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DIRECTOR'S MESSAGE

To: County Executive Barbara J. Fiala

On behalf of the staff of Broome County CASA and the people we serve, it is my pleasure to submit the 2010 Annual Report.

We continue to see a great deal of need for our services in people with disabilities who are less than 60 years of age. Obesity is one of the main contributors to disabling conditions. Thirty-five percent of the 1,455 people we assessed for care in 2010 had a body mass index (BMI) of greater than 30. According to the Centers for Disease Control (CDC), a BMI of over 30 indicates obesity. A BMI between 25 and 29 indicates that a person is overweight.

Obesity leads to a myriad of conditions including diabetes, heart disease, joint problems and high blood pressure. We've seen an increase in the number of people with a BMI over 30 in all age categories, even those over the ages of 75 and 85.

Another interesting trend that has emerged in the population we are serving is that the diagnostic category of Mental Health Disorders has risen to the top of most frequently noted conditions. In 2009 we changed the way we collected the data on diagnostic categories as outlined by the DSM IV. We note the primary diagnosis on our assessment form. While most of these come from our physician orders and other medical records, some are determined by the evaluating nurse based on the medications found in the home or client self reporting. While that might not be the most efficacious manner in collecting the data, it does denote a trend that has become apparent to our workers in the field; mental health issues are having a big impact on people's need for long term care.

The people we serve often have a combination of chronic conditions and social problems that impact their ability to manage their day-to-day lives. CASA staff is continually challenged to assist the people to be as independent as possible. Broome County CASA has a statewide reputation for long term care service delivery. I am proud of the work the staff does on a daily basis to assist many of the most vulnerable people in our community to live lives of dignity.

Respectfully submitted,

Michelle M. Berry

Restructuring Medicaid Home Care in New York State: A Call to Action

CASA Association of New York State 2009

Governor Paterson's 2009 - 2010 Budget proposed the creation of a demonstration that would allow a private entity to operate the personal care program in three counties. The CASA Association of New York State believes that effective reform requires a better understanding of who is being served in Medicaid home care programs and the current role that counties play in home care. County government in New York State (NYS) has historically been designated by the state to assess for and authorize a range of Medicaid funded long term care services. Counties play an integral role in the delivery of the Personal Care Services Program (PCSP), the largest Medicaid personal care program in the United States. Counties are also involved in authorizing and coordinating the delivery of the Long Term Home Health Care Program (LTHHCP), the Consumer Directed Personal Assistance Program (CDPAP), Personal Emergency Response Systems (PERS), as well as other community based programs.

There have been significant changes in the population served in the program since its inception in 1965, including an increase in the level of care needed in the home and an increase in the number of people served who are under the age of 60. These changes, along with an emphasis on keeping people at home, have increased the cost of service. Counties have experienced these changes and have critical information that is important to acknowledge in the effort to reorganize long term care in NYS.

As a national leader in home care, New York State has the opportunity to construct meaningful long term care system-wide reform. A partnership between the state, the local districts, consumers and providers will result in the development of an effective and efficient system that provides quality care. NYS is diverse and it is important to recognize that local resources are either available or limited by the nature of the communities served.

In restructuring home care, the CASA Association of New York State suggests the following recommendations be taken into consideration.

1. The goals and measurable expected outcomes of long term care need to be clearly defined for all Medicaid funded care.

2. The New York State departments of Health, Aging, Office for Persons with Developmental Disabilities (OPWDD), and Mental Health oversee a myriad of community based programs. These agencies must align their vision, culture and philosophies.

3. Data on long term care needs to be collected, analyzed and widely disseminated and examined before making any changes to the current system.

4. Revise the NYS Personal Care Service Program regulations (NYCRR 505.14) to clarify the allowed Medicaid funded care a client can receive.

5. Provide substantive and ongoing training to those administering all Medicaid home care programs and to State Fair Hearing staff.

6. Provide substantive and consistent public education/orientation to households applying for in-home care on their rights and responsibilities in relation to the program's services.

7. Create the resources and tools needed at the local level for service provision, including the development of a standardized assessment tool.

8. Create a state service corps for aides working in either home care or in nursing homes to broaden the available pool of workers.

9. Once the state has created the mechanisms and the tools to move the system forward, create opportunities that allow counties to cross county lines to consolidate the intake and assessment process for Medicaid funded care. Naturally occurring market areas could share program administration and delivery.

