalition for reviewers, and perhaps senior center directors, Pat Luby from AARP, and Jon Sherwood. We should solicit more provider participation than in the past. However, we should get DSDS comments first, before distributing a draft to anyone else. Linda will get a formal commitment from Bill Hogan and Rod Moline.

Future Meetings. This advisory committee will meet via teleconference, with mornings being the best time, and will attempt to meet in Anchorage on Friday, June 30th (after the aging advocacy conference and ACoA meeting earlier that week). We'll shoot for having a first draft ready for public review by the June ACoA meeting.