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CONSUMER TASK FORCE
APRIL 24, 2007

PROJECT UPDATES FOR APRIL

PERSON-CENTERED PLANNING GUIDELINES -
DRAFT

LTC CONNECTIONS LOGIC MODEL - DRAFT

CONSUMER TASK FORCE

UPDATE OF PROJECTS

APRIL 2007

Independence Plus and Money Follows the Person Grants April, 2007

MI Choice version of the PCP in LTC Policy and Practice Guideline

The scope of the document is for PCP in MI Choice Self-Determination Programs at this time. The draft form of this document was sent out for review and comments on April 13. The review period is 45 days. Written comments on the draft PCP in LTC document can be faxed or mailed back. Copies for CTF members were distributed at the March meeting. The next step will be to compile the comments and to write a summary document responding to the reviews.

Self-Determination Training and Conference Planning

- The 2007 June Self-Determination Conference will be on June 11 & 12 at the Lansing Holiday Inn South. If you have a suggestion for a presentation for this event, please contact Rob Curtner at 517 335-8710. At this time some of the keynote speakers have been contracted and a committee is working to identify the breakout speakers. Again this year, consumers are invited to sell goods and services from micro-enterprises. A “film festival” of disability related videos will occupy one of the breakout rooms.
- Additional training for Working with Fiscal Intermediaries, Consumers as Employers, and other topics is being planned at this time.
- The curriculum materials for the Paraprofessional Healthcare Institute course on “**Employing, Supporting and Retaining Your Personal Assistant**” can be found at this web address.
<http://198.109.129.5:3455/sdl/74>

The next scheduled meeting of the Self-Determination Leadership Implementation Seminar will be on May 8th at the Holiday Inn South.

1915bc Waiver Development

- An internal draft of a concept paper describing the scope, purpose and methods for a cost neutral Medicaid benefit in one or two counties in support of community living options for elders and persons with disabilities is being developed.
- Agreement on the content of this paper between OLTCSS and the MSA is nearly complete.
- The next steps towards a waiver request on this are to discuss the Concept Paper with CMS and to complete a feasibility study.
- The waiver request is scheduled to be completed by October 1, 2007.

The 2007 CMS Conference was held from March 5-7. The materials from presentations for this event are at:

http://www.nashp.org/_catdisp_page.cfm?LID=EF15BBC8-AF14-4F12-9534B1F025AD7AB1&CFID=775705&CFTOKEN=93802691

Systems Transformation Grant

April 2007

The three workgroups (54 participants) completed their work on the core elements (strategies, activities, outputs, outcomes and the role of consumers and family members in implementation) of the plan. The 3/28 Forum had 95 people in attendance and produced valuable input for the planning. The draft plan will be presented to CMS on April 25. CMS will provide comments in May and final plans will be due June 15. The Project Director position is being processed; it is not clear when it will be posted.

Deficit Reduction Act/Money Follows the Person Grant April 2007

The Department of Community Health has to submit an Operational Protocol by May 31. An internal group has met to identify those elements that already exist in current policy and documents. A stakeholder workgroup will be convened to further develop the plan by reviewing existing information and developing the additional information needed for the protocol.

LTC Connections/Single Point of Entry

April 2007

Information and Assistance

Staffs at all sites are now using Service Point and can enter client data while speaking with callers. Staff has been trained using the working draft standards which support a thorough and caller focused dialogue. The number of calls referred from Information and Assistance staff to an Options Counselors varies by site. We are unsure why this is and the transfer protocols that were developed by the South West Michigan Long Term Care Connection have been shared with other sites, these will be modified and adopted by all the sites. One of the advantages of service point is that it will help us collect this type of data so we can focus on continually improving service.

Evaluation

The contract with Michigan Public Health Institute is being modified to include the SPE evaluation. A logic model with expected outcomes has been shared with multiple stakeholders and groups. The Evaluation Steering Committee is beginning discussion of measurement methodologies. Copies of the Logic Model were shared during last months meeting. I welcome thoughts from Task Force members as we didn't have time to discuss last month.