Restructuring Medicaid Home Care in New York State: A Call to Action discusses the above recommendations in depth. The paper also examines the long term care environment we currently operate in, the lessons we have learned, myths surrounding care in the home, the barriers and obstacles we have encountered and the following notable trends:

1. The Personal Care Services Program serves an increasingly diverse and younger population.
2. People spend a significant portion of their lives in receipt of long term care, making numerous care transitions, all of which require planning.
3. NYS operates NINE Medicaid Waiver Programs, creating a complex environment in leading to consumer and provider confusion as to who qualifies for what service, why, when and how.
4. As people with chronic conditions live longer, the stress on informal caregivers increases and may prevent them from providing needed support to consumers.
5. There is a shortage of aides in upstate NY. The challenging conditions they work in and the lack of transportation for them further decreases the pool of workers.
6. One of the most prominent myths is that home care is always less expensive than Nursing Home care.

County workers serve on the 'front lines' of home care and have witnessed major changes in the needs and demographics of the people we serve. These changes are outlined in this report. Is there a need for system reform? Absolutely, but reform must be based on the needs of the current demographics.

MISSION AND PURPOSE STATEMENTS

MISSION: To serve as a central access point for assessing long term care needs of individuals and families to promote maximum independence and optimal use of available community resources.

PURPOSE: CASA will provide comprehensive assessment, care planning and case management services based on client need, regardless of age or income, and with consideration for the personal wishes of clients and their families. CASA will seek to assure that all services are designed to assist clients to live as independently as possible. CASA, in partnership with the consumer, family and provider community, will assist individuals in determining how best to use available resources in coordinating care that meets their needs in a dignified, individualized manner.

The three principle outcomes to be achieved through our central access point:

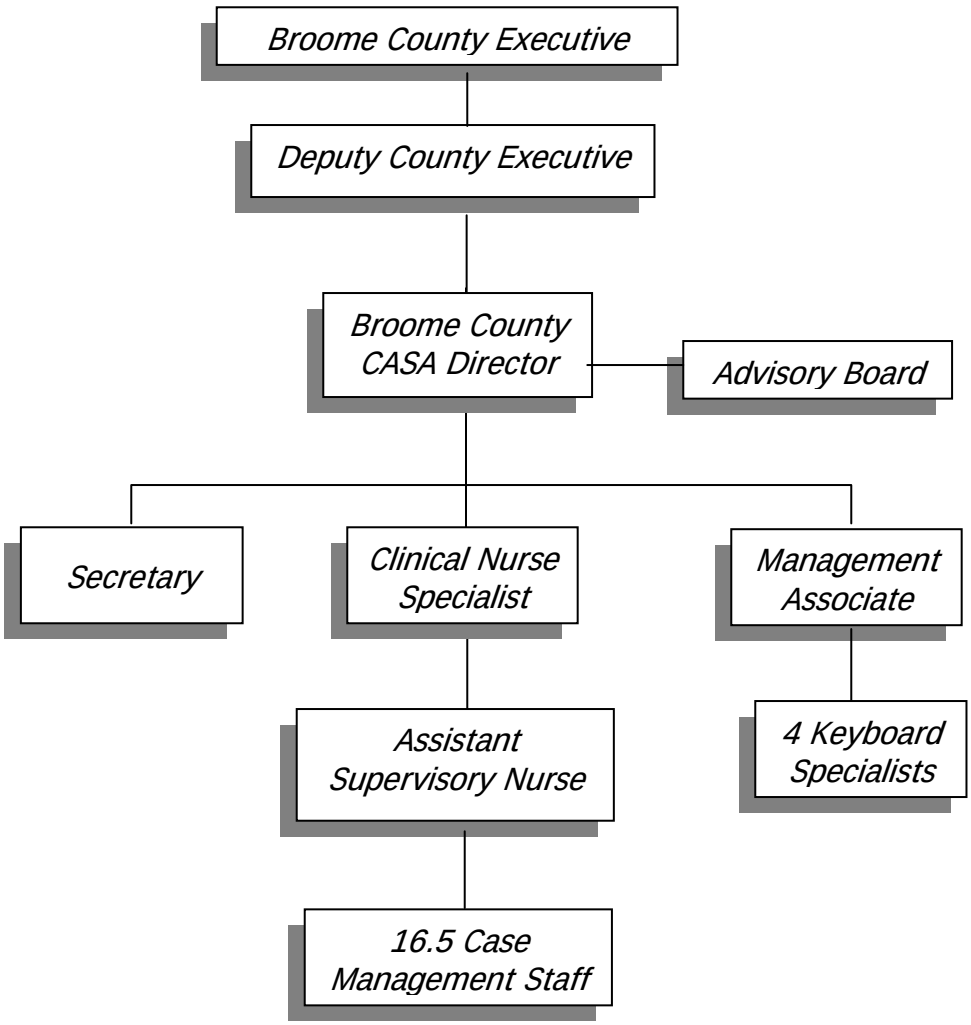
- Improved quality of life for the chronically impaired and their informal supports based on informed choices.
- Efficient, cost-effective long term care system that recognizes constraints and avoids unjustified expenditures.
- Effective coordination among service providers to meet the challenges of serving people with chronic conditions and disabilities by recognizing the value and worth of each type of service and their contribution to the overall quality of consumer care.

