Florida Department of Elder Affairs

LONG-RANGE PROGRAM PLAN
FISCAL YEARS 2005-2006 THROUGH 2009-2010

Terry F. White, Secretary
4040 Esplanade Way
Tallahassee, Florida 32399-7000
Phone - 850/414-2000 • Fax - 850/414-2004 • TDD - 850/414-2001
Internet addresses:
(English) http://myflorida.com
(Spanish) http://elderaffairs.state.fl.us/doea/ancianos.html

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Mission: "Promoting Elder Independence"
To create an environment that provides choices, promotes independence and enables older Floridians to remain in their communities for a lifetime

Vision:
To lead the nation in assisting elders to age in place, with dignity, purpose, security, and in an elder-friendly community

Values:

- Compassion
- Accountability
- Caregiver Support
- Quality
- Intergenerational
- Partnerships
- Diversity

Goals, Objectives, Outcomes

The Department of Elder Affairs will concentrate its efforts in the following three **priority areas**: *Create a Long-Term Care System that is Streamlined, Cost-effective and Consumer-friendly; Create a Greater Support Network for Elders, Families and Caregivers; and Create an Elder-Friendly Environment that Values the Contributions and Needs of Elders*. These provide the framework for the agency's objectives and outcomes.

Priority Area 1: Create a Long-Term Care System that is Streamlined, Cost-effective and Consumer-friendly

Strategies (in priority order):

- Design an Aging Resource Center to serve as a single point of access for information, counseling, referrals, assessment and eligibility functions for both publicly and privately funded services.
- Enhance interagency coordination of long-term care activities.
- Promote regulatory alignment that supports smooth transition between care settings and encourages multi-care settings.
- Develop efficient business processes to facilitate long-term care and apply information technology solutions as appropriate.
- Integrate Medicare services into capitated long-term care demonstration projects.
- Build long-term care service capacity tailored to geographic, cultural and economic needs of Florida's elder citizens.
- Expand consumer/caregiver-directed options in service delivery where possible.
- Increase participation in long-term care service delivery.
- Promote public/private partnerships including the business community and faith-based entities.

Priority Area 2: Create a Greater Support Network for Elders, Families and Caregivers

Strategies (in priority order):

- Expedite access to program services and resources.
- Promote and provide caregiver training and support activities.
- Expand health and wellness programs.
- Support innovation in health promotion/disease prevention, nutrition and in-home services.
- Support expansion of older worker training and employment programs.
- Promote public/private partnerships including the business community and faith-based entities.
- Enhance baby boomers and pre-retirees knowledge of strategic lifestyle issues that enable them to better prepare for the future.

Priority Area 3: Create an Elder-Friendly Environment that Values the Contributions and Needs of Elders

Strategies (in priority order):

- Create a greater awareness of the contributions of elders.
- Develop communities for a lifetime.
- Promote Florida as a retirement destination.
- Participate in economic development planning.
- Support and promote intergenerational programs.
- Work with state and local agencies to enhance quality of life for mature residents.
- Promote public/private partnerships including the business community and faith-based entities.
- Provide resources, training, recognition and state support of local *Communities for a Lifetime* efforts to participating, primed and potential communities.

Goals, Objectives, Outcomes
(In Priority Order)

Goal 1: **Create a Long-Term Care System that is Streamlined, Cost-effective and Consumer-friendly**

Objective 1a: To prevent/delay premature nursing home placement

Outcome: Percent of most frail elders who remain at home or in the community instead of going into a nursing home

Baseline Year 1999-00	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
91.6%	97%	97%	97%	97%	97%

(Explanatory note: This outcome refers to DOEA customers assessed in the top 20 percentile for risk of nursing home placement.)

NOTE: The Department continues to improve its targeting efforts; therefore entering customers are invariably frailer. Maintaining standards is, under the circumstances, a good outcome.

Objective 1b: To provide prompt and appropriate services to the most frail elders who are at risk of institutionalization

Outcome: Percent of elders the CARES program determined to be eligible for nursing home placement that are diverted into the community

Baseline Year 1998-99	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
15.3%	26.4%	26.4%	26.4%	26.4%	26.4%

Goals, Objectives, Outcomes

Objective 1c: To target services to help particularly vulnerable frail elders to live at home or in the community when safe and appropriate

Outcome: Percent of customers who are at imminent risk of nursing home placement who are served with community-based services

Baseline Year 2003-2004	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
90%	90%	90%	90%	90%	90%

Objective 1d: To provide prompt and appropriate services to elders referred from Adult Protective Services who meet the frailty level criteria

Outcome: Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours

Baseline Year 2000-2001	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
94%*	97%	97%	97%	97%	97%

*Based on 6 months of data. Changes were made to collect data more completely.

Goals, Objectives, Outcomes

Objective 1e: To improve the nutritional status of elders

Outcome: Percent of new service recipients with high-risk nutrition scores whose nutritional status improved

Baseline Year 1997-99	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
58.6%	66%	66%	66%	66%	66%

Objective 1f: To assist elders to maintain their independence and choices in their homes as long as possible

Outcome: Percent of new service recipients whose Activities of Daily Living (ADL) assessment score has been maintained or improved

Baseline Year 1997-99	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
59.1%	63%	63%	63%	63%	63%

Goals, Objectives, Outcomes

Objective 1g: To assist elders to maintain their independence and choices in their communities as long as possible

Outcome: Percent of new service recipients whose Instrumental Activities of Daily Living (IADL) assessment score has been maintained or improved

Baseline Year 1997-99	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
58%	62.3%	62.3%	62.3%	62.3%	62.3%

Objective 1h: To use long-term care resources in the most efficient and effective way

Outcome: Average monthly savings per consumer for home and community-based care versus nursing home care for comparable client groups

Baseline Year 1998-99	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
$2,221	$2,563	$2,755	$2,962	$3,184	$3,423

Goals, Objectives, Outcomes

Objective 1i: To leverage a variety of non-state resources whenever possible

Outcome: Average time in the Community Care for the Elderly program for Medicaid Waiver-probable customers

Baseline Year 2002-2003	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
2.8 months	4 months	4 months	4 months	4 months	4 months

NOTE: The Department will be implementing Aging Resource Centers, with the first three planned to begin operation by July 1, 2005. Successful implementation of the Aging Resource Centers will allow consumers in those areas to access Medicaid services more quickly, as long as funds for services are available. When the Aging Resource Centers are implemented statewide, the time for eligibility processing will be greatly reduced.

Goals, Objectives, Outcomes

Goal 2: Create a Greater Support Network for Elders, Families and Caregivers

Objective 2a: To provide caregivers with assistance/respite to help them to be able to continue providing care

Outcome 1: The percentage of caregivers whose ability to continue to provide care is maintained or improved after service intervention (as determined by the caregiver and the assessor)

Baseline Year 2002-2003	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
87%	90%	90%	90%	90%	90%

(Explanatory note: This outcome refers to caregivers of elders served by DOEA programs.)

Outcome 2: Percent of family and family-assisted caregivers who self-report they are very likely to provide care

Baseline Year 1997-1998	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
90.2%	89%	89%	89%	89%	89%

(Explanatory note: This outcome refers to caregivers of elders served by DOEA programs.)

Goals, Objectives, Outcomes

Goal 3: Create an Elder-Friendly Environment that Values the Contributions and Needs of Elders

Objective 3a: To ensure the security of vulnerable elders residing in long-term care facilities through annual facility reviews and complaint investigation

Outcome: Percent of complaint investigations initiated by the Ombudsman within 5 working days (applies to Long-Term Care Ombudsman Council)

Baseline Year 1998-99	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
90.2%	91%	91%	91%	91%	91%

Objective 3b: To ensure that consumers needing guardianship services are provided that protection

Outcome: Percent of service activity on behalf of frail or incapacitated elders initiated by public guardianship within 5 days of receipt of request

Baseline Year 1999-00	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
90%	95%	95%	95%	95%	95%

Goals, Objectives, Outcomes

Objective 3c: To help elders to have home environments that are as safe as possible

Outcome: Percent of elders assessed with high or moderate risk environments who improved their environment score

Baseline Year 1996-98	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
81.2%	66.5%	66.5%	66.5%	66.5%	66.5%

(Explanatory note: This outcome refers to elders served by DOEA programs.)

Linkage to Governor's Priorities

1. **Improve Education**
   - Goal 3: Create an Elder-Friendly Environment that Values the Contributions and Needs of Elders

2. **Strengthen Families**
   - Goal 1: Create a Long-Term Care System that is Streamlined, Cost-effective and Consumer-friendly
   - Goal 2: Create a Greater Support Network for Elders, Families and Caregivers
   - Goal 3: Create an Elder-Friendly Environment that Values the Contributions and Needs of Elders

3. **Promote Economic Diversity**
   - Goal 3: Create an Elder-Friendly Environment that Values the Contributions and Needs of Elders

4. **Reduce Violent Crime and Illegal Drug Use**
   - N/A

5. **Create a Smaller, More Effective, More Efficient Government**
   - Goal 1: Create a Long-Term Care System that is Streamlined, Cost-effective and Consumer-friendly
   - Goal 2: Create a Greater Support Network for Elders, Families and Caregivers

6. **Enhance Florida's Environment and Quality of Life**
   - Goal 1: Create a Long-Term Care System that is Streamlined, Cost-effective and Consumer-friendly
   - Goal 2: Create a Greater Support Network for Elders, Families and Caregivers
   - Goal 3: Create an Elder-Friendly Environment that Values the Contributions and Needs of Elders

Trends and Conditions Statement

Agency Primary Responsibilities

The Florida Department of Elder Affairs was created in 1991 as a result of a 1988 constitutional amendment and its later statutory enactment in the "Department of Elderly Affairs Act" (Chapter 430, Florida Statutes.) Since its creation, the Department of Elder Affairs has been successfully serving and advocating for elder Floridians.

The Department is charged with the following functions (s. 430.04, F.S.):

(1) Administer human services and long-term care programs ensuring that the elderly of this state receive the best services possible.

(2) To assist functionally impaired elderly persons in living dignified and reasonably independent lives in their own homes or in the homes of relatives or caregivers through the development, expansion, reorganization, and coordination of various community-based services.

(3) Serve as an information clearinghouse at the state level, and assist local-level information and referral resources as a repository and means for dissemination of information regarding all federal, state, and local resources for assistance to the elderly in among other areas: health, social welfare, long-term care, protective services, consumer protection, education and training, housing, employment, recreation, and transportation.

(4) Provide the lead and coordinate and review the roles and plans for state agencies that provide services for the aging.

(5) Develop a comprehensive volunteer program that includes an intergenerational component and draws on the strengths and skills of the state's older population and, to the extent possible, implements the volunteer service credit program.

(6) Combat ageism and create public awareness and understanding of the potentials and needs of elderly persons.

Priority Setting Framework

The vision, values and mission of the Department define its policy and drive its goals in serving older Floridians. These goals are consistent with Florida's Golden Choices, the state's blueprint for services to elders, which can be classified into five integral themes:

1. **Aging in Place**
   The right of Floridians to age in the communities of their choice in the least restrictive environment.
2. **Aging with Dignity**
   The right to live without fear of abuse, neglect, or any other crimes.
3. **Aging with Security**
   The right to live with dignity and respect.
4. **Aging with Purpose**
   The right to contribute talent, experience, or economic strength to the community at large.
5. **Aging in an Elder-friendly Environment**
   The right to participate in a community that fosters elders' quality of life, safety and independence both at home and throughout the community.

The Department's primary responsibilities have been synthesized into three policy goals identified during strategic planning sessions in early 2004 with senior agency leaders. They provide the foundation for the Department of Elder Affairs' efforts to build a better life in Florida for persons of all ages. The Department has developed an associated set of operational objectives and measurements for each of the goals that permit tracking of progress towards their achievement.

The following goals reflect the current strategic thinking of the Department of Elder Affairs:

1. **Create a Long-Term Care System that is Streamlined, Cost-effective and Consumer-friendly**
2. **Create a Greater Support Network for Elders, Families and Caregivers**
3. **Create an Elder-Friendly Environment that Values the Contributions and Needs of Elders**

These goals can only be achieved through a coordinated, fiscally sustainable and customer-oriented service delivery system that supports the diverse needs of Florida's elders.

Organizational Planning Values: The Department's operational priorities were determined through a comprehensive Strength, Weakness, Opportunity and Threat Analysis (SWOT). This analysis is founded in the department's organizational values.

In assessing programs and policies, the Department will keep the consumer's desires, service quality, fiscal sustainability, and the strengthening of the elder services network as its organizational values.

Consumer-centered service: Consumer choice and autonomy will remain a top priority as the Department works to innovate and expand programs that give older Floridians and their families the freedom to choose to remain in their communities enjoying the best possible lifestyle that their health will allow.

Partnering: A core value of the Department is the strengthening of the Elder Services Network. The Department will continue to function as one of the most highly privatized agencies of state government. This can only be achieved by delivering services through a network of highly committed for-profit and non-profit providers and contractors that are committed to the Department's customer-centered "Golden Choices" philosophy.

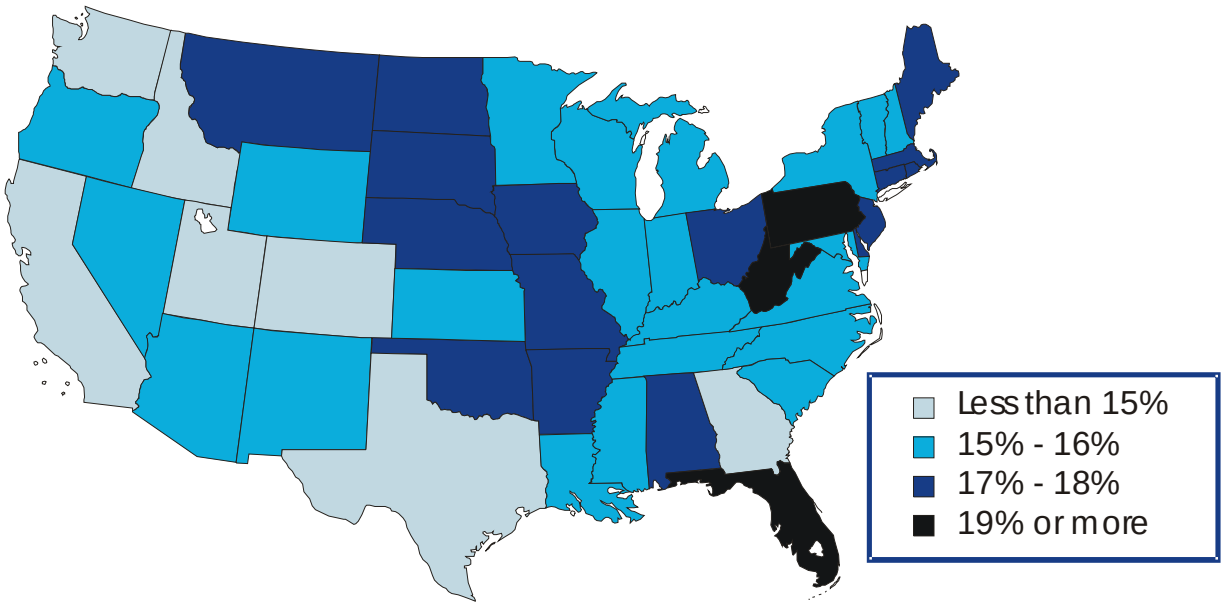
Fiscal Sustainability: To remain viable, the Department's programs and initiatives must be fiscally sound. Programs for elders can only be sustained over the long run if they generate value for all Floridians. Department programs have to show that they are efficient and effective.

The State of Aging in Florida – A Monograph and Needs Assessment

Population Growth and Distribution

Florida is the fourth most populous state, with almost 17.5 million citizens. Having over 3.9 million persons age 60 and older, Florida ranks number one in the percentage of its citizens who are elders (23 percent in 2004). (See Figure 1.)

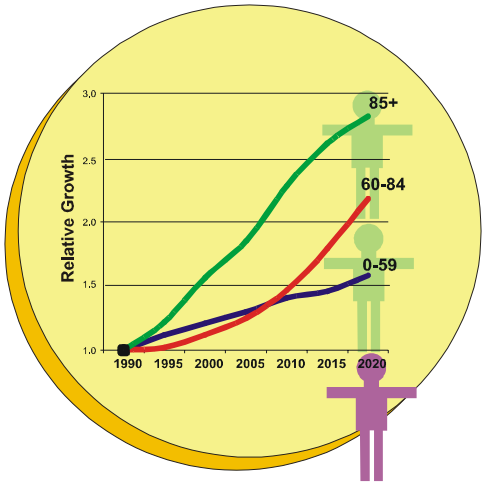
Figure 1
Percentage of the Population Age 60 And Older by State (2000)



Source: 2000 U.S. Census

Since 1990, Florida's elder population has increased by almost one million – a 29 percent increase. However, the rate of growth is not homogeneous among age groups; the oldest old increased fastest. (See Figure 2.) During the last ten years, the number of persons age 85 and older grew four times faster than persons age 60 to 84. This growth is significant for policy makers and planners as the oldest old are four times more likely to need long-term care services.

Figure 2
Florida's Population Growth
By Age Group
(1990 – 2020)



Source: Office of Economic and Demographic Research. The Florida Legislature. "Florida Census Day Population 1970 – 2020"

Nevertheless, in the near future this difference in growth rates among elderly age groups will be almost eliminated as baby boomers enter their early senior years starting in 2005. By 2020 when baby boomers start turning 75, demand for long-term care services will start to intensify. What this suggests is that, as a recent AARP report states, "there will not be a tidal wave for long-term supportive services for at least two decades, even if utilization trends stay constant at recent rates."[1]

The growth of the population age 60 and older has not been distributed uniformly throughout the state. About half of the population growth among the elderly comes from amenity-seeking retirees who move to Florida. In the past the traditional destination counties had been in Southeast Florida. During the last ten years, an increasing number of retirees has been moving into counties in Northeast, Northwest and Southwest Florida. Figure 3 shows the growth of the elder population by county.

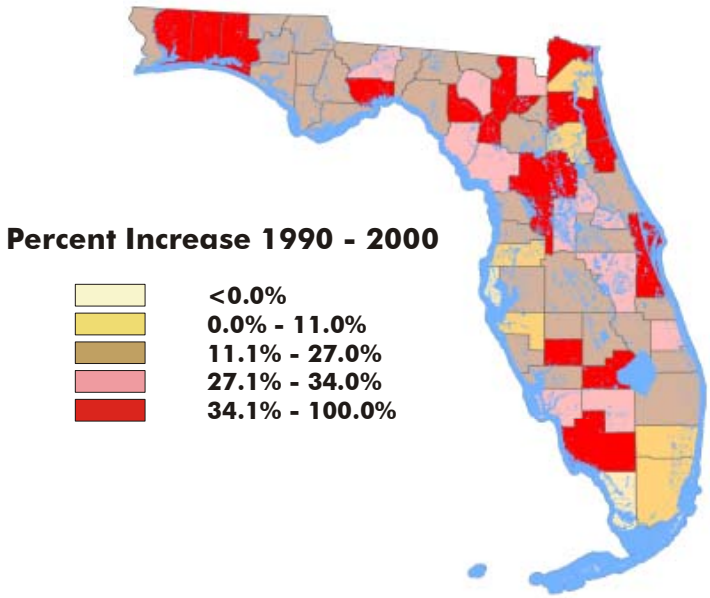
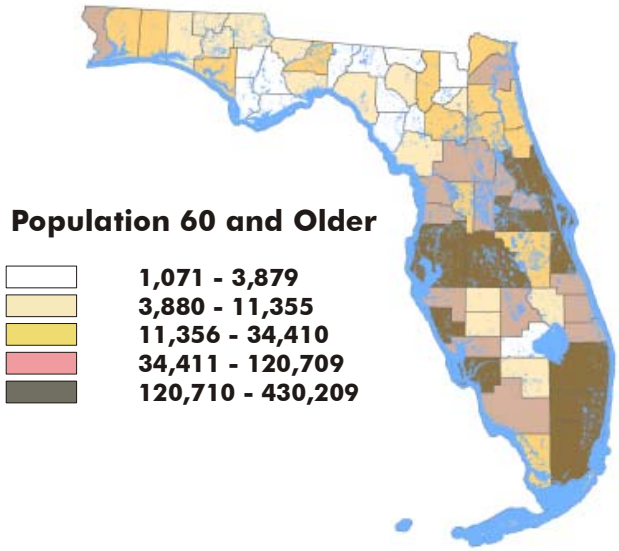


Figure 3
Florida's 60 and Older Population Growth by County (1990 – 2020)

Source: Department of Elder Affairs based on Office of Economic and Demographic Research, Florida Legislature

The counties with the largest number of elders are located in South and Central Florida. The top ten counties by size of their elder population are Miami-Dade, Broward, Palm Beach, Pinellas, Hillsborough, Lee, Sarasota, Orange, Brevard and Volusia. These ten counties (out of Florida's 67), account for 55 percent of the elder population in the state. (See Figure 4.)

