



Healthcare Association
of New York State

Point of Entry

The growing need for high quality, consumer-responsive long-term care is driven by factors including demographics, social trends, legislation, and court decisions. The increasing demands placed on the long-term care system and the limited resources available to meet them are fueling government interest in meaningful reform.

One proposed change to long-term care is a “single point of entry.” The State of New York is developing the framework for a point-of-entry system called NY ANSWERS (Access New York Services With Effective Responsive Supports) that would potentially provide long-term care information, assistance, assessment and screening, case management, and service coordination.

HANYS believes New York can benefit from the lessons learned by other states that have already adopted point-of-entry systems, particularly Minnesota and Wisconsin. These states’ experiences demonstrate the benefits of providing information and assistance; the challenges associated with timely patient transitions between settings, particularly acute care discharge; and the critical need for infrastructure to ensure adequate access to home- and community-based services.

~ CONTINUED ON BACK ~

Long-Term Care Reform Series

ISSUES BRIEF #1

AUGUST 2005

EXECUTIVE SUMMARY

HANYS recommends the following components for a single point-of-entry system:

INFORMATION AND ASSISTANCE

- ✓ Provide individuals, their caregivers, and their families comprehensive and objective information about providers, community services, and eligibility criteria.
- ✓ Assist with navigation, linking consumers with the opportunities, services, and resources available to help meet their particular needs.
- ✓ Deliver information and assistance consistently through person-to-person interactions, television, radio, the Internet, and other vehicles.

ASSESSMENT AND SCREENING

- ✓ Assessment and screening should facilitate appropriate care and transitions across settings.
- ✓ It should streamline consumers' transitions along the continuum of care and ease providers' barriers to delivering care, but not interfere with efficient discharges of acute care patients.
- ✓ It should not impose new and unnecessary provider documentation requirements.

CASE MANAGEMENT AND CARE/SERVICE COORDINATION

- ✓ Include a “service readiness assessment” conducted in every region of the state to determine any service gaps through analysis of the demographics of the populations requiring long-term care coupled with the available services and staff—identified service gaps need to be filled before patients can be safely transitioned to home- and community-based services.
- ✓ Use telemedicine, telehomecare, and telehealth to reduce barriers to accessing health care services and health education, thereby improving health care delivery across the continuum in a cost-effective and efficient manner.

FOR MORE INFORMATION ON THIS TOPIC, PLEASE CONTACT:

Robin Frank

Vice President, Governmental Affairs and Continuing Care
(518) 431-7712 / rfrank@hanys.org

Debora LeBarron

Director, Continuing Care
(518) 431-7702 / dlebarro@hanys.org

Rose Duhan

Senior Analyst
(518) 431-7620 / rduhan@hanys.org



Healthcare Association
of New York State

Point of Entry

There is no single definition or model for a point-of-entry system—there is no “one size fits all” approach. Experts across the country use the term “point-of-entry” in many ways. However, information and assistance are the core and foundation of any point-of-entry systems and HANYS supports improving and expanding consumer access to information and assistance to help individuals and families better navigate the long-term care continuum.

HANYS believes that:

- The goal of the point-of-entry system should be consumer choice and decision-making through the provision of enhanced consumer information, education, and navigation assistance.
- Technology is critical for making information accessible to consumers and maintaining up-to-date information on all services.
- A strong social infrastructure must be in place to support long-term care reforms, including non-medical services such as accessible, affordable housing and transportation.
- Support for informal caregivers should include respite and adult day care, personal care, and caregiver education and training.
- A point-of-entry system should not be a “point of control” or “gatekeeper” that could slow down the process of discharging patients from hospitals.

These principles can help New York State create consistent, comprehensive information and assistance for consumers in accessing long-term care services in a way that supports self-determination, promotes personal responsibility, meets consumer needs, and ensures quality and efficiency.

THE NEED FOR LONG-TERM CARE REFORM

The growing need for high quality, effective, flexible, consumer-responsive services is driving increased state and local spending on long-term care. The critical and worsening imbalance between the demands placed on the long-term care system and the resources available to meet them is fueling interest in meaningful reform.

Long-Term Care Reform Series

ISSUES BRIEF #1

AUGUST 2005

This Issues Brief on New York State’s proposed single point of entry system for long-term care services is the first in a series of papers on long-term care reform. This paper concentrates on key components of point-of-entry systems, challenges in creating a cohesive long-term care system, lessons learned by similar efforts in Wisconsin and Minnesota, and HANYS’ recommendations.

Subsequent HANYS’ Issues Briefs will focus on other emerging aspects of long-term care reform. HANYS hopes through this series to create a discourse on long-term care that will highlight challenges, provoke unconventional thinking, and generate ideas that can evolve into solutions.

