

CONSUMER TASK FORCE
Michigan Quality Community Care Council
August 25, 2009 10:00 - 12:30
AGENDA

INTRODUCTIONS

APPROVAL OF THE JUNE MINUTES

STATUS OF OFFICE

ADRC GRANT

PROJECT ACTION TEAMS (PATS)

MIG ACTIVITIES

OTHER

- PROJECT STATUS REPORTS
- MEETINGS WITH CHAIR OF LTC SUPPORTS AND SERVICES
ADVISORY COMMISSION

NEXT MEETINGS:

October 27, 2009

MICHIGAN QUALITY COMMUNITY CARE COUNCIL, 3186 PINE TREE
ROAD, LANSING, MICHIGAN 48911

PHONE IN NUMBER: 877-873-8018, passcode 7989381

SYSTEM CHANGE IDEAS (Action in bold)

- Increase the number of DHS staff (**Budget cuts have delayed this recommendation**)
- Change the financial eligibility for programs so it is consistent across the array of services. Rob Curtner is working on a grid that identifies the eligibility criteria for the array. Susan Steinke will send Doug Chalgian's eligibility descriptions from the Commission workgroup.
- Integrate acute and long-term care services. This is a national issue as well. (**This will be considered with the CHCS TA grant and subsequent proposed managed care plan.**)
- Treating multiple chronic conditions. Most physicians do not treat multiple conditions, only one at a time. (**This should be part of the prevention project action team.**)
- Physicians prescribe things that are not covered and as such must come out of the consumers pocket
- If you have multiple insurances, their policies sometimes contradict each other. For example, Medicare will not allow in-home physical therapy unless you are homebound. Or a consumer must be at home to receive in-home nursing, but insurance won't allow a visiting physician, so the person has to go to the doctor so they really aren't home bound so can't get the nursing!
- There is no back-up plan for home help

MICHIGAN QUALITY COMMUNITY CARE COUNCIL
DRIVING INSTRUCTIONS

From the West: Take 496 East to 127 South. Take 127 South to the Jolly Road Exit. Turn right onto Dunckel. Take Dunckel to Jolly Road. Turn left at the light. Get into your right hand lane. The lane ends at Pine Tree Road. Take Pine Tree Road for approximately .7 miles. Our driveway is on the left just before the Michigan Concrete Association sign. Look for our sign and the Williams Kitchen and Bath sign. We are the first building on that driveway on the right.

OR

Take 96 East to 127 North. Take 127 North to the Jolly Road Exit. Turn right onto Dunckel. Take Dunckel to Jolly Road. Turn left at the light. Get into your right hand lane. The lane ends at Pine Tree Road. Take Pine Tree Road for approximately .7 miles. Our driveway is on the left just before the Michigan Concrete Association sign. Look for our sign and the Williams Kitchen and Bath sign. We are the first building on that driveway on the right.

From the East: Take 96 West to 127 North. Take 127 North to the Jolly Road Exit. Turn left onto Dunckel. The next light is Collins Road. Turn right onto Collins. Collins ends at Jolly Road. Turn right onto Jolly. After the overpass, you will start to see Genesis buildings on your left and the big, red and white sign for Delphi Glass. Pine Tree Road is just before Delphi Glass on your left. Take Pine Tree Road for approximately .7 miles. Our driveway is on the left just before the Michigan Concrete Association sign. Look for our sign and the Williams Kitchen and Bath sign. We are the first building on that driveway on the right.

Questions? Call 1-800-979-4662.

INDEX OF DOCUMENTS

CONSUMER TASK FORCE

AUGUST 25, 2009

EXECUTIVE COMMITTEE NOTES

ADRC GRANT CONCEPT PAPER

ADRC GRANT LETTER OF SUPPORT

MIG - COMPREHENSIVE GRANT LETTER OF SUPPORT

CLASS ACT - OVERVIEW

2010 SCHEDULE OF CONSUMER TASK FORCE MEETINGS

NCIL ARTICLE

ALZHEIMER'S ASSOCIATION SAVE THE DATE - TECHNOLOGY MATTERS CONFERENCE

LOGIC MODEL - PROJECT ACTION TEAM FOR HEALTH PROMOTION ACTIVITIES

PROJECT ACTION TEAM FOR QUALITY IN LONG-TERM CARE DOCUMENTS

TRI-COUNTY OFFICE ON AGING NOTICE OF INFORMATION FAIR FOR ASSISTIVE TECHNOLOGY

ADRC GRANT AND NURSING HOME DIVERSION GRANT UPDATE FROM OSA

PROJECT UPDATES

Meeting Name CTF Executive Committee	Highlights Date: August 10 Time: 4pm Location: OLTCSS Conference Room
Meeting Lead:	Recorder: Jackie
Meeting Purpose:	Set the Agenda for This Month's Meeting
Participants:	CTF Executive Committee
1	Review Agenda
2	Status of Office
3	Agenda Items
4	PATs
5	MIG
6	Next Meeting Agenda
7	Review Record: Action Items, Open Issues, Decisions

Item	Discussion/Decisions
June Minutes	Approved by Executive Committee
Status of Office	Unchanged
Budget	<ul style="list-style-type: none"> • 2010 budget will be a battle. More cuts anticipated. • The SSI supplement (\$14/month) was not cut in July and is not proposed to be cut next year. State staff is considering a waiver to remove this but it appears to be against federal Medicaid rules
ADRC Grant	<ul style="list-style-type: none"> • Submitted Aug 10. • Commission approved the grant, as did the CTF Executive Committee • Partnership between CILs and AAAs • Information and Assistance only • The state is the only entity to receive funding. It will be used for training and infrastructure, with an emphasis on working with hospital discharge planners • Looking to include other entities such as Senior Centers, UCP, ARC, etc • Ending the SPEs has created trust issues with facility staff Community education critical
Progress Action Teams	<ul style="list-style-type: none"> • All are at different point • Quality and Health teams may provide presentation • Teams are still looking for consumer to attend. The OLTCSS has funding channeled through MDRC for this year and MIG is picking up the CTF for next year. Next year's funding is in development.

	<ul style="list-style-type: none"> • Laura will invite consumers to join the PATS, but they must go through her first.
MIG	<ul style="list-style-type: none"> • Joe is unable to attend the August meeting. Laura will get an update from him and present it. • Submitted for comprehensive grant. Will hear around late November • Ask CTF if they are aware of FTW • Ask Marty to do presentation to CTF • Susan Steinke and Leah March did presentation on MQCCC and FTW in Kent County. Well received
Laura Meet with Andy (Commission)	<ul style="list-style-type: none"> • Hasn't happened for a while. Laura will see if they can meet before the August CTF meeting. • The Commission has not been eliminated at this time.
System Change Ideas	<ul style="list-style-type: none"> • Nothing new, little action on existing items • PA 248 allows doctors to fill a prescription without prior authorization if no generic is available. Some legislators are looking to repeal this act and require prior authorization that may take up to 4-5 months. The Pharmacy Commission has not approved this suggestion so has failed for now. Not sure how much the CTF can advocate given the act is not related to a grant. • Community Choice Act - being ignored. There is some confusion regarding this and the CLASS Act Need to provide synopsis for clarification • Health Care Reform - very complicated. Need a general overview.

Action Items:

Item	Action/Note	Person Responsible
ADRC Grant	Provide a synopsis of the grant Copy of CTF support letter	RoAnne Laura
October 1 Fair	Provide "save the date" Information	Jacqui
MIG Grant	Copy of CTF support letter for information	Laura
Progress Action Teams	Ask Peggy about updates and what may be shared at this point	RoAnne
MIG	Get update Ask CTF if they are aware of FTW Have Marty do presentation - ask Joe	Laura Laura Laura
Community Choice Act/Class Action	Provide synopsis of issues	Laura
Health Care Reform	General Overview of reform bills	RoAnne

Michigan Office of Services to the Aging
DRAFT Concept for ADRC RFP
Stakeholder Meeting - July 23, 2009
Convener: Sharon L. Gire

I. Approach:

OSA will respond to the Administration on Aging (AoA) RFP- Aging and Disability Resource Centers: Empowering Individuals to Navigate Their Health and Long Term Support Options. These grant funds (if awarded) will support state-wide, local ADRC partnerships/collaborations. The focus will be on partnership/collaboration development, versus funding an entity. This is due to the limited AoA funds offered and their emphasis on operationalizing ADRCs state-wide. The AoA provides examples of promising practices (such as Oregon) which describe the type of model that Michigan will be referencing.

- Utilize existing LTC resources to develop a “No Wrong Door” approach in support of ADRC functions. This decentralized model will recognize all LTC stakeholders as equal partners and build on positive lessons learned from the Michigan SPE demonstration project. While agencies will retain their own autonomy, their presence will be strengthened through collaboration. The model also supports regional variations that build on existing systems to better serve LTC consumers and their families. These locally developed partnerships will decide leadership roles and division of labor and are empowered to customize their process to meet the unique needs of their community but there will be particular standards and quality measures that all of the partnerships will be expected to implement.
- Support regional/local ADRC developmental activities through state leadership, guidance, coaching, training and development of technology/tools. Includes training and support for building collaborative partnerships within locally defined ADRC service areas.
- Develop a multi-stage ADRC certification process that allows communities to define ADRC boundaries that correspond to local service delivery systems, access capacity and mark developmental milestones toward full ADRC functionality.
- Enhance I&A through the development of a statewide I&A system to capture data from all ADRC partners. System would include data importers so that local agencies would not have to abandon their current systems.

II. ADRC Core Function:

Information and Awareness (I & A)

- Development of a statewide, web-based I&A application within the OSA AIS system that will provide statewide data collection on a common set

of data elements as defined by AoA and the State. This AIS application will be available to all ADRC partners willing to provide the State access to their local data. An AIS application will also be developed to import data from ADRC partners who already have access to a comprehensive I&A data collection system.

- Expand the coordination of the Michigan Medicare/Medicaid Program (MMAP) to provide benefits counseling and assistance with eligibility determination. Capacity to be increased through development of peer support initiative and the expanded use of volunteers, including volunteers supported by CILs.
- Work with Benefits Outreach and Enrollment Centers including providing training on PCP, self-determination, and access to the proposed web-based I&A system.

Options Counseling (OC)

- To be determined within the local ADRC partnerships/collaborations.

Streamlined Access

- Re-activate the LTC website and continue development of a statewide resource database. Coordinate access to information on available services with OSA website, www.michigan.gov/miseniors. (09 ADRC/STG)
- Continue Geo-Routed Toll-Free LTC Phone Number with routing defined by local ADRC partners.
- Assistance with eligibility will be enhanced through expanded use of the Unified Benefits Application developed as part of the OSA AIS. This web-based application allows completion of the Michigan 1171 Medicaid application and can be used to determine eligibility for many forms of public assistance. OSA will also coordinate with DHS central office to streamline processes related to the processing and submission of the 1171 Medicaid application for LTC consumers.
- Required by AoA, within 18 months, develop a five year operational plan and budget for how statewide coverage of ADRCs that are fully operational will be accomplished.

Person-Centered Hospital Discharge Planning

- Through a PCP approach, enhance coordination and streamline processes with hospital discharge planners to rapidly respond to the needs of individuals at imminent risk of NF placement.
- Assist with avoiding unnecessary NF admissions and unnecessary hospital readmissions.

Quality Assurance and Evaluation

- Integrate monitoring of progress and oversight of ADRC activities in functions of State agencies responsible for specific LTC networks.
- Work with the LTC Advisory Commission, the Consumer Task Force, and the Michigan Commission on Services to the Aging for joint advocacy efforts and problem solving.
- Support planning function for development of the LTC External Advocate role and build capacity to provide this service in the community. (STG)
- Continue evaluation and quality management initiatives including: Quality Management PAT, analysis of consumer data and service utilization, consumer experience surveys, supervisory reviews, peer reviews, tracking of consumer complaints through follow-up and resolution.
- Establish and require I&A and OC standards of practice among the local ADRC partners. Performance metrics will be developed and monitored that assess objective and comprehensive I&A; person-centeredness; seamlessness among the partners (a “no wrong door” metrics); and customer satisfaction.

Michigan Consumer Task Force

August 6, 2009

Sharon Gire, Director
Michigan Office of Services to the Aging
P.O. Box 30676
Lansing, MI 48909-8176

Dear Ms. Gire:

On behalf of the Michigan Consumer Task Force (CTF), I am writing to express our strong support for the Michigan Office of Services to the Aging's application for the Aging and Disability Resource Center (ADRC) Grant.

The Michigan Consumer Task Force is a group, comprised and driven by people with disabilities and older adults who utilize the long term care system, that provides feedback to the State of Michigan on the development and implementation of grants and other policies as they relate to long term care. As Chair, I have had the opportunity to review and provide comment on this grant proposal, and feel as though the Office of Services to the Aging has an innovative plan to improve access to information and services within our long-term care system.

As people who utilize the long-term care system, members of the CTF understand, perhaps better than anyone, the level of confusion and frustration that occurs when trying to navigate through our various disability and aging organizations. While we know that all efforts are well intentioned, the fragmentation and lack of coordination among service providers often leads to more harm being done than good.

It is for these reasons that we are so excited about the development of the Aging and Disability Resource Centers. Michigan residents need places they can go receive information on *all* of their long-term care options, and we believe the ADRC's will create such a system through partnerships. We are also happy to see that consumers will play a significant role in the development and implementation of this model, should funding be awarded.

Again, the Michigan Consumer Task Force is pleased to support the Michigan Office of Services to the Aging. We look forward to future collaboration with OSA and stand ready to support them in this opportunity.

Sincerely,

Laura Hall
Chair

Michigan Consumer Task Force

Janet Olszewski, Director
Michigan Department of Community Health
201 Townsend Street
Capitol View Building – 7th Floor
Lansing, MI 48913

July 9, 2009

Dear Ms. Olszewski,

On behalf of the Michigan Consumer Task Force (CTF), I am writing to express our strong support for the Michigan Department of Community Health and their 2010 application for the Comprehensive Employment Systems grant.

The Michigan Consumer Task Force is a group, comprised and driven by people with disabilities who utilize the long term care system, that advises the State of Michigan on the development and implementation of grants and other policies as they relate to long term care. We have had the privilege of providing feedback for the Medicaid Infrastructure Grant (MIG) for the past five years and recognize that the project has done a great deal for promoting independence and general health through employment. At the heart of what the MIG has achieved in previous years, are the issues that we face daily, including lack of supports in the work environment (such as personal care), lack of information and misinformation about employment, and fear of losing health care benefits due to increased earnings. Much has been done to address these concerns on several fronts.

Despite these significant successes, many barriers to employment for people with disabilities still remain. Consumer Task Force members can express all too well the frustrations that come with trying to navigate the various employment and benefit “systems” (i.e. Social Security, Vocation Rehabilitation, Medicaid/Medicare, etc), and remain employed despite rules and policies that often act as disincentives. We are excited by the initiatives launched by the MIG project, and hopeful that, with continued funding, they will result in true systems change.

Again, the Michigan Consumer Task Force is pleased to support the Michigan Department of Community Health’s application for this grant. We look forward to future collaboration with the MIG and further efforts to address barriers to employment for people with disabilities.

Sincerely,

Laura Hall, Chairperson



THE ARC, AAIDD, AUCD,
UCP, NACDD AND SABE

FACT SHEET

COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS ACT (CLASS ACT), S. 697/H.R. 1721

Background

Many Americans who are born with or develop severe functional impairments can access coverage for the long term services critical to their independence (such as personal assistance, assistive technologies, long term therapies, and training in basic skills) only through the federal/state Medicaid program. Since there is currently no national public program to address long term needs, the Medicaid program has become the default long term services program and the last resort for millions of individuals and families who have nowhere else to turn to have their long term needs met. To become eligible for Medicaid, the individual must “spend-down” income and assets, essentially becoming impoverished and remaining in poverty for as long as s/he needs supports, often for a lifetime.

While recognizing the important role that Medicaid plays in the provision of long term services and supports, many policy makers believe that it is time to develop an approach that takes the pressure off of the Medicaid program and helps individuals and families avoid poverty. It is also critical that such an approach must be included in health care reform efforts to ensure that individuals are able to function as independently as possible within their homes, families, and their communities.

The Community Living Assistance Services and Supports Act (CLASS Act) would offer a meaningful non-means-tested complement to the Medicaid program with a focus on helping individuals overcome barriers to independence that they may confront due to severe functional impairments. The CLASS Act is hailed as a way to provide critical coverage without forcing people into impoverishment to qualify for Medicaid services; therefore, it would relieve pressure on the Medicaid program which now serves as the fall-back program for people without private insurance coverage for long term care. The Leadership Council of Aging Organizations and the Consortium for Citizens with Disabilities together have supported long term services financing principles which are reflected in the CLASS Act. A coalition of 96 national

organizations representing the aging and disability communities wrote to President Obama on March 25, 2009, urging inclusion of such a program in health care reform efforts.

CLASS Act Legislation

The CLASS Act would create a new national insurance program to help adults who have or develop severe functional impairments to remain independent, employed, and stay a part of their community. Financed through modest voluntary payroll deductions (with opt-out enrollment like Medicare Part B), this legislation would help remove barriers to choice and independence (e.g., housing modification, assistive technologies, personal assistance services, transportation) that can be overwhelmingly costly, by providing a cash benefit to those individuals who need support for basic functions. The large risk pool to be created by this approach would make added coverage affordable. It would give individuals added choice and access to supports without requiring them to become impoverished to qualify for Medicaid.

Premium payments collected through payroll withholding would be placed in a “National Independence Fund” managed by the Department of Health and Human Services as a new insurance program. Any individual who is at least 18 years old and actively working would be automatically enrolled (unless they opt out), and pay their premiums through payroll deduction or another alternative method. Any non-working spouse could enroll in the program and pay their premiums through an alternative method.

To qualify for CLASS Act benefits, individuals must be at least 18 years old and have contributed to the program for a “vesting” period of 5 years. Eligibility for benefits would be determined by state disability determination centers and will be limited to: (1) individuals who are unable to perform two or more activities of daily living (ADL) (e.g. eating, bathing, dressing), or (2) individuals who, due to a cognitive or psychiatric impairment, require supervision, cueing, or hands-on assistance to engage in activities that will enable the individual to perform at least 2 of the following critical life functions: communicating; taking medications; household management; and basic money management.

To account for differences in independence support needs, there would be two cash benefit tiers. Tier 1 benefits (\$50/day) will be payable to eligible individuals who are unable to perform 2 or 3 ADLs or have a cognitive or psychiatric impairment requiring assistance with 2 or 3 critical life functions. Tier 2 benefits (\$100/day) will be payable to individuals who are unable to perform 4 or more ADLs or have a cognitive or psychiatric impairment requiring assistance with 4 or more critical life functions. The cash benefit would be posted monthly to a debit account or a “Choice Account”. If an eligible individual does choose to move into an institutional facility, CLASS Act benefits would be used to defray those associated expenses.

Eligibility for CLASS Act benefits would have no effect on eligibility for Social Security retirement, survivors, or disability benefits, Supplemental Security Income (SSI) benefits, Medicare, or Medicaid. If an individual is eligible for both CLASS Act benefits and long term services under Medicaid, CLASS Act benefits could be used to offset the costs to Medicaid, thus producing Medicaid savings for the state. The CLASS program benefit would not replace the need for basic health insurance --- rather it is complementary to acute health care services and provides a mechanism to pay for those non-medical expenses that allow a person with a disability to remain independent. In addition, an individual could supplement CLASS program benefits through private insurance products.

Action Taken by Congress and the Administration

The CLASS Act was introduced by Senator Edward Kennedy (D-MA) as S. 697 and Representative Frank Pallone (D-NJ) as H.R. 1721. The Senate Special Committee on Aging held a hearing in March 2009 at which the CLASS Act was discussed extensively. Also in March, the Senate Finance Committee's Subcommittee on Health Care considered long term care, including the CLASS Act, as part of health reform. President Obama was a co-sponsor of the CLASS Act in the 110th Congress.

Recommendations

The 111th Congress should act swiftly to pass the CLASS Act to relieve the pressure on the Medicaid system and to ensure that workers and their families are covered by an affordable, premium-based long term support insurance program. The CLASS Act should be included as an essential element of national health care reform.