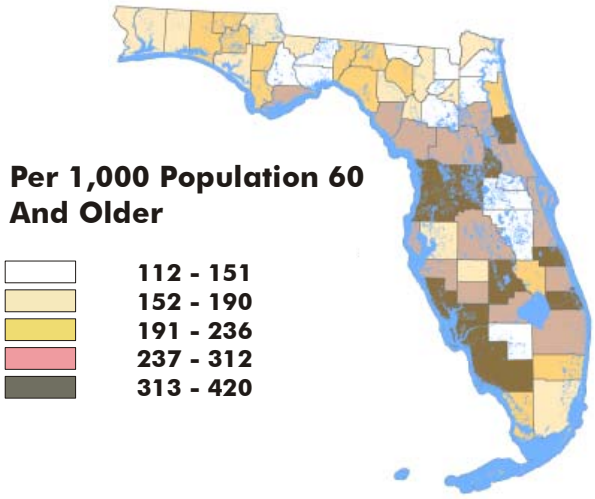
Figure 4
Florida's Population Age 60 and Older By County



Source: Department of Elder Affairs based on Office of Economic and Demographic Research, Florida Legislature

Having a large elder population does not necessarily mean having a relatively older population. For instance, counties such as Miami-Dade, Broward or Palm Beach also have sizable younger populations. On the other hand, some smaller counties have a much larger share of the population age 60 and older. Among counties with a population larger than 10,000, Florida has the three top counties in the nation with the largest share of elders: Charlotte, Citrus and Highlands. Each of these counties has an elder population density of more than 40 percent. There are another 13 counties with elder population densities in excess of 30 percent. Among large counties, Miami-Dade has 18 percent, Broward 20 percent and Palm Beach 28 percent. (See Figure 5.)

Figure 5
Population Density
Age 60 and Older
By County



Source: Department of Elder Affairs based on Office of Economic and Demographic Research, Florida Legislature

Income and Poverty

Although the median family income of elder Floridians is $26,796 (mean is $41,223), an estimated 11.2 percent of all residents age 60 and older have annual family incomes that fall below poverty level as defined by the U.S. Department of Health and Human Services (single person = $8,980). Among elders, the likelihood of being poor increases with age.[2]

Social Support Programs

The economic well being of elders is very dependent on social income-support programs such as Social Security, which provides the income safety net for a majority of elders. About 50 percent of the cash income of Floridians age 65 and older comes from Social Security and about 46 percent of those in this age group would be poor if not for this program. Another income support program for the elderly is Supplemental Security Income (SSI).

In-kind support programs are also very important for the well-being of the elderly. The most important of such programs is Medicare. Also included in this category are Medicaid, Food Stamps and supportive services under Title III of the Older Americans

Act. Medicare has a fungible value worth on average about $8,000 per family. Figures 6 and 7 show the importance of public programs. Figure 6 shows the distribution of income (cash and in-kind) for all elder households. Figure 7 shows the distribution of income (cash and in-kind) for elders who would be poor if not for public income support programs. These elders are labeled "at-risk" in Figure 7.

Figure 6
Income by Source
Elder Families
All Income Levels

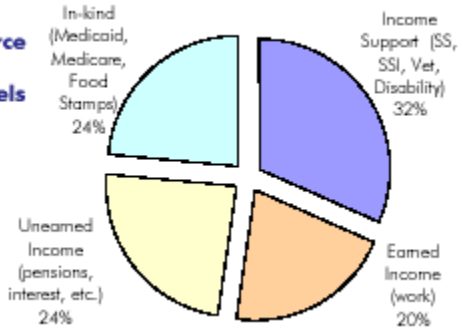
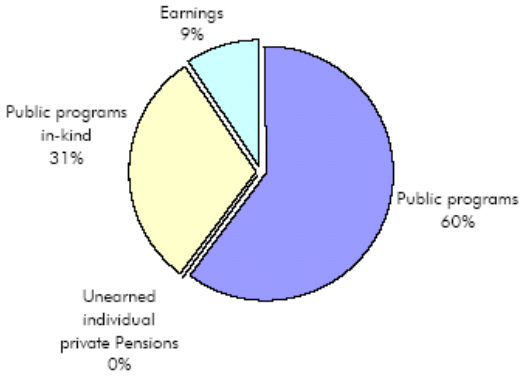


Figure 7
Income by Source
For At-Risk Elders

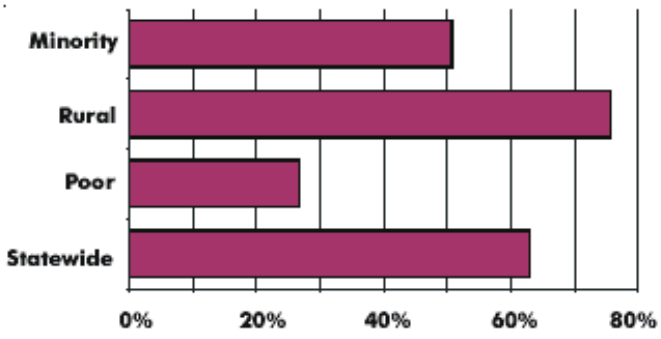


Living Situation

Over 60 percent of all elders in Florida live with their spouse. Some of these people might also live with children, grandchildren and/or other people. Elders living in rural areas are more likely to live with their spouse (over 75 percent). (See Figure 8.) Knowing the number of elders living with a spouse is important in assessing the needs of older adults. A spouse is often the first person called upon for caregiving.

Figure 8
Percent of Elders Who Live with Their Spouse

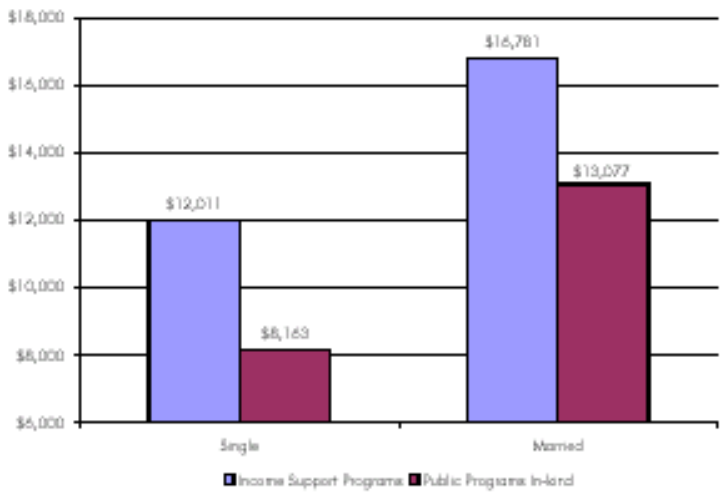
Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs



Additionally, federal income support programs favor married couples by providing increased benefits leading to lower poverty rates for married elders. (See Figure 9.) Over half of Florida elders living in high poverty areas are living alone. These elders are twice as likely as others to live alone.

Figure 9
Income and In-Kind Supports By Marital Status

Source: Department of Elder Affairs



Elders living alone are more likely to be at-risk for Medicaid nursing home care. They lack the family to care for them when frailty sets in and might lack the means to pay for such care. Figure 10 shows that the poor are more likely to live alone. Again, as explained above, poverty may be a consequence of living alone. Rural elders are least likely to live alone. The hardship of living alone in geographical isolation may encourage widowed rural elders to move to urban areas.

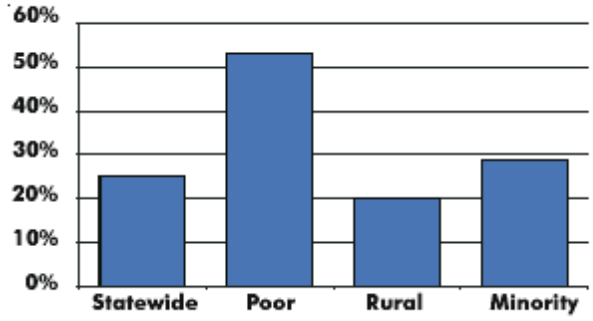


Figure 10
Percent of Elders Who Live Alone

Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Minority elders are three times as likely to be poor than non-minorities. (See Figure 11.) However, as Figure 12 shows, most of the difference in poverty rates is due to differences in government income-support programs. Non-minorities are more likely to

be married—due to longer life spans of white males— and have work histories that represent higher Social Security payments.

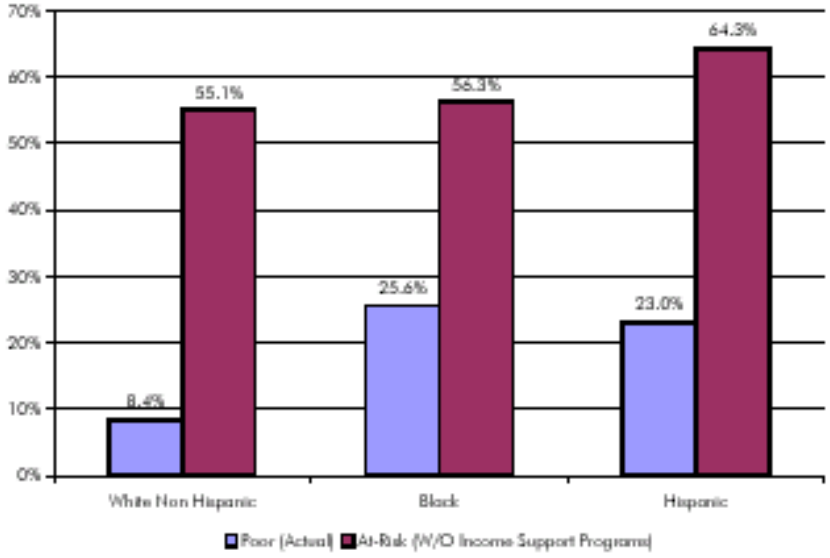


Figure 11
Poverty Rates
By Race/ Ethnicity

Source: Department of Elder Affairs

Figure 12
Income Support and
In-Kind Programs
By Race/ Ethnicity

Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

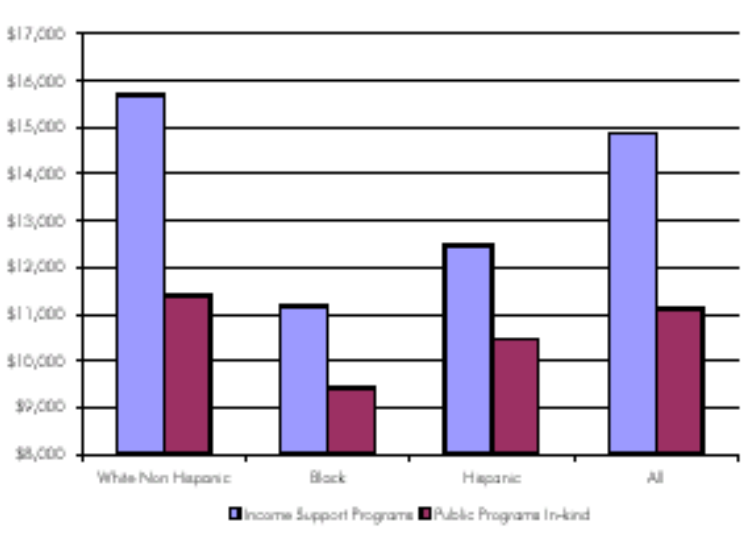
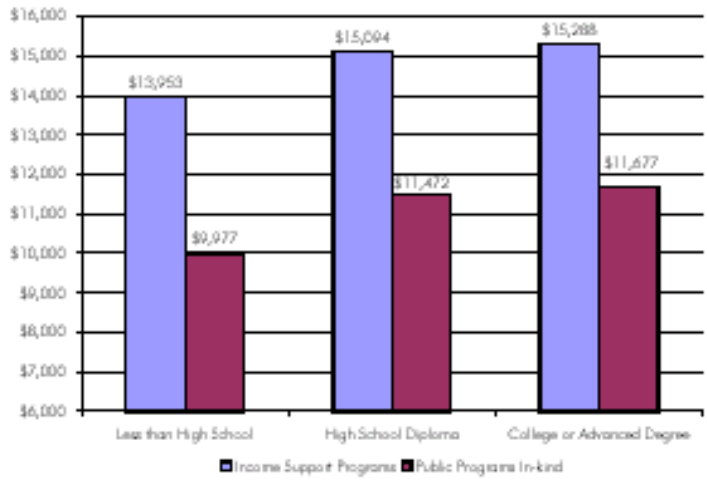


Figure 13 shows that education has an impact on the amount of support received from public programs, because higher educational levels are tied to higher earnings and higher support payments. To a large extent, poverty among the elderly is a reflection of racist educational policies of 60 years ago.

Figure 13
Income Support and In-Kind Programs By Educational Achievement

Source: Department of Elder Affairs



Gender and Marital Status

Women have a substantially longer lifespan than men. Figure 14 shows that, while men are 46 percent of the population in the 60 to 74 age group, they make up only 34 percent of those age 85 and older. Since the propensity to require long-term care is four times greater at age 85 than at age 60, most persons in need of long-term care are women who have outlived their male partners. Currently, about 47 percent of persons age 65 and older do not have a spouse, and the likelihood of not having a partner is much higher for elders age 85 and older.

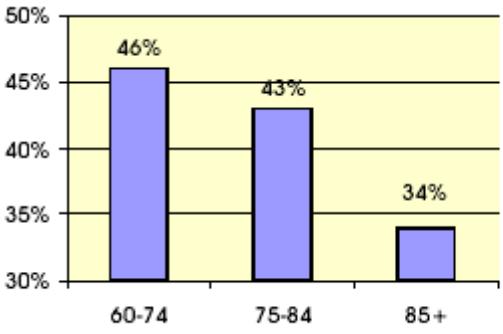


Figure 14
The Percentage of Males By Age Group in Florida (2000)

Source: Office of Economic and Demographic Research. The Florida Legislature.

Long-term trends indicate that the longevity gap has been narrowing, and is expected to continue to do so. (See Figure 15.) This trend has positive implications for the demand on public long-term care. The main determinant for the need for long-term care is the absence of a caregiver. As men's longevity increases, the number of years women live without a caregiving spouse will be reduced.

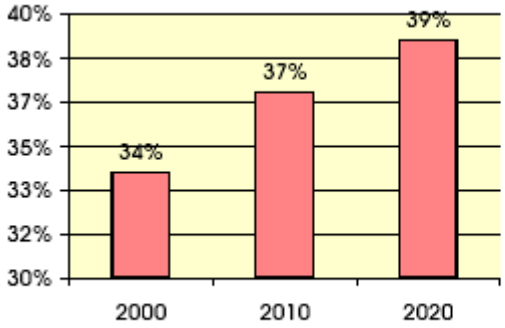


Figure 15
The Percentage of Males Among People Age 85 and Older in Florida (2000-2020)

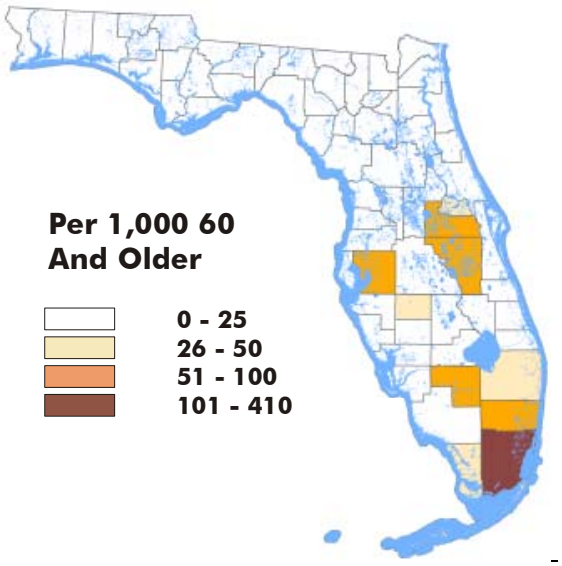
Source: Office of Economic and Demographic Research. The Florida Legislature.

Ethnicity and Linguistic Isolation

Minority populations constitute 18 percent of the total number of Floridians age 60 and older. Among minorities, Hispanics are most numerous accounting for ten percent of the elder population, African Americans seven percent and other minorities about one percent. For the period 1995 through 2010, U.S. Census projections predict an estimated 102 percent increase in the number of individuals of Hispanic origin age 65 and older residing in Florida, from approximately 237,670 to 479,556 individuals. Over this same 15-year period, the number of persons of Hispanic origin age 85 and older will grow from an estimated 24,734 individuals to 63,599, an increase of 157 percent. The distribution of minority and linguistically isolated elders is not uniform throughout the state, as Figures 16 and 17 show. The non-English speaking elder population is concentrated in seven of Florida's 67 counties, with a single county (Miami-Dade) accounting for two out every three elder Hispanics. Other minorities are more evenly distributed, with African Americans as the most prevalent minority in North Florida.

Figure 16
Non-English Speaking Density Within 60 and Older Population By County

Source: Department of Elder Affairs based on Office of Economic and Demographic Research, Florida Legislature



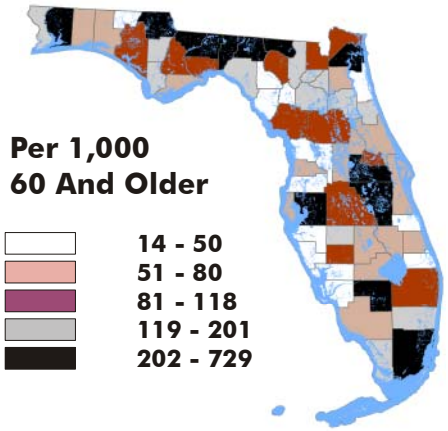


Figure 17
Minority Population Density within 60 And Older Population By County

Source: Department of Elder Affairs based on Office of Economic and Demographic Research, Florida Legislature

Dependency and Disability

The large majority of elder Floridians enjoys the good health necessary to lead active, productive and independent lifestyles. Nevertheless, about 23 percent of the population age 65 and older (652,149 individuals) have a disability that requires assistance with activities of daily living (such as bathing or dressing) or instrumental activities of daily living (such as paying bills or using the telephone). The disability rate increases with age, with people age 85 and older having four times the rate of disability as those who are age 60 to 84.

A growing body of evidence proves that during the last 20 years disability rates have declined substantially. Declining rates have proven overly pessimistic past forecasts wrong. Figure 18 illustrates that in 1999 the number of disabled elder Americans was 2.3 million less than would have been expected based on 1982-1984 age specific disability rates. That represents almost a 25 percent decline. Most of the research exploring this trend strongly suggests that the main forces behind this decline are improvements in elder health, socioeconomic improvements and medical advances.

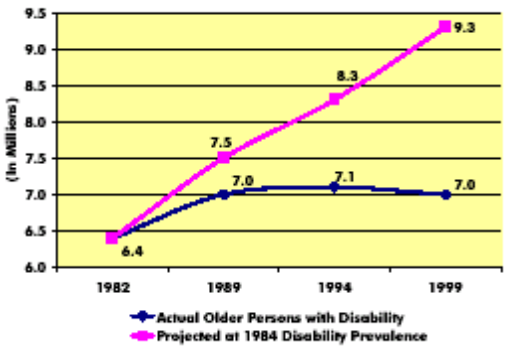


Figure 18
Past Estimates and Actual Number of Americans 65 and Older with any Chronic Disability

Source: AARP Public Policy Institute. Based on 1994 National Long-Term Care Survey and U.S. Census Bureau Population, Middle Series.

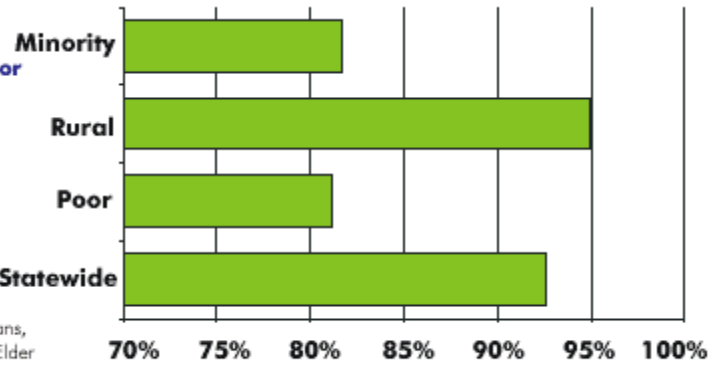
Improvements in elder health and medical advances reduce the demand for long-term supportive services by compressing morbidity and acute disability towards the end of life, resulting in significant gains in disability-free years.[3] Even as the prevalence of chronic conditions has increased, medical technology advances have made the effects of these conditions less incapacitating. Particularly notable are advances that mitigate the disabling effects of arthritis and eye problems, such as cataracts and diabetes induced retinopathies.

Evidence from the National Long-Term Care Survey and Social Security data demonstrates that disability declines are associated with a higher educational level and white-collar occupations. Continuing increases in educational levels and improvement in workplace safety suggest that disability rates will continue their decline. Therefore, projections assuming that current disability rates will not continue their downward trend could produce inaccurately high forecasts.

Survey data indicates that the impairment rate of Florida's elder population is seven percent less than the national rate, contributing to a relatively low nursing home occupancy rate in comparison with other states. Additional evidence comes from the 2000 Census, which reports that, even though Floridians have overall slightly higher physical disability rates, their disabilities are less likely to be of the type concomitant with the need for supportive care. The Census also reports that the prevalence of severe disability (two or more disabilities, including a self-care disability) among elder Floridians is 17 percent lower than the national average.

According to 2004 Department of Elder Affairs' needs assessment findings, over 90 percent of Florida elders surveyed said that they are able to do personal tasks either "always" or "most of the time." Rural elders are more likely to respond this way; poor and minority elders are less likely to respond this way. (See Figure 19.)

Figure 19
Percent of Elders Who Are Always or Most of the Time Able to Do Basic Personal Tasks



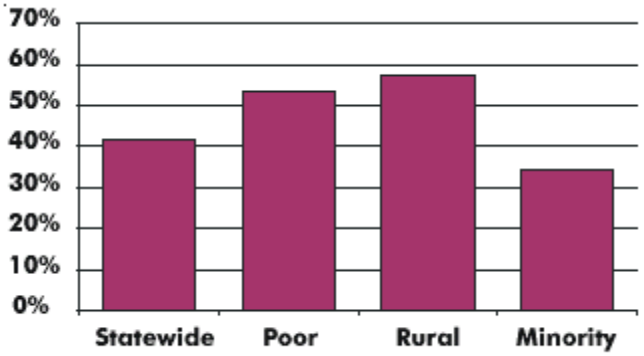
Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Less than half of those who need help with personal care receive such help either "always" or "most of the time." Poor and rural elders who need help are more likely to

receive the help they need. Only about one-third of minority elders are able to get the personal care they need. (See Figure 20.)

