

WORKGROUP ON PREVENTION

Charge to Workgroup

- Review and monitor the implementation of recommendation # 5 of the Medicaid Long-Term Care Task Force.
- Engage their members, volunteers, and constituencies in advocacy for the successful implementation of the Task Force recommendations.
- Assist the Commission in being an effective and visible consumer advocate for improving the quality of, and access to, prevention activities particularly in the area of informal caregiver support, healthy aging, and chronic care management.
- Present findings and recommendations regularly to the Commission for next steps and potential changes in policy that would encourage more effective provision of prevention activities particularly in the area of informal caregiver support, healthy aging, and chronic care management.
- Ensure all recommendations:
 - Involve consumers and broad public participation in planning.
 - Promote an array of long-term care services and supports.
 - Promote the concept of money (funding) following the person to wherever that person chooses to live.
 - Assure evaluation is addressed.
 - Assure consistency with the overall commission process for statewide impact.

Background - Task Force Recommendation # 5: Support, implement, and sustain prevention activities through (1) community health principles, (2) caregiver support, and (3) injury control, chronic care management, and palliative care

programs that enhance the quality of life, provide person-centered outcomes, and delay or prevent entry into the LTC system.

Strategies / Action Steps

Develop a DCH workgroup comprised of legislators, MSA, OSA, DHS, stakeholders / consumers, and others to oversee the collaborative process involving local public health entities engaged in prevention/chronic care. Under the direction of the DCH-led workgroup, local entities will:

1. Convene a broad-based coalition of aging, disability, and other organizations.
2. Review community resources and needs (including prevention, chronic care, and caregiver supports).
3. Identify existing local, culturally competent strategies to address prevention, chronic care needs, and substance abuse.
4. Develop and support programs to address prevention, chronic care, and caregiver supports.
5. Promote the use of culturally competent caregiver training on injury prevention, rights and benefits, and person-centered planning.
6. Develop wrap-around protocols for caregiver/consumer support needs.
7. Develop a public health caregiver support model.
8. Create initiatives and incentives to support caregivers.
9. Identify and promote the use of elements of established models for chronic care management and coordination (e.g., Wagner or ACOVE model).
10. Create incentives for implementing culturally competent chronic care models and protocols.
11. Develop and implement chronic care protocols, including, but not limited to:

- a. medication usage.
 - b. identifying abuse and neglect, caregiver burnout/frustration.
 - c. caregiver safety and health.
12. Promote the use of Assistive Technology (AT) for consumers and direct care workers/caregivers as a prevention tool.
 13. Investigate grant opportunities to pilot chronic care management models.

Benchmarks

1. Needs assessments are conducted and gap analysis reports are completed and reviewed.
2. Local and statewide groups complete plans to address local health and wellness gaps.
3. Executed contracts in place with local existing entities, which are broad-based (including the aging and disability community) to address gaps.
4. Completed workgroup report evaluating progress, outcomes, and identifying next steps.
5. Every local region has a program in place to train caregivers that is culturally competent to the needs and culture of the informal caregiver.
6. Consumer supports are increased and better utilized.
7. Caregiver needs screening incorporated into Medicaid-funded screening instruments.
8. Upon retrospective review, address caregiver needs.
9. Registries completed with processes in place for ongoing updates.
10. Legislative and administrative initiatives are in place and used.

11. Increase in the number of primary and LTC providers trained and adopting the best chronic care and culturally competent models.
12. Medical schools and nursing/ancillary healthcare programs expand their curricula to include chronic care.
13. Increased numbers of students graduating from schools with established chronic care curricula/programs.
14. Increased number of providers using screens and protocol-driven interventions.
15. Increased use of assistive technology as reflected in the person-centered plan.