Relevant Committees

Senate Finance Committee

Senate Health, Education, Labor and Pensions Committee

House Energy and Commerce Committee (Subcommittee on Health)

House Ways and Means Committee

For more information, please contact The Arc and United Cerebral Palsy Disability Policy Collaboration (202) 783-2229, Association of University Centers on Disability (301) 588-8252, American Association on Intellectual and Developmental Disabilities (202) 387-1968, National Association of Councils on Developmental Disabilities (202) 506-5813 or the Self Advocates Becoming Empowered (802) 760-8856.

4/13/09

CONSUMER TASK FORCE 2010 SCHEDULE

MICHIGAN QUALITY COMMUNITY CARE COUNCIL
3186 PINE TREE ROAD
LANSING, MICHIGAN 48911

FEBRUARY 23, 2010
APRIL 27, 2010
JUNE 22, 2010
AUGUST 24, 2010
OCTOBER 26, 2010
DECEMBER 28, 2010

*Location subject to change with advance notice

CONFERENCE CALL-IN PHONE NUMBER
1-877-873-8018 PASSCODE: 7989381

DCH CONTACT

Jackie Tichnell
517-335-7803
tichnellj@michigan.gov

From NCIL:

With an estimated 37.5 million eligible voters with a disability - and the aging baby boom generation means the ranks of the disabled will grow - disability rights is an emerging brand of identity politics. The Democratic Party has been attuned to the change. The Democratic National Committee (DNC) disability caucus is growing in size and prominence. The Obama campaign had a comprehensive disability - issues platform, and President Obama hired Kareem Dale to be the first White House special assistant for disability policy. On July 21 the president also announced the U.S. will sign on to the United Nations Convention on the Rights of Persons with Disabilities.

So why are disability activists in an uproar? Instead of celebrating Obama's announcement, on July 21 a coalition of disability-rights organizations held 26 simultaneous protests at the DNC headquarters, local Democratic Party offices, and at Senate Finance Committee Chair Max Baucus' state office in Missoula, Montana. In April, 400 activists chained themselves to the White House fence and were arrested for civil disobedience. Why do they say they are being ignored, and even that they are victims of political discrimination? Because, like other key progressive constituencies, such as gay-rights and reproductive-rights advocates, disability-rights groups are watching long-awaited priorities be delayed as the president and Congress focus on the economy, climate-change legislation, and health reform.

The disability community's top legislative priority, the Community Choice Act (CCA), has been floating around Congress since 1997 and is distinct from any of the current health-reform bills under consideration. The CCA would make it mandatory, rather than optional, for states to offer Medicaid funding to people who would prefer long-term care at home instead of living in a nursing home. For disability activists, who regularly compare nursing homes to prisons, there is no issue more important.

As a senator, Obama was a co-sponsor of the CCA, and as a candidate, he promised to support it as president. John McCain opposed the bill, citing concerns about its cost. For many disability-rights activists this constituted the major distinction between the two candidates. They now feel they supported Obama under false pretenses. The administration contends that Obama's pledge to support the CCA never implied that it had to be a part of health-care reform and that the president still wants to enact it at a later date. Disability activists fear, however, that later will mean never. "The political capital used to pass health reform will make it very unlikely that Congress will want to tackle any health-reform cost expansion in the next couple sessions," says Jason Beloungy, a policy analyst at the National Council on Independent Living. "This is our one opportunity."

http://www.prospect.org/cs/articles?article=should_disability_funding_be_part_of_health_reform



save the dates

Technology Matters Conference

Practical Solutions for Memory Loss using Assistive Technology

Keynote Speaker: Bruno Giordani, Ph.D.

Associate Professor, Psychiatry Department • Section Director, Neuropsychology, U of M Medical School

Caregiver Expo- November 8, 2009 • Professional Conference- November 9, 2009

Crystal Gardens Conference Center Brighton, MI

alzheimer's  association®

Michigan Great Lakes Chapter

310 N. Main St. Suite 100, Chelsea, Michigan 48118

Technology Matters Conference - November 8 & 9, 2009

- Expo includes innovative products and services to serve people worried about memory loss and their caregivers
- Caregiver Expo is free of charge
- Professional conference offers multiple CEU workshops and Expo
- Online Registration opens in September

Clinical topics will include:

- Home Safety
- Driving and Mobility
- Cognitive assessments
- Ethics

Target Audience: Case Managers, OTs, PTs, SLPs, Social Workers, Nurses, Administrators, and other medical professionals.

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For questions related to these conferences: **734.677.0503**

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Project Action Team Recommendation # 5 - Goal: 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 in the LTC system.

Objective #1	Activity	Output	Outcome	Indicator/ Measure	Responsible for/Timeline
<p>Increase communication, collaboration and support among state level departments for health prevention activities for older adults and persons with disabilities and a broad-based group of aging and disability representatives</p>	<p>Establish and maintain a commission workgroup to coordinate and align efforts and communication across state departments related to prevention.</p> <p>By October 2009, obtain number of current DCH and external partners that have programs and plans that address prevention activities.</p> <p>Identify and support state departments and local/regional community efforts related to prevention and regularly obtain updates.</p> <p>Seek timely updates and changes in programs.</p>	<p>Meet at least quarterly</p> <p>Health Listserv to promote communication</p> <p>Education</p> <p>Presentations</p> <p>Formal Support</p> <p>Meeting Notes</p> <p>Diverse Membership</p>	<p>Increased awareness of prevention activities.</p> <p>Increase in coordination of efforts and availability of information.</p> <p>Workgroup is a recognized “gold seal” for presentation efforts.</p>	<p>Baseline on # of current DCH and external partners that have programs and plans that address prevention activities.</p> <p>Increase (by %/x) in current DCH and external partners having goals and objectives regarding health and wellness promotion plans.</p> <p># of new programs seek support from workgroup.</p> <p>Attendance and # of new members increases.</p>	<p>Workgroup and OLTCCSS will collect data from Public Health/AAAs –</p> <p>Sherri King from OSA</p>

Project Action Team Recommendation # 5 - Goal: 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 in the LTC system.

Objective #2	Activity	Output	Outcome	Indicator/ Measure	Responsible for/Timeline
<p>Identify and promote methods for support to caregivers.</p>	<p>Identify and promote the use of culturally competent caregiver training on injury prevention, rights and benefits, and person-centered planning.</p> <p>Promote dissemination of wrap-around protocols for caregiver/consumer support needs.</p> <p>Promote initiatives and incentives to support caregivers.</p> <p>Promote and support availability of health benefits for caregivers.</p> <p>Share and support public health caregiver support model (Tailored Caregiver Assessment and Referral (T-Care) from Rhonda Montgomery and Savvy Caregiver.</p>	<p>Regular updates to various constituent groups</p> <p>Commission vote on support for using T-Care caregiver assessment</p> <p>Training to professional staff on use of T-Care caregiver Assessment and Savvy Care</p>	<p>Diverted or delayed NF placement for consumers</p> <p>Informal caregivers feel supported and not alone</p> <p>Informal caregivers have better health outcomes</p> <p>Increased use of T-Care and Savvy Care by more entities/agencies</p>	<p>Obtain data from the MI Choice Waiver and the OSA Care Mgt program</p> <p>Identify T-Care and Savvy Care baseline Baseline</p> <p>Increase in # of care givers identified.</p> <p># of T-Care and Savvy Care assessments and referrals.</p> <p># of caregivers who accessed caregiver services.</p> <p># of caregivers report reduced stress & capacity to continue caregiving</p>	<p>Workgroup/ OLTCSS</p>

Project Action Team Recommendation # 5 - Goal: 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 in the LTC system.

Objective #3	Activity	Output	Outcome	Indicator/ Measure	Responsible for/Timeline
<p>Increase the availability of and access to culturally competent chronic care management.</p>	<p>Promote information on and the use of evidence-based, culturally competent programs for self-management (mgt) of chronic conditions.</p> <p>Identify and promote tactics to expand evidence-based chronic care mgt, self-mgt and pain mgt (such as Personal Action Towards Health (PATH)) and the Wagner Model.</p> <p>Identify and promote simple, effective tools to reduce risk of disease/disability, (arthritis, diabetes, MRSA, and other communicable diseases).</p> <p>Promote the use of the CDC cost calculator to estimate costs of chronic condition and mgt. models.</p> <p>Track and understand payment models with health promotion incentives for consumers, physicians and payors.</p> <p>Promote methods to make chronic disease mgt tools & info widely available: public TV; on line web; telephone tapes; videos/ CDs; written info distributed by providers.</p>	<p>Regular updates to various constituent groups</p> <p>Culturally competent trainings conducted to professionals and consumers</p>	<p>Consumers have better access to culturally-competent health promotion and chronic care management programs.</p> <p>Participation in culturally competent health promotion and chronic care management programs is cost-effective for payors. providers and consumers.</p> <p>Caregivers are more informed of options.</p>	<p>Increase in # of persons participating in prevention prgms (PATH).</p> <p># of CILs and other disability and recovery groups that sponsor PATH and other evidence based workshops.</p> <p># of AAA's and Senior Centers that sponsor PATH.</p> <p># of Primary Care Practices follow principles in the Wagner model.</p>	<p>Workgroup/ OLTCCS with OSA and Public Health</p>

Project Action Team Recommendation # 5 - Goal: 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 in the LTC system.

Objective #4	Activity	Output	Outcome	Indicator/ Measure	Responsible for/Timeline
<p>Increase the availability and use of chosen assistive technology by consumers and caregivers.</p>	<p>Training about assistive technology for LTC professionals, consumers and the public including physical, sensory and cognitive aides (Train the Trainer program).</p> <p>Identify and promote opportunities to increase availability of affordable assistive technology by changes in:</p> <ul style="list-style-type: none"> • existing state programs (OSA, MI Choice, Home Help etc); • health coverage and other programs • utilization control mechanism such as prior authorization. <p>Participate in community dialogue on impact of universal design.</p> <p>Promote use of “smart” homes. Promote Harold Mast presentations.</p>	<p>MDRC Training and Web resources through National AT Center</p> <p>Workgroup meeting and listserv dissemination of education opportunities and material</p>	<p>Persons remain independent through use of assistive technology</p> <p>Persons who need supports remain in their preferred setting</p> <p>Policies are changed to promote more access to AT (OSA, Medicaid, Private Insurance)</p>	<p>Identify baseline and desired needs.</p> <p># of persons using assistive technology (in waiver, in care management, in Home Help, MRS, PPS, etc) increases</p> <p># of affordable accessible housing units increase</p>	<p>Workgroup/ OLTCSS</p> <p>NFTS – DRA/MFP Workgroup on housing?</p>

Attendees: Renee Beniak (MI County Medical Care Facilities); Brittany Bogan (MHA Keystone Center); Mark Bomberg (MA Waiver Directors Rep, UPCAP); Carol Callaghan (MDCH Medical Director's Office); RoAnne Chaney (MI Disability Resource Center); Andy Farmer (Chair, LTC Commission); Jill Gerrie (Disability Network of Michigan); Mary James (UoM/loG); Linda Lawther (MI Assisted Living Assoc) [phone]; Mike Pemble (MDCH, Bureau of Health Systems); Marion Owen (AAA Directors Rep, TCOA); Tom Renwick (MDCH Mental Health); Sarah Slocum (State LTC Ombudsman); and Erin Atchue, Nora Barkey, Peggy Brey, Ellen Sugrue Hyman, Tari Muñiz, & Pam McNab (OLTCSS)
Recorders: Erin & Tari

1. Peggy Brey and RoAnne Chaney welcomed and thanked the group for attending. The QM PAT is representative of experts in the field of LTC and Quality. We are hopeful that QM PAT members will share their expertise and resources from across the array of LTC support and services.
2. Introductions
 - a. **Action:** Consider sending a knowledgeable alternate representative when unable to attend.
 - b. **Action:** Let Pam, Peggy or RoAnne know of other stakeholders who should be at the table.
 - c. QM PAT meetings are scheduled for the fourth Wednesday of each month from 1:30 – 3:30 p.m. except for the months of November and December. Future meetings are scheduled for September 23rd, October 28th, and tentatively one meeting for November and December on December 2nd, 2009. In January, the QM PAT meeting will resume meeting on the fourth Wednesday of each month.
3. Ground Rules Discussion
 - a. Ground Rules were adopted with additions. **Action** The revised document will be provided at the next meeting. (Handout)
 - b. This committee will operate as a working committee. The group agreed to consensus decision making, use idea bank when consensus can't be reached or when issues need follow up.
4. Purposes of QM PAT:
 - a. Review and analyze the current state of LTC quality plans across the array of services;
 - b. Identify Q elements in each plan, common Q elements across the plans;
 - c. Identify Q plans containing person centered elements;
 - d. Reach consensus about "Gold Standard" Q elements that should be in LTC QM Plans, e.g.,
 - i. The LTC service has a Q Plan;
 - ii. The Q plan contains Q indicators and measurements;
 - iii. The Q plan contains person centeredness;
 - iv. Other
 - e. Identify Q "requirements" (State and Federal) that plans must contain;
 - f. Make recommendations for adoption of minimum expectations in quality plans across array of LTC supports and services.
5. **Action:** Pam will ask Sally Steiner, OSA, for a LTC Quality compendium compiled ten years ago.
6. History: The Long Term Care Commission and OLTCSS were established in 2006 in response to 2005 Michigan Medicaid Long Term Care Task Force (MA LTC TF) recommendations. The TF made nine specific recommendations to improve long term care. A Commission workgroup was established to review and monitor progress with implementing each of the recommendations. In January, 2009, an OLTCSS/Commission retreat was held to develop specific strategies, tasks and deliverables for each recommendation. This led to the development of logic models for each recommendation to guide the work that is being conducted by Staff and Commission members. Project action teams (PATs) were established to assist staff in accomplishing the work envisioned by the LTC Commission and Commission workgroups.
7. QM Commission Workgroup

- a. Sarah Slocum leads the Commission Quality Workgroup. The workgroup began meeting in August, 2008 and has been cataloging QM efforts across the array of LTC supports and services. 11 LTC Supports and Service selected for Q review were distributed. (Handout.) The QM PAT suggested adding to the list: PACE; Adult Day Care; Hospital (related to LTC); and Physicians' Office (related to LTC).
 - b. **Action:** Sarah will review the Commission's cataloging at the next meeting.
8. Definition of Quality: Roanne provided an overview of the MA LTC TF Quality definition, adopted by the LTC Commission. (Handout)
9. Person Centered Planning (PCP) improves quality outcomes. Implementation of PCP across the array of LTC supports and services is a primary focus of the MA LTC TF recommendations.
 - a. Tari provided an overview of what PCP is. **Action:** Tari will distribute copies of the MDCH "PCP Values and Essential Elements" at the next meeting.
 - b. RoAnne added that Person Centered is not the same as Patient Centered Planning or Resident Centered Planning.
10. Pam reviewed Common Elements of Quality
 - a. **Homework:** Review Common Elements of Quality and Quality Definitions (handouts).
Action: Comments and recommendations will be reviewed at the next meeting.
11. Quality Logic Model
 - a. Tari reviewed the QM Logic Model. The Logic Model is reflective of TF Recommendation #7 and the LTC Commission retreat prioritized objectives.
12. Other:
 - a. **Action:** Mary James will give a presentation on the Conundrum of Measuring Quality in LTC at the next meeting. (15 minutes)
 - b. **Parking Lot/Idea Bank:**
 - i. What role does QM play in Medicare/Medicaid?
 - ii. Mental health peer reviews. We'd like Tom to provide information on this MH strategy at a future meeting.
 - iii. What Quality Assurances will we want to see in all QM plans across the array of supports and services?
 - iv. Balance between regulatory and non-regulatory?
 - v. Integrated pilots
 - vi. Consider website "Wiki" or bulletin board for workgroup to upload/post Q information to for review by this committee. **Action:** Pam will look into this possibility and report findings at next meeting.
 - vii. New CMS NF survey measures presentation at a future meeting
 - c. **Next meeting:** August 26, 2009: 1:30 p.m.-3:30 p.m., Capitol View Building, 1st Floor, Conference Room B
13. Handouts:
 - a. Meeting Ground Rules
 - b. Differences between the Commission QM Workgroup & the Quality PAT
 - c. LTC QM Commission's Workgroup definition of quality
 - d. LTC Programs and Settings Selected for Review
 - e. Common Elements of Quality and Definitions
 - f. Task Force Recommendation Seven: Establish a New Quality Management System, Logic Model

Meeting Name OLTCSS QM Project Action Team (PAT)

Highlights

Date: 8/26/2009
Time: 1:30-3:30 pm
Location: Capitol View, 1st Floor,
Conference Rm B
201 Townsend St.
Lansing, MI (SE Corner of
Townsend & Allegan Sts)

Facilitators:	RoAnne Chaney & Pamela McNab	
Recorders:	Erin Atchue & Tari Muñiz	
Meeting Purpose:	To review LTC Commission's cataloging of current LTC QM activities, presentation on the conundrum of Q in LTC; brainstorm Quality frame of reference; & the logic model (tasks of workgroup) details	
Participants:	Donna Beebe (MPRO); Brittany Bogan (MI Hospital Assoc/Keystone Center); Mark Bomberg (Waiver Director Rep); Carol Callaghan (MDCH P.H. Admin Chronic Disease & Injury Control); Christine Chesny (Commission & Provider); Cynthia Farrell (DHS Home Help); Elizabeth Gallagher (MDCH Waiver Operations); Penny Gardner (OSA Commission); Jill Gerrie (Disability Network MI); Clark Goodrich (Consumer Chair MI Choice QM Collaboration); Bonnie Graham (OSA); Patricia Harney (Hospice of Michigan); Scott Heinzman (Consumer LTC Task Force & MI Choice QM Collaboration); Mary James (UoM/loG LTC Research); Marion Owen (AAA Director Rep); Mike Pemble, BHS Rep); Tom Rau (NF Provider); Tom Renwick (DMH); Brenda Roberts (MALA); Sarah Slocum (Chair, Commission Quality Workgroup); Hollis Turnham (LTC Commission & PHI); & Harvey Zuckerberg (Home Health Assoc)	
1	Welcome and Review meeting purpose - Purpose of Group	Pam & RoAnne 5"
	Introductions, one more time for new members - Who you are, what you do - Distribute member list	5"
2	Ground Rules and Idea Bank - Revised handouts - Member Binders	Pam Erin 5"
3	Handouts & meeting minutes: comments/feedback/recommendations from prior meeting? - Definition of Quality - Common elements of quality	Sarah, Pam & RoAnne 5"

4	Updates <ul style="list-style-type: none"> - “Wiki” or Bulletin Board to post Q information on for group review - Assembling the Q compendium - 10 year old Q compendium held by Sally Steiner, OSA 	Erin & Pam	10”
5	QM Commission’s Workgroup Cataloging	Sarah	20”
6	The Conundrum of Measuring Quality	Mary	20”
7	Brainstorming: What Quality means to you? Different meanings of Q depending on your point of reference about QA, QI & QM. What’s your frame of reference?	RoAnne	20”
8	The Logic Model Review in detail	Erin	15”
9	Other Issues	All	
10	Evaluate the meeting: What went well and what could be improved? Review Decisions	All	
11	Next Steps	All	

Action Item Log:

AI #	Description	Assigned	Due Date	Status
1				
2				
3				
4				
5				
6				

Resolution - Adopted by the LTCSS Commission July 27, 2009

-Submitted by the Long-Term Care, Supports and Services Workgroup on Health Promotion, Chronic Care Management and Caregiver Support

Whereas, according to the Assistive Technology Act of 1988 as amended and the Older Americans Act of 2006, as amended, assistive technology device means “any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities,” and assistive technology service means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device, and

Whereas assistive technology devices and services have been shown to slow functional decline, reduce institutional costs, and increase independence,¹ and

Whereas assistive technology devices and services are most often used for bathing and meal preparation and can also be used for dressing, leisure, use of the telephone, medication management, toileting, remembering, mobility, “wander” and fall management, incontinence and many other activities of daily living and instrumental activities of daily living,¹ and

Whereas assistive technology devices and services can be used to prevent falls, a key cause of hospitalizations in the elderly,² and

Whereas researchers have found that assistive technology is the most effective strategy for reducing and resolving limitations of disabilities,³ and

Whereas the current Operating Standards for Service Standards used by the Office of Services to the Aging, and similarly by many Area Agencies on Aging and Councils on Aging, is generally limited to coverage for Personal Emergency Response Systems (PERS) and items for Injury Control, thereby limiting the items purchased for an individual to a narrow list.