Figure 20
Percent of Elders, Who Need Help with Personal Tasks, Who Recieve the Help Always or Most of the Time

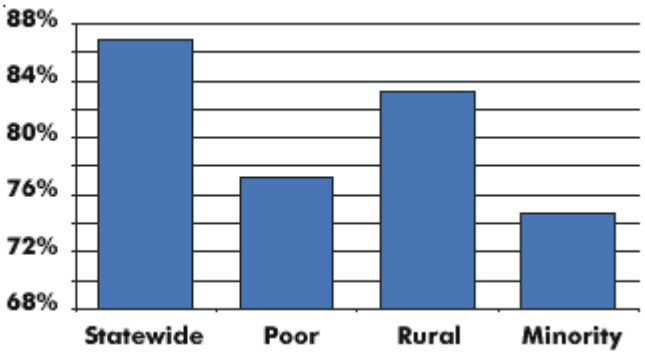
Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs



Statewide, over 85 percent of elders surveyed said that they are able to do household management tasks on their own either "always" or "most of the time." All three special populations were less likely to respond this way. Minority elders are the least likely to respond this way. (See Figure 21.)

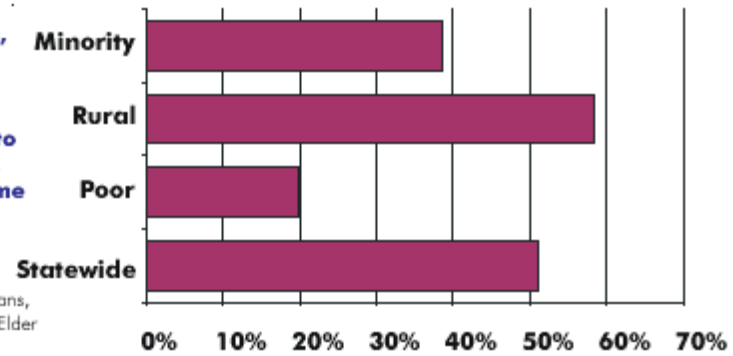
Figure 21
Percent of Elders Who Are Always or Most of the Time Able to Do Household Management Tasks

Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs



Among those who need help with household management tasks, some are more likely to get this help than others. Statewide, slightly more than half of these elders are able to get help with household management tasks if they need it. Rural elders are slightly more successful in getting this help. However, less than 40 percent of minority elders and less than 20 percent of poor elders are able to get help with household management when they need it. (See Figure 22.)

Figure 22
Percent of Elders, Who Need Help with Household Management Tasks, Are Able to Get Help Always or Most of the Time



Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Caregiving

The long-term care setting preferred by most elders is their own home. To make this happen, family members, neighbors, faith-based organizations and community volunteers are relied upon to provide the bulk of home and personal care services. It is estimated that there are 1,427,899 caregivers in Florida (about half being primary caregivers) currently providing $11.2 billion worth of informal care for disabled Floridians. Nationally, this figure tops $196 billion.[4] By comparison, Florida's total public expenditures on long-term care were about $2.5 billion in state fiscal year 2002-03. Therefore, in Florida, the value of informal (not for pay) services provided by caregivers constitutes approximately 81 percent of the total cost of all long-term care.

Findings of the National Caregivers Survey (1997) show that about one in four households in America is involved in caring for an elderly relative. About 72 percent of those providing care are women, and 68 percent of them are middle-aged or elders. More than 30 percent of caregivers are caring for two or more elderly relatives or friends, and almost one-fourth of caregivers are dealing with someone who suffers from some form of dementia.[5]

The survey also indicates that the average caregiver spends 18 hours a week providing care while many spend more than 40 hours a week. The typical recipient of care is a 77-year-old woman with chronic illnesses. About 64 percent of caregivers work full-time. Some quit their jobs or retire early to provide care; others take leaves of absence or reject promotions, while some try to accommodate the demands of both job and caregiving.

Results from a recent survey of caregivers conducted by the Department of Elder Affairs (DOEA) suggests that the greatest negative effects of caregiving are on household finances, with 62 percent of caregivers reporting that caregiving creates a financial burden. The survey also suggests that about one-fourth of caregivers are very frail and at high risk of discontinuing their caregiving. This survey also reported that the most frequently requested service by caregivers was help in navigating the maze of social and medical agencies that administer services to elders.[6]

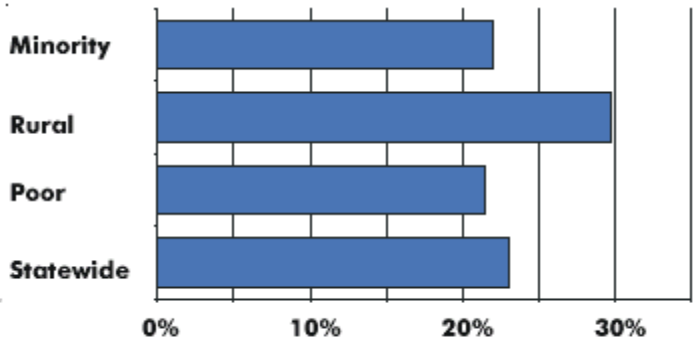
Programs that assist caregivers are highly cost effective. For example, it is estimated that the Home Care for the Elderly (HCE) program, a caregiver cash-support program targeted at caregivers of elders at high risk of nursing home placement, provides a savings of almost five-dollars in nursing home costs for every dollar spent by the program.[7]

Caregivers are also a critical component in the formal long-term care system. Without caregivers, the most impaired elders being served in the community through formal publicly-funded long-term care programs would not be able to stay out of nursing homes without substantially increasing their care plan costs. For example, only 32 percent of DOEA customers who are at medium risk for nursing-care placement have a caregiver. In contrast, 66 percent of those at very high risk of nursing home placement have a caregiver. Without such caregivers, customers would require either nursing home based care or a much more expensive publicly funded care plan.

A study done by the Florida Policy Exchange on Aging Center determined that "whereas exactly half of Florida's nursing home long term residents require assistance with all five activities of daily living, fully 40 percent of the state's home and community-based clients who have informal caregivers also need help with the five activities of daily living. When considering the specific amount of assistance needed with individual activities of daily living among the very impaired, the home and community-based sample was found to have a substantially higher percentage needing total help than was found in the nursing home sample. The home and community-based services clients who live with informal caregivers were also more likely to have severe impairment than nursing home residents."[8]

According to the Department of Elder Affairs' needs assessment survey, statewide, about 23 percent of elders are caregivers. This percentage is fairly consistent among poor and minority elders as well. Rural elders are more likely to be caregivers. (See Figure 23.)

Figure 23
Percent of Elder Floridians Who Are Caregivers

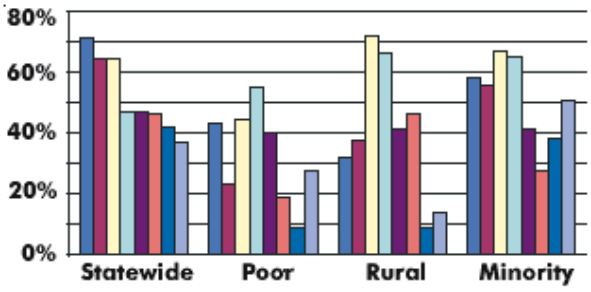


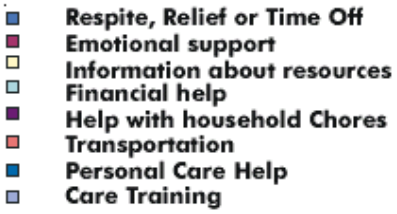
Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Statewide, caregivers choose respite care most often if they could have multiple services or are limited to one service choice. Emotional support and information about resources are the next most common choices, both if any number of services could be chosen and if they could only choose one.

Elders living in poverty areas, rural areas and minority elders are more interested in information about resources for elders than respite services. The results of the survey identify the need for greater outreach among the three subgroups. The types of services needed by minority, rural and poor elders vary considerably. Programs that target caregivers should focus on the unique needs of the clients (See Figures 24 and 25.)

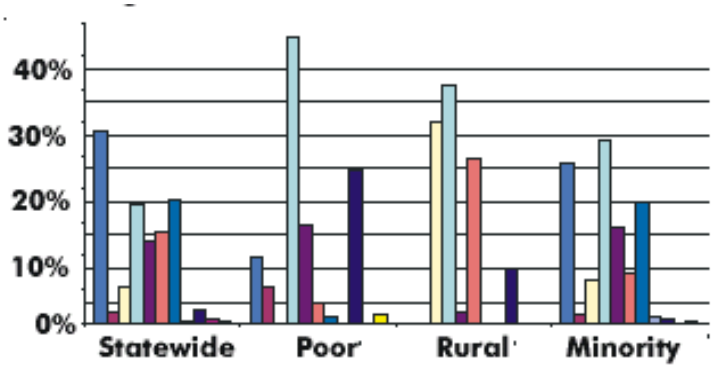
Figure 24
For Those Who Need and Want Help with Caregiving, What Kind of Help Is Wanted (Choosing Any Number)





Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

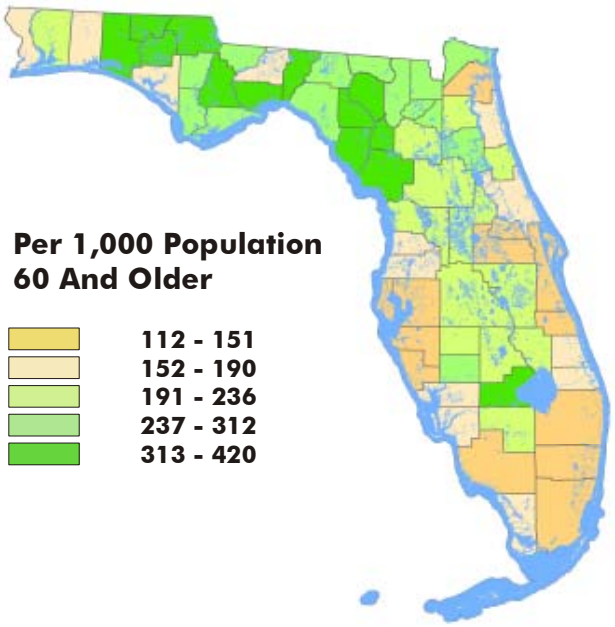
Figure 25
For Those Who Need and Want Help with Caregiving, What Kind of Help Is Wanted (Choosing Only One)



Rural Issues

The number of elders living in urban areas is about five times greater than those living in rural areas, according to the Florida data of the 2000 U.S. Census. Figure 26 shows the distribution of the rural population.

Figure 26
Rural Population Density of within the Population Age 60 And Older By County



Source: Department of Elder Affairs based on Office of Economic and Demographic Research, Florida Legislature.

Formal long-term care availability in rural areas is limited because of a low target population density that makes the provision of services unattractive for home health provider agencies. Some policymakers assume that providing services in rural areas is less expensive due to lower unit labor costs. However, rural service providers have to deal with issues related to lower density, such as longer travel times and severe shortages of qualified workers, factors that often make service provision more expensive than in urban areas.

Rural customers of long-term care services, whether frail elders or their caregivers, often face a lack of choice and service availability due to fewer service providers operating in the rural areas. This situation can result in earlier institutional placements relative to urban areas that have more services available. Unmet transportation needs are particularly acute in rural areas.

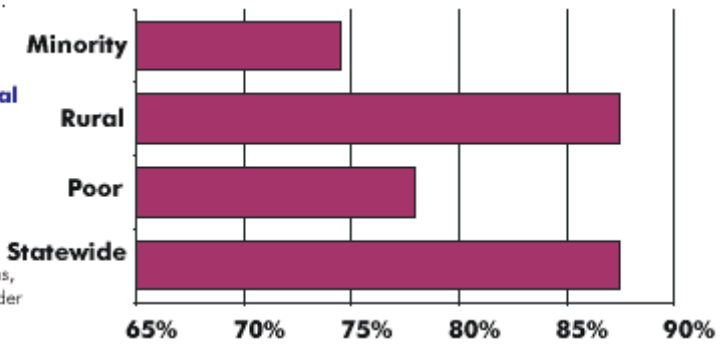
Affordable and available housing option needs for elders are especially evident in rural areas, where the elder population was 400,000 in the year 2000. Overwhelmingly, these elders prefer to own their own homes, and many do. Most people who live in rural areas do so by choice, but many aging rural residents are finding they need housing alternatives, such as rental housing or assisted living facilities. The scarcity of housing options significantly inhibits housing choices for elders in rural Florida.

Access to Health Care

Statewide, over 85 percent of Florida elders surveyed said that they are always able to get medical care. Rural elders are about as likely to respond this way as the general population. Minority elders are the least likely to respond this way and are the only group in which less than 75 percent responded that they were always able to get

medical care. (See Figure 27.) Access to medical care might be related to differences in insurance coverage.

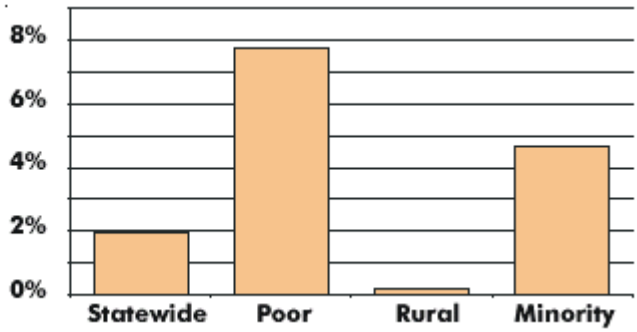
Figure 27
Percent of Elders Who Are Always Able to Get Medical Care



Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Since the survey targeted elders age 60 and older, some of the elders were not old enough to be eligible for Medicare. Even so, not all elders are eligible for Medicare on their 65th birthday. Although the percentage of elders not covered by any insurance is low relative to the under 65 population (20.6 percent, Florida Hospital Association), these elders might find private medical insurance nearly impossible to acquire. Poor and minority elders are the most likely groups not to have any insurance. (See Figure 28.)

Figure 28
Percent of Elders Who Do Not Have Health Insurance



Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Of particular concern, even among insured elders, is the affordability of items not typically covered by Medicare. Department of Elder Affairs' needs assessment survey reveals that there are about 390,000 elders statewide that have had to delay or do without prescription medications in the last 12 months. Also, there were about 600,000 that had to do without dental care and about 400,000 that had to delay acquiring eyeglasses in the last 12 months because of a shortage of money. Overall, about three quarters of elder Floridians had to limit health care due to financial concerns. Overall, access was limited to a higher degree among poor, minority and rural elders. (See Figure 29.)

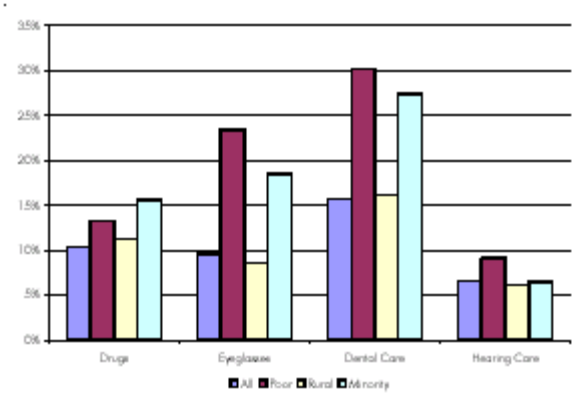


Figure 29
Percent of Elders Who Had to Postpone or Do without in the Last 12 Months

Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Access to Information

Most Florida elders get information about what is happening in their community from the newspaper. The newspaper was the most popular means of getting information for each of the special populations as well. Poor and minority elders are about as likely to get information from television as they are from newspapers. (See Figure 30.)

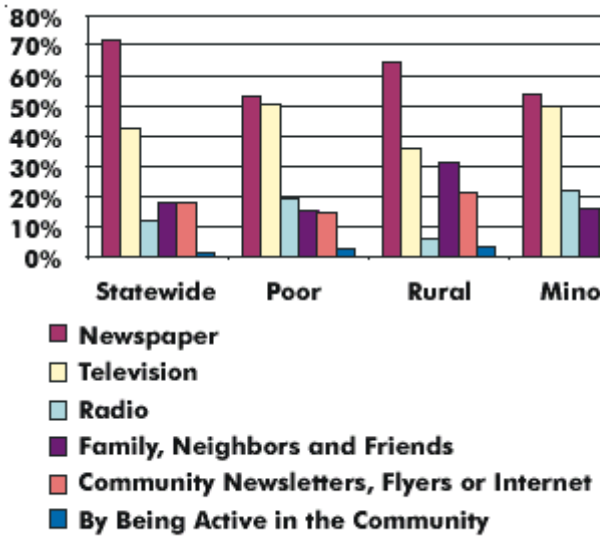


Figure 30
Percent of Elders Who Receive Information through Various Sources

Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Elders can and do receive information from a number of different sources. Responses to this survey question can be helpful in determining the most effective ways of disseminating information to elders.

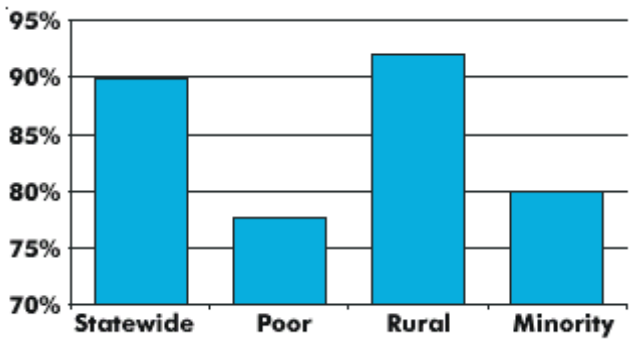
Access to Food

Statewide, about 90 percent of Florida elders surveyed report that they are able to get all of the food they need. Florida's rural elders are slightly more likely to have all of the

food they need. Florida's poor elders are the least likely to be able to get all of the food they need all of the time. (See Figure 31.)

Figure 31
Percent of Elders Who All the Food They Need (All of the Time)

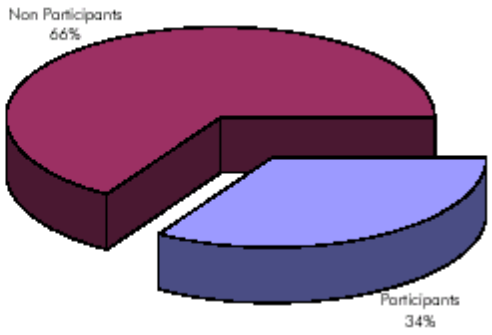
Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs



Even though 90 percent of elders get all of the food they need, that leaves almost 400,000 in Florida who do not. Lack of participation in the U.S. Department of Agriculture's Food Stamp Program for Florida's poor elderly is a problem. (See Figure 32.)

Figure 32
Percent of Eligible Elders Who Participate in the Food Stamp Program 2004

Source: Department of Elder Affairs based on Food Stamp Data, Department of Children and Families.



Financial issues are the main reason why elders are not always able to get all of the food they need. Health conditions that make eating difficult is the next most common reason. Difficulty in preparing food is the third main reason. This ranking is consistent across the subgroups. Successful strategies for improving elder access to food will depend on the reasons restricting access. Figure 33 presents the reasons elders are not able to get all the food they want.

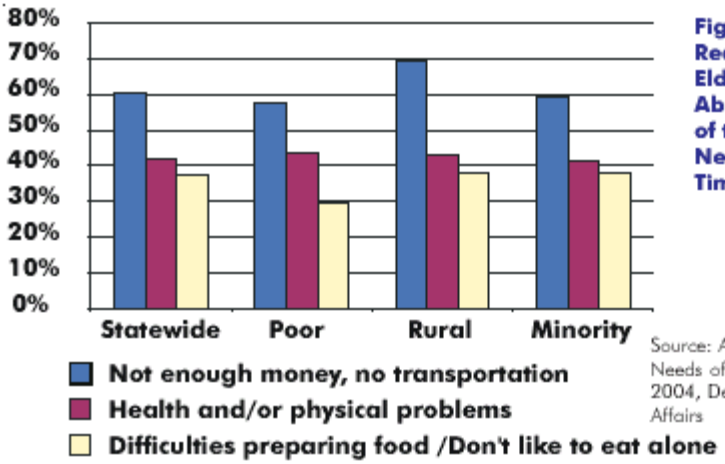


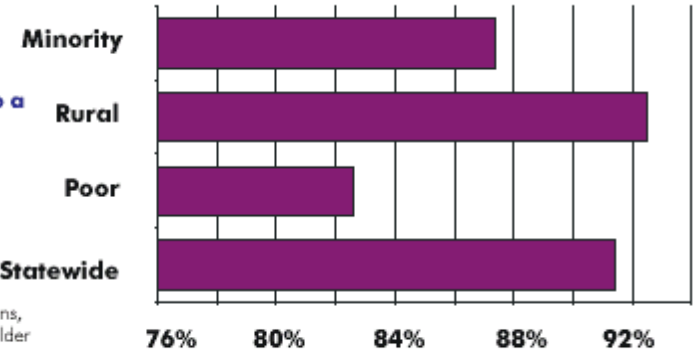
Figure 33
Reasons Why Elders Are Not Able to Get All of the Food They Need (All of the Time)

Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Senior Centers and Focal Points

Over 90 percent of Florida elders surveyed said that they "never or hardly ever" go to a senior center. Poor elders are the least likely to respond this way; however, over 82 percent of this population said they never or hardly ever go to a senior center. This low participation rate could reflect a special niche of clients on whom senior centers tend to focus or could indicate a greater need for outreach by senior centers. (See Figure 34.)