BUDGET AND STAFFING

Broome County CASA's approved operating budget for 2010 was $2,105,231.

The majority of the CASA operating budget is reimbursed by Federal and State Medicaid administrative dollars.

CASA, when fully staffed, is authorized to have 26 staff members.



PROGRAM DESCRIPTION AND FUNDING

Broome County CASA began operations in 1983. "If CASA is to manage effectively, it is essential that potential long term care clients be promptly identified; that those for who community based care appears a viable option be thoroughly assessed; and that CASA ensure that, wherever possible, the long term care system is accessed at the appropriate points. None of these functions can adequately be performed at a distance. In short, each CASA will need to become that partnership between government and providers envisioned by the New York State Long Term Care Systems Development Project; and each of the CASAs will need to intervene, directly and indirectly, in the long term care system to ensure the availability, accessibility and delivery of long term care services in the most appropriate and cost efficient manner possible." (CASA Operations Notebook, NYS DSS 1983.)

- **CASA serves people with chronic disabilities OF ALL AGES.**

- **CASA receives approximately 200 new referrals every month.** In 2010, CASA received 2,307 referrals for people in need of long term care.

- **CASA is the gatekeeper for those in need of long term care.** CASA assesses clients to determine their level of care and makes referrals to the appropriate programs and services.

- **CASA staff performs numerous functions:**

    1. Pre-Admission Program Assessments
    2. Medical Eligibility (level and locus of care determination)
    3. Case Management
    4. Data Systems
    5. Long Term Care Systems Planning and Development

- **CASA has developed innovative programs and services.** Broome County CASA began operating a Nursing Home to Community program in 1996 and the In-Home Mental Health program in 2001.

- **CASA was designated as the local NY Connects partner in 2006.** NY Connects provides information and assistance on available long term care services (see page 11).

CASA PROGRAMS AND PARTNERSHIPS

- ✓ NY Connects
- ✓ Personal Care Aide
- ✓ Shared Aide
- ✓ Consumer Directed Personal Assistant Program
- ✓ Long Term Home Health Care Programs
- ✓ Nursing Home to Community
- ✓ Nursing Home Placement
- ✓ Private Duty Nursing
- ✓ Family Homes for the Elderly
- ✓ Medical Day Care
- ✓ Assisted Living Programs
- ✓ Care At Home
- ✓ Home Community Based Waiver
- ✓ In-Home Mental Health Program
- ✓ Partnership with Tioga County DSS
- ✓ Personal Emergency Response Systems

CASA PROGRAMS

CASA operates AND/OR authorizes Medicaid payment for the following programs, which are MANDATED by the state of New York.

1. PERSONAL CARE PROGRAM

This program operates under three models: traditional **Personal Care, Consumer Directed Personal Assistance Program, and Shared Aide**. Between these three models, Personal Care serves 502 clients on a monthly average.

- The Personal Care Program represents the largest Medicaid home care program in the state, as well as in the United States.
- In New York State, personal care is a billion-dollar program.
- CASA assesses every person receiving personal care on a bi-annual basis.
- CASA develops a care plan for every person in the program on a bi-annual basis.
- CASA authorizes the Medicaid payment and coordinates the care with the assistance of five contracted licensed nursing agencies and the Southern Tier Independence Center (STIC).
- 46% of the people receiving this service on a monthly basis are less than 60 years old.
- Beginning in the early 1990's, the Personal Care Program became available to developmentally disabled children and adults via the Home and Community Based Waiver programs and the Traumatic Brain Injury program.

2. LONG TERM HOME HEALTH CARE PROGRAM

This program is referred to as the "Nursing Home Without Walls Program." It provides a higher level of nursing case management and assessment than the Personal Care Program. There are two providers in Broome County that service approximately 204 clients on a monthly basis. CASA assesses and authorizes the Medicaid services for these clients and is the number one referral source for both programs.