MINNESOTA AND WISCONSIN— LESSONS LEARNED

Information and Assistance

- 1) Information and assistance is critical to consumer-focused long-term care planning and the efficient use of services.
- 2) A variety of ways to access information and assistance should be used, including the use of tools such as Web pages, telephone hotlines, and face-to-face counseling.
- 3) Providers and consumers should have access to a complete directory of services and providers.
- 4) Ongoing education for discharge planners on the continuum of services available in their communities will help create greater awareness of HCBS.

Assessment and Screening

- 1) Hospital discharge planning focuses on immediate safe options. To avoid inappropriate delays in transferring patients to other settings, long-term care planning should be done outside of the hospital setting during a non-crisis period.
- 2) Planning for long-term care and resource maximization as a follow-up to discharge from an acute setting has proven to be effective and reduce costs.
- 3) Assessments should utilize existing paperwork requirements and not add layers of bureaucracy to existing information collection systems. There should be no increased paperwork burden for nurses and discharge planners.
- 4) Provider collaboration and consensus is critical to developing an unbiased, standardized, Web-based screening tool.

Factors influencing long-term care include:

- The aging of “baby boomers” combined with longer life expectancies is resulting in more people needing long-term care.
- Fewer informal supports, such as family caregivers, are available to help with long-term care.
- An increasing demand for non-institutional care alternatives for the elderly and for younger people with disabilities is exacerbating the current unmet need for home- and community-based services (HCBS).
- Federal legislation and court decisions, including the Americans with Disabilities Act, the New Freedom Initiative, and the *Olmstead vs. LC* Supreme Court decision are driving reforms that require more HCBS.

The availability of long-term care services varies in communities across the state depending on need, funding, medical practice patterns, local customs, and other factors. Some communities have a full range of available services. In other communities, the service delivery system may focus on particular types of care.

Navigating the long-term care system can be a challenging task, even under the best of circumstances. Often decisions about long-term care services are made during a crisis, when it is difficult to obtain and evaluate the options available to a particular individual. Physicians, discharge planners, and others do their best to help consumers and their families obtain the information necessary to help them to make the best decisions possible to meet the patient’s needs and preferences. When properly constructed, a point of entry system can help consumers, families, and providers to better understand, use, and coordinate long-term care services.

GOVERNMENTAL LONG-TERM CARE REFORM EFFORTS

Federal and state governments are seeking ways to reform Medicaid and the debates in Washington, D.C. need to be factored into deliberations in Albany. Going forward, major Medicare and Medicaid challenges can be anticipated in Washington that will have ideological, budget-driven, and redistributive aspects nationally.

Over the past two years in Albany, state lawmakers have engaged in policy discussions on health care and Medicaid reform. The Senate’s Task Force on Medicaid Reform and Governor Pataki’s Working Group on Health Care Reform have proposed changes to both acute and long-term care.

In December 2003, the State Senate Medicaid Reform Task Force issued a report that proposed restructuring Medicaid. The Senate Medicaid Reform Task Force proposed single access points, comprehensive information, and other long-term care access and delivery initiatives. In January 2004, the Governor’s Health Care Reform Working Group released its Interim Report calling for a new long-term care system, including the creation of

a point-of-entry into long-term care, called NY ANSWERS (Access New York Services With Effective Responsive Supports). Its proposed functions would fall into three major categories: information/assistance, assessment/screening, and case management/service coordination.

In April 2004, the Department of Health (DOH) and the State Office for Aging (SOFA) issued a request for information (RFI) about the proposed point-of-entry system. The RFI summarized the minimum functions, outcomes, and performance standards envisioned by DOH and SOFA for NY ANSWERS. The guiding design concepts listed by DOH and SOFA are impartiality, maximum consumer choice, individual and family preferences, patient independence, interdisciplinary coordination, and universal availability. HANYS' response to the RFI endorsed the goals stated by the Governor's Working Group to improve consumer knowledge, choice, and access to long-term care services. However, we also expressed concern that a single point-of-entry entity, charged with the responsibility to evaluate each potential user of long-term care services, would slow access to such services, unnecessarily extend acute stays for patients in hospitals, and become a barrier to post-acute services.

WHAT OTHER STATES ARE DOING: WISCONSIN AND MINNESOTA MODELS

To better understand the potential benefits and challenges of a point-of-entry system, HANYS and six other statewide health care associations sponsored a daylong symposium in November 2004 on the concept. Because Minnesota and Wisconsin are nationally recognized for their advanced point-of-entry systems, government administrators and providers from these states were asked to share their experiences at the symposium. The Wisconsin and Minnesota experiences can provide important lessons for New York State in developing a point-of-entry system.