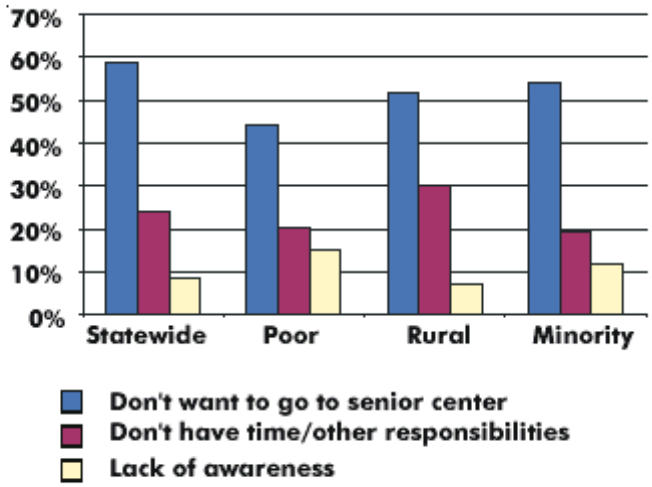
Figure 34
Percent of Elders Who Never or Hardly Ever Go to a Senior Center



Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

When asked for the reason why they do not go to the senior center, most elders responded that they don't want to go. This reason is the most common for the three subgroups as well. This response suggests that senior centers might have an image problem. (See Figure 35.) Other reasons include a lack of time and a lack of awareness of senior centers. These results were consistent in their rank order for each of the sub populations.

Figure 35
Main Reasons Elders Give for Not Going to a Senior Center



Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Access to Transportation

According to the survey, most older Floridians are fully capable of driving. Over 70 percent of Florida elders surveyed said that nothing limits them from driving. Elders living in high poverty areas are more likely to have limitations in their driving. However, about half of elders living in high poverty areas are able to drive whenever they wish. (See Figure 36.)

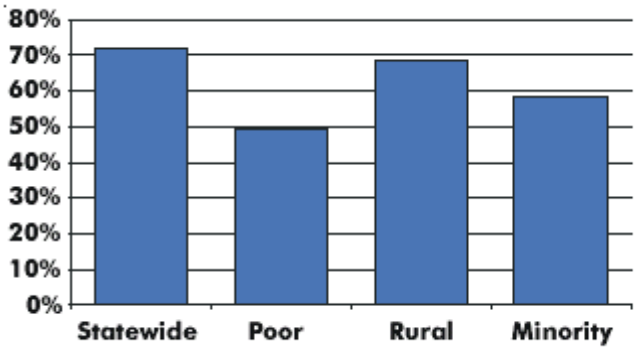
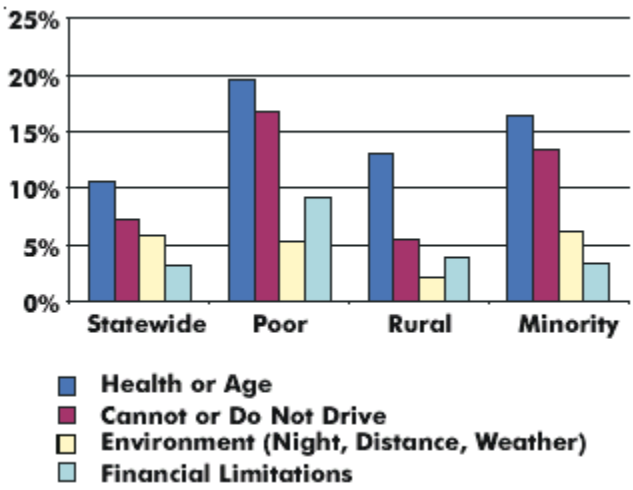


Figure 36
Percent of Elders Who Have No Driving Limitations

Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Nonetheless, over one million elder Floridians are limited in their ability to drive. This situation represents a major challenge for transportation providers. Among the elders who reported limitations in their driving, health and age issues are the most common. Other reasons given include financial considerations, including insurance, gas or car maintenance expenses; having never learned to drive; and certain limitations related to night driving, weather conditions, highway driving and other special conditions. Poor elders are more likely to be limited in their driving, and most likely to be limited by health conditions and financial restrictions. (See Figure 37.)

Figure 37
What Limits Elders from Driving

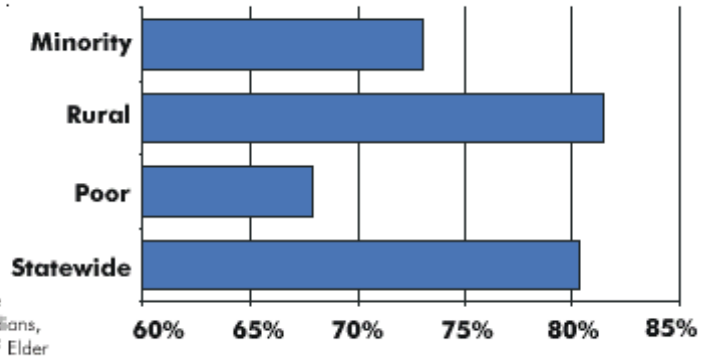


Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Most Florida Elders Feel Valued by Community

Over 80 percent of Florida elders surveyed said that they feel their community values older people. Rural elders are more likely to feel valued. Even though poor elders are less likely to feel that elders are valued in their city or town, a strong majority do feel valued. (See Figure 38.) The Department of Elder Affairs' Communities for a Lifetime program might have an impact on this sense of value by drawing attention to the important role seniors play in Florida's communities.

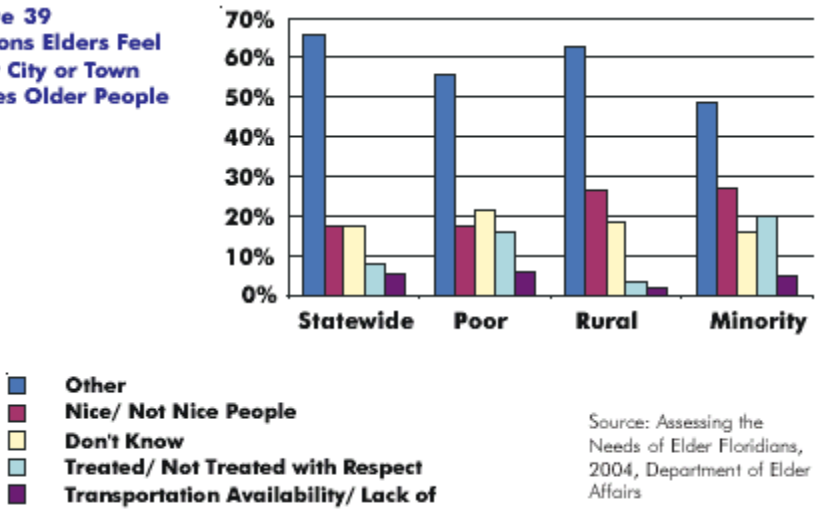
Figure 38
Percent of Elders Who Feel Their City or Town Values Older People



Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

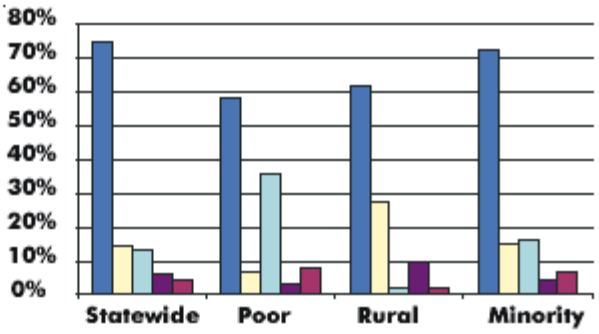
When asked why they felt the community valued or did not value elders, most elders responded with broad general statements. Two concepts appeared fairly often in survey responses: "nice people" and "being treated/not treated with respect." Respondents who said that their communities valued elders tended to attribute this to "nice people," while elders who did not feel valued attributed this to lack of respect by their communities. Issues regarding respect are more pronounced in the high poverty areas and among minorities than other groups (See Figures 39 and 40.)

Figure 39
Reasons Elders Feel Their City or Town Values Older People



Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

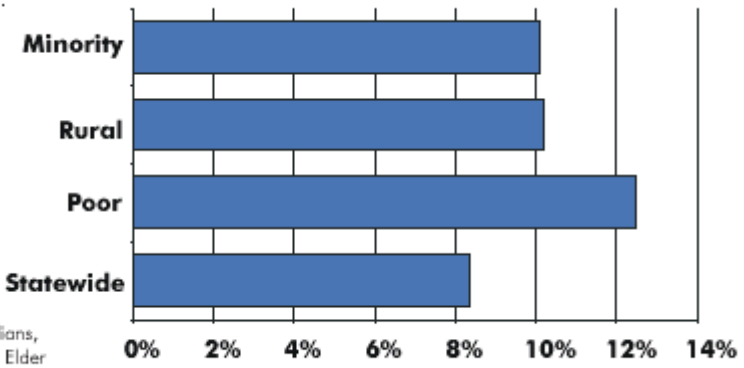
Figure 40
Reasons Elders Feel Their City or Town Does Not Value Older People



Access to Housing

Statewide, less than ten percent of Florida elders surveyed noted that they had housing problems, such as repairs, upkeep or crime. Housing problems are more common among the special populations, especially among Florida's poor elders. (See Figure 41.)

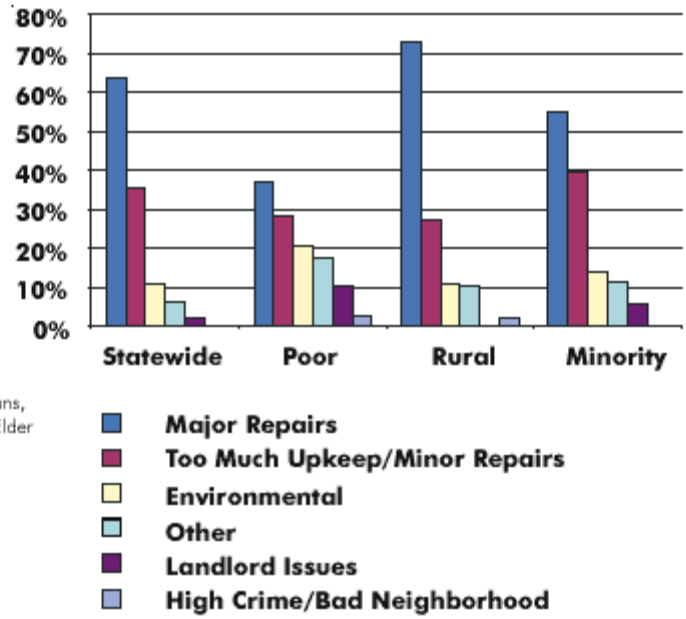
Figure 41
Percent of Elders with Housing Problems



Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

For those elders reporting problems with their homes, the need for major repairs is the most common issue. Minor repairs and upkeep is the second common problem. Environmental (pest control, flooding, etc.), landlord and other problems tend to be more common among elders living in high poverty areas and minorities. (See Figure 42.)

Figure 42
The Nature of Elders' Problems with Their Homes



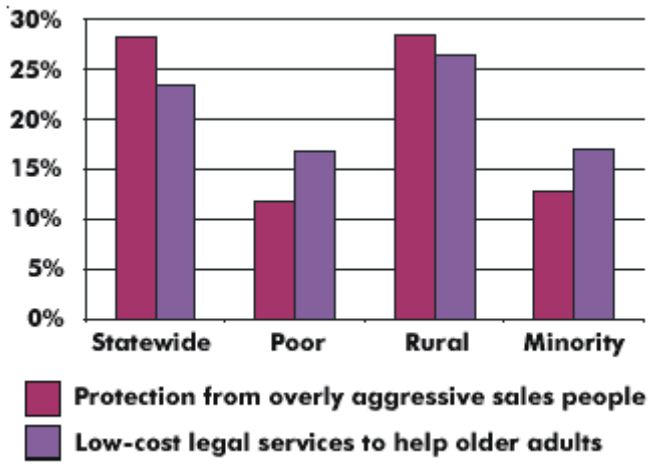
Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Advocacy and Consumer Protection

Less than a third of elders surveyed were aware that Florida has special programs and low-cost legal services that protect elders from overly aggressive sales people. Poor and minority elders are the least likely to be aware of these programs. (See Figure 43.) Since poor and minority elders are among Florida's most vulnerable populations and arguably the most in need of the services, greater outreach to those elder populations might make these programs more effective.

Figure 43
Percent of Elders Who Are Aware of Special Programs

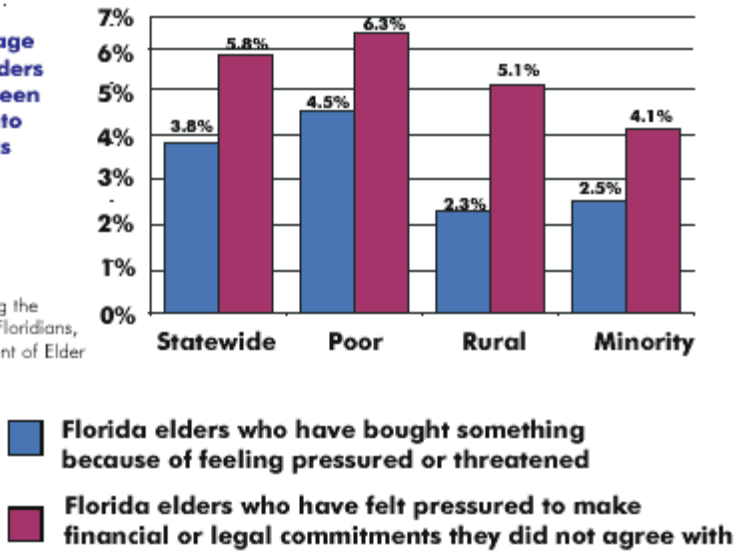
Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs



Some Florida elders have made purchases or financial/legal commitments as a result of pressure tactics. These problems are more pervasive among elders living in high poverty areas (see Figure 44). Since these elders are some of the most vulnerable people in the state, increased awareness of this issue and greater outreach of programs that help seniors avoid these problems would be helpful in reducing victimization of elders by consumer fraud.

Figure 44
The Percentage of Florida Elders Who Have Been Pressured into Commitments

Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

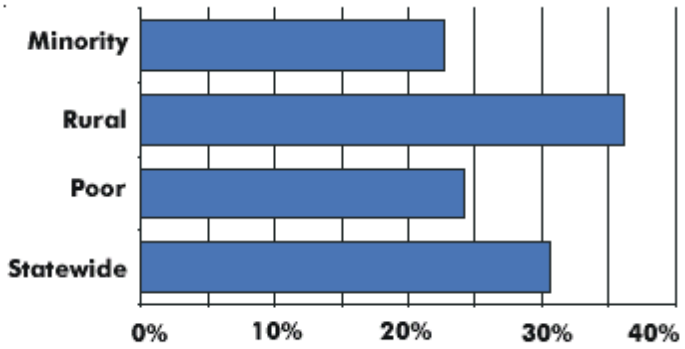


Volunteering

One way that elders contribute to the community is through volunteering. Overall, about 30 percent of Florida's elders volunteer. Part of the Department of Elder Affairs' mission is to facilitate the work of volunteers. The annual value of the contributions by volunteers age 60 and older is estimated to be $2.5 billion. Rural elders are more likely

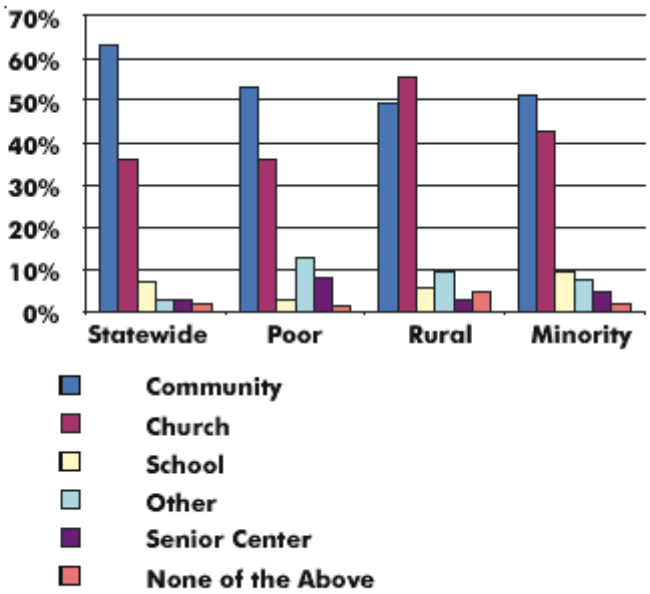
to volunteer. (See Figure 45.) Elder Floridians are generous with their time. In the year 2000, elders contributed volunteer time and talent totaling 7.5 million person days.

Figure 45
Percent of Elders Who Volunteer



Older Floridians volunteer for a large variety of programs. However, most volunteer for community programs and religious groups. Other programs include volunteer efforts sponsored schools and senior centers. Many seniors volunteer for multiple programs across multiple categories. Rural elders are more likely to volunteer for religious groups than the community at large. (See Figure 46.)

Figure 46
Organizations Where Elders Volunteer



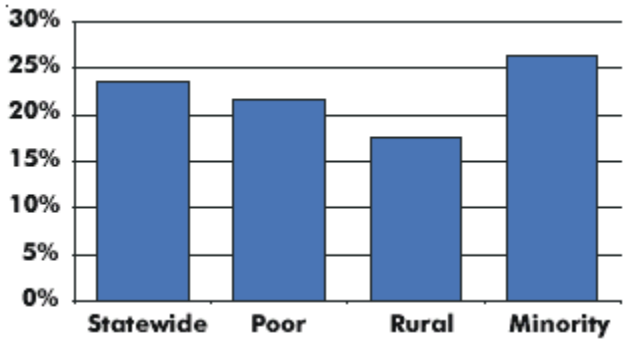
Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs

Employment

Florida elders are a vital part of the state's workforce. According to the needs assessment survey, nearly a quarter of elders are working. (See Figure 47.) Minority elders are more likely to be employed than other elders. Older Floridians work in a wide variety of positions and situations.

Figure 47
Percent of Elders Who Are Employed

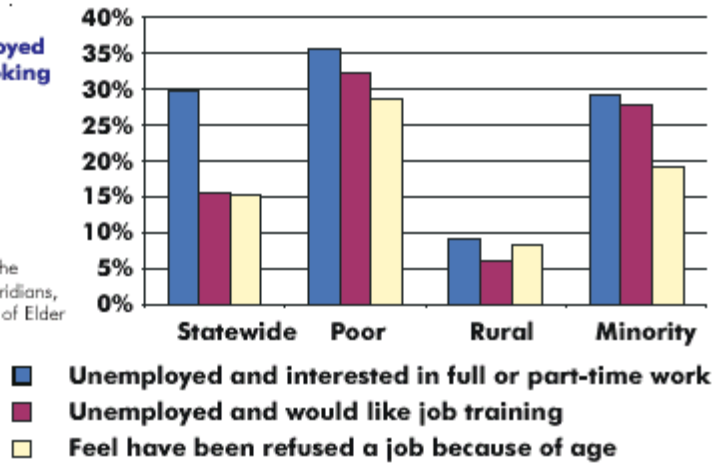
Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs



Of those elders in Florida who are unemployed, roughly a third are interested in full or part-time work. A smaller percentage is interested in job training. Fewer still believe they have been refused a job because of age. Unemployed elders living in high poverty areas are more likely to be interested in full or part-time work or job training. Unemployed elders living in rural areas are less likely to be interested in full or part-time work or job training. (See Figure 48.)

Figure 48
What Unemployed Elders Are Looking For

Source: Assessing the Needs of Elder Floridians, 2004, Department of Elder Affairs



Elders as Consumers

Historically, Florida's economy has rested on three legs: tourism, agriculture and retirees. A healthy retirement industry is critical for the ongoing prosperity and well-being of the state of Florida. Direct spending by mature Floridians[9] and the value of their federal health benefits is estimated at $150 billion. From a fiscal perspective, Florida's elder residents represented a net benefit of $2.8 billion in taxes, to state and local governments, in the year 2000.

Every month in the year 2000, $2.8 billion in Social Security and military retirement payments are transferred to mature Floridians; these payments represent over $60 billion in direct and indirect spending. Federal transfers on behalf of mature Floridians account for about 55 percent of the amount of Florida's total share of federal revenue.

In that same year, for every dollar that Florida workers and employers paid in Social Security taxes, the state received $1.40 in social security benefits for its citizens.

Trends and Conditions In Long-Term Care

Trends in supply and demand for elder services and care can be explained on the basis of population growth patterns and disability rates. Disability rates are, in turn, dependent on demographic factors, particularly age, health conditions and available medical and assistive technologies. In addition, the demand for publicly financed services will be influenced by the economic conditions of the elder population, the availability of informally (not for pay) provided care, the affordability of privately provided formal (for pay) care and the public's attitude towards using public assistance services.

In Florida, a very small percentage, 2.4 percent, of the population age 65 and older reside in nursing homes; this number compares very favorably with the national average of 4.3 percent.[10] Floridians age 65 and over are 45 percent less likely to require long-term nursing home care than elders from other states.[11]

Possible reasons for Florida's lower demand for nursing home care include Florida's lower disability rates, a specialized supply of medical services and assistive technologies and affordable options for custodial care. The supply of medical services and assistive technologies and the affordable options for custodial care are made possible by the state's high incidence of elders and favorable migratory patterns.