Therefore be it resolved that the Long-Term Care, Supports and Services Advisory Commission recommends the Michigan Office of Services to the Aging and its network broaden coverage of assistive technology to the federal definition, including assistive technology devices and services thus increasing the scope of assistive technology devices and services available in their programs to increase the benefit to participants.

Sources:

1. Mann WC, Ottenbacher KJ, Fraas L, Tomita M, Granger CG (1999). Effectiveness of Assistive Technology and Environmental Interventions in Maintaining Independence and Reducing Home Care Costs for the Frail Elderly: A Randomized Trial, *Archives of Family Medicine*, 8(3):210-217.
2. Margaret Ellis, Jacqueline Close, Richard Hooper, Edward Glucksman, Stephen Jackson, Cameron Swift (1999). Prevention of falls in the elderly trial (PROFET): a randomised controlled trial. *The Lancet*. Jan 9, 1999 v353 i9147 p93(1).
3. Verbrugge, LM, Rennert, C, and Madans, JH (1997) The great efficacy of personal and equipment assistance in reducing disability. *American Journal of Public Health*, Vol. 87, Issue 3 384-392.

Differences between the Commission QM Work Group & the Quality PAT

The Long-Term Care Services & Supports Commission's Quality Management System Work Group has as its primary charge to review and monitor the implementation of Recommendation # 7 of the Medicaid Long-Term Care Task Force. This is an all volunteer workgroup.

The Quality PAT has as its charge to guide the quality improvement team and staff through the staff work that needs to be accomplished to complete the quality work as envisioned by the LTC Commission and the Commission workgroup. Work to be conducted and accomplished by the OLTCCS Evaluation and Quality Improvement Staff.

Workgroup C, Governor's Medicaid Long Term Care Task Force
Long Term Care Quality Subcommittee
Report 9/7/2004
Chair, Sarah Slocum

Draft Revision-September, 2008
First Draft by Toni Wilson

INTRO VALUE STATEMENT

The Long-Term Care Services & Supports Commission's Quality Management System Work Group has as its primary charge to review and monitor the implementation of Recommendation # 7 of the Medicaid Long-Term Care Task Force. Recommendation # 7 states:

"Establish a new Quality Management System for all LTC programs that includes a consumer advocate and a Long-Term Care Administration that would be responsible for the coordination of policy and practice of long-term care."

As a first step to establishing a new Quality Management System, we have reviewed and revised the Task Force's subcommittee report which created an agreed-upon working definition of long-term care quality. This definition presumes the following core values which can be identified in a quality system of long-term care services and supports:

Good Quality is defined and measured by the person receiving supports and services and not through surrogates such as payers, regulators, families or professionals / advocates. Quality includes both high-quality technical performance, such as competent clinical care, and consumer satisfaction measures. Quality long-term care treats as high priorities the following factors:

- **The individual receiving long-term care supports and services has the *freedom to choose or refuse* his own supports and services. This is based on the core value of personal choice and autonomy.**
- **The quality of this person's *relationships* with care providers and others is known, monitored, and held accountable. This priority is based on the core value of the importance of human relationships.**
- **There is a *continuity of community* involvement in the person's life. This is also based on the core value of the importance of relationships.**
- **The person receiving supports and services has his or her *well-being* treated as a high priority. This is based on the core value of the importance of our basic human needs, both physical and emotional, being met.**
- **The person receiving supports and services must be afforded *the dignity of risk-taking*, which further supports the core value of personal autonomy and control of one's own destiny.**
- **The supports and services are regularly evaluated through *Performance and Customer Satisfaction Measures* which have been developed and refined with consumer involvement and broad public participation. This supports the core value of program accountability to the recipient of services, the regulatory system and the general public.**
- **A quality long-term care system structures public funding in such a way as to support personal autonomy, continuity of community and relationships, the highest possible sense of well-being, and appropriate monitoring and accountability.**

1. FREEDOM TO CHOOSE OR REFUSE

- Choice is *informed*; fully presented and explained to the person receiving long-term care supports and services, and *supported* by persons providing care to the fullest extent possible; what the care consumer says matters, is heard and is acted upon.
- Choice always involves consequences and responsibilities
- The implications for others need to be considered
- Choice is one of the core values in quality
- Choice is not an event; it continues throughout the person's experience of long-term care
- Choice depends on the availability of options
- Providers should offer as many options as possible for choice to be meaningful
- Providers / caregivers / families have an obligation to search for ways to understand choices and preferences of all types of persons receiving care (e.g. those with dementia or other cognitive impairment).

2. RELATIONSHIPS (Partnerships/Collaboration)

The relationships between the person receiving care and others includes:

- Mutual trust and respect as defined by the consumer
- Mutual knowledge **and shared information**
- Caregiver continuity
- Accountability-both parties demonstrate a commitment to the relationship, encourage each others' growth and well-being, and maintain appropriate boundaries
- *Accountability specific to the caregiver*-training, competence, reliability
- *Accountability specific to the person receiving care*-prompt payment, keeping benefits up to date

3. CONTINUITY OF COMMUNITY

The resident or person needing supports and services continues, re-establishes and/or forms and builds community connections through the following individual and system elements.

Individual Elements:

- Individual definition / design of desired community, according to a person-centered plan
- Sensitivity to racial / socioeconomic / ability disparities needs to be observed
- Community is not necessarily a place, but care should be delivered in a setting where the person receiving care feels comfortable. In the event of a transition, the importance of community connections must be recognized and supported; i.e. as in rural areas, where distance between communities or services drives the need to move to new settings, away from familiar community.
- Campus approach to long-term care can sometimes be helpful; however, aging in place (with no transitions) should be an option for the person receiving care as often as possible.
- A consistent care coordinator or friend follows the person through any needed transitions of setting or service.

System Elements:

- Prior to long-term care need, the system needs to encourage people to plan finances and living situations to try to avoid life disruption when care is needed.
- Urban planning needs to include design elements such as:
 - walkable communities and wheelchair accessibility;
 - Transportation availability and accessibility;
 - Housing affordability, proximity to and accessibility of services and social functions;
 - Economic health of the community, jobs, infrastructure.
- Quality includes a conscious effort to weave community connections through all levels and settings of LTC.

4. WELL-BEING (Quality of Life Focus)

Physical well-being-Comfort, safety, support available when needed

Cognitive/Mental well-being-strengths and independence maintained, opportunity for learning and growth, support available when needed

Psychosocial well-being-meaningful relationships, engaged in preferred pursuits, feeling valued, able to care for others, feeling secure and able to cope, feeling of control and sense of purpose.

Spiritual well-being-at peace with self, access to chosen form of worship or practice.

5. DIGNITY OF RISK-TAKING

All people have freedom to make decisions that include risk, including people who use long-term care supports and services. Avoiding all risk prevents people from leading a life that is full and rich.

- A network of supports and services makes risk possible by weaving a safety net **with a flexible, person-centered plan that supports the person's freedom to choose or refuse at any time and provides for the maximum possible autonomy and the lifelong opportunity for growth.**
(note—this is one of the phrases we struggled with a lot. The notes said "...weaving a safety net that supports choice and growth" and we couldn't agree on those.)
- Risk needs to be managed, not just avoided. The care provider and person receiving care can manage risk together through a person-centered plan.
- There needs to be a realistic assessment of the potential positive and negative outcomes, considered by both the care provider and care recipient, analyzing the proposed risk
- The provider has to accept the risk of supporting the individual's decision
- There needs to be clarity about who is choosing and accepting the risk and the possible consequences
- **Ultimately, the choice of what risk to take rests with the person receiving supports and services.**

6. PERFORMANCE/SATISFACTION MEASUREMENT

Performance Measurement

- Enforcement must support the *intent* of OBRA (federal requirements), and not be used to limit personal control or choice by residents
- Measurement of outcomes, such as maintenance of function and community
- Customer satisfaction level considered
- Information from regulatory structures also considered
- Consider ways to improve and transform the medical model
- Format should provide as objective a measurement as possible

Satisfaction Measurement

- Customer trumps everybody
- Some form of education for persons receiving care and their families to understand what constitutes reasonable expectations
- Would care recipients recommend this service to others?
- Were your original expectations not met / met / exceeded?
- Is this a life that the person receiving services and supports wants to live?
- Format should provide as objective a measurement as possible

RECOMMENDED ACTION STEPS

1. *Cabinet level review of all parts of state government about how each entity touches the long-term care system. Align regulations, reimbursement and incentives to promote this vision of quality and move toward that alignment.*
2. *Have stakeholders from within Michigan and experts from outside Michigan review the Cabinet level review and give input on areas to address for alignment.*
3. *Develop and use consumer satisfaction surveys and measurements.*
4. *Review and analyze current performance measures (regulatory and non-regulatory)*
5. *Design performance measures that move us toward this vision of quality.*

Office of Long Term Care Supports and Services Quality Management PAT
LTC Supports and Services Selected for Quality Review

1. Home Help
2. Subsidized (I.L.) Housing
3. Home Health
4. Adult Foster Care
5. Homes for the Aged
6. MI Choice Waiver
7. Certified Hospice Facilities
8. Nursing Home Facilities
9. Non-Licensed "Assisted Living"
10. Home-Based Hospice
11. MSHDA/Affordable Assisted Living
12. Program for All Inclusive Care of the Elderly (PACE)
13. Other Adult Day Care
14. Hospital (related to LTC)
15. Physician's offices (medical home care)
16. AAAs
17. CILs
18. Commissions on Aging

Task Force Recommendation Seven: Establish a New Quality Management System
 To ensure LTC services across the spectrum are consumer centered
 7/29/2009 QM PAT

Objective	Activity	Output	Outcome	Indicator/measures	Responsible for & time line
1. To identify areas in current quality management activities, practices and outcome measures that could be improved by recognizing consumer as center of quality in developing new methodologies.	Conduct gap analysis A. Review and analyze current performance measures, both regulatory & non-regulatory	Evaluation report of findings	Plan to make current quality management performance outcomes readily available to consumers on websites, other publicly disseminated materials, written in easily understandable language, standard 8 th grad level	# of areas identified in current quality management activities, practices and measures to be improved	
	B. Identify missing consumer centered & other preferred practice/measures, i.e., independent advocate	List of recommendations to improve quality	Missing preferred practices /measures are added to quality plans related to consumer centeredness	# of new quality activities to be added	
	C. Conduct environmental scan	Compendium of current quality groups & activities, coordinate with LTC Commission	Evaluation report is readily available for committee & public review and comment		
	D. Groups, missions, tasks & activities are identified to work in collaboration to promote LTC improvements		Evaluation report identifies strengths & weaknesses in current quality systems.		
	E. Identify existing consumer experience survey tools used locally &	List of current consumer experience survey tools	Compendium of consumer and worker experience survey tools is made publicly available	Baseline data for consumer experience	

Task Force Recommendation Seven: Establish a New Quality Management System
 To ensure LTC services across the spectrum are consumer centered
 7/29/2009 QM PAT

Objective	Activity	Output	Outcome	Indicator/measures	Responsible for & time line
1. To identify areas in current quality management activities, practices and outcome measures that could be improved by recognizing consumer as center of quality in developing new methodologies.	nationally F. Identify worker experience survey tools used locally nationally	List of current worker experience survey tools		Baseline data for worker experience	

Task Force Recommendation Seven: Establish a New Quality Management System
 To ensure LTC services across the spectrum are consumer centered
 7/29/2009 QM PAT

Objective	Activity	Output	Outcome	Indicator/measures	Responsible for & time line
<p>2. To develop & promote new quality improvements systemic practices, strategies, interventions & measures across LTC sectors that recognize consumer as the center of quality improvement activities</p>	<p>Develop centralized quality authority</p> <p>A. Quality plan(s) developed</p> <p>B. Consumer Centered standards created</p> <p>C. Training plan developed</p> <p>Design new survey tools as needed</p> <p>Test new tools</p>	<p>List of new consumer centered recommended practices and measures added to quality plans</p> <p>Standards for each program</p> <p>Plan for implementing surveys in each LTC survey</p> <p>Training plans available for LTC programs and partners</p> <p>New consumer and worker experience survey tools</p> <p>Report cards for each types of programs</p>	<p>Consensus is reached to adopt and implement new practices & measures across LTC sectors</p> <p>Information is readily available to consumers and the public</p> <p>New tools are reliable & provide useful information, available in numerous public sources.</p>	<p># of providers adopting use of new practices & measures</p> <p># of distribution sites/ publishing materials</p>	

Task Force Recommendation Seven: Establish a New Quality Management System
 To ensure LTC services across the spectrum are consumer centered
 7/29/2009 QM PAT

Objective	Activity	Output	Outcome	Indicator/measures	Responsible for & time line
<p>3. Oversight of QM is established within LTC Commission and LTC administration</p>	<p>Implementation of oversight plan</p> <p>Feedback loop</p> <p>A. Consumers</p> <ul style="list-style-type: none"> • experience and QoL surveys conducted • consumer rating system of providers developed 	<p>State monitoring, Oversight reports</p> <p>Consumer ratings system for LTC services and providers</p>	<p>Broader accountability across LTC array of services and supports</p> <p>Consumers experience a higher quality of care and report an increase in quality of life</p> <p>Consumer ratings & recommendations of providers across LTC sectors are available publicly</p>	<p>- # providers who meet minimum standards</p> <p>- % of change of participants QM relative to initial gap analysis</p> <p>- % penetration of new consumer centered quality practices & measures added to QM plans across sectors</p> <p>- # of LTC programs participating</p> <p>Changes/revisions to QM processes based on feedback</p> <p>% increase in consumer satisfaction (compared to baselines)</p> <p># of consumers using rating system publicly</p> <p># of hits for reviewing consumer ratings</p> <p># of consumers provided with & using consumer ratings system</p>	

Task Force Recommendation Seven: Establish a New Quality Management System
 To ensure LTC services across the spectrum are consumer centered
 7/29/2009 QM PAT

Objective	Activity	Output	Outcome	Indicator/measures	Responsible for & time line
3. Oversight of QM is established within LTC Commission and LTC administration	B. Workers <ul style="list-style-type: none"> • experience surveys conducted C. Peer Measures <ul style="list-style-type: none"> • Measuring tools developed D. Training evaluations <ul style="list-style-type: none"> • coordinate with PCP and Workforce workgroups E. Consumer Advocacy <ul style="list-style-type: none"> • Forums initiated • Networks developed 	Evaluation tools	Workers are competently trained, valued and respected Decrease in staff turnover Peer Review system in place Improved trainings across the LTC system Advocates contribute to the QM process	% increase in worker satisfaction (compared to baselines) # of providers participating in peer review *Develop measures in concordance with the PCP and Workforce workgroups* # of open forums held # of advocate recommendations, and # of which are incorporated into the QM process	

SAVE THIS DATE & SHARE WITH OTHERS!

Thursday, October 1, 2009

11:00 am to 3:00 pm

Assistive Technology & Options At Home

“You Have a Choice for Independence”

Join us for a Community Info Fair at
Grace United Methodist Church
1900 Boston Blvd., Lansing

Sponsored by

Tri-County Office on Aging
Project Choices Advisory Group
Quality = Choice, Satisfaction & Independence (CSI)

Call 517-887-1440 for more information.

Michigan Office of Services to the Aging
Project Planning Division
August 24, 2009

Update of ADRC and NHD Grants

NHD Grants

The second NHD grant is in its last 6 months, and the third NHD grant has already been applied for.

We will not know the results of this third grant process until September 30, 2009.

If received, the third grant would:

1. Cover the six remaining groups with PCP and SD
2. Include training for CILs and service providers
3. Provide Train the Trainer instruction and materials

ADRC Grants

We have applied for ADRC funding, but will not know the results until September 30, 2009.

The key elements of this funding would entail:

Working with AAAs, CILs, and Advocates

Going with “No Wrong Door” approach (opposite the SPE approach)

Agencies and organizations at the local level deciding how ADRCs will be fashioned to meet their communities (i.e., the state will not proscribe this)

The whole grant would be 750K for 3 years, with no money going to the field.

Funds will be used for infrastructural development, partnering development, and other supports to emerging ADRCs.

OSA will be happy to provide copies of the proposal to anyone who would like more detailed information by emailing: Drew Walker at walkerdr@michigan.gov

PROJECT UPDATES

AUGUST, 2009

Michigan Long-Term Care Supports & Services Advisory Commission
August 2009

Recent work of the Commission has focused on funding and revenue advocacy to reform and modernize the State's revenue system to assure adequate resources to current and future full array of LTC supports and services. At the May meeting, Commissioners were briefed by House Fiscal Agency staff, state Treasury staff, and respected economists on sources of our state's deficits, revenue projections and range of strategies for tackling our budget crisis. Next steps towards budget advocacy, the Commission sent letters to the Governor and members of the Michigan Legislature with messages on the Commission's dismay over news of the elimination of the SPE Demonstration sites, and about investing in Michigan's LTC infrastructure by addressing structural budget deficits, modernizing taxation and revenue system. Commissioners will do their part by hosting local advocacy activities in their respective communities to build awareness and discussion about adequate funding being provided for the state's long term care supports and services and to address future needs.

The remaining meetings for 2009 are September 28, 2009 and November 23, 2009 in Lansing at the Capitol View Building.

PERSON-CENTERED PROGRESS ACTION TEAM
AUGUST 2009

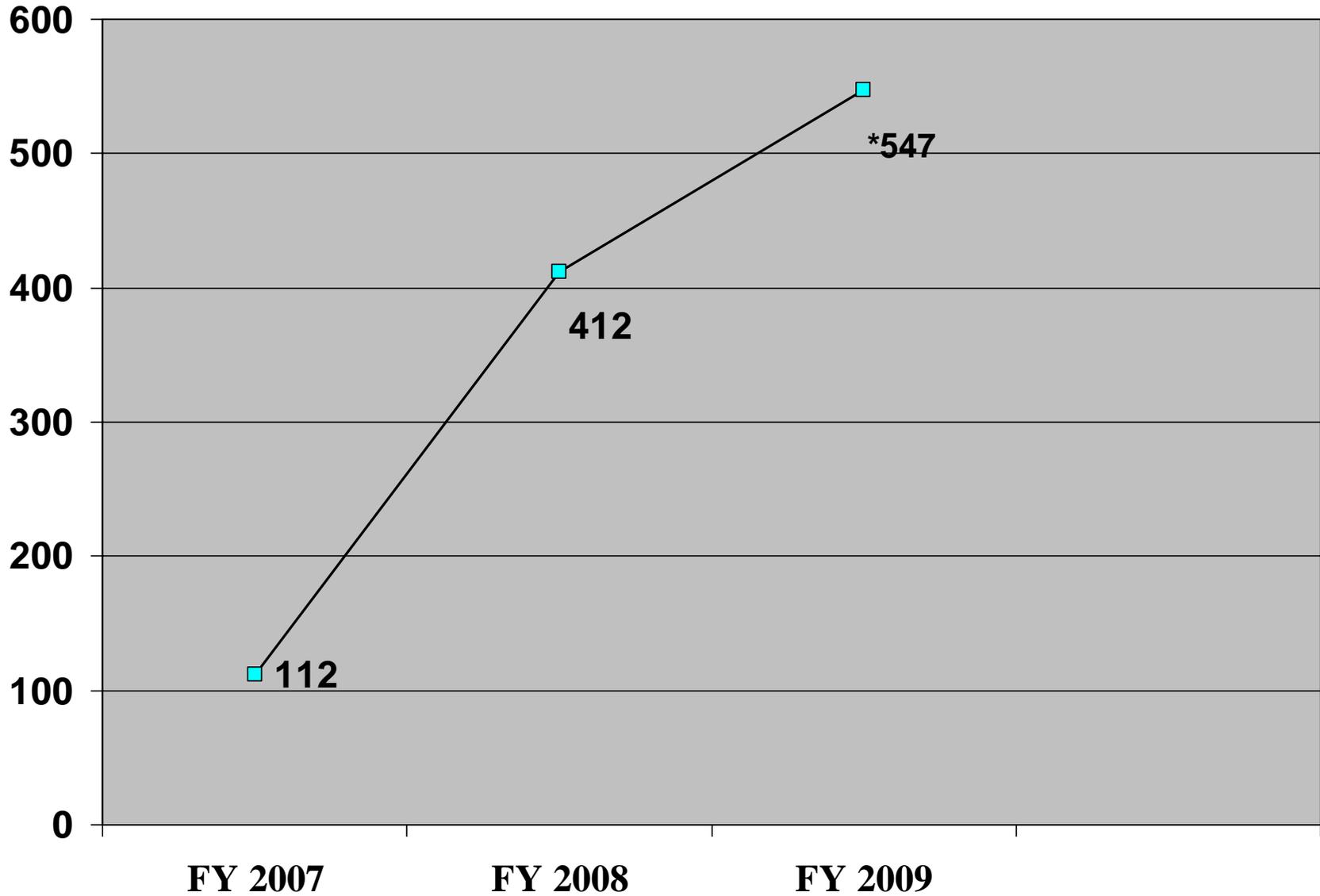
The Michigan Department of Community Health and stakeholders, including advocates and providers continue to work together to facilitate the adoption and implementation of person-centered planning core values and principles, and essential elements. The Michigan Department of Community Health (MDCH) is committed to ensuring that the person-centered planning process is implemented across the long-term care continuum.