Training

All Options Counselors and Information and Assistance (I & A) staff attended a day and a half training on March 29th and 30th. We had three topics, the majority of the time was focused on understanding and using person centered planning process to develop long term care support plans. Sally Burton Hoyle, led the training and Carolyn Lejuste and Terri Cady facilitated group learning exercises. (2) In addition, staff was trained on recognizing and using Stages of Change methodology. This skill will improve communication between LTCC staff and persons when

discussing health care and self care choices. (3) Sarah Slocum presented on the Long Term Care Ombudsman Program.

In addition, a webinar was held on April 12th, Dr. Montgomery presented information on Caregiver Identity Theory and development of a uniform caregiver assessment and referral process. The staff at all four Long Term Care Connection sites participates, as well as staff from the Office Of Services to the Aging,

Medicaid, and Care Mangers from Area Agencies on Aging and from Mi Choice Waiver providers.

Contracts

Efforts are underway to move contracts from existing Area Agency on Aging organizations to the new independent entities. It is hoped that new contracts will be in place June 1, 2007. This is somewhat dependent on state budget and contracting processes that are affected by the current state budget crisis.

Long-Term Care Supports and Services Advisory Commission April 2007

The Advisory Commission and Office of LTC Supports and Services mourn the loss of Commissioner James Francis-Bohr who passed away on April 10, 2007. His wit and wisdom will be missed.

The March 26 gathering of the LTCSS Advisory Commission was the first official meeting under the direction of Andrew Farmer, the newly appointed chair. Mr. Farmer and the Executive Committee presented a robust multi-month agenda to the full Commission that represented an action plan to implement activities agreed to at the February retreat. Agenda items will now be structured into four main topic areas: What's Happened Since the Last Meeting, What's Happening Now, What Are We Going to Do About It, and Getting it Done. This structure will allow a monthly environmental scan and a more immediate response to critical issues.

Several draft operating guidelines were presented and discussed. These included: 1) Commission Response to Public Comment; 2) Meeting Protocols and Management; 3) Planning and Setting Priorities; and 4) SPE Monitoring and Evaluation. They will be formally adopted and others developed in the coming months to guide the conduct of Commission business.

Jan Hudson from the Michigan League for Human Services gave a presentation for the purpose of increasing Commissioners' understanding of the fiscal crisis facing Michigan and to put the numbers into perspective. Commissioners were encouraged to use the information to educate the public on the crisis situation by explaining what it means to them in terms of service cuts. The official Commission position is that the ongoing structural deficit threatens both individuals and the State of Michigan, and is supportive of revenue enhancement to address the structural deficit.

Commission members granted authority to the Executive Committee to send a letter to the Legislature urging them to find a permanent solution to the structural deficit and to spare long term care from further cuts. This is the second communication sent from the Commission to legislators in recent months.

The next meeting of the LTC Supports and Services Advisory Commission is Monday, April 23 from 1:00 - 4:30 p.m. in Conference Rooms A-C, 1st Floor, Capitol View Building. The focus of the agenda, and main business item, will be the Commission's first serious review of the status of the four SPE demonstrations.

Medicaid Infrastructure Grant (MIG) Update:\n
April 2007

There are presently 964 Freedom to Work (FTW) participants. This is up from 949 last month.

MSA is working with CMS to get the personal care services state plan amendment approved. CMS has a major question about language noting a “flat rate paid to foster home providers.” CMS sees this as bundling as well as expects the payment to go directly to the person providing the personal care service. Mike Head and the MIG are working with MSA to resolve this question area.

Joe Longcor presented Logan Dreasky with a memo requesting that MSA facilitate transitioning current single working AD Care participants to FTW as soon as possible with a goal date of June 9th. There are several thousand people that meet FTW criteria and this increase in FTW/Medicaid buy-in participation provides an opportunity to seek a larger MIG grant to further address barriers to employment.