Relative to the rest of the country, Florida has a rich supply of specialized medical services and assistive technologies which result in lower disability rates among elders and in improvements to caregivers' health. Lower disability rates reduce the number of people requiring nursing home care on two accounts. It reduces the number of disabled persons potentially requiring nursing home care and, at the same time, increases the supply of able caregivers who can provide care longer and at a higher intensity.

Demand for Long-Term Care

Favorable migratory patterns also help reduce Florida's demand for nursing home care. The large majority of elders who relocate to Florida after retirement are "amenity seeking" retirees. They are characterized by good health and economic self-sufficiency, and most are married. These retirees are usually young elders in their sixties. On the other hand, Florida has a net outflow of elders relocating due to increasing frailty, severely disabled migrants, who relocate seeking nearness to adult children, and readily available of nursing home facilities. According to Census 2000 figures, Florida had a net migratory loss of persons age 85 and older.

Florida's demand for nursing home care is further reduced by the availability of affordable substitutes for custodial care, most notably assisted living facilities. These options will be discussed below under the heading "The Supply of Long-Term Care in Florida." Alternative projections of Medicaid nursing home utilization are illustrated in Figure 49.

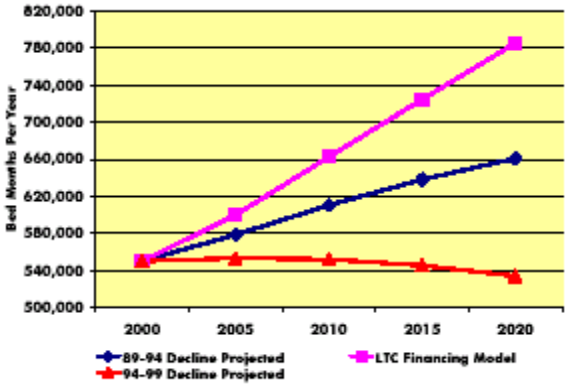


Figure 49
Projected Demand for Medicaid Nursing Home Beds. Alternative Scenarios in Florida (2000-2020)

Source: Department of Elder Affairs. Projections based on National Long-Term Care Survey: Disability Rates 1989- 1999. Population Projections, Economic and Demographic Research, Florida Legislature.

The trends represented in the chart show future use patterns of long-term nursing home care that are in keeping with the decline in the overall incidence rate of severe disability among the aged. This chart shows a range of three alternative scenarios. The first scenario shows the forecasted number of nursing home bed months under the assumption of declines in disability rates that are consistent with the declines observed from 1989 through 1994. This represents the medium growth scenario and projects nursing home bed use to grow by 20 percent between the years 2000 and 2020.

The second scenario assumes that disabilities will continue to decline at the rates observed from 1994 through 1999. This scenario represents the low growth option and projects a marginal absolute decline between the years 2000 and 2020.

The third scenario is the high growth option based on the assumptions of a national model developed by the Lewin Group, which assumes mortality and disability declines of 0.6 percent per year, for a total growth in demand of 42 percent over the twenty year period.

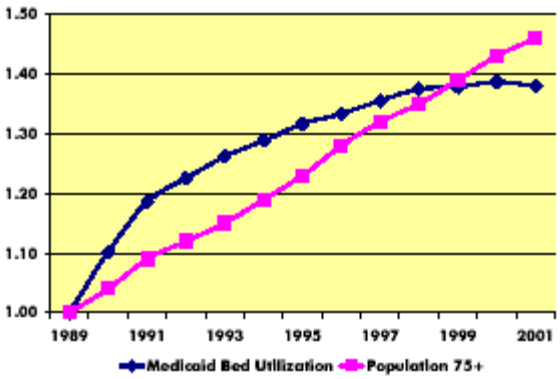
These scenarios yield annual growth rates in the Medicaid nursing home caseload of 0.67 percent, 1.36 percent and 0.17 percent for the medium, high and low scenarios, respectively.

Additional evidence about Florida's declining growth rate in the use of Medicaid nursing home care is provided by nursing home utilization historical reports from the Agency for Health Care Administration. Figure 50 shows that the growth in Medicaid nursing home

bed day use has been declining steadily for at least 12 years, even as the population age 75 and older was growing at an average rate of 3.1 percent per year.

Figure 50
The Relative Growth of Medicaid Nursing Home Bed Day Utilization and Population Age 75+ in Florida (1990-2001)

Source: Department of Elder Affairs based on Agency for Health Care Administration reports and Economic and Demographic Research, Florida Legislature.



While acute care is temporary and episodic, with a focus on restoration of health, long-term care has a focus on trying to help a person manage an irreversible disabling condition. Long-term care can be provided in a variety of settings: in the home with formal (paid) assistance; informal (unpaid) assistance by family members, relatives or friends; or in a long-term care facility. In-home formal assistance includes community-based long-term care that encompasses an array of interventions such as day care, caregiver respite and in-home services, including personal care and home-delivered meals.

A variety of service providers comprise the community-based long-term care system. They can range from senior centers, which also provide many preventive services, to Councils on Aging, home health agencies and others. Many of these agencies provide a host of services. Others may provide a single service through a contractual agreement with the case management or lead agency. Long-term care facilities in Florida are comprised of nursing homes, assisted living facilities and adult family care homes.

Occupancy rates in nursing homes have declined from about 91 percent in 1990 to 85 percent in 2001, even though the population age 85 and older grew very rapidly during the same period. Since 2001, the occupancy rate has inched up to a current level of 87 percent, possibly due to the nursing home bed moratorium established in 2001 by the state legislature.

Unfortunately, the scenarios regarding control in the growth of Medicaid expenditures for nursing homes are not so positive. Per diem reimbursement rates have been growing at a fast pace for the last few years. Indeed, from January 1997 to July 2002, this amount went from $93.25 to $136.89 for a compounded growth rate of 7.3 percent per year. A continuation of recent trends in per diem reimbursement growth would result in expenditure growth doubling the nursing home Medicaid budget every ten

years, for a compounded growth of 490 percent from 2000 through 2020. (See Figure 51.)

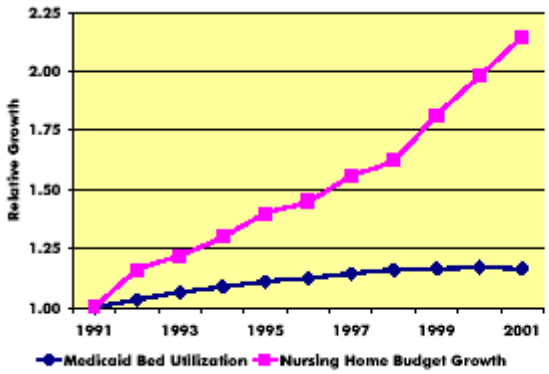


Figure 51
The Relative Growth of Medicaid Nursing Home Bed Day Utilization and Nursing Home Budget in Florida (1990-2001)

Source: Department of Elder Affairs based on Agency for Health Care Administration reports.

These figures suggest that, in order to control the Medicaid nursing home budget, there is a need to control the growth in the caseload through community diversions and the growth in the per diem reimbursement to nursing homes. A projection of nursing home caseload growth through 2020 yields a growth rate of less than one percent per year. Assuming per diem increases equal to the general inflation rate, growth would yield a projected future cost of $2.5 billion in constant 2003 dollars for a net increase of 20 percent. On the other hand, if per diem reimbursement rates were to increase at the rate observed over the last five years - five percent over inflation - the projected future cost, in constant 2003 dollars, would be $5.5 billion for a net increase of 164 percent. (See Figure 52.)

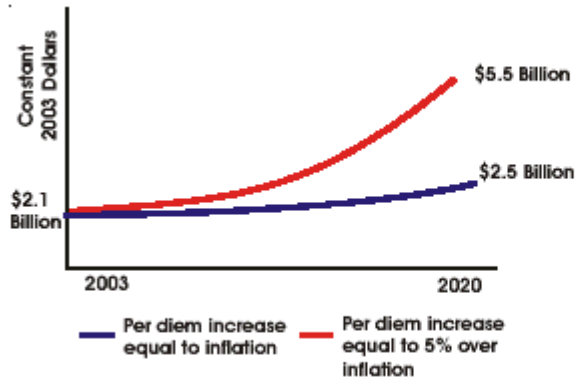


Figure 52
Projected Future Florida Medicaid Nursing Home Costs in Constant 2003 Dollars (2003-2020)

Source: Department of Elder Affairs

Since caseload assumptions are the same under both of these scenarios, the difference in the projected level of expenses for 2020 is due only to differences in per diem assumptions, and the enormous size of such differences points to the importance of reimbursement rates vis-à-vis caseloads in budget control.

Home and Community-Based Services Supply

Under Medicaid rules, all qualified individuals are entitled to the services included in the state's Medicaid plan. Since nursing home care is part of the state Medicaid plan, it is a Medicaid entitlement. On the other hand, most Medicaid home and community-based services (HCBS) are provided on a "waiver" basis. Therefore, unlike nursing home long-term care, home and community-based services are not entitlements for medically and economically qualified persons. Federal Medicaid participation requirements mostly determine which services are covered by the state plan. However, states can elect to add optional services. Examples of such services are prescription drugs, physical therapy, durable medical equipment and community mental health.
On the other hand, provision of home and community-based services is dependent upon availability of appropriations within the state budget and federal approval of "waivers" to Medicaid rules. Unlike nursing home care, non-Medicaid programs provide much of the funding for HCBS.

HCBS non-independent housing options in Florida's communities include adult family care homes (AFCHs), assisted living facilities (ALFs) and ALFs within public housing. These forms of non-independent housing provide elders with needed personal services in a supportive, residential environment. There is wide diversity in the accommodations, types of services offered and overall cost among these non-independent housing categories. A significant problem in Florida is that the supply of these types of housing arrangements is very limited in rural areas.

Generally speaking, assisted living is a residential setting that provides housing, meals, personal care services, 24-hour supervision and social and recreational activities. In the 1990s, assisted living was the fastest growing type of elder housing, with an estimated 15 to 20 percent annual growth rate, with less than 19,000 beds in 1991 to about 75,000 beds in 2003. Over the past few years, however, there has been a slight decline. As of December 2003, there were about 2,250 licensed assisted living facilities in Florida. (See Figure 53.)

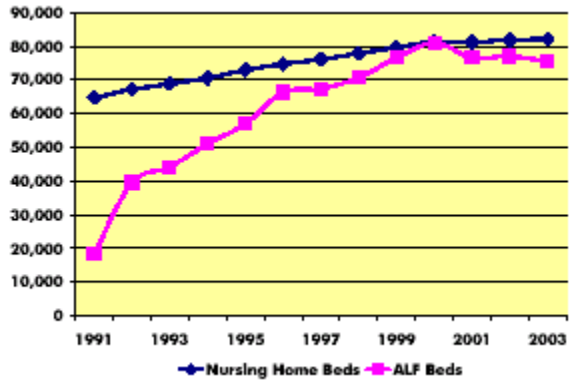


Figure 53
Number of Licensed Nursing Home and Assisted Living Facility Beds in Florida (1991-2003)

Source: Agency for Health Care Administration

There is little doubt that the emergence of the ALF industry has had a major impact on the demand for nursing home beds. The growth of ALFs in the 1990s corresponds with a decline in the growth rate of the nursing home industry. For non-Medicaid participants, assisted living is an affordable, more appropriate alternative to nursing home care.

There is evidence that in Florida, a significant proportion of ALF residents exceeds the minimum acuity criteria for nursing home placement. The estimates of this proportion vary from a low of 20 percent to a high of 30 percent.[12] Based on these estimates, it is possible that nearly 20,000 potential nursing home patients are served in assisted living facilities at substantial savings to the state. In contrast to the nursing home industry, most ALF residents are private pay.

The concept of allowing elders to age in their own communities and avoid nursing home placement has led to several innovative programs. For example, with the assistance of the Department of Elder Affairs' Coming Home Program, public housing authorities have recently begun to explore and utilize assisted living as way to serve their elder-housing consumers.

Currently, there are three housing authorities in Florida that have successfully licensed assisted living facilities. By combining federal housing subsidies with available assisted living programs in Florida, these housing authorities are able to provide assisted living services to low-income, subsidized housing consumers who, without services, would be at-risk of displacement or nursing home placement. Many other housing authorities have also expressed an interest in pursuing assisted living facility licensure.

Adult family care homes represent another assisted housing option for Florida's elders. As with ALFs, adult family care homes provide housing, meals and personal services to frail elders and disabled adults. The primary differences between assisted living facilities and adult family care homes are that adult family care home providers must reside in the same home as the residents they serve, and adult family care homes are limited to a maximum of five residents. On December 1, 2003, there were 452 licensed adult family care homes in Florida. Public funding for this housing option is limited to the Optional State Supplementation (OSS) and Assistive Care Services (ACS) programs.

Although significant efforts are being made to increase elders' access to supportive services, as individuals age and become frail, their need for a more supportive environment increases. If elders do not have access to affordable assisted living options, nursing homes become their only alternative. Without extending such options to lower-income and rural elders, there will be an increase in the number of households forced prematurely into institutional settings at a higher cost.

System Fragmentation

Table 1 illustrates the complexity of Florida's long-term care system. This complexity can be challenging as consumers become more involved in care decisions. Many different state agencies have one or more long-term care functions. It is not uncommon for several agencies to be involved when a person receives publicly funded long-term care.

Table 1
State Agencies with Long-Term Care Functions

Agency	Major Long-Term Care Related Functions
Department of Elder Affairs	1. Nursing Home Pre-Admission Screening (CARES program - Comprehensive Assessment and Review for Long-Term Care Services) (Certify medical eligibility for Medicaid nursing home and community-based waiver services with goal of recommending least restrictive placement appropriate to their needs) 2. Going into nursing homes (placed in receivership) to assess individuals for potential community placement 3. Contract and monitor home and community-based services for elders 4. Special services for persons with Alzheimer's disease 5. Policy development and rule promulgation for Chapter 400 Florida Statutes, long-term care programs and facilities except for nursing homes 6. Approves or certifies Alzheimer's disease training providers and curriculum 7. Ombudsman for nursing homes, assisted living facilities and adult family care homes 8. Statewide Public Guardianship Office
Department of Children and Families	1. Conduct financial eligibility for Medicaid services - all ages 2. Contract and monitor for mental health and substance abuse services - all ages 3. Administration and operation of state mental hospitals 4. Protective Services (all ages) 5. Contract and monitor home and community-based services for disabled adults 6. Assistive Care Services
Agency for Health Care Administration	1. Designated single state Medicaid agency 2. Long-term care facility licensure, regulation, inspections 3. Payment of Medicaid claims 4. Medicaid policy development ,rule writing, fraud, and recoupment 5. Policy development and rule promulgation for ntursing homes, hospitals, nurse registries, etc. 6. Hospitals ,medical clinics, and home health agencies licensure and regulation 7. Physical plant plan review for health care facilities 8. Certificate of need (CON) for nursing homes 9. Operate two managed long-term care programs - Frail Elder Option, Channeling 10. Toll-free hotline for health care quality of care, billing or HMO concerns
Department of Health	1. Traumatic Brain and Spinal Cord Injury Program 2. AIDS Programs - patient care programs for people who do not have insurance 3. Home and community-based services for children who have chronic and life threatening d iseases or who are fragile and have medical complications (Children's Medical Services) 4. Medical professional licensure
Department of Veterans' Affairs	1. Nursing home and domiciliary care for veterans
Agency for Persons with Disabilties	1. Developmental Disabilities (DD) services - contract and monitor Medicaid waiver services to DD population

Innovative Programs

Florida is seeking a better system of long-term care that will contain costs, improve outcomes and increase consumer satisfaction. Developing a system that focuses on prevention and provides care in the least restrictive setting will involve the coordination of acute and long-term care services to ensure that services are targeted optimally. Another approach is Consumer Directed Care (CDC). CDC empowers consumers to decide what they will need and who will provide the services.

Consumer Directed Care

The CDC program is authorized under a Medicaid 1115 Research and Demonstration waiver, which allows the state maximum flexibility in program design. Consumers already enrolled in a home and community-based waiver program are given the opportunity to manage a budget that is based on the value of the home and community services they were receiving. The consumers then hire caregivers of their choice who, unlike in traditional waivers, do not have to be enrolled Medicaid providers and can be family members. DOEA implemented the program for elders in various areas of the state, achieving measurable success in improving consumer satisfaction and attaining cost neutrality compared to the traditional home and community-based service waiver model. During its 2002 session, the Florida Legislature authorized expansion of the program to other areas of the state.

Home Care for the Elderly

Another program that increases consumer autonomy is Home Care for the Elderly (HCE). Under HCE, caregivers receive a monthly cash subsidy that can be used for any purpose. The subsidy is relatively small, but since it is targeted to the poorest caregivers, its impact is substantial.

Consumer Directed Care and HCE are different in several respects. CDC is a Medicaid program and provides the customer with spending authority that can only be used to purchase HCBS. Also, the customer/provider relationship is mediated by a “fiscal intermediary” who makes payments and retains tax deductions from payments made to the nontraditional providers. The amount of the monthly allowances under CDC is comparable to those provided under the existing traditional Medicaid HCBS program. On the other hand, the HCE subsidy is much smaller but can be used for any purpose, including paying for groceries, utility bills, non-medical supplies, etc. The HCE subsidy is a straight cash payment to the caregiver. Internal DOEA estimates suggest that HCE provides a savings of almost five dollars in nursing home costs per dollar spent by the program.

The Department of Elder Affairs is also pursuing models to integrate services in nontraditional locations, such as public housing. To facilitate aging in place, the Department is seeking alternatives to augment traditional approaches and settings. Portability of payment, such as having vouchers individuals can use for any provider, including assisted living facilities, adds to the flexibility of options and creates greater consumer satisfaction.

Managed Care Approaches

Managed care is a strategy to maximize the use of long-term care resources. An important aspect of managed care is the integration and case management of long-term care social and medical needs. There is evidence that medical in-home care can either substitute for nonmedical home and community-based services or boost their positive effects. The net effect is that federal Medicare dollars substitute or boost the effects of state Medicaid funds. Therefore, integration of services reduces the use of state funds by substituting Medicaid waiver services with Medicare health care services or by reducing the incidence of negative fiscal outcomes, such as hospitalization or nursing home placements.

Access to Long-Term Care

Access to services and choice of care options can be limited by numerous factors, such as the payer source, immediacy of need, knowledge of care options and availability of care options within the community. People who have not had experience with the system are often unaware of the challenges faced by frail elders entering the system. Early planning can make the long-term care process easier and help elders to receive preferred care options when care is needed. Pre-planning can also reduce unnecessary expenditures incurred as a result of premature and inappropriate institutionalization. Education for elders and their caregivers can provide the foundation for informed choices, resulting in cost-effective service delivery and increased consumer satisfaction.

Accessing information on services and choice options can be confusing. Many entities provide limited information about social services which can help individuals enter and progress through the system. Hospitals, Community Care for the Elderly lead agencies, mental health providers, public housing offices, Department of Children and Families, nursing homes and assisted living facilities are a few examples.

Access to each may be limited, depending on where the elder lives or is receiving acute care. To help simplify access to information and referral services, the Department of Elder Affairs created the Elder Helpline. A statewide toll-free number can connect elders with the resources to meet their needs. National elder care information sources have also been developed. The Elder Care Locator provides referrals anywhere in the

country through a single toll-free number. The Internet has also increased information availability throughout the country.

Agency Priorities for the Next Five Years

In order to meet the demand outlined in the previous section and in keeping with its mission, vision, and values, the Department will concentrate its efforts in the three **priority areas**: *Create a Long-Term Care System that is Streamlined, Cost-effective and Consumer-friendly; Create a Greater Support Network for Elders, Families and Caregivers; and Create an Elder-Friendly Environment that Values the Contributions and Needs of Elders*.

Together these priority areas provide the Florida Department of Elder Affairs with a strategic **Action Framework**. The strategies that will be used to address the priority areas are discussed below.

1 Priority Area: Create a Long-Term Care System that is Streamlined, Cost-effective and Consumer-friendly

Guiding principles: The Long-Term Care System should:

- Expedite access to program services and resources.
- Ensure high quality, cost effective services.
- Offer consumer-friendly diversions.
- Feature a flexible and portable funding system.
- Allow for better predictability of costs and encourage cost containment.
- Build on existing prioritization methods.
- Preserve and expand options for services for all persons.

Strategies (in priority order):

① Design an Aging Resource Center to serve as a single point of access for information, counseling, referrals, assessment and eligibility functions for both publicly and privately funded services.

② Enhance interagency coordination of long-term care activities.

③ Promote regulatory alignment that supports smooth transition between care settings and encourages multi-care settings.

④ Develop efficient business processes to facilitate long-term care and apply information technology solutions as appropriate.

⑤ Integrate Medicare services into capitated long-term care demonstration projects.

⑥ Build long-term care service capacity tailored to geographic, cultural and economic needs of Florida's elder citizens.

⑦ Expand consumer/caregiver-directed options in service delivery where possible.

⑧ Increase participation in long-term care service delivery.

⑨ Promote public/private partnerships including the business community and faith-based entities.

2 Priority Area: Create a Greater Support Network for Elders, Families and Caregivers

Guiding principles: The Support Network should:

- Sustain the informal care system, including family, friends, volunteers and existing community resources.
- Empower consumers to make decisions about their long-term care when they are capable of doing so.
- Enhance the personal responsibility of Floridians and their families for addressing their own long-term care needs.