This has been a busy summer and several efforts identified in PCP Logic Model planning tool are moving forward.

- The training subcommittee has written draft core competencies, these competencies will be the basis for at least two learning tracks one for administrators and policy makers and one for persons providing service. Each track will have learning objectives, curriculum and training materials.
- Training material developed by the committee will be used in a web based training made available to Department of Community Health staff. Larry Doele, (MPHI), who has worked on other web based training will provide information about the technical issues related to developing and hosting at the PCP meeting on August 28th,
- A draft brochure for consumers and a narrative for a web page are being developed with help from Ellen Hyman; Consumer Task Force members will be invited to review and provide input to as we work to develop a brochure that is useful for consumers and families.
- The Bureau of Health Professionals has several newsletters and communication tools and we are exploring how to use them to share information about person-centered planning with health professionals, their associations, trainers and boards;
- We met with staff from the Bureau of Health Systems to discuss how we might work together to assure common understanding among surveyors and nursing home providers. We will pursue joint training and communications with them;

- The Quality PAT Workgroup had a preliminary presentation on PCP and will receive more information. They will work to develop a quality management plan that reaches across the array of long term care supports and services, collects and uses consumer experience, including feedback on consumer experience of the person-centered planning process which supports their preferences and authority;
- The PCP workgroup decided to use a strategy to develop support called diffusion of information. That strategy includes uses persons identified as “ambassadors.” A revised draft of the role of an ambassador has been developed. Ambassadors will be identified for stakeholder groups (so far over 40 have been identified.) The ambassador will work with us to share information so that persons who work in home and community based settings or services and in nursing homes, hospitals, as well as policy makers understand the person-centered approach and the benefits for persons who use long term care services. We invite members of the consumer task force to continue to play a part in assuring the PCP values and core elements are available to all.

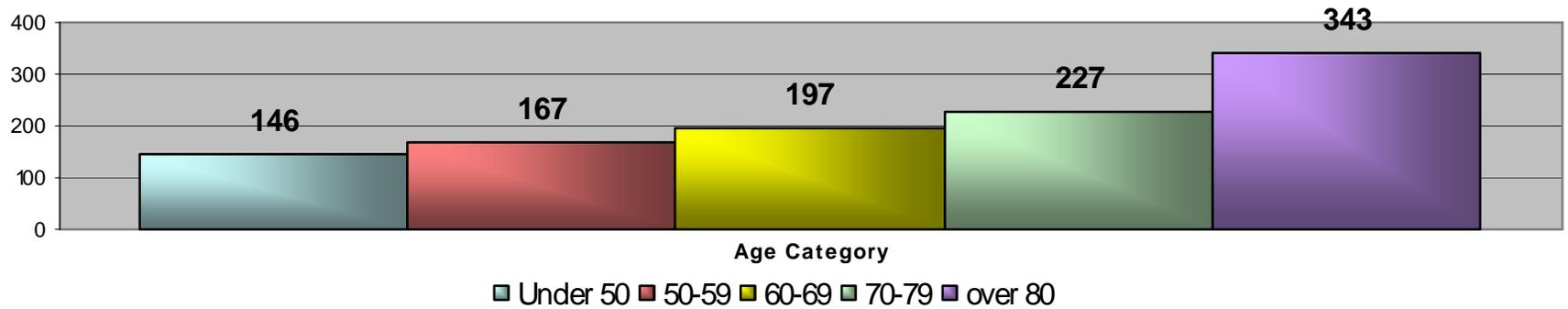
SD Enrollments for FY '07, '08, '09



8/17/2009 * FY 2009 is updated as of 7/28//09

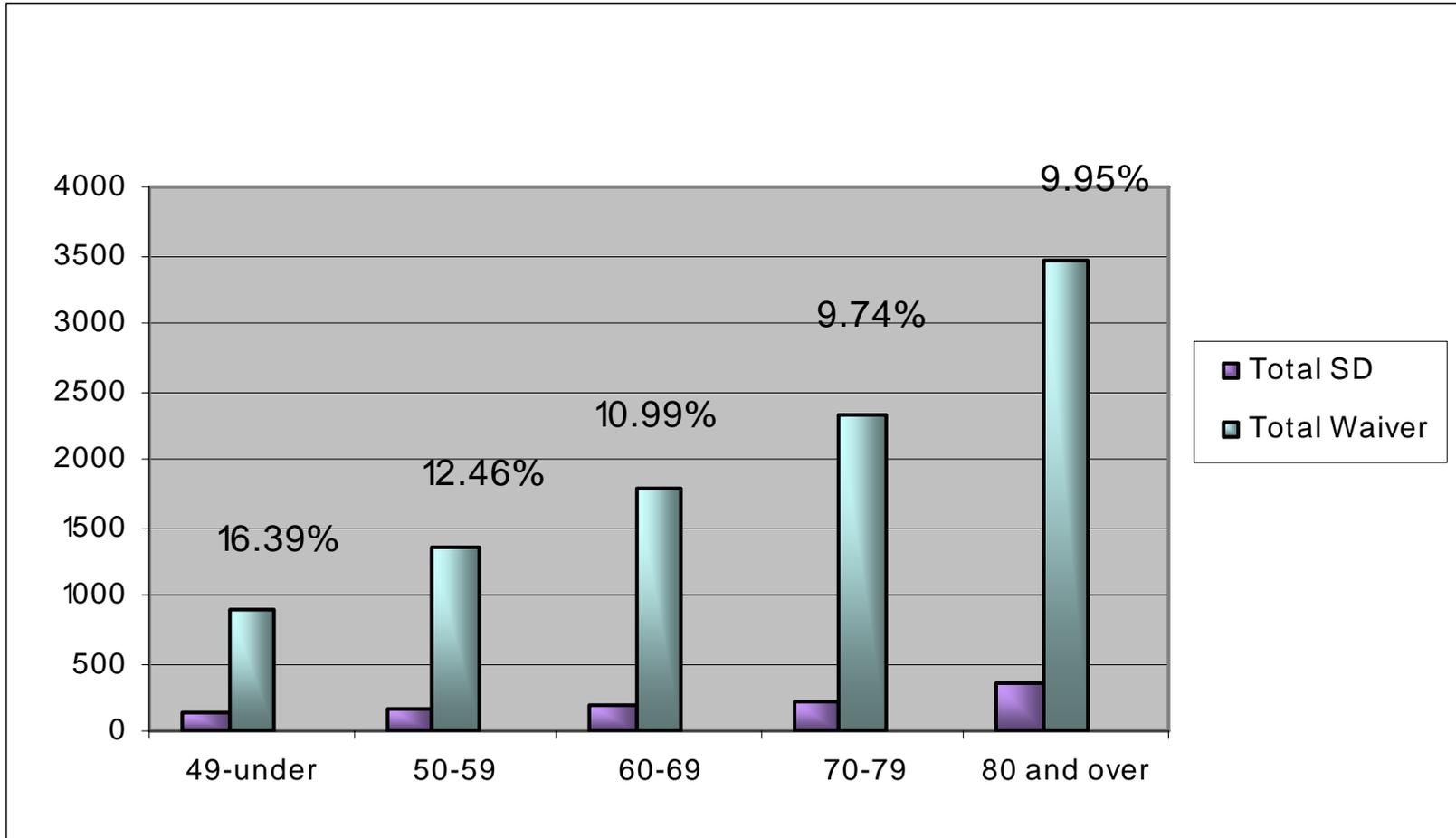
Age Distribution of Participants in SD

12/12/06-7/29/09



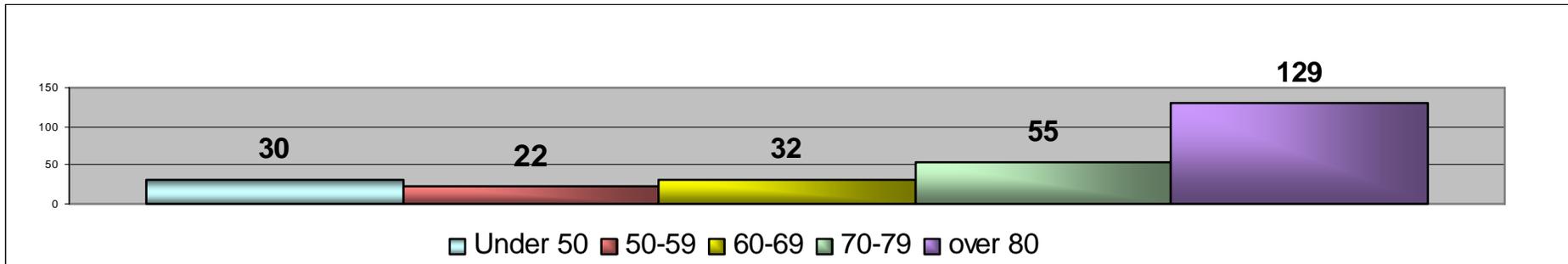
Age % of SD's in Waiver

12/12/06-7/29/09



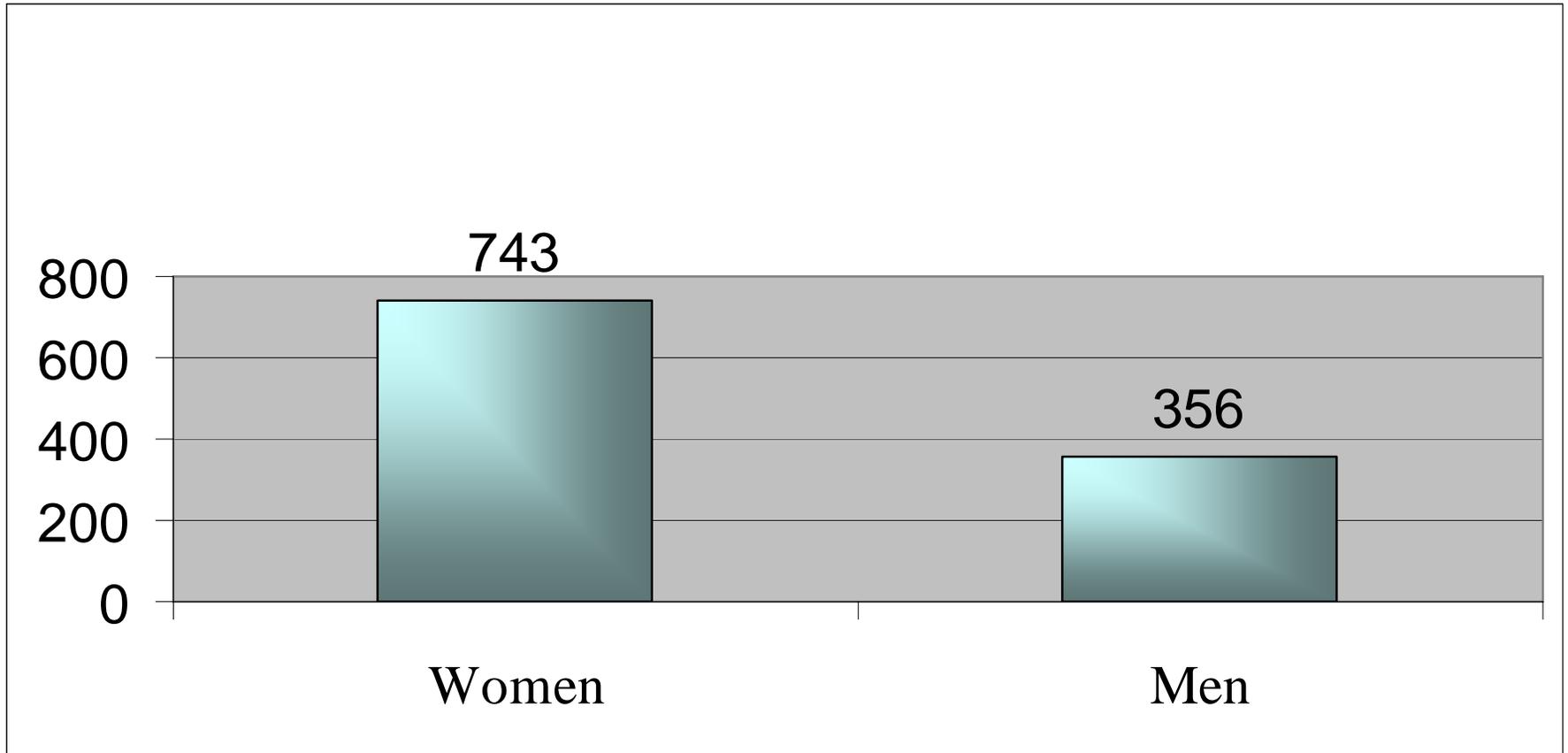
Age Distribution of Participants in SD who have a Representative