3. ***ASSISTED LIVING PROGRAM***

There are four providers of these residential care programs in Broome County with a total of 105 beds, approximately one-third are Medicaid recipients. CASA assesses all clients, private pay or Medicaid, who want to access the program and authorizes payment for Medicaid residents. Assisted Living supports seniors in need of long term care, but not infirmed enough for skilled nursing care.

4. ***MEDICAL DAY CARE***

Susquehanna Nursing Center operates the only Medical Day Care Program in Broome County. CASA assesses and authorizes the care for all Medicaid clients served by the program.

5. ***PRIVATE DUTY NURSING***

On behalf of the state, CASA assesses all Medicaid private duty nursing cases in Broome County for an average of 23 clients per month. People in receipt of this care are mainly children with high tech nursing and intense nursing management needs.

6. ***CARE AT HOME***

CASA provides assessment and Medicaid payment authorization to this program designed to serve children.

The goal of every CASA assessment is to develop the best care plan, at the least cost for all payers, whether private pay or Medicaid.

Combined with the referrals we receive on a monthly basis, CASA staff manages approximately 1,000 clients per month.

CASA PARTNERSHIPS

During CASA's existence, we have worked with many community agencies to implement new programs in an effort to better manage long term care Medicaid expenditures. Programs that have resulted in these partnerships are as follows:

1. FAMILY HOMES FOR THE ELDERLY

One provider coordinates approximately 20 private homes and serves an average of 38 clients on a monthly basis. CASA determines eligibility and authorizes the Medicaid payment for clients served in this program. The program is operated by Family & Children's Society and is the most successful program of its kind in New York State.

2. NURSING HOME PLACEMENT

CASA assesses residents in the community who are in need of nursing home care and assists the families in accessing care.

3. NURSING HOME TO COMMUNITY

This effort is a model program for the state and nation. Since 1996, Broome County CASA has assisted over 5,000 people achieve nursing home discharge.

4. IN-HOME MENTAL HEALTH PROGRAM

Broome County CASA recognized the need for greater management of psychotropic drugs in home care. Community Mental Health Reinvestment money was obtained by Family & Children's Society to assist people in their homes stay on their medication regime. There are no Medicaid dollars involved in the delivery of this service, yet it has the potential to save Medicaid dollars by assisting clients in managing their care.

5. PARTNERSHIP WITH TIOGA COUNTY

Broome County CASA entered into a partnership with Tioga County DSS in 1998 to review their residents for post-hospital or nursing home care who are served by Broome County hospitals and nursing homes.

2010 HIGHLIGHTS

1. NY CONNECTS

In October of 2006 the NYS Departments of Aging and Health provided financial assistance to counties across New York State to create or support long term care points of entry or NY Connects. CASA, in partnership with the Broome County Departments of Aging and Social Services, is the designated NY Connects partner in Broome County. CASA has been functioning as a point of entry for long term care in Broome County for over 20 years. The support provided by the state for NY Connects has allowed us to enhance our information and referral services and educate both the public and provider community on the benefits of having one place to call for information on long term care.

The contract year (September 2009 – August 2010) represented the third full year of operation under the NY Connects "banner." At the end of the third year of operations it was not clear if the state would continue to fund the project. However, entering into 2011 the state did restore money for NY Connects.

NY Connects has provided our community with the resources to develop two well received educational initiatives: *My Little Book…A Health Diary* and the *Know the ABC's of Broome County Senior Services*.

2. NURSING HOME TO COMMUNITY

Nursing Home to Community remains a touchstone for Broome County CASA. In learning more about other areas of the nation where similar programs have developed, it must be noted that CASA developed this program in 1996 by reorganizing existing resources. We did not receive any grant dollars as have other agencies, or any additional operating dollars. We recognized the need in our community for this activity in the early 1990's and by 1996 began by servicing two out of nine skilled nursing facilities. Today we serve all ten skilled nursing facilities in Broome County and in 2010 we received 436 referrals and assisted in coordinating discharges for 197.

TRENDS IN LONG TERM CARE (LTC)

In order to understand the factors that have contributed to the increase in the number of hours of service delivered by the Personal Care Program, as well as an increase in the number of people served under the age of 60, it is important to acknowledge the following national trends.