Strategies (in priority order):

① Expedite access to program services and resources.

② Promote and provide caregiver training and support activities.

③ Expand health and wellness programs.

④ Support innovation in health promotion/disease prevention, nutrition and in-home services.

⑤ Support expansion of older worker training and employment programs.

⑥ Promote public/private partnerships including the business community and faith-based entities.

⑦ Enhance baby boomers and pre-retirees knowledge of strategic lifestyle issues that enable them to better prepare for the future.

3 Priority Area: Create an Elder-Friendly Environment that Values the Contributions and Needs of Elders

Guiding principles: The Elder-Friendly Environment should:

- Recognize the diverse needs of elders and value their unique contributions to their communities.
- Allow community residents to retain control over their own lives.
- Foster a creative and supportive environment in which elders can actively participate in community life, contributing their wisdom, skills and abilities.
- Promote mutually rewarding experiences for people of all ages to interact.

Strategies (in priority order):

① Create a greater awareness of the contributions of elders.

② Develop communities for a lifetime.

③ Promote Florida as a retirement destination.

④ Participate in economic development planning.

⑤ Support and promote intergenerational programs.

⑥ Work with state and local agencies to enhance quality of life for mature residents.

⑦ Promote public/private partnerships including the business community and faith-based entities.

⑧ Provide resources, training, recognition and state support of local *Communities for a Lifetime* efforts to participating, primed and potential communities.

Proposed New Programs

Implementation of Aging Resource Centers

The Department of Elder Affairs will be overseeing the transformation of the aging network over the next several years. This conversion is made possible by the enactment of SB 1226 as Chapter No. 2004-386, Laws of Florida, and the award of an $800,000 federal grant. The legislation, passed by the Florida Legislature in 2004 and signed into law by the Governor, establishes a multi-year period for transitioning the existing 11 Area Agencies on Aging in Florida into Aging Resource Centers (ARC). The federal grant, funded jointly by the Administration on Aging and the Centers for Medicare and Medicaid (CMS) for a three-year period, provides for the implementation of several Aging and Disability Resource Centers (ADRC) in the state; these centers will address the needs of the elderly and adults with severe mental illness.

Justification:

The goal of the ARC/ADRC is to provide elders and their families with customer-friendly access to services, seamlessly and efficiently, by minimizing service fragmentation, reducing duplication of administrative paperwork and procedures, enhancing individual choice, supporting informed decision-making, and increasing the cost effectiveness of long-term care support and delivery systems. In keeping with the recommendations of the elder services network, the ARC/ADRC is envisioned as an entity accessible through multiple points that makes referrals, determines eligibility, prioritizes and determines funding commensurate with risk, and provides options counseling to all elders in an area who are in need of long-term care regardless of economic considerations.

By consolidating these functions, the ARC/ADRC makes the multitude of programs, funding sources, and eligibility functions invisible to the consumer. At the same time, while the ARC/ADRC is a single entity, it provides multiple doors—such as senior centers, AAAs, lead agencies, local government offices, qualified information and referral systems and other community organizations—to ease entry into the long-term care system. In a nutshell, the ARC/ADRC will guarantee “no wrong door” access to all elders in need of long term care services.

The ARC/ADRC functions revolve around triage and fiscal control protocols that optimally match customer needs to available resources, regardless of which door the customer came through to enter the system. As proposed, the ARC/ADRC will collocate, physically or virtually, frailty and economic program eligibility with fiscal control and will provide referrals to the most appropriate long-term care option. The ARC/ADRC will also make referrals for customers who are able to afford their care. By using a multiple door approach, targeting and ease of access are improved. All persons

entering through these doors will be referred to the most appropriate programs, by matching need to available resources.

Primary functions are: information and referral; financial and functional eligibility determination; triaging; and budget authorization. Other services such as health and wellness, employment initiatives, food stamps, and Medicaid will also be accessible through the Center. The ARC/ADRC will be a “one-stop” for all elder services. It is anticipated that approximately 80% of questions and service needs will be handled through individualized, self directed or personally assisted information and referral to community, faith-based, charitable, for profit and public non long-term care programs. Others needing more intensive assistance or services that require eligibility determination will have a streamlined, simplified system to obtain these services. Elders will be able to receive a single financial eligibility determination for all services including Medicaid, Food Stamps and Supplemental Security Income.

Justification of the final projection for each outcome and impact statement relating to demand and fiscal implications

The standard for each of the outcome measures is projected to remain stable at the 2004-2005 target. Given the Department's continuing commitment to improvements in targeting services to the most frail and impaired, preventing further deterioration of the existing level of functionality in an older person is a success. The Department continues to strive to achieve more, but often, marginal improvements in performance may come at the cost of serving fewer customers. The nature of the services provided forces the aging network to face decisions similar to those in the public health arena, offer very effective and expensive interventions for a few, or somewhat less effective more economical interventions for the many.

Case in point: The Department plans to maintain the current level of the outcome "Percent of most frail elders who remain at home or in the community instead of going into a nursing home." If, by maximizing resources, an increased number is served and, at the same time, an increasingly frailer group of elders is targeted, then maintaining the current standard of 97 percent would be meritorious.

Policy context and guidelines used by the agency to develop its five-year workforce plan

The Department is one of the most privatized agencies in state government (94 percent privatized); so workforce reduction considerations pose considerable challenges. Although the aging network includes thousands of case managers and service workers, none of them is an employee of the state. Unlike other social services agencies in state government, the Department contracts those services to the private sector.

The Department has functioned with as limited staffing as possible to efficiently carry out its legislative mandates. Since 1998-99, the Department's funding has increased by 60.7 percent while the staff has decreased by over four percent from 373 to 357.5. Because most of the Department's services are contracted to the private sector, a minimum yet efficient level of contract monitoring and contractor performance evaluation is required to responsibly steward public resources entrusted to the Department.

It is the expressed desire of the people of Florida for a leaner, more efficient government sector. In keeping with that desire, the Department continues to critically review all of its activities to determine what programs could potentially be performed as efficiently or better through additional privatization without jeopardizing federal funding streams which help to support the entire Department.

LIST OF POTENTIAL POLICY CHANGES AFFECTING THE AGENCY BUDGET REQUEST

Proposed policy changes:

1) Implementation of the Aging Resource Centers
2) Information Technology Improvements and Enhancements
3) Serving the Priority Level 4 and 5 Clients Awaiting Medicaid Aged/Disabled Waiver and Assisted Living for the Elderly Waiver Services

Discussion:

Implementation of the Aging Resource Centers

The growth in the cost of Medicaid programs is a threat to the fiscal stability of the state. A major component in the growth of the Medicaid budget is the growth in the cost of long-term care. A strategy that Florida employs to reduce Medicaid long-term care costs is to offer home and community-based services as a substitute for more expensive nursing home based care. This strategy has been partly successful. Nursing home caseloads have grown at rates that are less than one percent per year, while the at-risk population (persons aged 85 and older) has grown at rates exceeding three percent. However, the overall cost of Medicaid long-term care has continued to grow at much higher rates (over 13 percent and 11 percent during the last two fiscal years respectively.)

The reason for the large growth rates in the cost of providing long-term care, even as the size of the nursing home population has been kept almost constant, is that the unit costs of providing nursing home care (nursing home per diem rates) and home and community-based care (per member per month rates) have been growing very fast, more than offsetting any gains from nursing home caseload control. Per diem nursing home rates have grown at a rate of 7.3 percent yearly for the last five years, likewise per member per month rates for home and community-based care have been growing at a rate of 12 percent per year over the same period of time.

The above figures suggest that to control the growth of Medicaid long-term care, holding the line in Medicaid nursing home bed utilization cannot by itself control the rising budgets for Medicaid long-term care. Reductions in the use of expensive nursing home based long-term care through the use of home and community-based care must be coupled with strategies that will control the unit costs of providing care in nursing homes and in a home and community based setting.

To address the need to control long-term care unit costs, during its last session, the Florida Legislature deferred the implementation of enhanced staffing ratios in nursing homes as a means to control the growth in the nursing home care unit cost (the per diem). In addition, it passed SB1226 mandating the Florida Department of Elder Affairs to implement a system of Aging Resource Centers and to develop capitation rates for the services that it administers under the Community Care for the Elderly Program.

Aging Resource Centers will help control the growth in home and community-based care unit costs (per member per month) while at the same time improve program targeting. Controlling the per member per month and improving targeting will ensure that program dollars maximize nursing home care cost avoidance in a cost efficient manner.

Aging Resource Centers will control the growth in per member per month costs by being the single agency authorizing care plans with costs commensurate to the cost avoidance that program intervention creates, i.e. care plan costs for any particular individual will be commensurate to the risk that, lacking program intervention, this individual will use nursing home, hospital, or acute medical Medicaid subsidized care. Currently individuals can access Medicaid long-term care through a multitude of entry points, with no entity being uniquely charged with assuring that the cost of the care plan meets cost effectiveness guideline.

Further, capitation of the Community Care for the Elderly Program, and eventually of most other programs, including Medicaid waivers, currently provided on a “fee-for-service” basis will provide a needed degree of certainty to projecting and budgeting for home and community-based long-term care expenditures.

In addition to controlling costs, Aging Resource Centers will be charged with screening and prioritizing access based on risk. Also, Aging Resource Centers will be making referrals of customers that can pay, either wholly or partially, to “for-pay” providers. This helps control Medicaid budgets by allowing individuals and families to contribute to the cost of their care to the extent possible. This is a significant departure from the traditional “all-or-nothing” approach to public long-term care.

Discussion:

Information Technology Improvements and Enhancements

The most significant new Elder Affairs business objective for SFY 2004-05 is the Aging Resource Center. Support of this initiative will require a significant investment of resources for a new Information and Referral System. This coupled with the integration of the Client Information Referral and Tracking System (CIRTS) and the Care

Management System (CMS) into a single operating assessment information system, also required by SB 1226, will require a major effort to achieve.

Technology can be employed to help address the ever-increasing workload without a proportional increase in staffing. Examples of opportunities to explore are wireless connections to browser-based systems and laptop versions of caseworker software that could increase the time available for working with consumers while improving service.

Information technology hardware typically has a lifetime of three to five years. Maintenance for hardware can generally be purchased with new hardware for up to three years. The three-year limit is related to repair frequency and associated cost increases in the fourth year. Also, the performance of hardware has typically increased appreciably in any three-year period, thus for the same cost significant performance improvements can be achieved. In addition, software is continually being enhanced to provide more benefit to those using the hardware although hardware more than three years old is not always up to the task; it either requires upgrades with a short useful life or degradation of personnel productivity. Another consideration is that hardware more than three years old will typically have an older operating system, which might not be compatible with newer application software or may be more vulnerable to security risks and computer viruses that can affect all computers in a network.

Discussion:

Serving the Priority Level 4 and 5 Clients Awaiting Medicaid Aged/Disabled Waiver and Assisted Living for the Elderly Waiver Services

Continuing increases of the Medicaid budget represent a major diversion of state fiscal resources and constitute a major threat to the future functioning of other needed state services such as education, public safety, or transportation. A major component in the Medicaid budget is the cost of nursing home long-term care. A major strategy to reduce the rate of growth in Medicaid nursing home based long-term care is to substitute such care with home and community based alternatives.

At the federal level, the agency that administers Medicaid—The Centers for Medicare and Medicaid (CMS) —gives states the choice to provide Medicaid subsidized long-term care at home instead of nursing home based care to customers that are determined to need nursing home level of care. States can access this choice by applying for "waivers" to certain federal Medicaid requirements. Florida has applied for—and currently operates—several waivers, each targeting narrowly defined constituencies. The Department of Elder Affairs (DOEA) manages two such waivers: The Aged and Disabled and the Assisted Living Medicaid home and community-based services waivers.

The effectiveness of these programs in saving Medicaid long-term care dollars depends heavily on two factors: How effectively services are targeted only to those that would have—in the absence of the program services—gone to a nursing home and how much the programs spend for the home and community-based services for each customer served. DOEA addresses targeting efficiency by prioritizing customers based on service need to avoid nursing home placement.

The wait list is an integral part of DOEA customer targeting management system. After initial contact, customers are formally assessed and their frailty and level of need is determined. These applicants are enrolled in a list of assessed customers where they receive case management and monitoring services. Those that are at highest level of need—levels 4 and 5—receive the highest priority and are put in the wait list for in-home services. Statistics based on several years of actual customer data indicate that consumers assessed at levels 4 and 5 are at the highest risk for nursing home placement, with 3 being average and 1 and 2 below average.

As of June 2004, the wait list for the Aged and Disabled and the Assisted Living Medicaid Waivers contained 1,544 priority level 4 and 5 frail elders. Based on the risk level of these individuals and current nursing home costs, the expected Medicaid cost of providing them with nursing home services would be $39.6 million. If served with home and community-based services, the cost to Medicaid is estimated to be $11.4 million. Therefore the expected value of Medicaid nursing home costs avoided would be about $28.2 million.

LIST OF CHANGES WHICH WOULD REQUIRE LEGISLATIVE ACTION

Not Applicable

The Department has no changes that would require legislative action.

LIST OF ALL TASK FORCES AND STUDIES IN PROGRESS

WORK GROUP/TASK FORCE	LEGISLATIVE MANDATE	COMMENTS
Administration on Aging Performance Outcome Measures Project		DOEA is a grant recipient to participate in the development of tangible performance measures for Older Americans Act programs.
Adult Protective Services Interagency Committee	Establishment of Committee Recommended by OPPAGA	DOEA and DCF.
Alzheimer's Disease Initiative Advisory Council	Section 430.501, Florida Statutes	Council meets quarterly and is composed of 10 members selected by the Governor. Its responsibility is to advise the Department of Elderly Affairs in the performance of its duties under this act regarding legislative, programmatic, and administrative matters that relate to Alzheimer's disease victims and their caretakers.
Big Bend Coalition on Affordable Housing and Assisted Living Facilities		The Department serves as an advisory committee member.
Blue Ribbon Task Force on Inclusive Community Living, Transition & Employment of Persons with Developmental Disabilities	Executive Order 04-62	Appointed by Governor.
Center for Housing and Long-Term Care	Sponsored by the University of South Florida	The Department serves as an advisory committee member.

WORK GROUP/TASK FORCE	LEGISLATIVE MANDATE	COMMENTS
Citizens First Work Group	Established by the Governor's Office of Citizens' Services	Interagency group to serve as: a way to keep the Governor informed as to what is going on; a forum for sharing ideas and discussing issues across agencies; and to make Recommendations for Solutions to citizen issues.
Commission for Transportation Disadvantaged	Section 427.012, Florida Statutes	Secretary or Secretary's designee is mandated member.
Community Assistance Advisory Council, Dept. of Community Affairs	10 CFR, Part 440.17 and 9B-24.006 FAC	DOEA representative appointed by Secretary.
Davis Productivity Awards Committee		Davis Productivity Awards is a privately funded program that honors individuals, teams and work units of Florida state government for innovation, creativity and smart work that measurably increases performance and productivity in the delivery of state services and products.
Diabetes Implementation Work Group		Partnership of stakeholders with the purpose of coordinating diabetes education and prevention services.
Digital Divide Council	State Technology Office	Determining computer needs of underserved elders and implementing programs and initiatives capable of providing computer education and training in intergenerational settings.
Florida At-Risk Driver Advisory Council	Section 322.181, Florida Statutes	Membership includes representatives of state agencies involved with issues facing older drivers.

WORK GROUP/TASK FORCE	LEGISLATIVE MANDATE	COMMENTS
Florida Developmental Disabilities Council	US Public Law 106-402 Developmental Disabilities Assistance & Bill of Rights Act of 2000	Appointment by Governor.
Florida Interagency Food and Nutrition Committee (FIFNC)		All state agencies receiving USDA funding.
Florida Older Adult Work Group (DCF)		Participation by request from the Secretary of DCF.
Florida Supportive Housing Coalition		The purpose is to reduce fragmentation. The Department participates to represent elder issues.
FLAIRS (Florida Alliance of Information & Referral Services)		Responsibilities include determining the organization's policy in the area of organizational operations, planning, finance and community relations. Emphasis is placed on ensuring organization's programs and services appropriately address community and clients' needs. FLAIRS membership is composed of comprehensive and specialized I&R programs.
Florida Accounting Information Resource (FLAIR) and Cash Management System (CMS) Replacement Project - Interagency Workgroup		This advisory group of state agency representatives serves as a liaison between the FLAIR Replacement project and State agencies and provides input on agency-specific needs.
Florida Arthritis Partnership (FLAP)		Partnership of stakeholders with the purpose of coordinating arthritis education and services.

WORK GROUP/TASK FORCE	LEGISLATIVE MANDATE	COMMENTS
Florida Association of Housing and Redevelopment Officials (FAHRO)		The Department has executed a Memorandum of Understanding with the association to collaborate on challenges and opportunities regarding assisted living and public housing.
Florida Cardiovascular Health Council		Partnership of stakeholders with the purpose of coordinating cardiovascular health education and services.
Florida HIV/AIDS & Aging Consortium		Partnership of stakeholders with the purpose of coordinating HIV/AIDS education and services for seniors.
Florida Partnership for Promoting Physical Activity and Healthful Nutrition (FPPAHN)		Partnership of stakeholders with the purpose of coordinating physical activity and healthful nutrition services.
Food and Nutrition Advisory Council	Fulfills requirements established in 42 USC 1766, Richard B. Russell National School Lunch Act	Child nutrition and Department of Agriculture programs funded by USDA.
Front Porch Community "A" (advance) Team	Established by Governor's Office of Urban Opportunity	Representatives from all state agencies and private sector partners. Established to improve coordination of programs, services, resources, etc. in designated communities.
Gold Seal Panel	Section 400.235, Florida Statutes	Reward nursing home best service.
Governor's Alliance for the Employment of Citizens with Disabilities Advisory Council		Also known as Able Trust. Appointed by Secretary in response to request from Able Trust.

WORK GROUP/TASK FORCE	LEGISLATIVE MANDATE	COMMENTS
Information & Referral Workgroup		Established to inventory the assortment of sub-state I&R/A efforts and draft a proposed work plan to guide the development and implementation of a statewide I&R/A system.
Northwest Regional Cancer Control Collaborative		Partnership of stakeholders with the purpose of coordinating cancer education and services for northwest Florida.
Office of Long-Term Care Policy Interagency Coordinating Team	SB 1226 2004 Legislative Session	The membership of interagency team is listed in the legislation.
Osteoporosis Advisory Council		Partnership of stakeholders with the purpose of coordinating osteoporosis education and services.
Pilot Nursing Home Quality Initiatives		Aids in choosing a nursing home.
Real Choice Partnership Project Coalition (ADA Work Group)		Interagency Grant in response to the Olmstead Decision.
Rural Economic Development Initiative	288.0656 F.S.	DOEA is not specified in legislation. Appointed by Secretary in response to request from Governor's Office of Tourism, Trade and Economic Development.
Stamp Out Hunger Committee	USDA Regional Director declaration to work together signed by States	All state agencies receiving USDA funding and some private organizations.
State Mental Health Planning Council	Section 914 U.S. Public Health Service Act; Requires states to establish and maintain councils.	DOEA is not specified in legislation. Established by DCF. Appointed by Secretary in response to request from DCF.

WORK GROUP/TASK FORCE	LEGISLATIVE MANDATE	COMMENTS
State Partnership for the Elimination of Barriers Initiative (Mental Health)		The Department participates as part of a three-year demonstration program of DCF and Center for Mental Health Services.
Supportive Housing Workgroup		DCF Mental Health Office sponsors this workgroup
Workforce Florida Inc. Board of Directors		Deputy Secretary is designated a member of Board.

LRPP Exhibit I: Agency Workforce Plan

Fiscal Years	Total FTE Reductions	Description of Reduction Issue	Positions per Issue	Impact of Reduction
FY 2005-2006	0			
FY2006-2007	0			
Total*	**0**			

*to equal remainder of target

LRPP Exhibit II: Performance Measures and Standards

Department: Department of Elder Affairs	Department No.: 65

Program: Services to Elders	Code: 65100000
Service/Budget Entity: Comprehensive Eligibility Services	Code: 65100200

NOTE: Approved primary service outcomes must be listed first.

Approved Performance Measures for FY 2004-05 (Words)	Approved Prior Year Standard FY 2003-04 (Numbers)	Prior Year Actual FY 2003-04 (Numbers)	Approved Standards for FY 2004-05 (Numbers)	Requested FY 2005-06 Standard (Numbers)
Percent of elders CARES determined to be eligible for nursing home placement who are diverted	30%	26.1%*	30%	26.4%
Total number of CARES assessments	96,000	74,162*	96,000	80,000

* estimate - final data is not yet due to Dept.

Department: Department of Elder Affairs	Department No.: 65

Program: Services to Elders	Code: 65100000
Service/Budget Entity: Home and Community Services	Code: 65100400

NOTE: Approved primary service outcomes must be listed first.