12/12/06-7/29/09



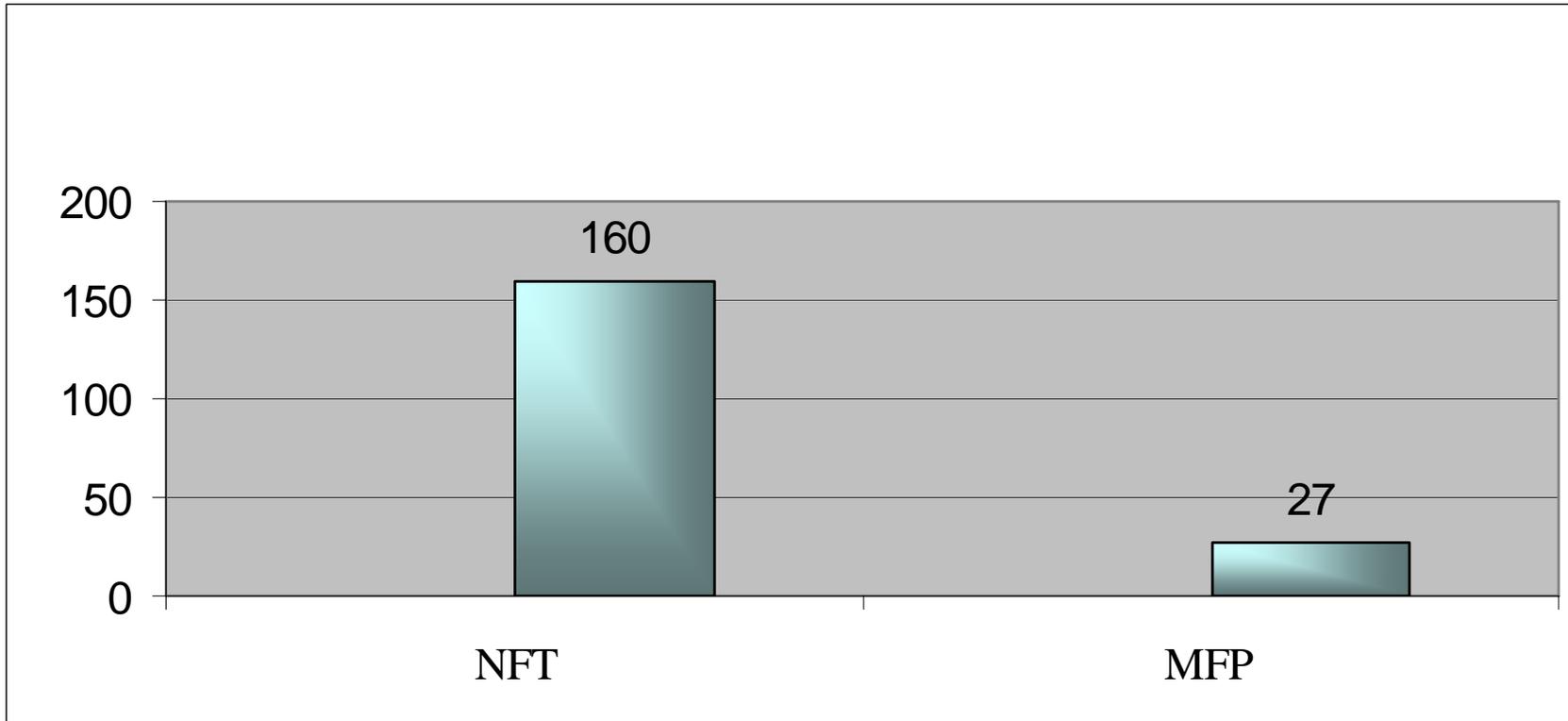
Participants by Gender

12/12/06-7/29/09



Number of NFT & MFP Enrollments in SD

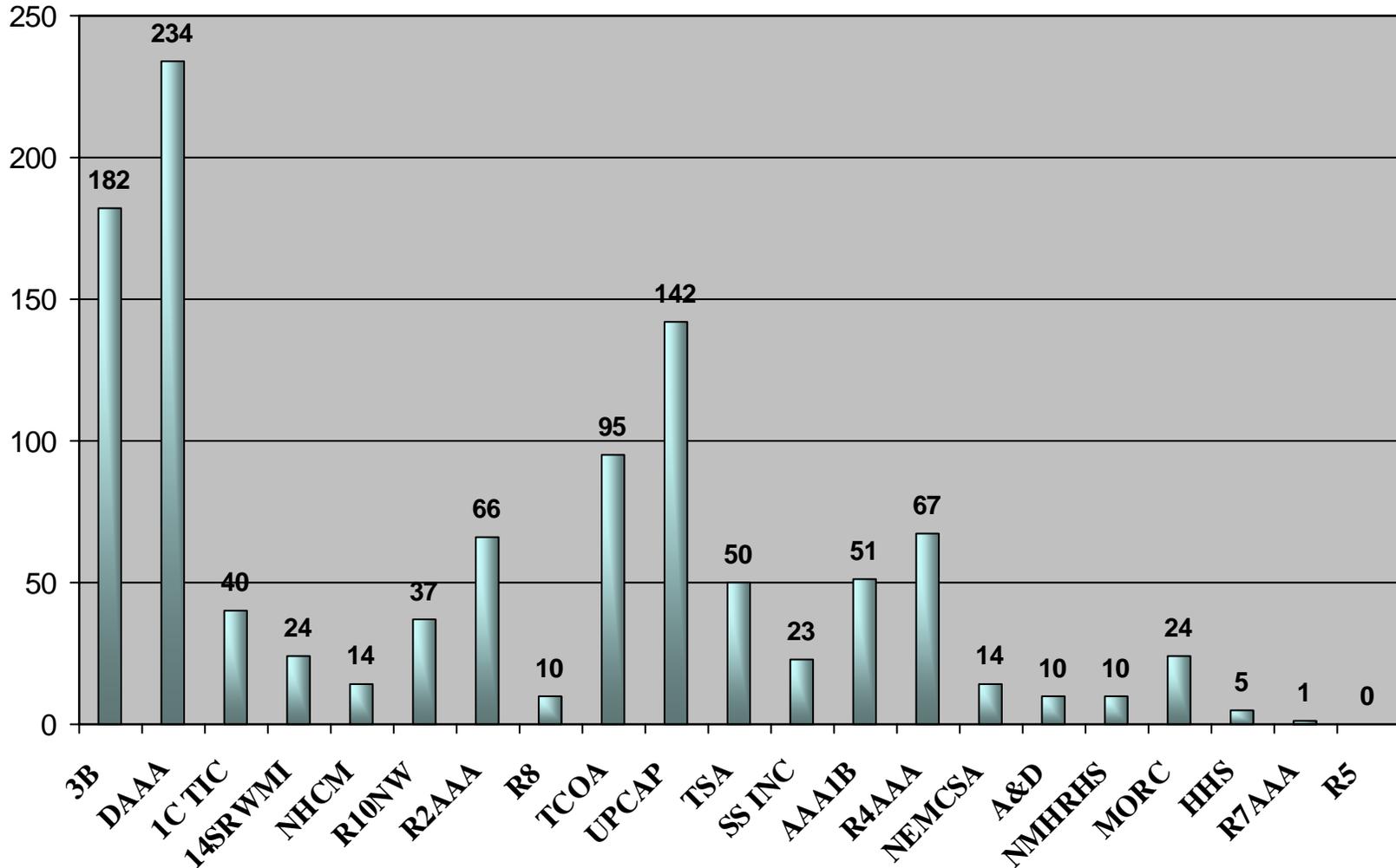
7/10/08-7/29/09



**Average Annual Budget, Hours, and Number of Workers in SD
12/12/06-7/29/09**

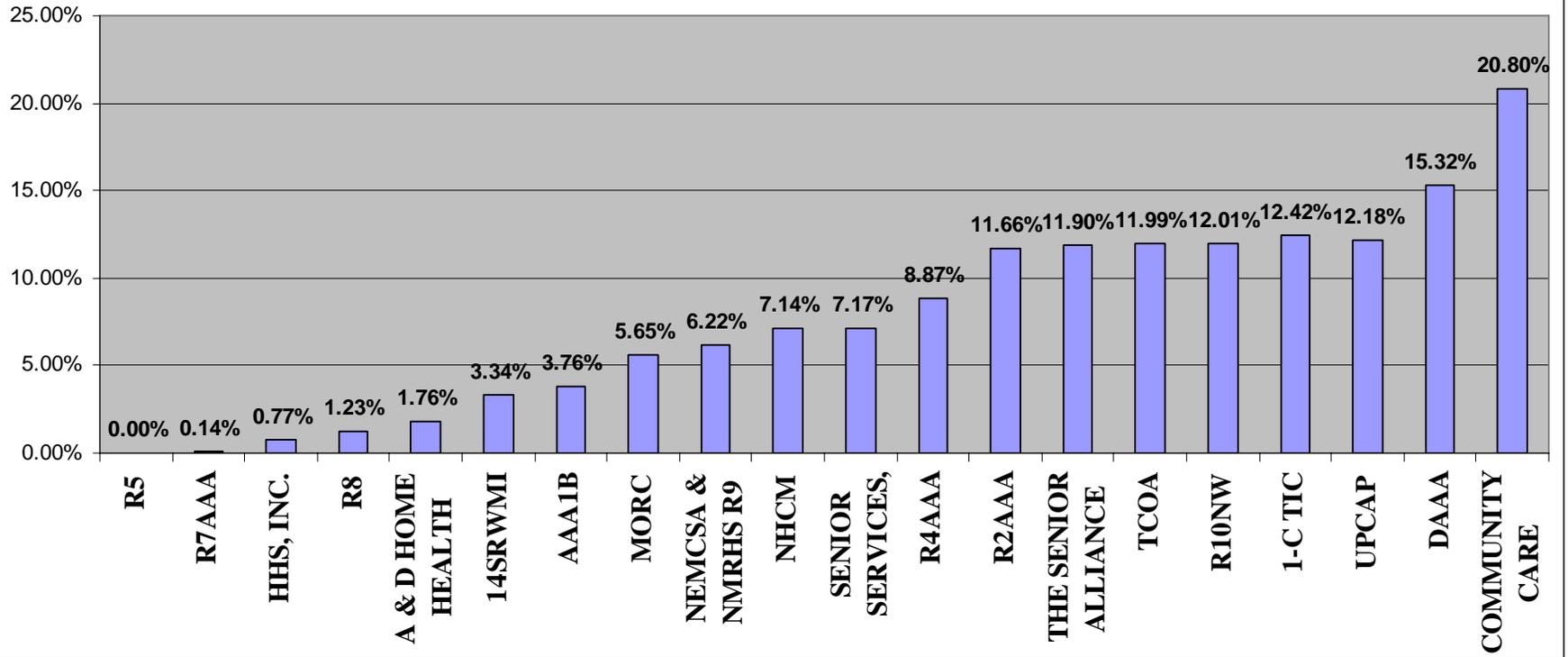
- Budget: \$14,275.17
- Hours: 1030 hrs
- Number of Workers:1.3

Number of Enrollments by Waiver Agent 12/12/06-7/29/09 (n=1099)