- Decrease occupancy in nursing homes
- Increase in Medicaid spending on home care services
- Decrease in disability rates of elders
- Increase in disability rates of young adults
- Increase in public policy initiatives around the issues of deinstitutionalization and disabled rights: Olmstead, New Freedom Initiatives, Medicaid Buy-In
- Growth in Medicaid Waivers
- Advances in medicine enable people to live longer: traumatic brain and spinal cord injuries, developmental disabilities, advances in cancer treatment and most obvious, how HIV/AIDS has quickly become a chronic disease due to drug therapy
- Obesity as a defining factor in disability, especially among young adults.

Disability and Obesity

The Rand Corporation Research Brief Series 2004, (updated in 2007) titled *Obesity and Disability, The Shape of Things to Come,* reported the following key findings:

- Obesity in the U.S. population has been increasing steadily over the last two decades – and severe obesity is increasing the fastest.
- Obesity is linked to higher health care costs than smoking or drinking.
- Obesity plays a major role in disability at all ages.
- The cost consequences of disability among the young could swamp recent Medicare and Medicaid savings stemming from increasingly good health among the elderly.
- **The explosive increase in bariatric surgery has had no noticeable effect on the prevalence of severe obesity.**

This chart represents the number and percentage of people assessed in 2010 by CASA.

BODY MASS INDEX (BMI) BY AGE GROUP

Age Groups	BMI > 30	Total Assessments	% BMI > 30
18 – 49	81	205	40%
50 – 54	54	110	49%
55 – 59	57	102	56%
60 – 64	69	115	60%
65 – 74	103	232	44%
75 – 84	113	385	29%
85+	38	306	12%
TOTAL	515	1455	35%

The National Long Term Care Studies

A National Institute of Health news release in December of 2006 noted the following: "chronic disability among older Americans has dropped dramatically, and the rate of decline has accelerated during the past two decades, according to a new analysis of data from the National Long-Term Care Survey (NLTCS). The study found that the prevalence of chronic disability among people 65 and older fell from 26.5 percent in 1982 to 19 percent in 2004/2005. The findings suggest that older Americans' health and function continue to improve at a critical time in the aging of the population."

The analysis also showed that from 1982 to 2004/2005:

- Chronic disability rates decreased among those over 65 with both severe and less severe impairments, with the greatest improvements seen among the most severely impaired. The researchers note that environmental modifications, assistive technologies and biomedical advances may be factors in these declines.

- The proportion of people without disabilities increased the most in the oldest age group, rising by 32.6 percent among those 85 years and older.

- The percentage of Medicare enrollees age 65 and older who lived in long term care institutions such as nursing homes dropped dramatically from 7.5 percent to 4.0 percent. The emergence of assisted-living options, changes in Medicare reimbursement policies and improved rehabilitation services may have fueled this decrease in institutionalization.

While it has been interesting to follow the NLTCS and their findings on an aggregate decrease in disability in the 65 and older population, a public policy alarm must be sounded in regard to obesity and its potential impact on disability rates for both adults under the age of 60 and for this population as they approach their golden years.

The gains in decrease in rates of disability among the 65+ age group could rapidly be eroded by the increase in disability among those less than 60 years of age.

Increase in Disability Rates Among the Young

46% of people served by CASA in the 2010 total unduplicated Personal Care caseload were less than 60 years old.

An article in Health Affairs, 29, no. 4 (2010) titled: Trends In Disability And Related Chronic Conditions Among People Ages Fifty To Sixty-Four noted:

"Although still below 2 percent, the proportion of people ages 50–64 who reported needing help with personal care activities increased significantly from 1997 to 2007. The proportions needing help with routine household chores and indicating difficulty with physical functions were stable. These patterns contrast with reported declines in disability among the population age sixty-five and older. Particularly concerning among those ages 50—64 are significant increases in limitations in specific mobility-related activities, such as getting into and out of bed. Musculoskeletal conditions remained the most commonly cited causes of disability at these ages. There were also substantial increases in the attribution of disability to depression, diabetes, and nervous system conditions for this age group."

CASA staff is experiencing the changes in the population as described by these researchers. CASA is serving more adults under the age of 60 as their disability rates increase and fewer adults over the age of 60 as their disability rates have declined.