Approved Performance Measures for FY 2004-05 (Words)	Approved Prior Year Standard FY 2003-04 (Numbers)	Prior Year Actual FY 2003-04 (Numbers)	Approved Standards for FY 2004-05 (Numbers)	Requested FY 2005-06 Standard (Numbers)
Percent of most frail elders who remain at home or in the community instead of going into a nursing home	96%	96.5%	97%	97%
Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours	97%	96.4%	97%	97%

Approved Performance Measures for FY 2004-05 (Words)	Approved Prior Year Standard FY 2003-04 (Numbers)	Prior Year Actual FY 2003-04 (Numbers)	Approved Standards for FY 2004-05 (Numbers)	Requested FY 2005-06 Standard (Numbers)
Average monthly savings per consumer for home and community-based care versus nursing home care for comparable consumer groups	$2,384	$3,592	$2,384	$2,563
Percent of elders assessed with high or moderate risk environments who improved their environment score	79.3%	66.4%	79.3%	66.5%
Percent of new service recipients with high-risk nutrition scores whose nutritional status improved	66%	64.2%	66%	66%
Percent of new service recipients whose ADL assessment score has been maintained or improved	63%	65%	63%	63%
Percent of new service recipients whose IADL assessment score has been maintained or improved	62.3%	62.5%	62.3%	62.3%
Percent of family and family-assisted caregivers who self-report they are very likely to provide care	88.9%	87.9%	89%	89%
Percent of caregivers whose ability to provide care is maintained or improved after one year of service intervention (as determined by the caregiver and the assessor)	90%	93.2%	90%	90%
Average time in the Community Care for the Elderly program for Medicaid Waiver probable customers	2.8 months	6.6 months	2.8 months	4 months
Percent of customers who are at imminent risk of nursing home placement who are served with community-based services	90%	86.6%	90%	90%
Number of elders served with registered long-term care services	167,250	183,764 (est.)	167,250	167,250
Number of congregate meals provided	5,105,950	5,385,152	5,105,950	5,105,950
Number of elders served (caregiver support)	38,180	40,973	49,070	49,070
Number of elders served (early intervention/ prevention)	237,260	244,818 (est.)	257,260	257,260
Number of elders served (home & community services diversion)	56,539	46,734	51,272	51,272
Number of elders served (LTC initiatives)	2,970	4,239	5,800	5,800
Number of elders served (meals, nutrition education and nutrition counseling)	81,903	75,512	81,903	72,500

Approved Performance Measures for FY 2004-05 (Words)	Approved Prior Year Standard FY 2003-04 (Numbers)	Prior Year Actual FY 2003-04 (Numbers)	Approved Standards for FY 2004-05 (Numbers)	Requested FY 2005-06 Standard (Numbers)
Number of elders served (residential assisted living support and elder housing issues)	3,421	3,997	3,421	3,421
Number of elders served (self care)	303,629	314,087 (est.)	303,629	303,629
Number of elders served (supported community care)	60,540	57,577 (est.)	60,540	60,540

Department: Department of Elder Affairs	Department No.: 65

Program: Services to Elders	Code: 65100000
Service/Budget Entity: Executive Direction and Support Services	Code: 65100600

NOTE: Approved primary service outcomes must be listed first.

Approved Performance Measures for FY 2004-05 (Words)	Approved Prior Year Standard FY 2003-04 (Numbers)	Prior Year Actual FY 2003-04 (Numbers)	Approved Standards for FY 2004-05 (Numbers)	Requested FY 2005-06 Standard (Numbers)
Agency administration costs as a percent of total agency costs / agency administrative positions as a percent of total agency positions	2.1% / 19.6%	TBD	2.1% / 19.6%	TBD

Department: Department of Elder Affairs	Department No.: 65

Program: Services to Elders	Code: 65100000
Service/Budget Entity: Consumer Advocate Services	Code: 65101000

NOTE: Approved primary service outcomes must be listed first.

Approved Performance Measures for FY 2004-05 (Words)	Approved Prior Year Standard FY 2003-04 (Numbers)	Prior Year Actual FY 2003-04 (Numbers)	Approved Standards for FY 2004-05 (Numbers)	Requested FY 2005-06 Standard (Numbers)
Percent of complaint investigations initiated within five working days	91%	92%	91%	91%
Percent of service activities on behalf of frail or incapacitated elders initiated by public guardianship within 5 days of receipt of request	95%	95% (est.)	95%	95%
Number of judicially approved guardianship orders	1,350	1,673	1,350	1,350
Number of complaint investigations completed	8,712	9,133	8,712	8,712

LRPP Exhibit III: Performance Measure Assessment

Department: Department of Elder Affairs
Program: Services to Elders
Service: Consumer Advocate Services
Measure: Number of judicially approved guardianship orders
Action:
☐ Performance Assessment of Outcome Measure ☒ Revision of Measure
☐ Performance Assessment of Output Measure ☐ Deletion of Measure
☒ Adjustment to GAA Performance Standard

Approved GAA Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
1,350	1,673	323	24%

Factors Accounting for the Difference:

Internal Factors (check all that apply)

☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect
☐ Other (Identify)

Explanation:

N/A

External Factors (check all that apply)

☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission

Explanation:

N/A

Management Efforts To Address Differences/Problems (check all that apply)

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations:

The current measure reads: Number of judicially approved guardianship orders. The Department requests a change from the words "guardianship orders" to "guardianship plans, including new orders." There has been on-going confusion between the terms "plans" and "orders." The Department has actually been tracking "plans," but calling them "orders," due to confusion in terminology. "Orders" actually refers to new cases and "plans" are the on-going cases. The Department would like to better represent the total work of the program, not just the new or the ongoing plans. So, the Department would like the measure to reflect both the on-going plans and the new orders as a combined total.

For 2003-04, the number of guardianship plans is 1,673, and the number of new guardianship orders is 430, for a total combined count of 2,103.

With the change in language, which would also modify the methodology slightly and include a larger count, **the Department requests the standard for 2005-2006 to be 1,600**. It is not expected for the number of new orders to continue, due to changes in funding for 2004-2005. While the state increased funding to the program, the change is to offset the elimination of other funding that the local guardianship offices were formerly receiving.

LRPP Exhibit III: Performance Measure Assessment

Department: Department of Elder Affairs
Program: Services to Elders
Service: Comprehensive Eligibility Services
Measure: Percent of elders CARES determined to be eligible for nursing home placement who are diverted

Action:
☒ Performance Assessment of Outcome Measure ☐ Revision of Measure
☐ Performance Assessment of Output Measure ☐ Deletion of Measure
☒ Adjustment to GAA Performance Standard

Approved GAA Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
30%	26.1% (estimate)	(3.9)	13%

Factors Accounting for the Difference:

Internal Factors (check all that apply)

☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☒ Previous Estimate Incorrect
☐ Other (Identify)

Explanation:

The percent of diversion is not what was anticipated due to several reasons. The freeze on enrollments in the Aged and Disabled Adult Medicaid Waiver program that was imposed in many areas of the state for many months during the 2003-2004 fiscal year limited the number of diversions. To divert applicants from nursing home placement, appropriate alternative services must be available in the community to accommodate their needs. Level funding for the ADA and ALF waivers which accommodate most diversions forced an enrollment freeze for several months therefore reducing the number of diversions. Funding increases to the nursing home diversion waiver do not offset "slot" losses in the ADA and ALE programs. The ALE and ADA slots are on average 2.5 times less expensive.

External Factors (check all that apply)

☐ Resources Unavailable ☐ Technological Problems

☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission

Explanation:

Management Efforts To Address Differences/Problems (check all that apply)
☒ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations:

The Department requests that the **standard be adjusted to 26.4%,** the 2002-2003 achieved performance level. Since the largest portion of the work of the CARES program is determining level of care for consumers who are already residing in the nursing home, it is not realistic to expect almost a third of the consumers would be diverted from the nursing home to community care.

LRPP Exhibit III: Performance Measure Assessment

Department: Department of Elder Affairs
Program: Services to Elders
Service: Comprehensive Eligibility Services
Measure: Total number of CARES assessments
Action:
☒ Performance Assessment of Outcome Measure ☐ Revision of Measure
☐ Performance Assessment of Output Measure ☐ Deletion of Measure
☒ Adjustment to GAA Performance Standard

Approved GAA Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
96,000	74,162 (estimated)	(21,838)	22.7%

Factors Accounting for the Difference:

Internal Factors (check all that apply)

☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☒ Previous Estimate Incorrect
☐ Other (Identify)

Explanation:

The reason that the number of assessment being completed is fewer than anticipated is that additional diversion slots were available mostly in the nursing home diversion waiver, rather than as in past in the ADA and ALE waivers. The assessments conducted for the nursing home diversion program are much more time consuming than most of the other assessments the CARES program conducts. Each of the nursing home diversion assessments must be conducted in the client's home and involve a more extensive assessment. A fairly large percentage of the other assessments are conducted in nursing homes or hospitals, where CARES staff can see several people during one trip.

External Factors (check all that apply)

☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)

☐This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission

Explanation:

Management Efforts To Address Differences/Problems (check all that apply)

☐ Training	☐ Technology
☐ Personnel	☐ Other (Identify)

Recommendations:

The Department is requesting the **standard be adjusted to 80,000**, which would be greater than the 2002-2003 performance level of 77,843, but more realistic.

LRPP Exhibit III: Performance Measure Assessment

Department: Department of Elder Affairs
Program: Services to Elders
Service: Home and Community Services
Measure: Percent of APS referrals who are in need of immediate service to prevent further harm who are served within 72 hours

Action:
☒ Performance Assessment of Outcome Measure ☐ Revision of Measure
☐ Performance Assessment of Output Measure ☐ Deletion of Measure
☐ Adjustment to GAA Performance Standard

Approved GAA Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
97%	96.4%	(.6)	.01%

Factors Accounting for the Difference:

Internal Factors (check all that apply)

☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect
☒ Other (Identify)

Explanation:

The performance variance from the standard is not large enough to be statistically significant and therefore does not indicate a need for adjustment in current procedures.

External Factors (check all that apply)

☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission

Explanation:

Management Efforts To Address Differences/Problems (check all that apply)

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations:

No recommendations are suggested at this time, since performance variance from the standard is not statistically significant. The standard reflects an improved performance over last fiscal year.

LRPP Exhibit III: Performance Measure Assessment

Department: Department of Elder Affairs
Program: Services to Elders
Service: Home and Community Services
Measure: Percent of elders assessed with high or moderate risk environments who improved their environment score

Action:
☒ Performance Assessment of Outcome Measure ☐ Revision of Measure
☐ Performance Assessment of Output Measure ☐ Deletion of Measure
☒ Adjustment to GAA Performance Standard

Approved GAA Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
79.3%	66.4	(12.9)	16.3%

Factors Accounting for the Difference:

Internal Factors (check all that apply)

☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect
☐ Other (Identify)

Explanation:

N/A

External Factors (check all that apply)

☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☒ Other (Identify)
☒ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission

Explanation:

This measure continues to be a challenge for the providers in the aging network. Many people with high or moderate risk environments are in rental units to which they are not permitted to make environmental modifications and others are in homes they are

unwilling to leave, in spite of case managers' efforts to work with the clients. They often are in a physical structure with numerous problems that are too costly for Departmental programs to repair.

Management Efforts To Address Differences/Problems (check all that apply)

☒ Training
☐ Personnel
☐ Technology
☒ Other (Identify)
Monitoring

Recommendations:

The Department requests that the **standard be adjusted to 66.5%.**

LRPP Exhibit III: Performance Measure Assessment

Department: Department of Elder Affairs
Program: Services to Elders
Service: Home and Community Services
Measure: Percent of new service recipients with high risk nutrition scores whose nutrition status improved

Action:
☒ Performance Assessment of Outcome Measure ☐ Revision of Measure
☐ Performance Assessment of Output Measure ☐ Deletion of Measure
☐ Adjustment to GAA Performance Standard

Approved GAA Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
66%	64.2%	(1.8)	2.7%

Factors Accounting for the Difference:

Internal Factors (check all that apply)

☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect
☐ Other (Identify)

Explanation:

N/A

External Factors (check all that apply)

☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☒ Target Population Change ☐ Other (Identify)
☐This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission

Explanation:
The Department continues to target frail elders (priority levels 4 and 5) and high-risk groups such as low-income minorities and elders residing in rural areas. Many factors that place a person at high nutritional risk, such as taking 3 or more medicines a day, are factors that cannot be changed.

Management Efforts To Address Differences/Problems (check all that apply)

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations:

Since the variance from the standard is less than 5%, no change in procedures is needed nor is an adjustment to the standard requested.

LRPP Exhibit III: Performance Measure Assessment

Department: Department of Elder Affairs
Program: Services to Elders
Service: Home and Community Services
Measure: Number of elders served (meals, nutrition education and nutrition counseling)

Action:

☐ Performance Assessment of Outcome Measure ☐ Revision of Measure
☒ Performance Assessment of Output Measure ☐ Deletion of Measure
☒ Adjustment to GAA Performance Standard

Approved GAA Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
81,903	72,512	(9,391)	11.5%

Factors Accounting for the Difference:

Internal Factors (check all that apply)

☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☒ Previous Estimate Incorrect
☐ Other (Identify)

Explanation:

The congregate and home delivered meals programs both faced a decrease in service allocations, while at the same time, the average per meal cost in the home delivered meals program increased by 9 percent.

External Factors (check all that apply)

☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐ This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission

Explanation:

N/A

Management Efforts To Address Differences/Problems (check all that apply)

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations:

The Department requests that the **standard be adjusted for 05-06 to 72,500**. Funding for services in the nutrition programs has increased only slightly. With per meal costs likely to increase, it is not expected that increased number of elders will be served in these programs.

LRPP Exhibit III: Performance Measure Assessment

Department: Department of Elder Affairs
Program: Services to Elders
Service: Home and Community Services
Measure: Percent of family and family-assisted caregivers who self-report they are very likely to provide care

Action:
☒ Performance Assessment of Outcome Measure ☐ Revision of Measure
☐ Performance Assessment of Output Measure ☐ Deletion of Measure
☐ Adjustment to GAA Performance Standard

Approved GAA Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
88.9%	87.9%	(1.0)	1.1%

Factors Accounting for the Difference:

Internal Factors (check all that apply)

☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect
☒ Other (Identify)

Explanation:

Although outreach activities target high-risk populations, the Department does not select consumers who seek services. Therefore, the Department cannot select which caregivers to serve. The percentage difference is small, so the amount of variance is not a concern.

External Factors (check all that apply)

☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission

Explanation:

Management Efforts To Address Differences/Problems (check all that apply)

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations:

No change is considered necessary since the variance from the standard is so minimal.

LRPP Exhibit III: Performance Measure Assessment

Department: Department of Elder Affairs
Program: Services to Elders
Service: Home and Community Services
Measure: Average time in the Community Care for the Elderly program for Medicaid Waiver probable customers

Action:
☒ Performance Assessment of Outcome Measure ☐ Revision of Measure
☐ Performance Assessment of Output Measure ☐ Deletion of Measure
☒ Adjustment to GAA Performance Standard

Approved GAA Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
2.8 months	6.6 months	3.8 months	137%

Factors Accounting for the Difference:

Internal Factors (check all that apply)

☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☒ Previous Estimate Incorrect
☐ Other (Identify)

Explanation:

The ADA waiver program had a freeze on enrollments during 2003-2004, so consumers remained in the Community Care for the Elderly program for more extended periods. The enrollments had to be frozen because, for new clients brought into the program later in the prior year, not enough budget was allocated for the costs of care plans for a full year. There then were not sufficient funds to properly serve the consumers in the ADA waiver and take on new clients.

External Factors (check all that apply)

☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐This Program/Service Cannot Fix The Problem

☐ Current Laws Are Working Against The Agency Mission

Explanation:

Management Efforts To Address Differences/Problems (check all that apply)

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations:

The Department requests that the standard be changed from 2.2 months to **4 months**, which is more realistic if the caseloads of case workers conducting eligibility assessments is considered. The original standard of 2.2 months was based on a timeframe during which there was new waiver funding available enabling consumers to be enrolled quickly and does not properly reflect the broader trends.

LRPP Exhibit III: Performance Measure Assessment

Department: Department of Elder Affairs
Program: Services to Elders
Service: Home and Community Services
Measure: Percent of customers who are at imminent risk of nursing home placement who are served with community-based services

Action:
☒ Performance Assessment of Outcome Measure ☐ Revision of Measure
☐ Performance Assessment of Output Measure ☐ Deletion of Measure
☐ Adjustment to GAA Performance Standard

Approved GAA Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
90%	86.6%	(3.4)	3.8%

Factors Accounting for the Difference:

Internal Factors (check all that apply)

☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☒ Previous Estimate Incorrect
☐ Other (Identify)

Explanation:

The freeze on enrollments in the Aged and Disabled Adult Medicaid Waiver program that was imposed in many areas of the state for many months during the 2003-2004 fiscal year limited the number of new clients who could be served. In addition, this is the first year of implementing this performance measure as it was changed from CARES imminent risk to the broader population of providers. The Department had no specific way to anticipate what performance would be; but could only make an educated guess. Since performance is within 5 percent of the standard, no change in approach is needed at this point.

External Factors (check all that apply)

☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐This Program/Service Cannot Fix The Problem

☐ Current Laws Are Working Against The Agency Mission

Explanation:

Management Efforts To Address Differences/Problems (check all that apply)

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations:

No recommendations to change approach or to request an adjusted standard are submitted at this time, since performance was within 5 percent of the standard for this first year of implementing the new measure.

LRPP Exhibit III: Performance Measure Assessment

Department: Department of Elder Affairs
Program: Services to Elders
Service: Home and Community Services
Measure: Number of elders served (home and community services diversion)
Action:
☒ Performance Assessment of Outcome Measure ☐ Revision of Measure
☐ Performance Assessment of Output Measure ☐ Deletion of Measure
☐ Adjustment to GAA Performance Standard

Approved GAA Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
56,539	47,759	(9,780)	17.3%

Factors Accounting for the Difference:

Internal Factors (check all that apply)

☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☒ Previous Estimate Incorrect
☐ Other (Identify)

Explanation:

This activity is comprised of the Community Care for the Elderly and the Aged and Disabled Adult Medicaid Waiver (which also includes the Consumer Directed Care) programs. The output data only includes the people in the program aged 60 or older. Fewer people were served in the ADA waiver program than anticipated due to a freeze on enrollments. The enrollments had to be frozen because, for new clients brought into the program later in the prior year, not enough budgets was allocated for the costs of care plans for a full year. There then were not sufficient funds to properly serve the consumers in the ADA waiver and take on new clients. In addition, as providers do a better job of serving consumers who are priority levels 4 and 5 as directed, care plans to serve the frailer individuals are more costly. Another factor is that it is taking longer to implement the two new waivers, the Alzheimer's Disease and the Adult Day Health Care. These programs were factored into the development of the standard.

External Factors (check all that apply)

☐ Resources Unavailable ☐ Technological Problems

☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission

Explanation:

Management Efforts To Address Differences/Problems (check all that apply)
☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations:

Since it is anticipated that both new waivers will be fully operational during 2004-2005, an adjustment to the standard is not requested.

LRPP Exhibit III: Performance Measure Assessment

Department: Department of Elder Affairs
Program: Services to Elders
Service: Home and Community Services
Measure: Number of elders served (supported community care)
Action:
☒ Performance Assessment of Outcome Measure ☐ Revision of Measure
☐ Performance Assessment of Output Measure ☐ Deletion of Measure
☐ Adjustment to GAA Performance Standard

Approved GAA Standard	Actual Performance Results	Difference (Over/Under)	Percentage Difference
60,540	57,819	(2,721)	4.5%

Factors Accounting for the Difference:

Internal Factors (check all that apply)

☐ Personnel Factors ☐ Staff Capacity
☐ Competing Priorities ☐ Level of Training
☐ Previous Estimate Incorrect
☒ Other (Identify)

Explanation:

As the Department targets frailer individuals for in-home services, fewer people can be served with the same amount of resources. Since the variance from the standard is within 5 percent, no changes in approach need to be undertaken. The Department will monitor the issue to determine if any policy adjustments need to be made.

External Factors (check all that apply)

☐ Resources Unavailable ☐ Technological Problems
☐ Legal/Legislative Change ☐ Natural Disaster
☐ Target Population Change ☐ Other (Identify)
☐This Program/Service Cannot Fix The Problem
☐ Current Laws Are Working Against The Agency Mission

Explanation:

Management Efforts To Address Differences/Problems (check all that apply)

☐ Training ☐ Technology
☐ Personnel ☐ Other (Identify)

Recommendations:

No recommendations for changes in approach or adjustment to the standard are made at this time.

LRPP Exhibit IV: Performance Measure Validity and Reliability

Department: Department of Elder Affairs
Program: Services to Elders
Service: Consumer Advocate Services
Activity: Public Guardianship Program
Measure: Number of judicially approved guardianship orders
Proposed new wording of the output measure:
Number of judicially approved guardianship plans, including new orders (applies to the Public Guardianship program)

Action: (check one)
☒ Requesting revision to approved measure
☒ Change in Data Sources or Measurement Methodologies
☐ Requesting new measure
☐ Backup for Performance Outcome and Output Measure

Data Sources and Methodology:

1. The data source for this measure is data tracked by each of the circuit courts with an Office of Public Guardian.
2. Each office keeps a record of the total number of plans, which is their current caseload, and new orders.
3. The measure is the combined number of guardianship plans and orders.

Validity:

1. The methodology was developed through staff analysis of data available. Each Office of the Public Guardian has operated independently under the direction of the local circuit court. The Department now has oversight of the guardianship program statewide.
2. The measure is appropriate for determining if the ward's best interest and safety are being considered. If the guardianship plan is not satisfactory, the court has an opportunity to disapprove the plan and require an alternate approach.

Reliability:

1. Reliability was established through interaction with each of the Offices of the Public Guardian. Each keeps a record of the number of plans submitted and approved by the circuit court and new orders.
2. The measure is reliable. Any person reviewing the data submitted would draw the same conclusions because the measure is a simple count of numbers provided from each circuit with a guardianship program.

APPENDIX I: GLOSSARY OF TERMS AND ACRONYMS, INCLUDING UNIQUE AGENCY TERMS AND ACRONYMS

Note: Underlined acronyms and terms are those listed in Long-Range Program Plan instructions issued by the Executive Office of the Governor.