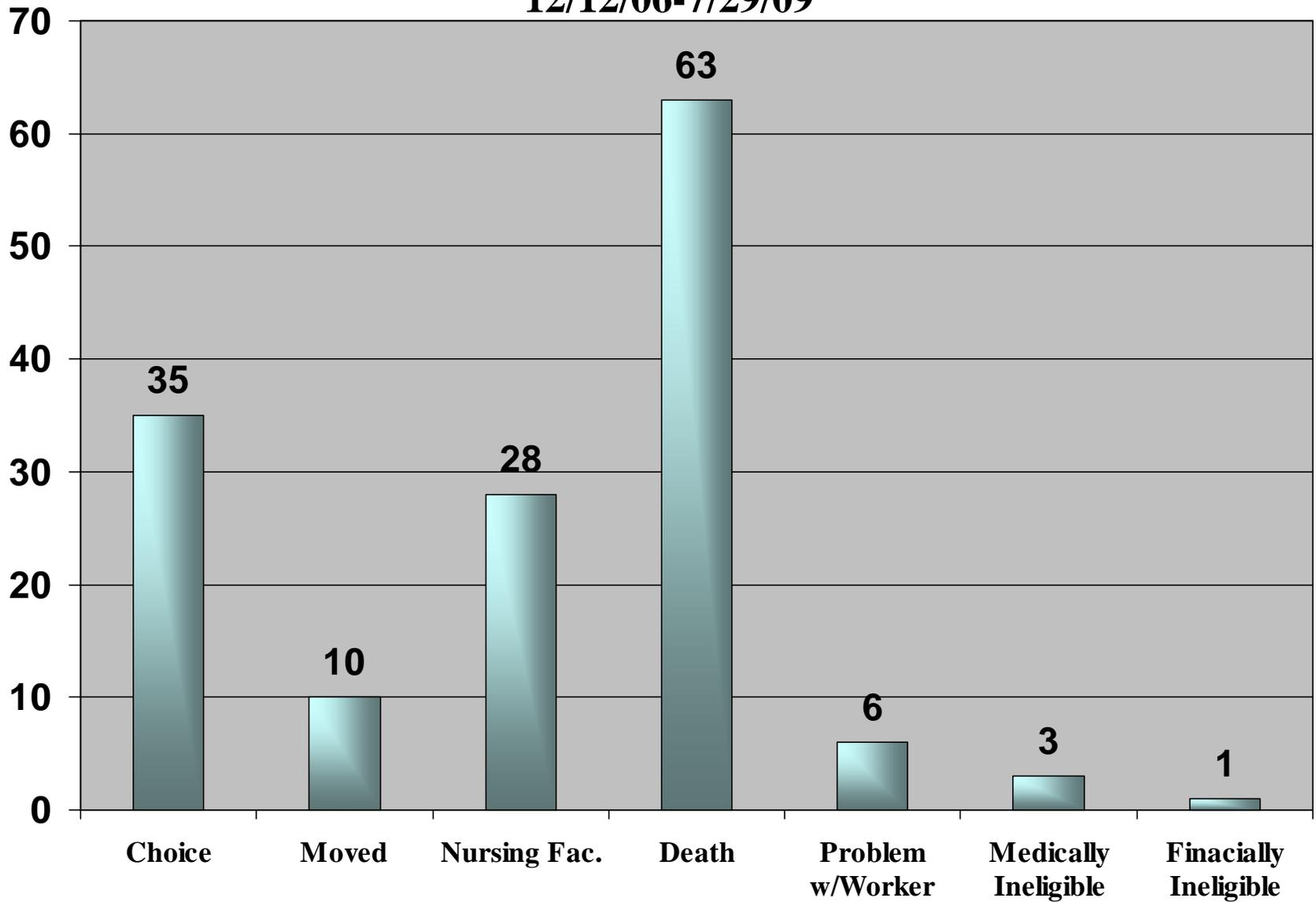
Percent of Waiver in SD

12/1/06-7/29/09



Number of Dis-Enrollments in SD

12/12/06-7/29/09

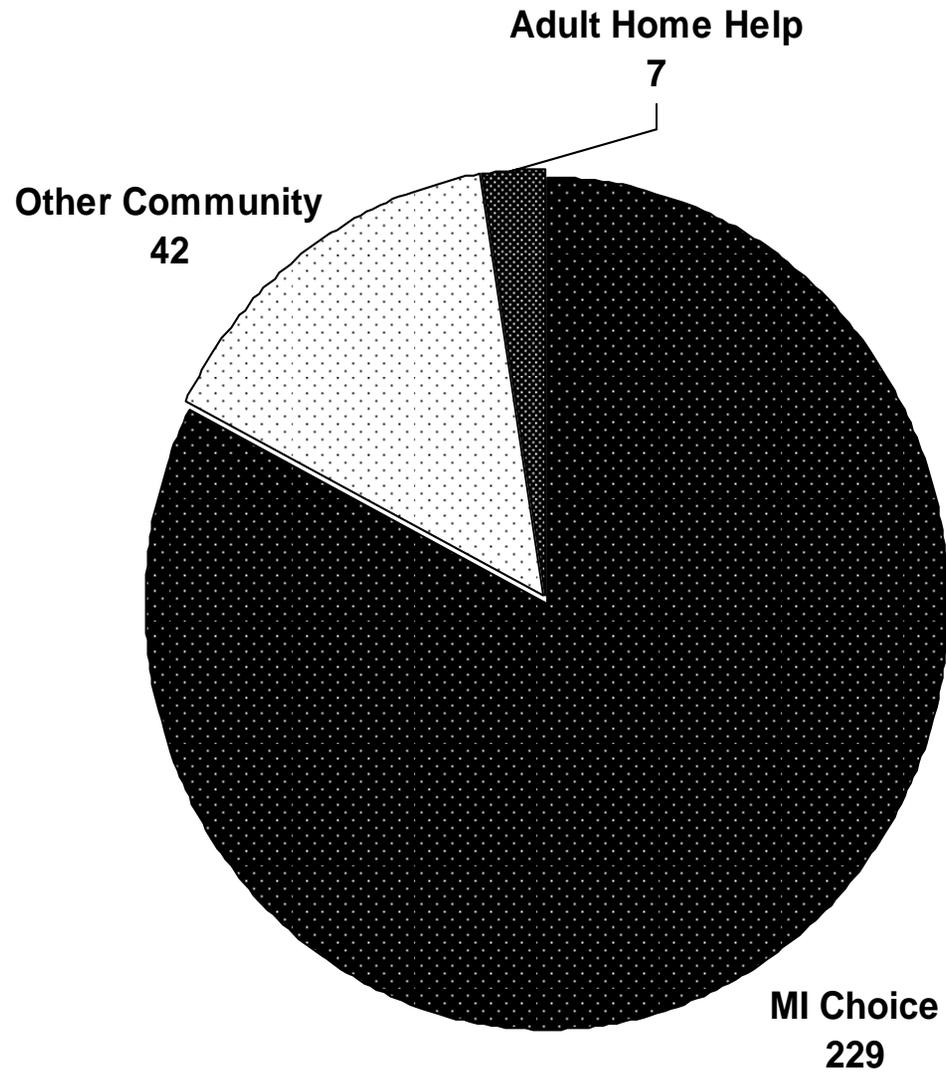


Nursing Facility Transitions

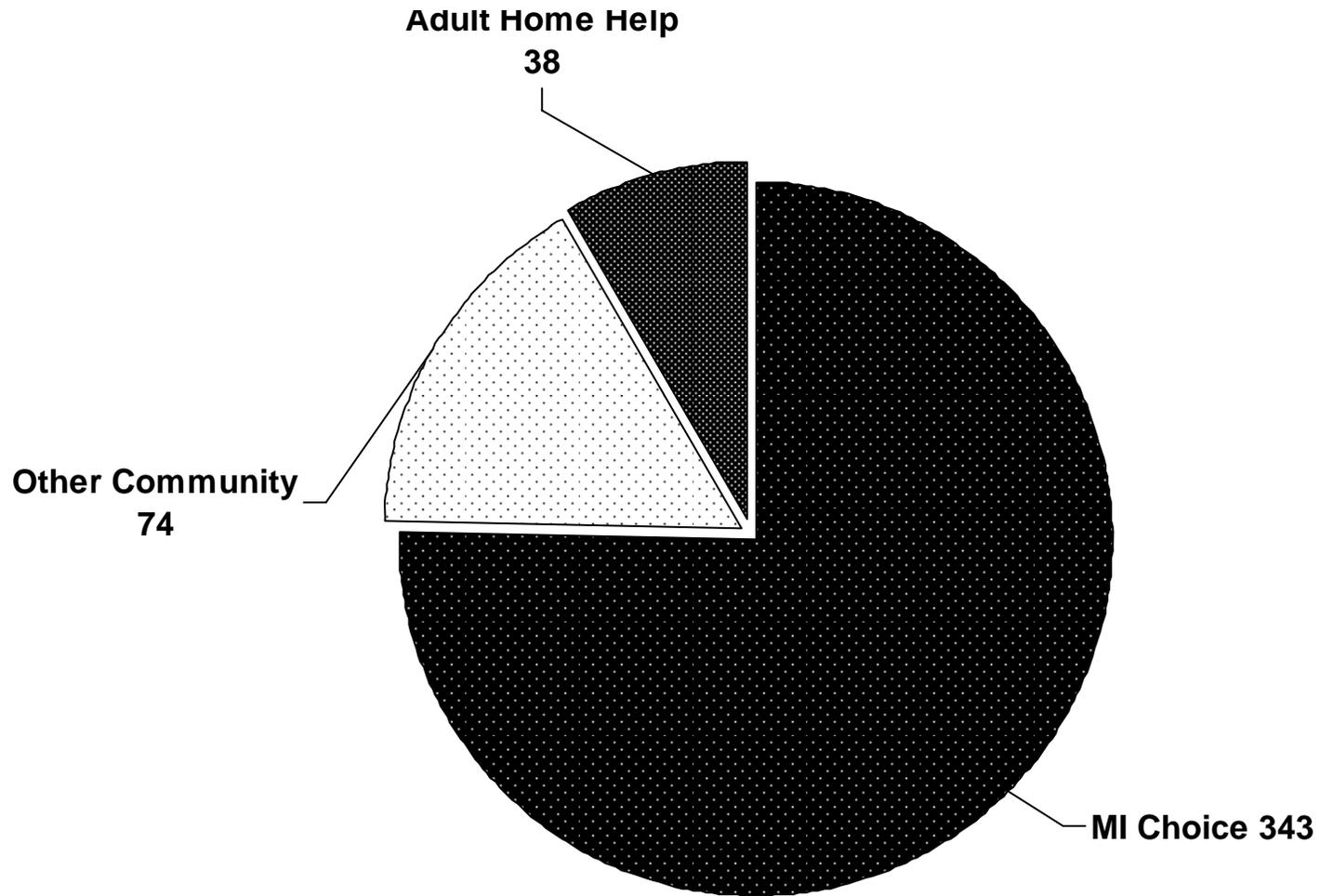
July 29, 2009

**Ellen Speckman-Randall,
MDCH**

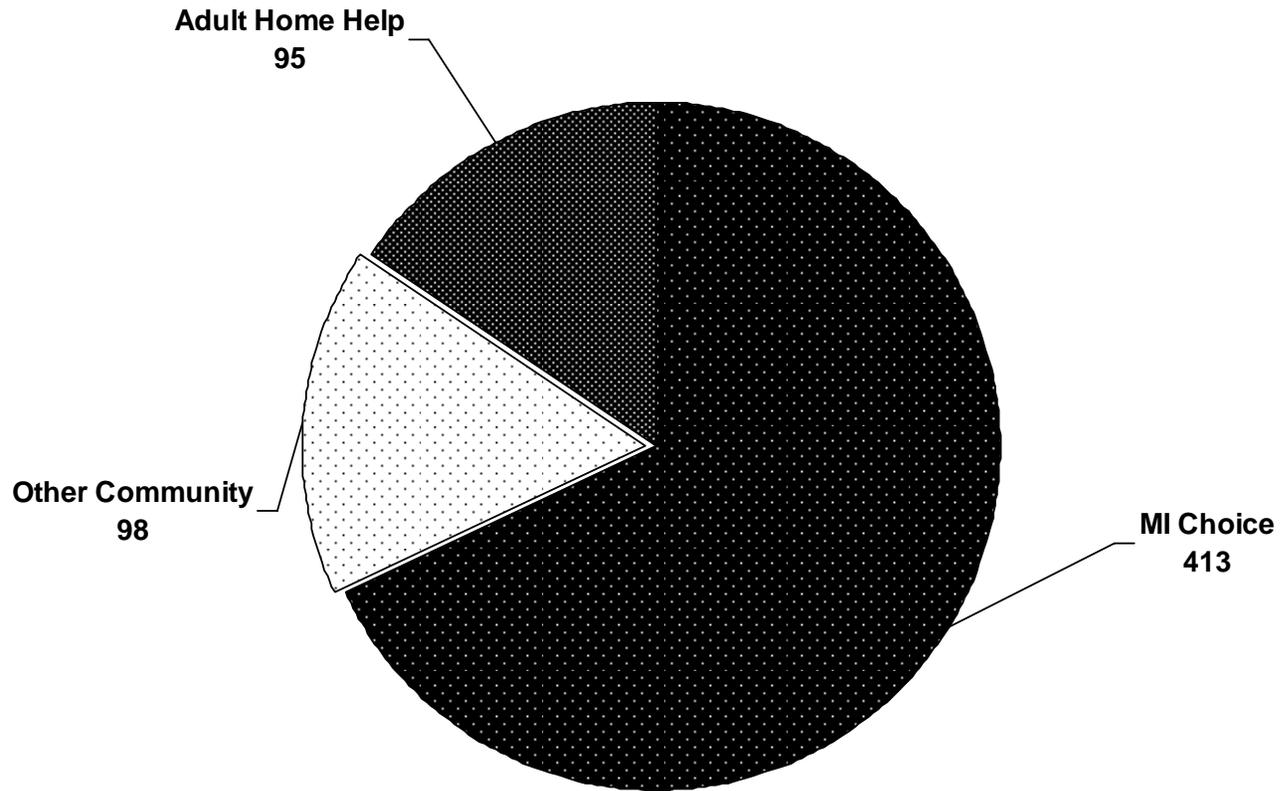
FY 2006 NF Transitions = 278



FY 2007 NF Transitions = 455

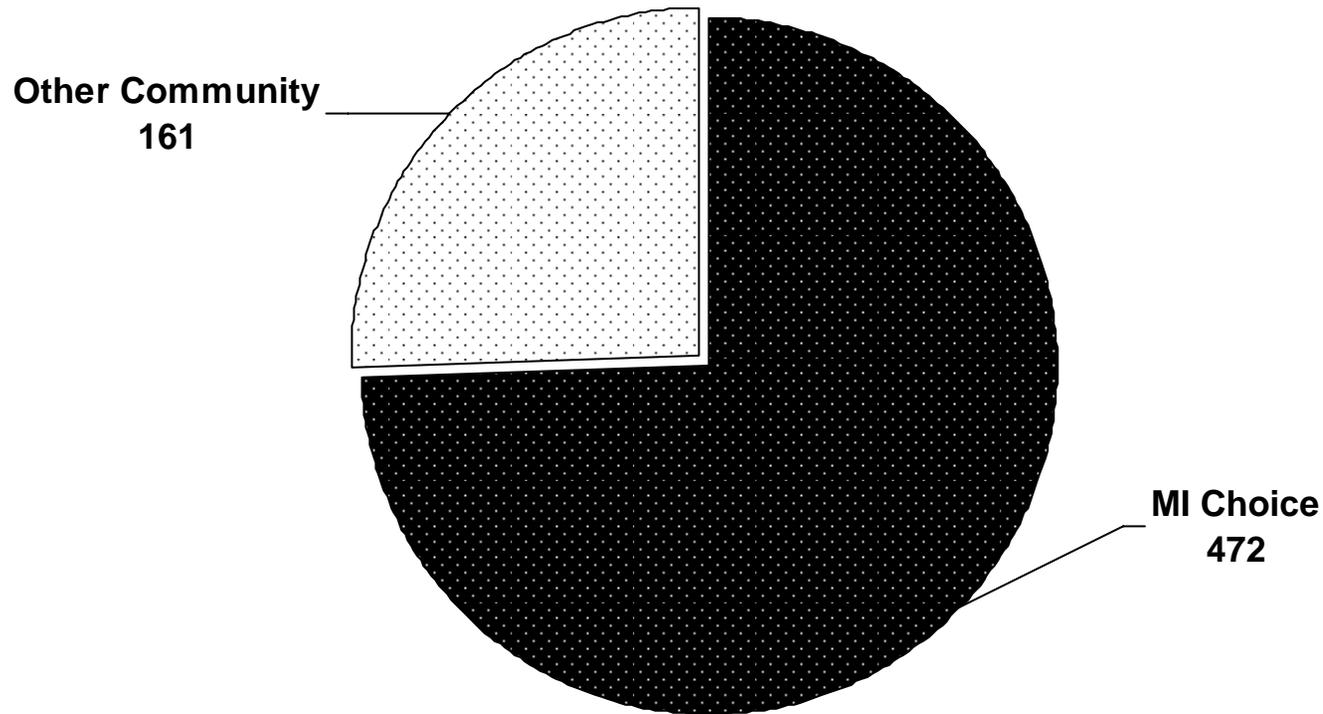


FY 2008 NF Transitions = 606

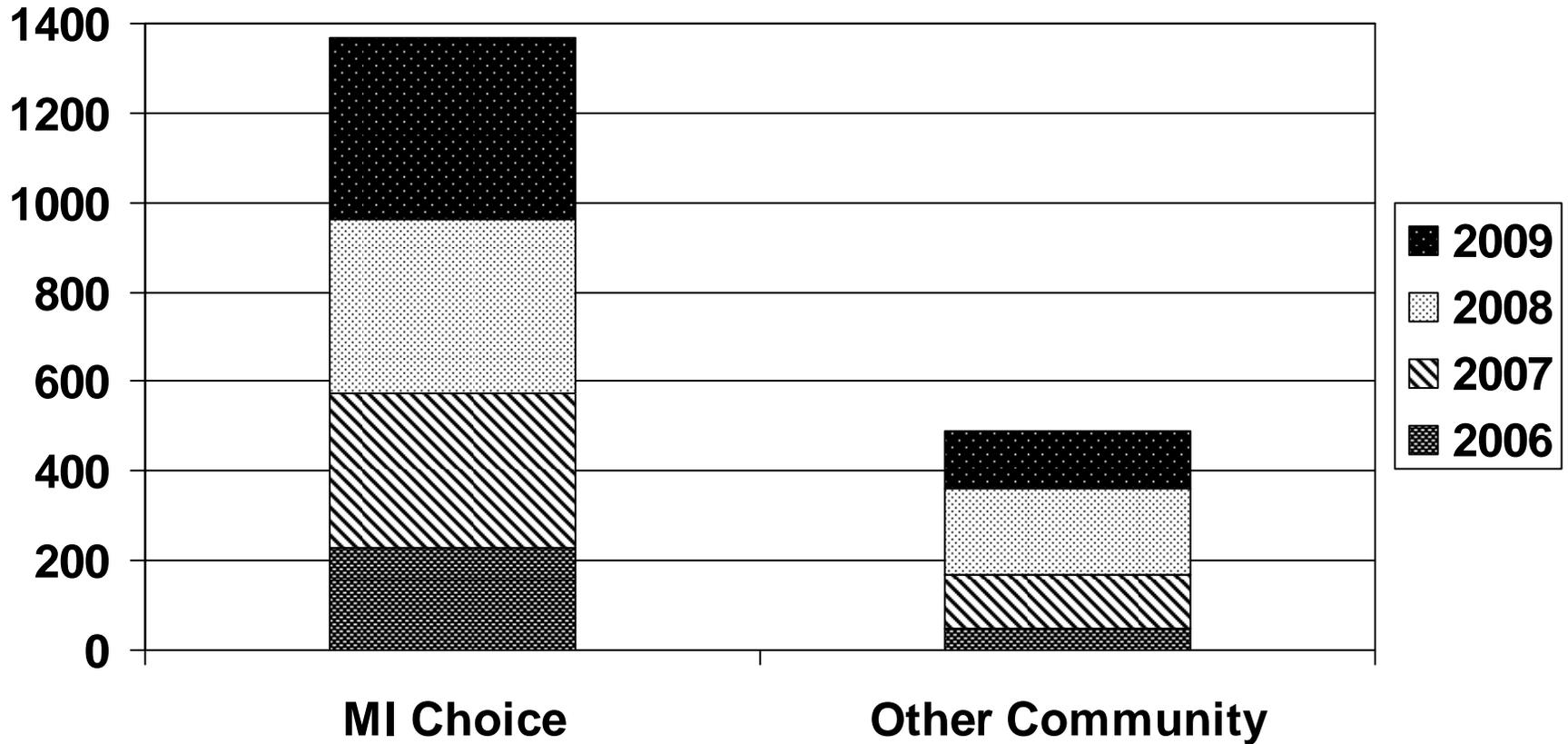


FY 2009 October thru July 27

NF Transitions = 633



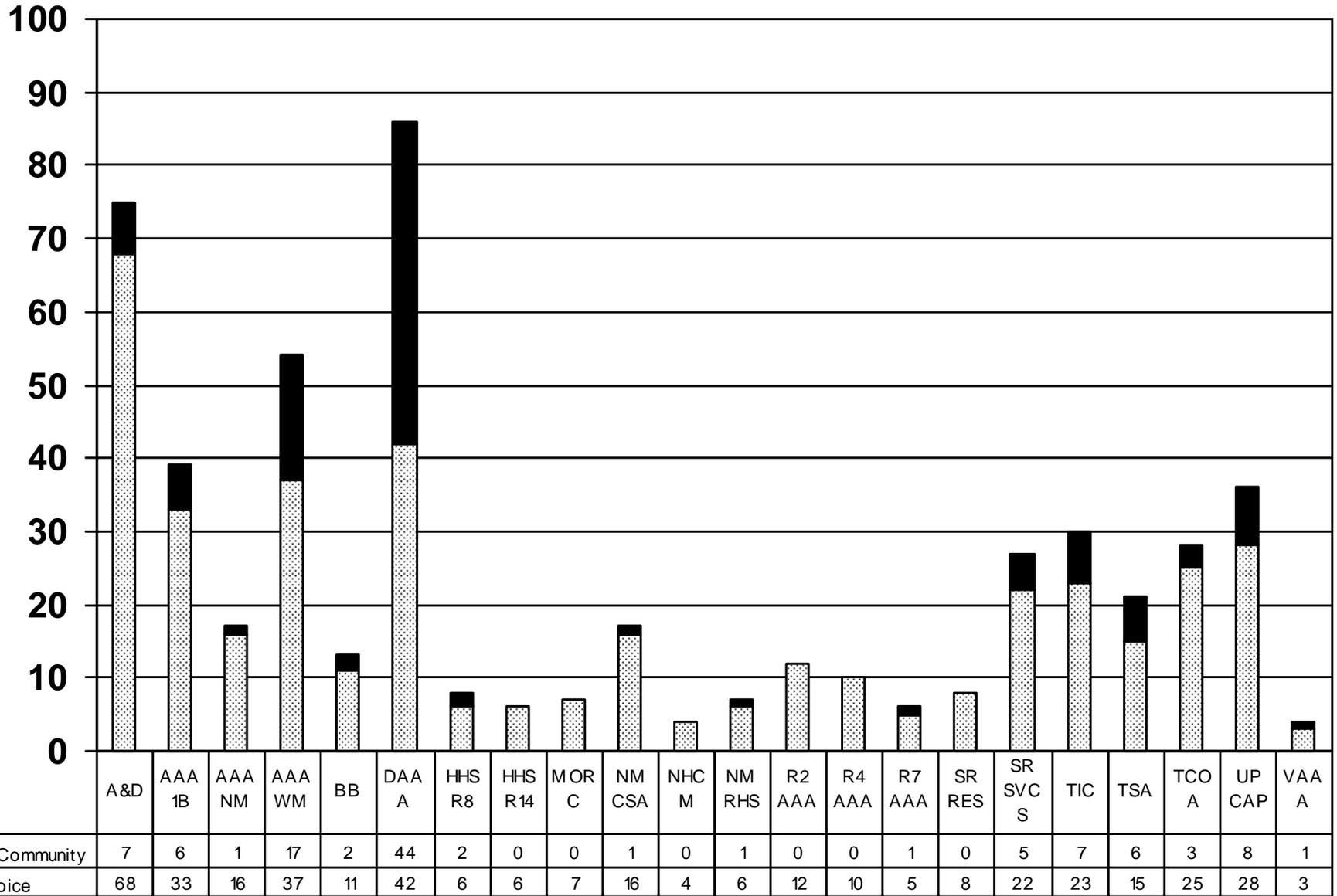
FY '06, '07, '08 & '09 NF Transitions by Program



Waiver Agent Codes

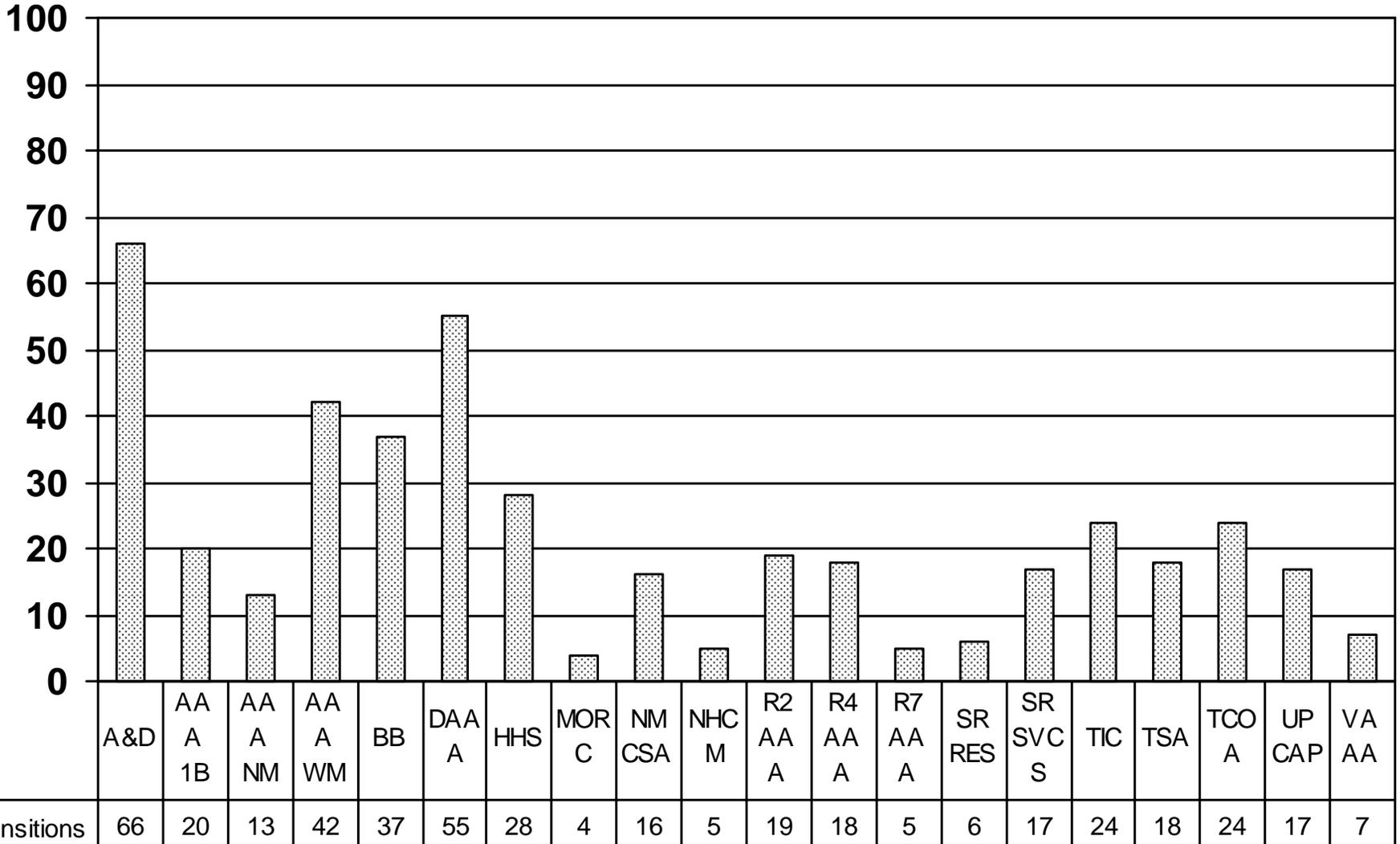
- A&D – A & D Home Health Care, Inc., Saginaw, MI
- AAA1B – Area Agency on Aging 1B, Southfield, MI
- AAANM – Area Agency on Aging of Northwest Michigan, Traverse City, MI
- AAAWM – Area Agency on Aging of Western MI, Grand Rapids, MI
- BB – Region 3B AAA @ Burnham Brook Center, Battle Creek
- DAAA – Detroit Area Agency on Aging, Detroit, MI
- HHS R8 – Health Options, Grand Rapids, MI
- HHS R14 – Health Options, Grand Rapids, MI
- MORC – Macomb Oakland Regional Center, Clinton Township, MI
- NMCSA – Northeast MI Community Service Agency, Inc., Alpena, MI
- NHCM – Northern Lakes Community Mental Health, Traverse City, MI
- NMRHS – Northern Michigan Regional Health System, Petoskey, MI
- R2 AAA – Region 2 Area Agency on Aging, Brooklyn, MI
- R4 AAA – Region 4 Area Agency on Aging, St. Joseph, MI
- R7 AAA – Region VII Area Agency on Aging, Bay City, MI
- SRRES – Senior Resources, Muskegon Heights, MI
- SRSVCS – Senior Services of Kalamazoo, Kalamazoo, MI
- TIC – The Information Center, Taylor, MI
- TSA – The Senior Alliance (AAA), Wayne, MI
- TCOA – Tri-County Office on Aging, Lansing, MI
- UPCAP – Upper Peninsula Area Agency on Aging, Escanaba, MI
- VAAA – Valley Area Agency on Aging, Flint, MI

FY 2008 Transitions by Waiver Agent

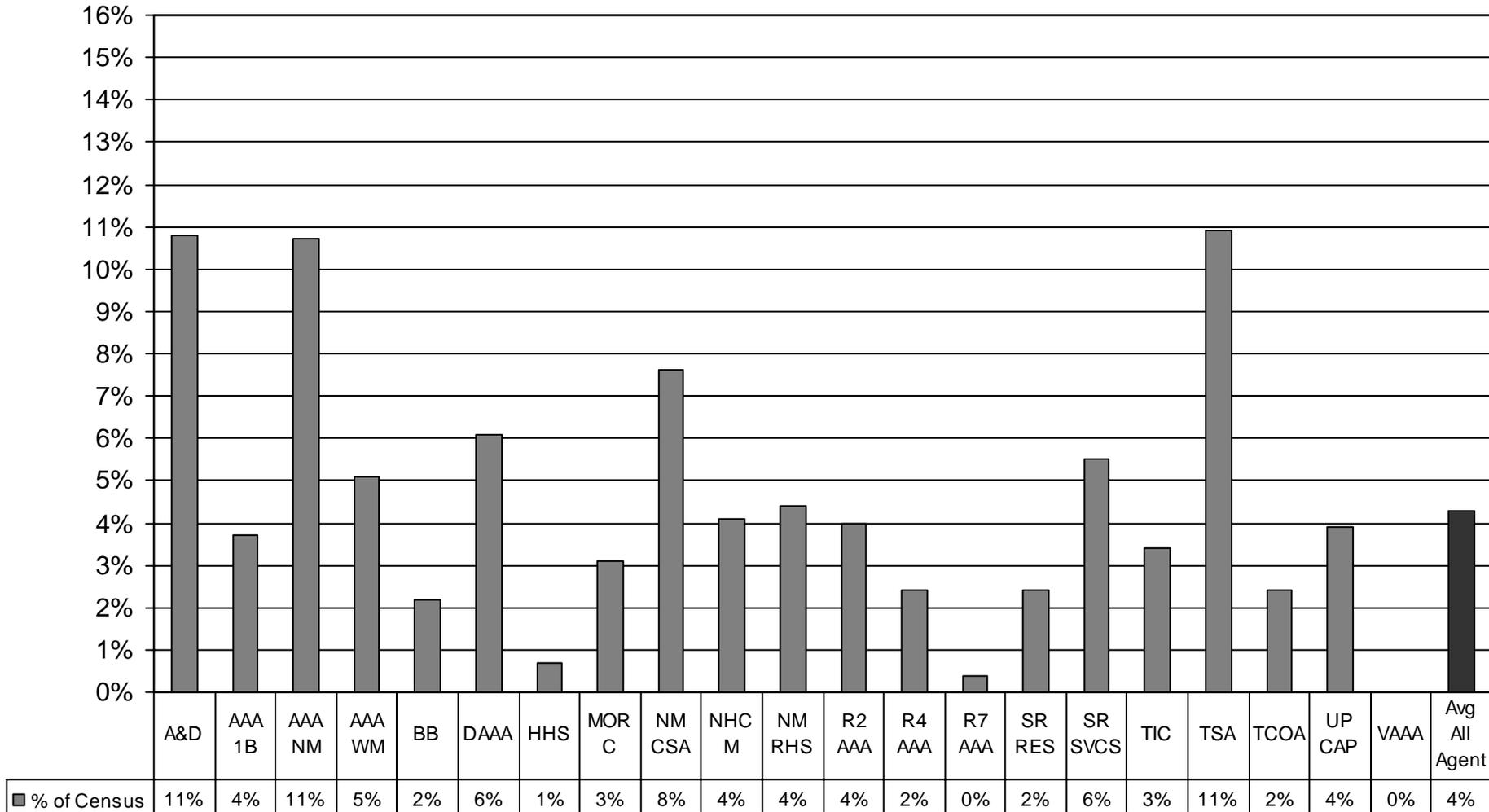


FY 2009 (October - July 27) NF Transitions (not including diversions) by Waiver Agent