Implications for serving an increased number of young adults in long term care:

- *They will spend a longer time in receipt of long term care services.*
- *They will make many transitions between care settings over the course of their lifetime.*
- *They will reverse the trend of declining disability among elders as they age.*
- *They will have a major impact on health care expenditures over their lifetimes.*

COMPARISON OF AGES OF CLIENTS

Age Range	Total Referrals in 2010	Total Unduplicated Count (PCA)* in 2010	Total Unduplicated Count (LTHHCP) in 2010
Unknown	2	0	0
21 & under	26	80	0
22 – 24	7	12	0
25 – 29	19	16	0
30 – 34	13	11	3
35 – 39	23	16	3
40 – 44	45	28	9
45 – 49	61	33	13
50 – 54	94	71	19
55 – 59	100	57	23
60 – 64	140	57	23
65 – 69	127	68	26
70 – 74	156	60	43
75 – 79	283	51	31
80 – 84	431	66	32
85 & over	780	76	56
TOTALS	**2307**	**702**	**281**

Note the following:

- 17% of total referrals are less than 60 years old.
- 53% of total referrals are 80 and over.

- 46% of active PCA recipients are less than 60 years old.
- 20% of active PCA recipients are 80 and over.

- 25% of LTHHCP clients are less than 60 years old.
- 31% of LTHHCP clients are 80 and over.

*PCA includes: Traditional Personal Care, Shared Aide, and Consumer Directed Personal Assistance, and Home & Community Based Waiver.

MAJOR PROGRAM & PERFORMANCE MEASURES

PROGRAMS	2007	2008	2009	2010
PCA Hours Billable to Medicaid	206,803	188,610	211,768	184,600
Shared Aide Sites	18	18	18	18
Client Referrals (Total)	2,372	2,530	2,386	2,307
AVERAGE CASES MANAGED / MONTH				
Personal Care:				
• Traditional	155	173	181	164
• Shared Aide	191	171	166	158
• Consumer Directed Personal Assistance Program	168	167	174	180
SUBTOTALS	514	511	521	502
Long Term Home Health Care Program	180	182	190	204
Nursing Home Placement	80	74	59	49
Family Homes for the Elderly	37	35	36	38
Assisted Living Program	26	27	51	52
Care At Home	7	7	7	9
Home & Community Based Waiver	51	56	53	53
Nursing Home to Community	221	253	145	124
Golden Days	17	23	26	29
Private Duty Nursing	23	21	22	23
Case Management Only	317	345	337	356
Traumatic Brain Injury	7	12	11	10
TOTALS	1,480	1,546	1,458	1,449
Personal Emergency Response System	228	231	248	228
PRIs Completed/Reviewed	399	416	484	52
UNDUPLICATED COUNT				
Personal Care Programs	770	740	760	702
Long Term Home Health Care Programs	241	270	278	281

PERSONAL CARE AIDE BY LEVEL OF CARE

Program	PCA Level I*		PCA Level II*		Totals
Personal Care Aide	97	*43%*	126	*57%*	223
Shared Aide	103	*47%*	115	*53%*	218
Consumer Directed Personal Assistance Program	28	*14%*	170	*86%*	198

***** See Page 18 for description of PCA Level I and Level II.

Personal Care Aide: Levels of Care

Personal Care Aide services can be accessed in three main standards of operation:

- ***Personal Care Aide (PCA):***
  CASA assesses, authorizes and case manages services to individual consumers and contracts for the services through traditional licensed care agencies. Service is billed in one hour time increments.

- ***Shared Aide (SA):***
  CASA assesses, authorizes and case manages services for consumers who live in clusters that allow CASA to authorize care for many consumers delivered by one agency. Each agency aide is able to serve more clients in shorter periods of time by being centralized in one area and/or building. Aide time is billed in 15-minute increments instead of hourly.

- ***Consumer Directed Personal Assistance Program (CDPAP):***
  CASA assesses and authorizes care for self directing consumers who hire their own aides and manage their own care.

Care Plan Development

Within these categories of care, CASA works with the consumer to determine a care plan that best meets the consumer's needs. CASA builds the care plan around three basic questions:

1. **What are you able to do for yourself?**
2. **Who is helping you now?**
3. **How do you maintain your maximum level of independence?**

While cost of care is a factor in all of our care planning, it is not the overruling or overriding factor.

Determining Need for PCA Level I or PCA Level II

CASA works with the consumer to determine the type and amount of home care needed: hands off (PCA I) or hands on (PCA II) care, or a combination.

- **PCA Level I:** These are services that are referred to in the vernacular of long term care and aging as "Instrumental Activities of Daily Living" (IADLs). They include meal preparation, shopping, housekeeping, laundry, assistance with bill paying, and other essential errands.

- **PCA Level II:** These services are called the "Activities of Daily Living" (ADLs). They include bathing, dressing, grooming, toileting, transferring, and assistance with walking, feeding, and meal preparation.

Which level of service a consumer receives is based on the three questions listed in the "Care Plan Development" section, as well as the consumer's desire, determination, or physical need for the service.