AAA – Area Agency on Aging

ACFP – Adult Care Food Program

Activities of Daily Living (ADL) - Functions and tasks for self care, including ambulation, bathing, dressing, eating, grooming, toileting and other similar tasks.

Activity – A set of transactions within a budget entity that translates inputs into outputs using resources in response to a business requirement. Sequences of activities in logical combinations form services. Unit cost information is determined using the outputs of activities.

Actual Expenditures – Disbursement of funds including prior year actual disbursements, payables and encumbrances. The payables and encumbrances are certified forward at the end of the fiscal year. They may be disbursed between July 1 and December 31 of the subsequent fiscal year. Certified forward amounts are included in the year in which the funds are committed but are not shown in the year the funds are disbursed.

ADC – Adult Day Care

ADI – Alzheimer's Disease Initiative

ADL - Activities of Daily Living

Adult Care Food Program (ACFP) - A program that reimburses eligible Adult Care Centers for meals provided to Adult Care participants. Adult Care Centers include licensed Adult Day Care Centers, Mental Health Day Treatment Centers and In-Facility Respite Centers.

Adult Family Care Home (AFCH) - A full-time, family-type, living arrangement in a private home, in which a person or persons who own/rent and live in the home provide room, board and personal services, as appropriate for the level of functional impairment, for no more than five disabled adults or frail elders who are not relatives.

Adult Protective Services (APS) – The provision or arrangement of services to protect a disabled adult or an elderly person from further occurrences of abuse, neglect or exploitation. Services may include protective supervision, placement and in-home/community-based services.

AFCH - Adult Family Care Home

AFDC – Aid to Families with Dependent Children

AHCA - Agency for Health Care Administration

ALF - Assisted Living Facility

ALW – Medicaid Assisted Living for the Elderly Waiver

Alzheimer's Disease Initiative (ADI) - Programs, including caregiver respite, memory disorder clinics, model day-care programs and a research database, which provide services to meet the needs of caregivers and individuals with Alzheimer's disease and related cognitive disorders.

AmeriCorps – AmeriCorps, the domestic Peace Corps, funds grants for elder programs such as ElderServe, Care and Repair and Homeland Security. AmeriCorps members and volunteers provide a variety of community outreach, education, respite, and support services for elders. ElderServe emphasizes respite service for frail elders who are at risk of institutionalization, focusing mainly on those elders with Alzheimer's disease and other forms of dementia. Care and Repair provides home repairs, home modifications and related services to assist elders in making their domiciles accessible and safe, allowing these elders to age in place and enhancing their quality of life. Homeland Security assists elders in preparing for acts of terrorism, emergencies and natural disasters.

AoA - Administration on Aging

Appropriation Category - The lowest level line-item of funding in the General Appropriations Act representing a major expenditure classification of the budget entity. Within budget entities, these categories may include: salaries and benefits, other personal services (OPS), expenses, operating capital outlay, data processing services, fixed capital outlay, etc. These categories are defined within this glossary under individual listings.

APS – Adult Protective Services

Area Agency on Aging (AAA) - A local public or private nonprofit entity mandated by the Older Americans Act. The Department of Elder Affairs designates entities as AAAs

to coordinate and administer the Department's programs and to contract out services within a planning and service area.

Assisted Living Facility (ALF) - Any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.

Baseline Data - Indicators of a state agency's current performance level, pursuant to guidelines established by the Executive Office of the Governor in consultation with legislative appropriations and appropriate legislative committees.

BPL – Below Poverty Level

Budget Entity – A unit or function at the lowest level to which funds are specifically appropriated in the appropriations act. "Budget entity" and "service" have the same meaning.

Caregiver - A person who has been entrusted with, or has assumed the responsibility for, the care of an older individual, either voluntarily, by contract, by receipt of payment for care or as prescribed by law.

Care Management System (CMS) – DOEA's database system for the Comprehensive Assessment and Review of Long-Term Care Services (CARES) program.

CARES - Comprehensive Assessment and Review for Long-Term Care Services

Case Aide - An individual who, under the direction of a case manager, provides assistance with the implementation of a care plan, accessing resources, services, oversight, supervision of service provider activities and facilitation of linkages with service providers.

Case Management - A service provided to an older individual by a professional who is trained or experienced in the skills required to deliver and coordinate services. Includes assessing for care needs and arranging, coordinating and monitoring an optimum package of services to meet the identified needs of the older individual.

CCDA - Community Care for Disabled Adults

CCE - Community Care for the Elderly

CCRC - Continuing Care Retirement Community

CDBG - Community Development Block Grant

CDC – Consumer Directed Care

Centers for Medicare & Medicaid Services (CMS) - administers Medicare, Medicaid, and the Child Health insurance programs. Formerly called the Health Care Finance Administration (HCFA).

CFL – Communities for a Lifetime

CIO - Chief Information Officer

CIP – Capital Improvements Program Plan

CIRTS - Client Information Registration and Tracking System

Client Information Registration and Tracking System (CIRTS) – DOEA's centralized customer registry and database, with information about every customer that has received a service from Area Agencies on Aging (AAAs) since 1997. CIRTS is a dynamic database that is updated on a real-time basis every time a new customer enrolls or an existing customer receives a service. The information captured in CIRTS includes client name, address, telephone number, all physical and mental assessment data (ADL, IADL, etc.), and services received by date of service and number of units of service provided.

CMS - Centers for Medicare & Medicaid Services

CMS - Care Management System

COA - Council on Aging

Coming Home – A DOEA program, funded by a Robert Wood Johnson grant, that prevents premature nursing home placement while increasing the quality of life of elders by fostering affordable assisted living.

Community Care for the Elderly (CCE) - A state-mandated service delivery system, which contracts out community-based services. The services provide assistance with daily tasks to help make it possible for functionally-impaired elders to live independently in their own homes.

Communities for a Lifetime (CFL) – A DOEA initiative encouraging Florida community development which enhances the quality of life for all age groups, offers a variety of

elder-friendly housing options from apartments to home sharing, and incorporates the experience and skills of older workers.

Comprehensive Assessment and Review for Long-Term Care Services (CARES) - A federally mandated nursing home pre-admission screening and objective assessment service that determines the appropriate level of care for persons applying for Medicaid nursing home care, identifies long-term care needs, establishes level of care and, if appropriate, recommends the least-restrictive safe alternative to institutional care.

CON - Certificate of Need Program

Consumer Directed Care (CDC) - Projects that demonstrate the value of consumers, or caregivers on their behalf, taking charge of directing their own care. The premise is that consumers or their caregivers are in the best position to make decisions about services and how they should spend associated service dollars. For example, the consumer can elect to have a family member, neighbor, or a formal service provider perform services such as bathing, transporting, feeding and other tasks needed for the individual to remain safely in his/her home. Thus, the consumer can decide who provides needed care, when the care is provided and how it is provided.

CSBG - Community Services Block Grant

CSRA - Community Spouse Resource Allowance

Customers - The consumers of an organization's products or services.

D3-A – A legislative budget request (LBR) exhibit, which presents a narrative explanation and justification for each issue for the requested years.

DD - Developmentally Disabled

Demand - The number of output units, which are eligible to benefit from a service or activity.

Diversion - A strategy that places participants in the most appropriate care settings and provides comprehensive community-based services to prevent or delay the need for long-term placement in a nursing facility.

DME - Durable Medical Equipment

DOEA - Department of Elder Affairs

DRG - Diagnostic Related Group

ECC - Extended Congregate Care (Florida)

ECHO - Elder Cottage Housing Opportunity

EHEAEP - Emergency Home Energy Assistance for the Elderly Program

Emergency Home Energy Assistance for the Elderly (EHEAP) - A program that provides vendor payments to assist low-income households, with at least one person aged 60 or above, which are experiencing a home-energy emergency.

EOG - Executive Office of the Governor

Estimated Expenditures - Include the amount estimated to be expended during the current fiscal year. These amounts will be computer generated based on the current year appropriations adjusted for vetoes and special appropriations bills.

Family Caregiver Support Program (FCSP) - Provides support services for family caregivers, including grandparents or other elders caring for relatives. The program encourages the provision of multifaceted systems of support services to assist individuals in providing care to older family members, adults with disabilities, and children. The primary program consideration is to relieve emotional, physical, and financial hardships of individuals providing care.

FCO - Fixed Capital Outlay

FCOA - Florida Council on Aging

FCSP – Family Caregiver Support Program

FEMA - Federal Emergency Management Agency

FFMIS - Florida Financial Management Information System

FFP - Federal Financial Participation

FFS - Fee for Service

FGP - Foster Grandparent Program

Fixed Capital Outlay (FCO) - Real property (land, buildings including appurtenances, fixtures and fixed equipment, structures, etc.), including additions, replacements, major repairs, and renovations to real property, which materially extend its useful life or materially improve or change its functional use, and including furniture and equipment necessary to furnish and operate a new or improved facility.

FLAIR - Florida Accounting Information Resource Subsystem

Florida Social Health Maintenance Organization Initiative - Demonstration programs designed to deal with acute and long-term care needs of persons eligible for both Medicare and Medicaid. Persons electing to participate receive medical and long-term care services, including community-based and institutional services, through one managed care organization.

F.S. - Florida Statutes

FY - Fiscal Year

GAA - General Appropriations Act

GR - General Revenue Fund

HCBS - Home and Community-Based Services

HCE - Home Care for the Elderly

HHA - Home Health Agency

HHS - U.S. Department of Health and Human Services

HMO - Health Maintenance Organization

Home Care for the Elderly (HCE) - A program that provides a basic subsidy averaging $106 per month for support/maintenance services and supplies to allow frail elders to remain in their home with a live-in caregiver. Case management services are also provided.

I & A - Information and Assistance

I & R - Information and Referral

IADL – Instrumental Activities of Daily Living

ICF - Intermediate Care Facility

ICF/MR - Intermediate Care Facility for the Mentally Retarded

ICP - Institutional Care Program

Indicator - A single quantitative or qualitative statement that reports information about the nature of a condition, entity or activity. This term is used commonly as a synonym for the word "measure."

Information Technology Resources - Includes data processing-related hardware, software, services, telecommunications, supplies, personnel, facility resources, maintenance, and training.

Input – See performance measure.

Instrumental Activities of Daily Living (IADL) - Functions and tasks associated with management of care such as preparing meals, taking medications, light housekeeping, taking medication, shopping and other similar tasks.

IOE - Itemization of Expenditure

IT - Information Technology

ITB - Invitation to Bid

Judicial Branch - All officers, employees, and offices of the Supreme Court, district courts of appeal, circuit courts, county courts, and the Judicial Qualifications Commission.

Key Cost Driver - A factor that has a major impact on activity cost. Understanding key cost drivers is important in controlling costs and maximizing efficiency.

LAN - Local Area Network

LAS/PBS - Legislative Appropriations System/Planning and Budgeting Subsystem. The statewide appropriations and budgeting system owned and maintained by the Executive Office of the Governor.

LBC - Legislative Budget Commission

LBR - Legislative Budget Request

Legislative Budget Commission (LBC) - A standing joint committee of the Florida Legislature. The Commission was created to: review and approve/disapprove agency requests to amend original approved budgets; review agency spending plans; issue instructions and reports concerning zero-based budgeting; and take other actions related to the fiscal matters of the state, as authorized in statute. It is composed of 14 members appointed by the President of the Senate and by the Speaker of the House of

Representatives to two-year terms, running from the organization of one Legislature to the organization of the next Legislature.

Legislative Budget Request (LBR) - A request to the Florida Legislature, filed pursuant to s. 216.023, F.S., or supplemental detailed requests filed with the legislature, for the amounts of money an agency or branch of government believes will be needed to perform the functions that it is authorized, or which it is requesting authorization by law, to perform.

Level of Care (LOC) - A term used to define medical eligibility for nursing home care under Medicaid and Medicaid Waiver community-based non-medical services. (To qualify for Medicaid Aged and Disabled Waiver or Medicaid Assisted Living for the Elderly Waiver services, the applicant must meet the nursing home level of care.) Level of care also is a term used to describe the frailty level of a consumer seeking DOEA services and is determined from the frailty level prioritization assessment tool. The Customer Profiles by Assessment Level shows the prioritization levels and describes the average consumer's health, disability level, caregiver situation and nursing home risk score for each level.

LIHEAP - Low Income Home Energy Assistance Program

L.O.F. – Laws of Florida

Long-Range Program Plan (LRPP) - A plan developed on an annual basis by each state agency that is policy-based, priority-driven, accountable, and developed through careful examination and justification of all programs and their associated costs. Each plan is developed by examining the needs of agency customers and clients and proposing programs and associated costs to address those needs based on state priorities as established by law, the agency mission, and legislative authorization. The plan provides the framework and context for preparing the legislative budget request (LBR) and includes performance indicators for evaluating the impact of programs and agency performance.

Long-Term Care Ombudsman Council (LTCOC) - A statewide system of volunteers who receive, investigate and resolve complaints made by, or on behalf of, individuals living in nursing homes, assisted living facilities or adult family care homes. This program is administratively housed in DOEA and has district staff who coordinate the work of the volunteers.

Long-Term Care Policy - The DOEA unit that provides policy development and rule promulgation for assisted living facilities, adult day care centers, hospices, and adult family care homes. In addition, training on Alzheimer's Disease and related disorders is provided for administrators/providers and staff of assisted living facilities, nursing homes, hospice and adult day care.

LRPP - Long Range Program Plan

LSP - Local Services Program

LTC - Long-Term Care

LTCOC - Long Term Care Ombudsman Council

MAN - Metropolitan Area Network (Information Technology)

MCO - Managed Care Organization

MDC - Memory Disorder Clinic

Medicaid Aged and Disabled Waiver (MW) – This DOEA program provides home and community-based services to frail or functionally impaired elders and individuals with disabilities who are at risk of nursing home placement. Case managers conduct a comprehensive assessment of needs and plan services designed to assist recipients remain at home. DOEA administers this program through an agreement with the Agency for Health Care Administration.

Medicaid Assisted Living for the Elderly Waiver (ALW) – This DOEA program provides Assisted Living Facility services to eligible elders at risk of nursing home placement. DOEA also administers this program through an agreement with the Agency for Health Care Administration.

MedPARD - Medicare/Medicaid Assistance Program

MEDS-AD - Medicaid Expansion Designated by SOBRA

MIRA - Medical Insurance Retirement Accounts

MMAP - Medicare/Medicaid Assistance Program

MW – Medicare Aged and Disabled Waiver

NACDA - National Archive of Computerized Data on Aging

NAPIS - National Aging Program Information System

NASBO - National Association of State Budget Officers

NASUA - National Association of State Units on Aging

Narrative - Justification for each service and activity is required at the program component detail level. Explanation, in many instances, will be required to provide a full understanding of how the dollar requirements were computed.

NCOA - National Council on Aging

NCSC - National Council of Senior Citizens

NIA - National Institute on Aging

Nonrecurring - Expenditure or revenue that is not expected to be needed or available after the current fiscal year.

OAA - Older Americans Act

OLC - Office of Licensure and Certification

OPB - Office of Policy and Budget, Executive Office of the Governor

OSS - Optional State Supplementation (Florida)

OTA - Office of Technology Assessment (NASUA)

OTC - Over the Counter

Outcome – See Performance Measure.

Output – See Performance Measure.

Outsourcing - Describes situations where the state retains responsibility for the service, but contracts outside of state government for its delivery. Outsourcing includes everything from contracting for minor administrative tasks to contracting for major portions of activities or services that support the agency mission.

PAS - Pre-Admission Screening

Pass Through – Funds the state distributes directly to other entities, e.g., local governments, without being managed by the agency distributing the funds. These funds flow through the agency's budget; however, the agency has no discretion regarding how the funds are spent, and the activities (outputs) associated with the expenditure of funds are not measured at the state level. ***NOTE: This definition of "pass through" applies ONLY for the purposes of long-range program planning.***

PBPB/PB2 - Performance-Based Program Budgeting

Performance Ledger - The official compilation of information about state agency performance-based programs and measures, including approved programs, approved outputs and outcomes, baseline data, approved standards for each performance measure and any approved adjustments thereto, as well as actual agency performance for each measure.

Performance Measure - A quantitative or qualitative indicator used to assess state agency performance.

- *Input* means the quantities of resources used to produce goods or services and the demand for those goods and services.
- *Outcome* means an indicator of the actual impact or public benefit of a service.
- *Output* means the actual service or product delivered by a state agency.

PHA - Public Housing Agency

Planning and Service Area (PSA) - A distinct geographic area, established by the Department of Elder Affairs, in which Older Americans Act and related programs are administered by an Area Agency on Aging (see definition above).

Policy Area - A grouping of related activities to meet the needs of customers or clients, which reflects major statewide priorities. Policy areas summarize data at a statewide level by using the first two digits of the ten-digit LAS/PBS program component code. Data collection will sum across state agencies when using this statewide code.

POS - Point of Service

PPO - Preferred Provider Organization

PPS - Prospective Payment System

Primary Service Outcome Measure – The service outcome measure, which is approved as the performance measure which best reflects and measures the intended outcome of a service. Generally, there is only one primary service outcome measure for each agency service.

Privatization - Privatization occurs when the state relinquishes its responsibility or maintains some partnership type of role in the delivery of an activity or service.

PRO - Peer Review Organization

Program - A set of activities undertaken in accordance with a plan of action organized to realize identifiable goals based on legislative authorization (a program can consist of single or multiple services). For purposes of budget development, programs are identified in the General Appropriations Act for FY 2001-02 by a title that begins with the word "Program." In some instances a program consists of several services, and in other cases the program has no services delineated within it; the service is the program in these cases. The LAS/PBS code is used for purposes of both program identification and service identification. "Service" is a "budget entity" for purposes of the LRPP.

Program of All Inclusive Care for the Elderly (PACE) – A program in which elder services are delivered through adult day care centers with case management by multi-disciplinary teams. In addition, PACE sites receive an enhanced capitation payment from Medicare, beyond that of a traditional Medicare HMO.

Program Purpose Statement – A brief description of approved program responsibility and policy goals. The purpose statement relates directly to the agency mission and reflects essential services of the program needed to accomplish the agency's mission.

Program Component - An aggregation of generally related objectives which, because of their special character, related workload and interrelated output, can logically be considered an entity for purposes of organization, management, accounting, reporting, and budgeting.

PSA - Planning and Service Area

PSN - Provider Service Network

Public Guardianship Program - A statewide program established to address the needs of vulnerable persons in need of guardianship services. Guardians protect the property and personal rights of incapacitated individuals.

QMB - Qualified Medicare Beneficiary

RD - Registered Dietician

Reliability - The extent to which the measuring procedure yields the same results on repeated trials, and data are complete and sufficiently error free for the intended use.

Respite - In-home or short-term facility-based assistance for a homebound elderly individual from someone who is not a member of the family unit, to allow the caregiver to leave the premises of the homebound elderly individual for a period of time.

RFP - Request for Proposal

RSVP - Retired Senior Volunteer Program

RUGS - Resource Utilization Groups

SCP - Senior Companion Program

SCSEP - Senior Community Service Employment Program

Senior Community Service Employment Program (SCSEP) - A federal program funded by Title V of the Older Americans Act that provides low-income elders with paid part-time work experience in community services, to provide them with the experience and skills needed to obtain unsubsidized employment in the local job market.

Senior Companion Program (SCP) - A peer volunteer program that provides services such as transportation to medical appointments, shopping assistance, meal preparation and companionship to elders at risk of institutionalization. Lower-income elder volunteers receive a stipend to help defray expenses, transportation reimbursement and an annual medical checkup.

Service – See Budget Entity.

Service Coordinator - An individual who through training and experience can assist in identifying, accessing, coordinating and arranging cost-effective services for clients. The service coordinator will follow up and perform liaison activities on behalf of consumers for the purpose of eliminating barriers to responsive, reliable and efficient service delivery.

Serving Health Insurance Needs of Elders (SHINE) - A statewide program with a statewide network of trained volunteers offering free health insurance education and counseling to elders, their families and caregivers.

SHINE - Serving Health Insurance Needs of Elders

Standard - The level of performance of an outcome or output.

SHL - Silver Haired Legislature

SHMO - Social Health Maintenance Organization

SLIAG - State Legalization Impact Assistance Grant

SLMB - Specified Low-Income Medicare Beneficiary

SNF - Skilled Nursing Facility

SOBRA - Supplemental Omnibus Reconciliation Act (Federal Law)

SSA - Social Security Administration

SSBG - Social Service Block Grant

SSI - Social Security Supplemental Income

Statewide Health and Wellness Initiatives - Programs that include research, education and awareness activities related to senior health issues. DOEA contracts with Area Agencies on Aging and local service providers to provide wellness and health promotion activities in the local communities and to support volunteers in program endeavors.

STO - State Technology Office

SUA - State Unit on Aging

SWOT - Strengths, Weaknesses, Opportunities and Threats

TA - Technical Assistance

TANF - Temporary Assistance for Needy Families Program

TCS - Trends and Conditions Statement

TD - Transportation Disadvantaged

TF - Trust Fund

TRW - Technology Review Workgroup

UA - Uniform Assessment (Florida)

Unit Cost - The average total cost of producing a single unit of output (goods and services for a specific agency activity).

URC - Utilization Review Committee

USDA - U.S. Department of Agriculture

Validity - The appropriateness of the measuring instrument in relation to the purpose for which it is being used.

WAGES - Work and Gain Economic Stability (Agency for Workforce Innovation)

WAN - Wide Area Network (Information Technology)

WHCOA - White House Conference on Aging

ZBB - Zero-Based Budgeting