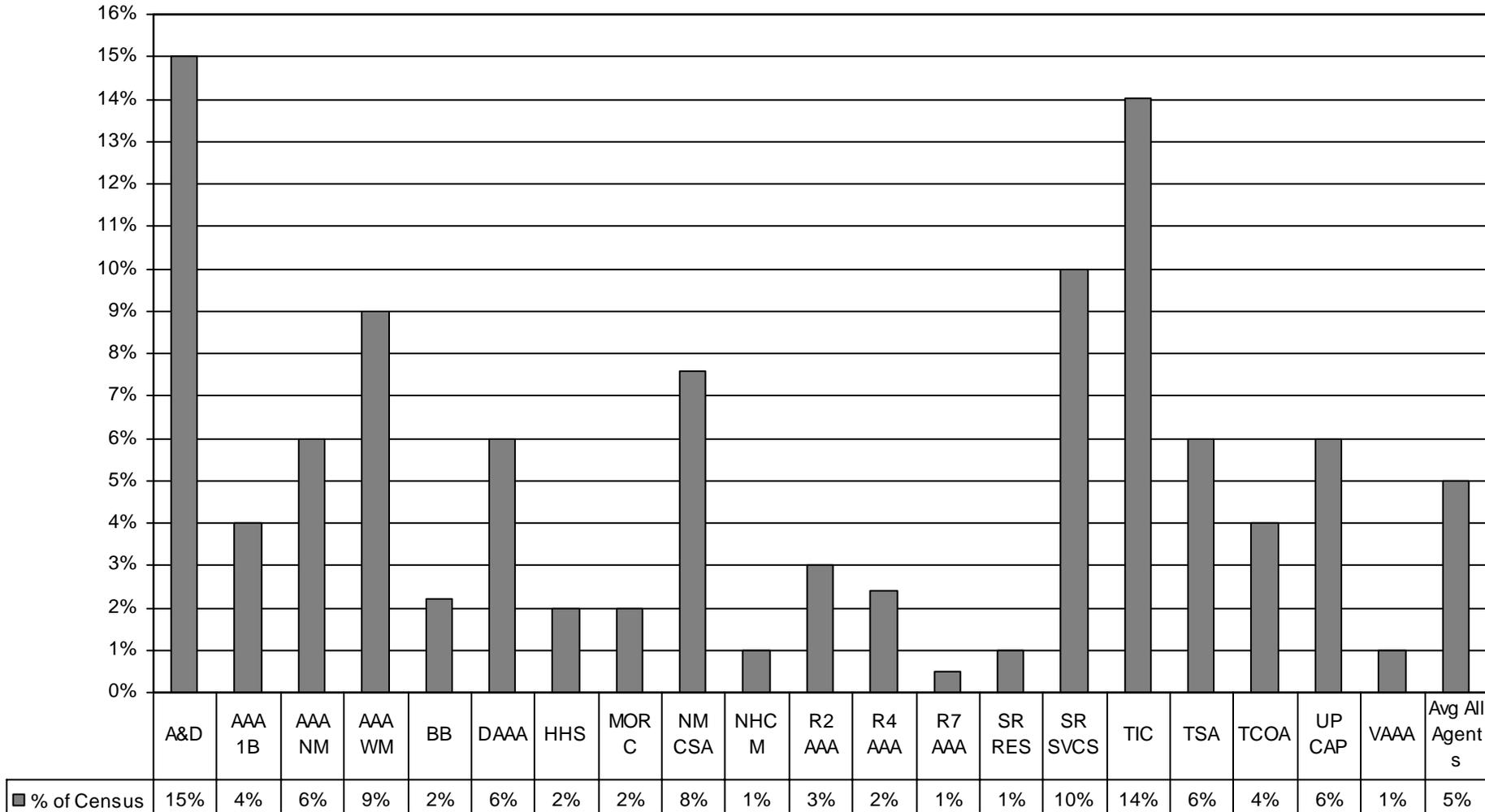
Total 441



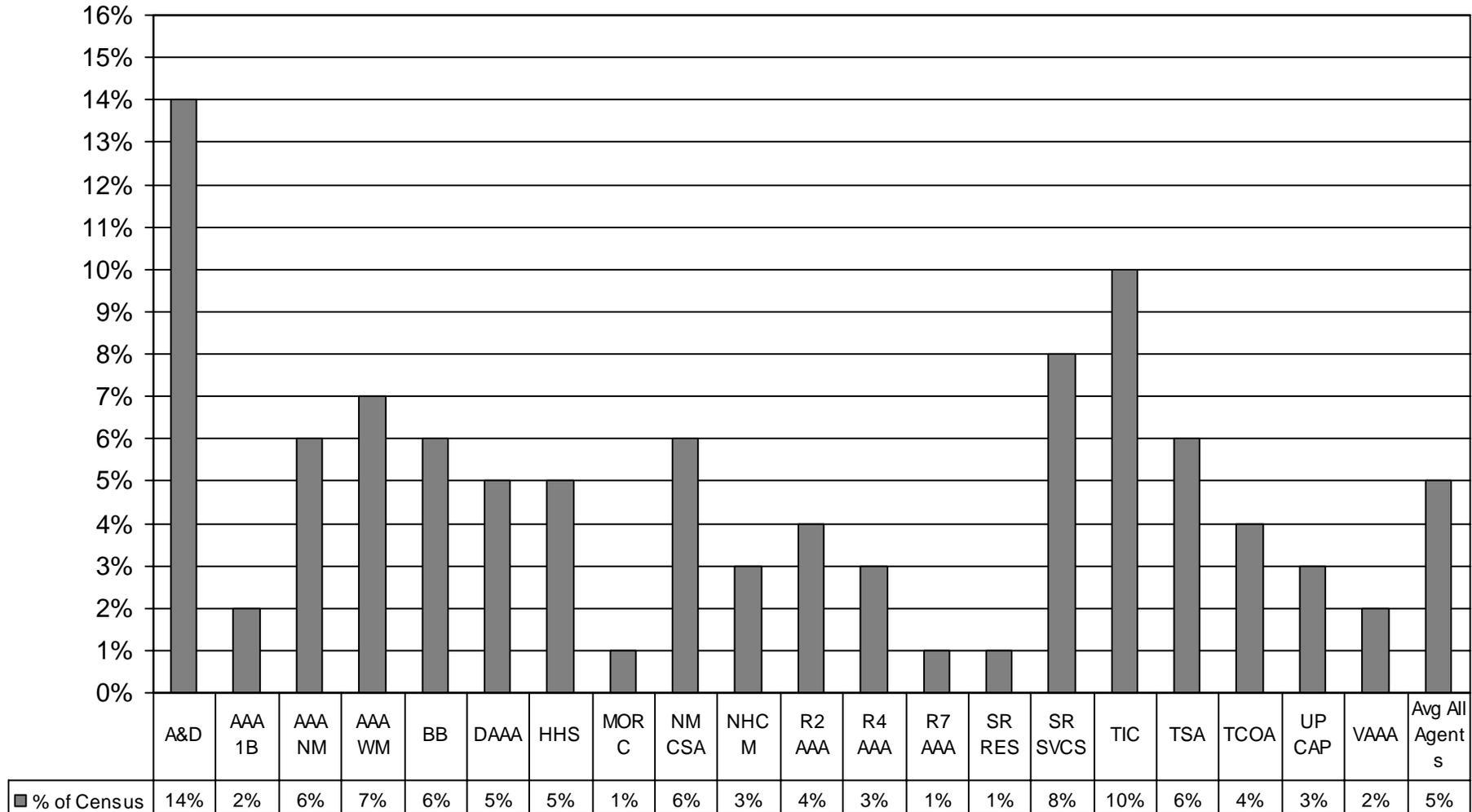
FY 2007 NF Transitions as a Percent of Census by Waiver Agent



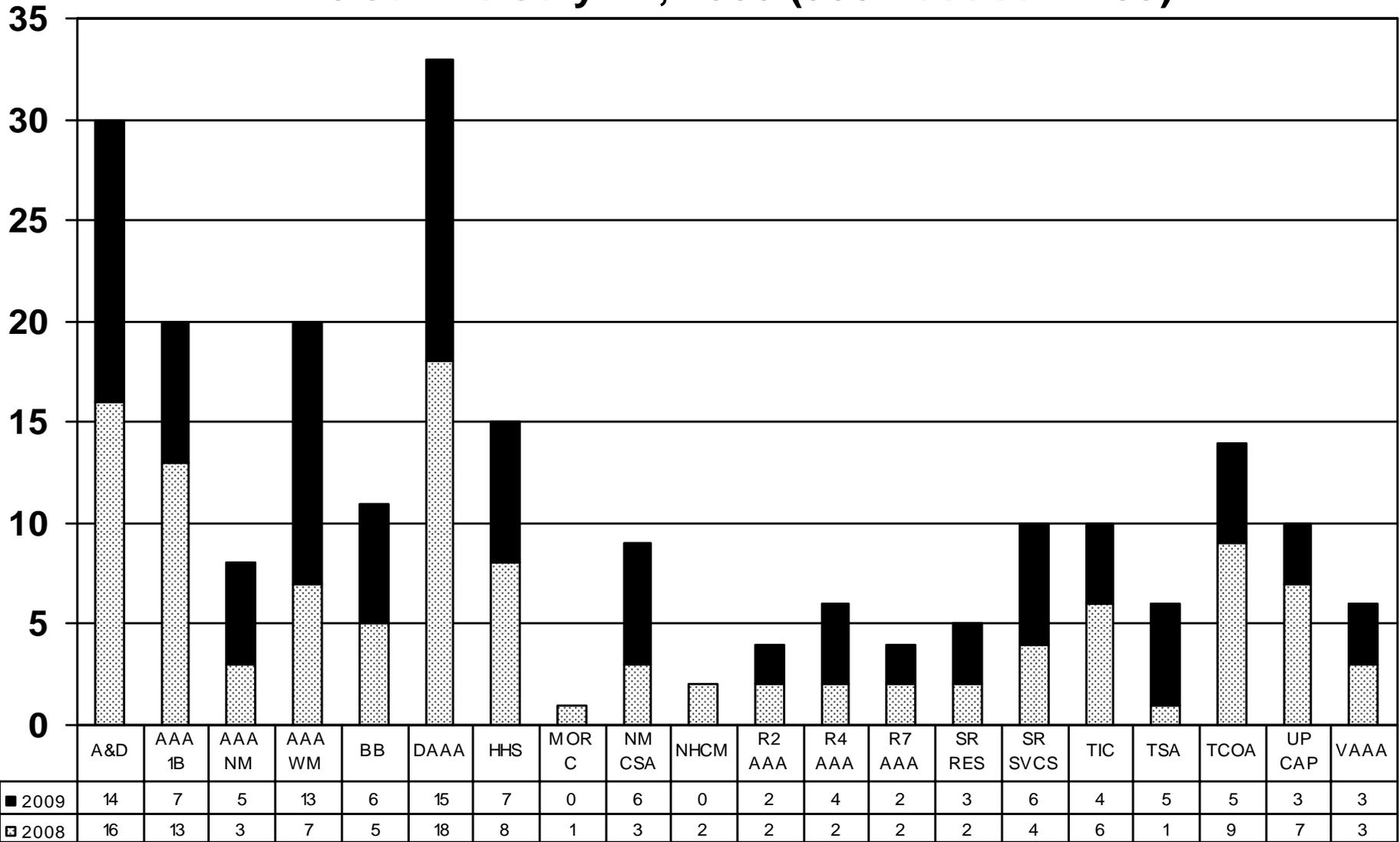
FY 2008 NF Transitions as a Percent of Census by Waiver Agent



FY 2009 to 7/27/09 Transitions as % of Census by Waiver Agent



MFP Transitions by Waiver Agent - 114 in CY 2008, 110 Jan. to July 27, 2009 (300 needed in '09)



Over and Under 6 Months for Past 12 Months

7/1/08 – 6/30/09

- 259 Transitions of individuals who were in a nursing facility for more than 6 months before transitioning
- 276 Transitions of individuals who were in a nursing facility for less than 6 months before transitioning
- 82 Diversions

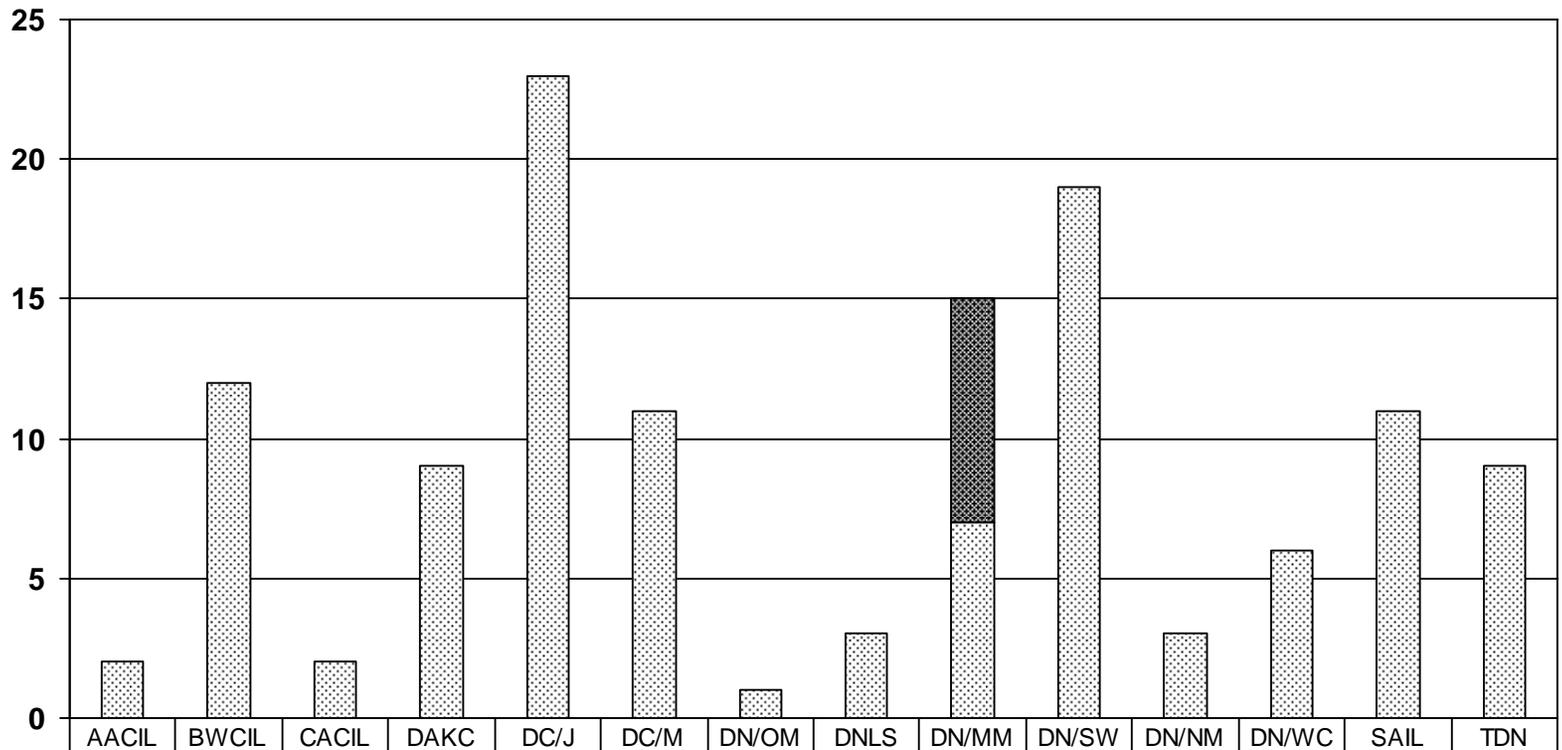
CIL Codes

- AACIL – Ann Arbor CIL
- BWCIL – Blue Water CIL
- CA – Capital Area CIL, Lansing
- CC – Community Connections
- DAKC – Disability Advocates of Kent County
- DCJ – disABILITY Connections, Jackson
- DC – Disability Connections, Muskegon
- DNOM – Disability Network Oakland & Macomb
- DNLS – Disability Network Lakeshore
- DNMM – Disability Network Mid-Michigan
- DNSW – Disability Network Southwest Michigan
- DNN – Disability Network Northern Michigan
- DNWC – Disability Network Wayne County
- SAIL – Superior Alliance for Independent Living
- TDN – The Disability Network, Flint

FY '09 (October 1 – July27)

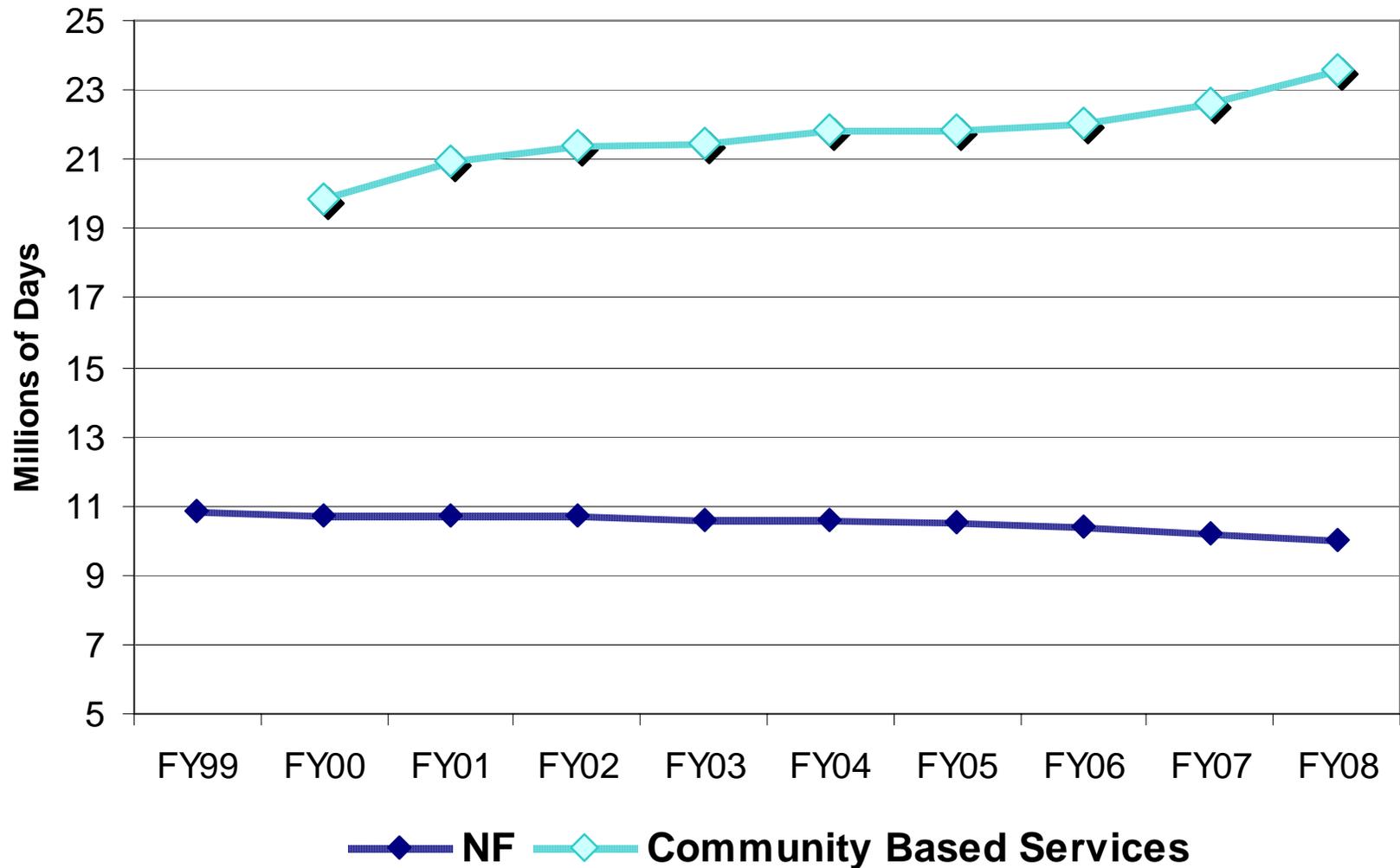
Transitions by CIL

Total Transitioned 118 (not including those completed under contract with a waiver agent)

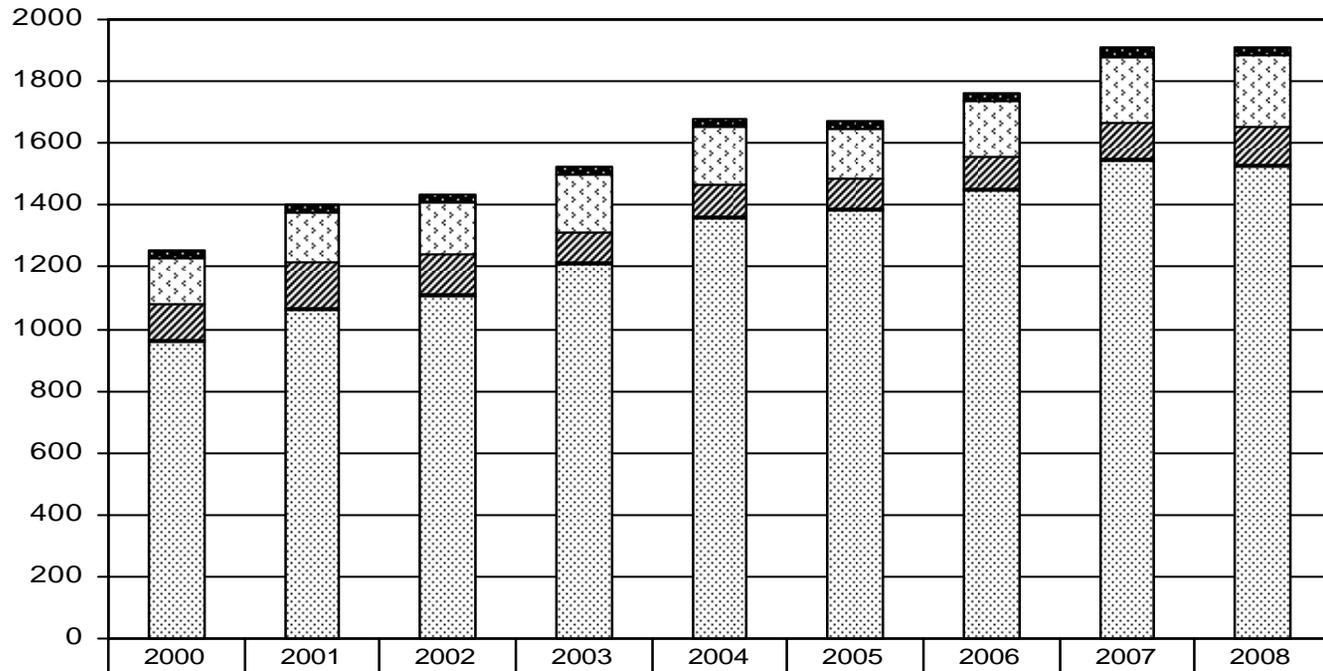


■ Under contract w/ WA								8						
▨ Transitioned	2	12	2	9	23	11	1	3	7	19	3	6	11	9