Many of our PCA Level I clients could use assistance with Level II tasks as a result of their physical limitations, yet due to their desire to remain as independent as possible, they prefer that we take care of the PCA Level I tasks while they take care of their bathing and grooming needs.

2010 DMS-1 SCORES BY PROGRAM

DMS-1 Score	CASA Case Management		Traditional PCA		Shared Aide Program		Lourdes LTHHCP		Ideal LTHHCP		CDPAP		PDN		TOTALS	
0 – 59	128	*48%*	162	*66%*	167	*70%*	28	*37%*	19	*19%*	87	*33%*	0	*0%*	591	*49%*
60 – 179	93	*35%*	63	*26%*	51	*22%*	28	*37%*	50	*50%*	67	*26%*	1	*5%*	353	*29%*
180 +	46	*17%*	19	*8%*	20	*8%*	19	*26%*	31	*31%*	109	*41%*	21	*95%*	265	*22%*
Totals	267	*100%*	244	*100%*	238	*100%*	75	*100%*	100	*100%*	263	*100%*	22	*100%*	1209	*100%*

0 – 59 Indicates a need for a minimal amount of service, much of it related to housekeeping and chores.

60 – 179 Referred to as the Health Related level of care and at this level people begin to need personal care assistance.

180 + Referred to as the Skilled Nursing level of care and often indicates a high level of physical disability or related inability to care for oneself due to dementia.

PRIMARY DIAGNOSIS OF CLIENTS

Ages 22 – 59		*60 Years & Over*		*Combined Age Groups*	
Nervous System Disorders*	79	Mental Health Disorders	170	Mental Health Disorders	199
Mental Health Disorders	29	Cardiovascular Disorders	78	Nervous System Disorders*	156
Musculoskeletal Problems & Injuries	27	Nervous System Disorders*	77	Cardiovascular Disease	96
Diabetes	23	Respiratory/Pulmonary Disease	74	Diabetes	94
Respiratory/Pulmonary Disease	19	Diabetes	71	Respiratory/Pulmonary Disease	93
Cardiovascular Disorders	18	Musculoskeletal Problems & Injuries	59	Musculoskeletal Problems & Injuries	86
Arthritis	12	Arthritis	54	Arthritis	66
Congenital	11	Hypertension	33	Genitourinary System Disorders	37
Genitourinary System Disorders	9	Genitourinary System Disorders	28	Hypertension	37
Heart Disease	9	Heart Disease	27	Heart Disease	36
Cancer	8	Cancer	25	Cancer	33
Infectious Immune Disorders	7	Sensory	16	Sensory	21
Digestive System Disorders	6	Digestive System Disorders	9	Digestive System Disorders	15
Sensory	5	Skin Disease	8	Congenital	13
Hypertension	4	Miscellaneous	5	Skin Disease	12
Skin Disease	4	Infectious Immune Disorders	4	Infectious Immune Disorders	11
Miscellaneous	1	Congenital	2	Miscellaneous	6
Obesity**	1	Obesity**	1	Obesity**	2

* Nervous System Disorders have a potentially high impact on the ability to perform ADL's and IADL's.
** Obesity is not often listed as the primary diagnosis.

REFERRAL STATISTICS

TOTAL NUMBER OF REFERRALS

	2007	2008	2009	2010
Community	1,568	1,560	1,574	1,621
Hospital	808	970	812	686
TOTALS	2,376	2,530	2,386	2,307

REFERRALS BY PAYOR SOURCE

	MEDICAID				NON-MEDICAID			
	2007	2008	2009	2010	2007	2008	2009	2010
Community	485	483	519	560	1,083	1,077	1,055	1,061
Hospital	201	246	207	199	607	724	605	487
TOTALS	686	729	726	759	1,690	1,801	1,660	1,548

HOSPITAL REFERRALS

	MEDICAID				NON-MEDICAID			
	2007	2008	2009	2010	2007	2008	2009	2010
Greater Bing. Health Center	6	1	1	4	5	0	0	2
General	69	64	61	40	94	101	99	56
Lourdes	63	89	51	48	216	290	192	156
Wilson	62	90	92	105	292	332	313	273
Other	1	2	2	2	0	1	1	0
TOTALS	201	246	207	199	607	724	605	487