MINNESOTA OVERVIEW. After conducting research on how information affects consumer choices and the best ways for consumers to receive information, Minnesota created a three-pronged information and assistance structure. This structure incorporated specialty information telephone lines known as the "LinkAge Lines" network, a mechanism for consultants and consumers to meet face-to-face for planning, and an extensive database of community resources for both consumers and professionals known as MinnesotaHelp.info. This Web-based decision support tool helps consumers, discharge planners, and providers navigate the spectrum of service options in any community in the state, including housing, human services, disability services, prescription drug assistance, and translation assistance.

A comprehensive assessment conducted by a social worker and a nurse to assess health, psychological, social, and caregiver needs and preferences was being administered in hospitals as a nursing home pre-admission screening. Given the pressure for shorter

MINNESOTA AND WISCONSIN— LESSONS LEARNED (continued)

Case Management and Care/ Service Coordination

- 1) **Sufficient services must be available in a community to support patients' transitions between levels of care. A major goal of both states was to develop more HCBS, as both long-term care systems were dominated by nursing homes.**
- 2) **Funding of HCBS is critical. In Wisconsin, the implementation of a Medicaid waiver program increased consumer choice and service options and eliminated waiting lists for services. Additionally, reimbursement for preventive home care services helped alleviate the need for institutional care, creating long-term cost savings.**
- 3) **Case coordination may not require more services; solutions may lie in engaging and supporting family and community in responding to people's needs.**
- 4) **Non-medical social supports critical to supporting HCBS, such as transportation, are often scarce. Investments are needed to support a range of affordable housing options.**

HANYS' RECOMMENDATIONS

There is significant potential to create better informed consumers of long-term care services and to improve access to those services through components of a point-of-entry model. HANYS supports those aspects of point of entry that focus on consumer information and assistance and that can be used to identify and fill gaps in the current continuum of care. At the same time, there is also the potential to slow patient access to services and create barriers to receiving services—problems that HANYS wants to avoid.

Information and assistance should:

- ✓ provide individuals, their caregivers, and their families comprehensive and objective information about providers, community services, and eligibility criteria;
- ✓ assist with navigation, linking consumers with the opportunities, services, and resources available to help meet their particular needs; and
- ✓ be delivered consistently through person-to-person interactions, television, radio, the Internet, and other vehicles.

The assessment and screening process should:

- ✓ facilitate appropriate care and transitions across settings—a single assessment tool could assist with this goal;
- ✓ streamline consumers' transitions along the continuum of care services and ease providers' barriers to delivering care, but not interfere with efficient discharges of acute care patients; and
- ✓ not impose new and unnecessary provider documentation requirements.

Case management and care/service coordination should:

- ✓ include a "service readiness assessment" conducted in every region of the state to determine any service gaps through analysis of the demographics of the populations requiring long-term care coupled with the available services and staff—identified service gaps need to be filled before patients can be safely transitioned to HCBS; and
- ✓ use telemedicine, telehomecare, and telehealth to reduce barriers to accessing health care services and health education, thereby improving health care delivery across the continuum in a cost-effective and efficient manner.

hospital stays and timely discharge planning, Minnesota shifted the timing of the assessment from the end of an acute care stay to a non-acute setting. Caseworkers now conduct this comprehensive assessment in a planning capacity in an individual's home or other non-acute care setting.

WISCONSIN OVERVIEW. Wisconsin established Aging and Disability Resource Centers, designed to be single entry points where older people and those with disabilities and their families can get information and advice about resources available in their local communities. County benefit specialists assist with applying for private and government benefits, are available for troubleshooting problems, and can help obtain federal and private funding. The Wisconsin Family Care Program combines funding and services from a variety of existing programs into one flexible, long-term care benefit, tailored to an individual's needs, circumstances, and preferences.

Through direct experience, Wisconsin learned that patients and families were not prepared to make long-term care decisions when dealing with an acute health care crisis. Long-term care counseling, initially conducted in the hospital before discharge, delayed hospital discharges and kept patients in the hospital longer than necessary. Counseling is now conducted in a home or nursing home following hospital discharge. This post-hospitalization functional and social assessment is the basis for the long-term plan of care involving individuals, their families, and support systems.

CONCLUSION

As financial and demographic pressures build, government, providers, and other community groups are developing a variety of proposals for long-term care reform. HANYS will continue to work with members on policy and operational issues as they evolve and with state government on development and implementation of proposals. HANYS continues to advocate for health care reform that promotes consumer choice and facilitates providers' delivery of services. We will maintain our vigilance regarding legislative and regulatory changes in New York's health care system with a focus on these principles.

FOR MORE INFORMATION ON THIS TOPIC, PLEASE CONTACT:

Robin Frank

Vice President, Governmental Affairs and Continuing Care
(518) 431-7712 / rfrank@hanys.org

Debora LeBarron

Director, Continuing Care
(518) 431-7702 / dlebarro@hanys.org

Rose Duhan

Senior Analyst
(518) 431-7620 / rduhan@hanys.org