Michigan Medicaid Long Term Care Days

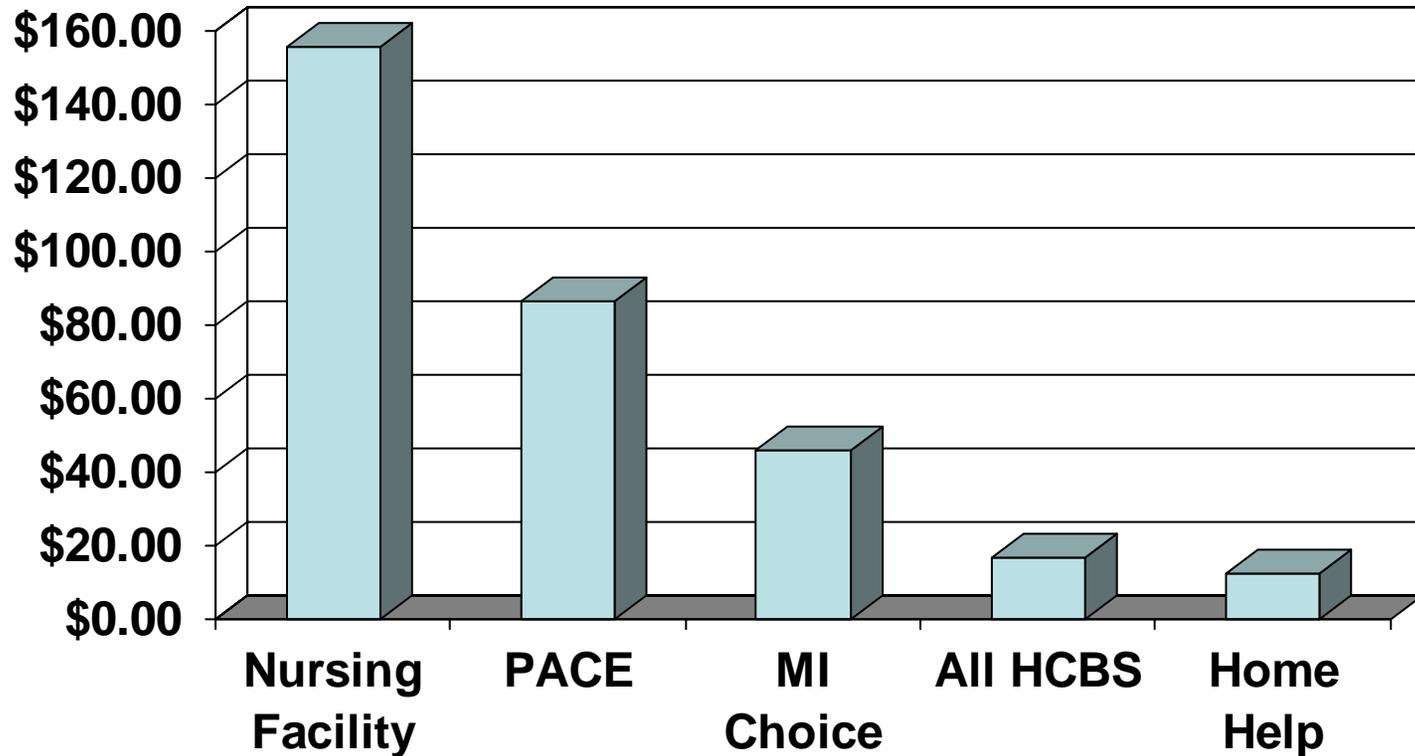


Long Term Care Spending in Michigan FY 2000 - 2008



	2000	2001	2002	2003	2004	2005	2006	2007	2008
■ Personal Care Supplement	26.4	27	26.8	26.4	25.8	23.1	22.9	30.5	31.4
□ Adult Home Help	148.8	158.3	172.2	185.2	187.8	160.5	181.9	214.8	226.7
▨ MI Choice	115.8	151	128	98.6	98.8	98.2	102.8	114	120.7
■ PACE	3.9	4.5	6.5	5.6	6	3.5	6.1	7.5	9.5
▤ Nursing Facility Care	960.5	1062.9	1103.7	1208.6	1360.1	1385.2	1447.7	1542.5	1524.2

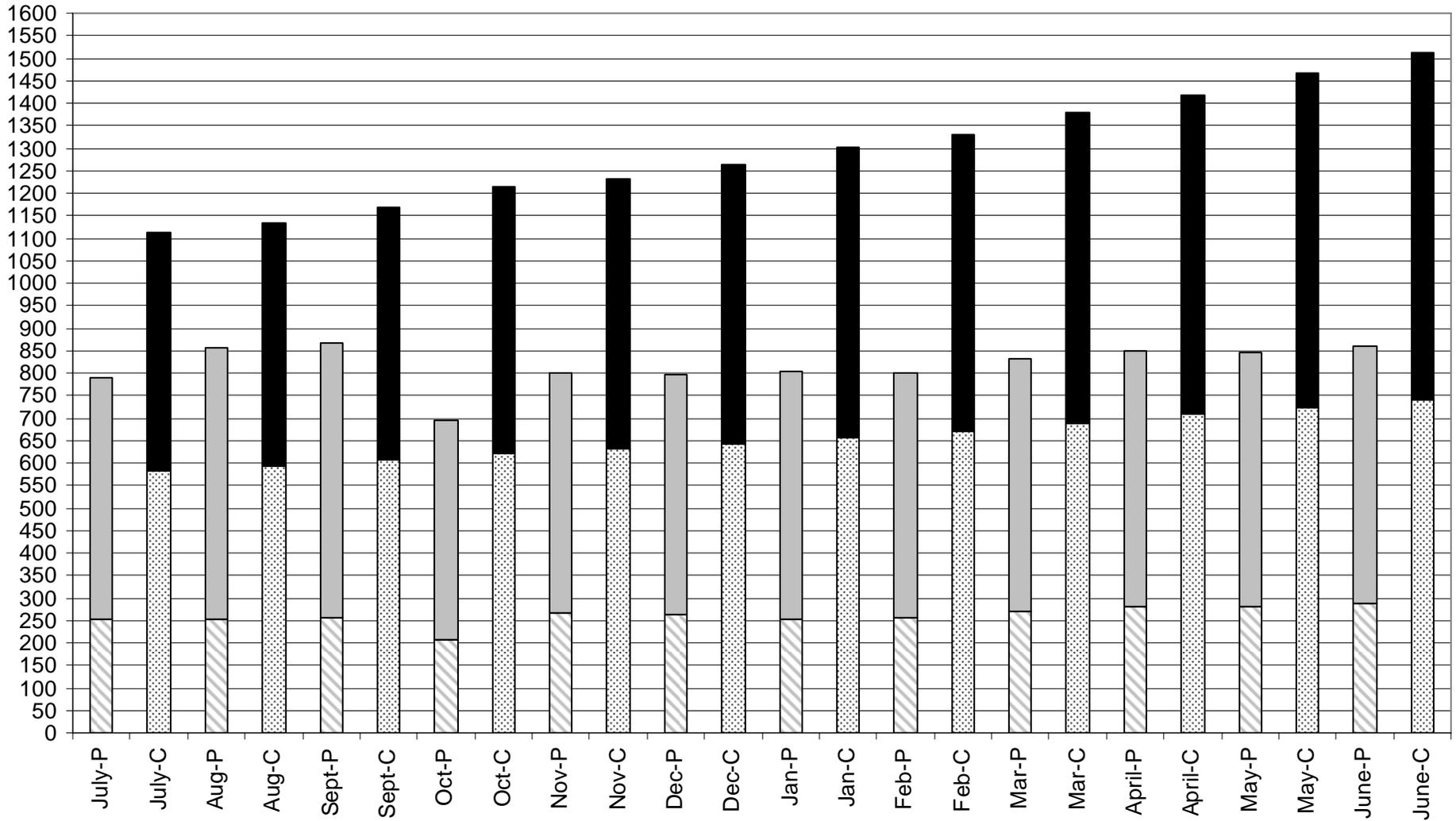
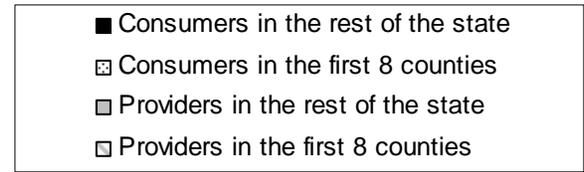
Michigan Medicaid Cost Per Day for Long Term Care in FY 2008



Impact of Transitions on Michigan's Budget

Governor Granholm and the Michigan legislature are looking for \$15.3 million in savings from nursing facility transitions in FY 2010.

**Michigan Quality Community Care Council
Growth Over a Year
July 08- June 09**



June 09

Michigan Quality Community Care Council Consumers, Referrals, and Providers, by County

County #	County Name	HH* Consumers	# Served as of 07/31/09	% of HH Served	DHS Referrals	% of HH DHS Referred	# Served as of 06/30/09	Increase in # Served	Percent Increase	Providers Available
1	Alcona	42	1	2.38%	1	2.38%	1	0	0.00%	1
2	Alger	24	0	0.00%	0	0.00%	0	0	0.00%	1
3	Allegan	250	7	2.80%	6	2.40%	7	0	0.00%	8
4	Alpena	127	1	0.79%	1	0.79%	1	0	0.00%	0
5	Antrim	99	1	1.01%	1	1.01%	1	0	0.00%	1
6	Arenac	170	28	16.47%	28	16.47%	27	1	3.70%	17
7	Baraga	50	0	0.00%	0	0.00%	0	0	0.00%	0
8	Barry	169	1	0.59%	1	0.59%	1	0	0.00%	5
9	Bay	727	128	17.61%	122	16.78%	127	1	0.79%	86
10	Benzie	78	0	0.00%	0	0.00%	0	0	0.00%	2
11	Berrien	798	3	0.38%	1	0.13%	3	0	0.00%	2
12	Branch	114	0	0.00%	0	0.00%	0	0	0.00%	5
13	Calhoun	662	0	0.00%	0	0.00%	0	0	0.00%	2
14	Cass	173	1	0.58%	1	0.58%	1	0	0.00%	2
15	Charlevoix	81	1	1.23%	1	1.23%	1	0	0.00%	0
16	Cheboygan	174	1	0.57%	1	0.57%	1	0	0.00%	1
17	Chippewa	173	0	0.00%	0	0.00%	0	0	0.00%	0
18	Clare	180	8	4.44%	7	3.89%	8	0	0.00%	19
19	Clinton	124	1	0.81%	3	2.42%	3	-2	-66.67%	13
20	Crawford	64	4	6.25%	2	3.13%	4	0	0.00%	2
21	Delta	218	0	0.00%	0	0.00%	0	0	0.00%	0
22	Dickinson	134	0	0.00%	0	0.00%	0	0	0.00%	0

Highlighting counties where 3% or more of the Home Help population has been served by the Registry and/or referred by DHS.

June 09

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23	Eaton	282	19	6.74%	17	6.03%	19	0	0.00%	25
24	Emmet	130	0	0.00%	0	0.00%	0	0	0.00%	0
25	Genesee	2796	136	4.86%	131	4.69%	130	6	4.62%	95
26	Gladwin	153	1	0.65%	0	0.00%	1	0	0.00%	9
27	Gogebic	52	0	0.00%	0	0.00%	0	0	0.00%	0
28	Grand Traverse	212	4	1.89%	3	1.42%	4	0	0.00%	7
29	Gratiot	136	3	2.21%	1	0.74%	3	0	0.00%	1
30	Hillsdale	190	6	3.16%	6	3.16%	6	0	0.00%	5
31	Houghton	135	0	0.00%	0	0.00%	0	0	0.00%	0
32	Huron	129	7	5.43%	7	5.43%	7	0	0.00%	8
33	Ingham	1277	194	15.19%	143	11.20%	190	4	2.11%	49
34	Ionia	216	18	8.33%	16	7.41%	18	0	0.00%	7
35	Iosco	133	0	0.00%	0	0.00%	0	0	0.00%	6
36	Iron	96	0	0.00%	0	0.00%	0	0	0.00%	0
37	Isabella	276	6	2.17%	4	1.45%	5	1	20.00%	7
38	Jackson	699	4	0.57%	3	0.43%	4	0	0.00%	6
39	Kalamazoo	1150	2	0.17%	0	0.00%	2	0	0.00%	5
40	Kalkaska	76	0	0.00%	0	0.00%	0	0	0.00%	1
41	Kent	1982	95	4.79%	73	3.68%	92	3	3.26%	66
42	Keweenaw	13	0	0.00%	0	0.00%	0	0	0.00%	0
43	Lake	106	9	8.49%	8	7.55%	8	1	12.50%	1
44	Lapeer	159	11	6.92%	11	6.92%	7	4	57.14%	29

Highlighting counties where 3% or more of the Home Help population has been served by the Registry and/or referred by DHS.

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45	Leelanau	15	0	0.00%	0	0.00%	0	0	0.00%	2
46	Lenawee	249	1	0.40%	0	0.00%	1	0	0.00%	6
47	Livingston	229	6	2.62%	6	2.62%	5	1	20.00%	3
48	Luce	34	2	5.88%	2	5.88%	2	0	0.00%	0
49	Mackinac	33	1	3.03%	1	3.03%	1	0	0.00%	0
50	Macomb	3634	166	4.57%	161	4.43%	164	2	1.22%	162
51	Manistee	189	0	0.00%	0	0.00%	0	0	0.00%	3
52	Marquette	212	0	0.00%	0	0.00%	0	0	0.00%	3
53	Mason	109	0	0.00%	0	0.00%	0	0	0.00%	2
54	Mecosta	253	2	0.79%	1	0.40%	1	1	100.00%	4
55	Menominee	151	1	0.66%	0	0.00%	1	0	0.00%	0
56	Midland	348	2	0.57%	2	0.57%	1	1	100.00%	18
57	Missaukee	45	1	2.22%	1	2.22%	1	0	0.00%	3
58	Monroe	377	0	0.00%	0	0.00%	0	0	0.00%	1
59	Montcalm	268	6	2.24%	4	1.49%	6	0	0.00%	7
60	Montmorency	61	2	3.28%	2	3.28%	2	0	0.00%	2
61	Muskegon	943	3	0.32%	3	0.32%	3	0	0.00%	6
62	Newaygo	296	10	3.38%	10	3.38%	10	0	0.00%	6
63	Oakland	3853	206	5.35%	199	5.16%	199	7	3.52%	177
64	Oceana	155	5	3.23%	2	1.29%	5	0	0.00%	2
65	Ogemaw	278	0	0.00%	0	0.00%	0	0	0.00%	9
66	Ontonagon	43	1	2.33%	1	2.33%	1	0	0.00%	0

Highlighting counties where 3% or more of the Home Help population has been served by the Registry and/or referred by DHS.

June 09

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67	Osceola	152	0	0.00%	0	0.00%	0	0	0.00%	5
68	Oscoda	52	2	3.85%	2	3.85%	2	0	0.00%	2
69	Otsego	173	21	12.14%	17	9.83%	21	0	0.00%	7
70	Ottawa	272	12	4.41%	10	3.68%	12	0	0.00%	12
71	Presque Isle	48	0	0.00%	0	0.00%	0	0	0.00%	0
72	Roscommon	182	1	0.55%	1	0.55%	1	0	0.00%	4
73	Saginaw	1389	113	8.14%	107	7.70%	110	3	2.73%	101
74	St. Clair	587	8	1.36%	7	1.19%	7	1	14.29%	13
75	St. Joseph	189	5	2.65%	5	2.65%	5	0	0.00%	3
76	Sanilac	216	2	0.93%	2	0.93%	2	0	0.00%	12
77	Schoolcraft	68	0	0.00%	0	0.00%	0	0	0.00%	7
78	Shiawassee	257	22	8.56%	22	8.56%	22	0	0.00%	5
79	Tuscola	192	1	0.52%	1	0.52%	1	0	0.00%	17
80	VanBuren	365	41	11.23%	38	10.41%	41	0	0.00%	9
81	Washtenaw	1010	32	3.17%	28	2.77%	31	1	3.23%	27
82	Wayne	18729	172	0.92%	126	0.67%	168	4	2.38%	296
83	Wexford	177	3	1.69%	3	1.69%	3	0	0.00%	6
Total		50862	1551	3.05%	1363	2.68%	1511	40	2.65%	

Percentage of Consumers served, referred by DHS. 87.88%

**Numbers based on data from July, 2008.*

Highlighting counties where 3% or more of the Home Help population has been served by the Registry and/or referred by DHS.

MASTER MONTHLY FTW ENROLLMENT, BY COUNTY
AUGUST 2009

County Code	County Name	Ben IDs		County Code	County Name	Ben IDs
1	Alcona	3				
2	Alger	2		50	Macomb	56
3	Allegan	25		51	Manistee	12
4	Alpena	12		52	Marquette	37
5	Antrim	4		53	Mason	9
6	Arenac	8		54	Mecosta	15
7	Baraga	3		55	Menominee	15
8	Barry	9		56	Midland	41
9	Bay	56		57	Missaukee	3
10	Benzie	7		58	Monroe	29
11	Berrien	44		59	Montcalm	10
12	Branch	14		60	Montmorency	6
13	Calhoun	60		61	Muskegon	76
14	Cass	10		62	Newaygo	8
15	Charlevoix	10		63	Oakland	279
16	Cheboygan	7		64	Oceana	6
17	Chippewa	26		65	Ogemaw	15
18	Clare	10		66	Ontonagon	4
19	Clinton	13		67	Osceola	9
20	Crawford	4		68	Oscoda	4
21	Delta	25		69	Otsego	12
22	Dickinson	26		70	Ottawa	53
23	Eaton	38		71	Presque Isle	6
24	Emmet	8		72	Roscommon	7
25	Genesee	108		73	Saginaw	47
26	Gladwin	3		74	St. Clair	53
27	Gogebic	9		75	St. Joseph	21
28	Grand Traverse	51		76	Sanilac	16
29	Gratiot	12		77	Schoolcraft	0
30	Hillsdale	15		78	Shiawassee	27
31	Houghton	22		79	Tuscola	10
32	Huron	8		80	VanBuren	11
33	Ingham	126		81	Washtenaw	92
34	Ionia	12		82	Wayne	90
35	Iosco	8		83	Wexford	3
36	Iron	9		49	Mackinac	2
37	Isabella	29		50	Macomb	56
38	Jackson	33		51	Manistee	12
39	Kalamazoo	113		52	Marquette	37
40	Kalkaska	4		53	Mason	9
41	Kent	189		54	Mecosta	15
42	Keweenaw	0		55	Menominee	15
43	Lake	3		56	Midland	41
44	Lapeer	20		57	Missaukee	3
45	Leelanau	2		58	Monroe	29
46	Lenawee	24		59	Montcalm	10
47	Livingston	39		60	Montmorency	6
48	Luce	2		61	Muskegon	76
49	Mackinac	2		62	Newaygo	8

TOTAL

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