COMMUNITY REFERRALS

	MEDICAID				NON-MEDICAID			
	2007	2008	2009	2010	2007	2008	2009	2010
Neighbor/Friend	11	11	11	10	15	25	27	12
Self/Family	177	156	151	174	546	594	554	572
Community Agencies	142	119	162	160	165	155	134	95
CHHA	34	56	53	53	48	45	56	67
ACF	17	11	21	36	55	39	49	54
LTHHCP	4	2	3	4	1	0	0	3
PCA Providers	5	15	16	20	8	5	4	6
Physicians	40	27	29	22	97	63	58	64
RHCF	55	86	73	81	148	151	173	188
TOTALS	485	483	519	560	1,083	1,077	1,055	1,061

NURSING HOME TO COMMUNITY PROGRAM

	Nursing Home Residents Assessed by CASA						Nursing Home Residents Discharged with CASA Involvement				
Year	Age 0-59	%	Age 60+	%	**Totals**		Age 0-59	%	Age 60+	%	**Totals**
2003	40	*6%*	597	*94%*	**637**		31	*5%*	539	*95%*	**570**
2004	57	*8%*	616	*92%*	**673**		62	*10%*	556	*90%*	**618**
2005	37	*6%*	582	*94%*	**619**		55	*8%*	607	*92%*	**662**
2006	56	*9%*	559	*91%*	**615**		44	*9%*	423	*91%*	**467**
2007	44	*8%*	475	*92%*	**519**		36	*9%*	372	*91%*	**408**
2008	31	*5%*	648	*95%*	**679**		23	*5%*	452	*95%*	**475**
2009	47	*7%*	617	*93%*	**664**		29	*7%*	377	*93%*	**406**
2010	39	*9%*	397	*91%*	**436**		25	*13%*	172	*87%*	**197**

In 2010, CASA experienced staff shortages due to extended health related absences and vacated positions. The lack of these staff members is evidenced by the marked decrease in the number of referrals for this time period. Staff members accepted additional job responsibilities along with their regular duties during this time in an effort to cover all the programs. We anticipate these numbers will continue to increase as we become fully staffed.

IN-HOME MENTAL HEALTH CARE PROGRAM

16 Active Clients

GENDER	Number of Clients	*Percentage*
Male	4	*25%*
Female	12	*75%*
TOTALS	16	*100%*
AGE RANGES		
Less than 60 years old	5	*31%*
60 years old and over	11	*69%*
TOTALS	16	*100%*
IS CLIENT COMPLIANT WITH TAKING MEDICATIONS?		
Yes	12	*75%*
No	4	*25%*

Activities of Daily Living

Activities	Clients	*Percentage*
Bathing	4	*25%*
Mobility	0	*0%*
Transferring	0	*0%*
Dressing	0	*0%*
Personal Hygiene	5	*31%*
Toileting	0	*0%*
Eating	0	*0%*

Instrumental Activities of Daily Living

Activities	Clients	*Percentage*
Shopping	14	*88%*
Getting to Places	11	*69%*
Housework/Cleaning	13	*81%*
Meal Preparation	6	*38%*
Personal Business	9	*56%*
Telephone	0	*0%*
Medications	8	*50%*

CLIENT DEMOGRAPHICS

Our client demographics tell the following story about the people we serve in the Medicaid home care programs (Personal Care, Consumer Directed and Long Term Home Health Care).

They are overwhelmingly female. Seventy percent of the people in the Personal Care or Long Term Home Health Care Programs are women.

Most likely they are not married. They are either widowed, divorced or have never been married.

By virtue of the fact that they are served by Medicaid programs, they are low income. Their primary source of income comes from three government programs: Social Security, Supplemental Security Insurance, or Social Security Disability.

Eighty-nine percent of the people we serve depend on others to transport them around town, thus the high percentage that requires their aides to shop for them. While they report being dependent on others for transport, 28% or less report using public transportation.

Home ownership is low among the people we serve. Seventy-two percent of them rent. Forty-two percent live with someone else and 58% live alone.

In the Personal Care Program which includes Consumer Directed Care, 46% of the recipients are under the age of 60. In the LTHHCP 25% are less than 60 years old.

CASA authorizes shopping and housekeeping for almost the entire population of people receiving home care from any program. Three-fourths of the population requires assistance with bathing and personal hygiene.

So who is being served in the Medicaid home care programs in Broome County? Out of the 983 people served in 2010, they were mostly low income women who are not necessarily elderly. They live alone, do not own their own homes and are dependent on others for transportation. The most frequently requested services are shopping, housekeeping, and personal care. Most likely they each have more than one chronic condition related to the top five diagnostic categories: mental health disorders, nervous system disorders, cardiovascular disorders, diabetes, and respiratory/pulmonary disease.

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