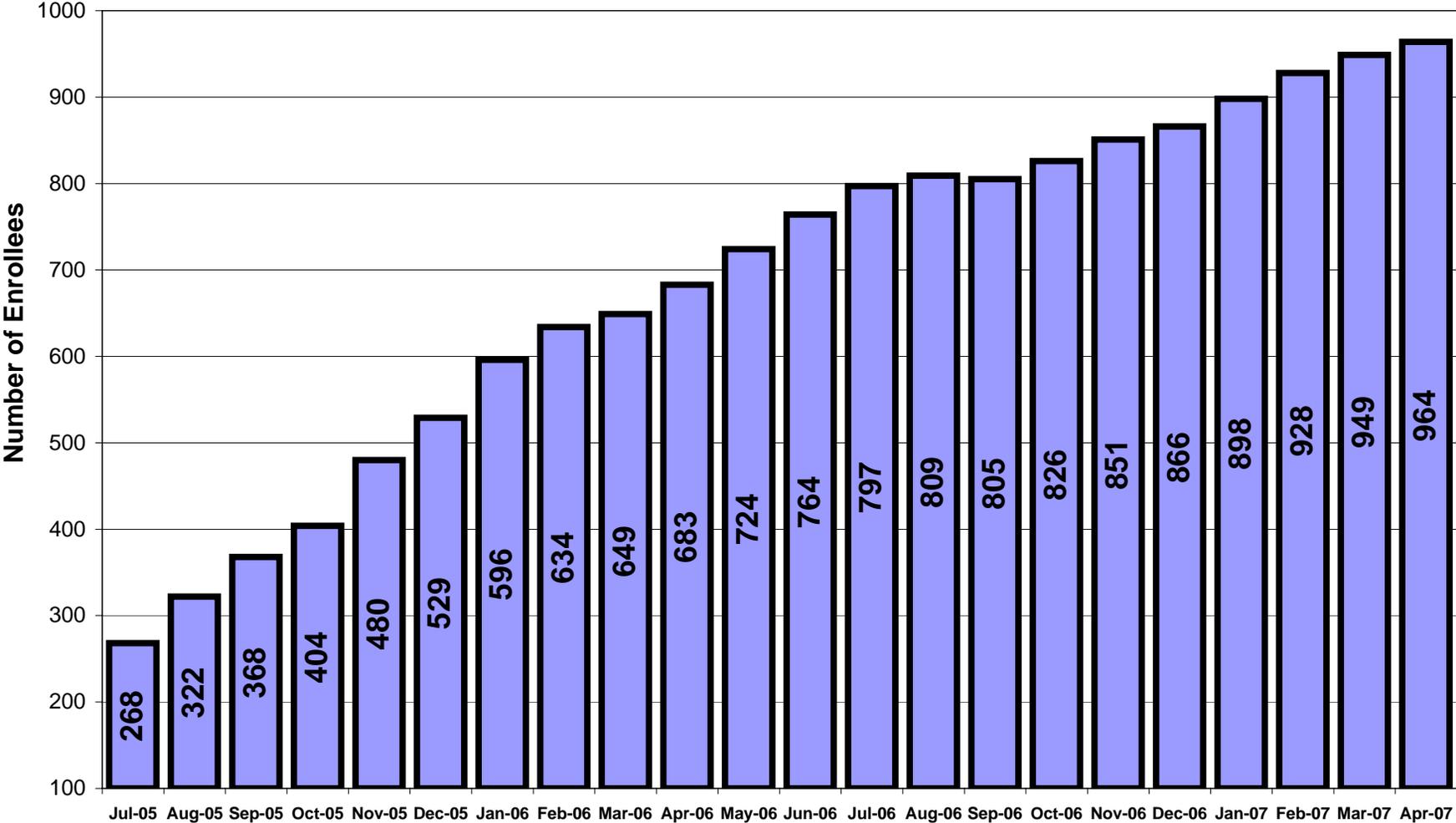
Theresa has outlined other key issues being addressed by MIG and MSA are outlined on the attached issues grid.

Marty is conducting outreach to clubhouses and drop-in centers around the state to encourage work. He has found a repeating theme of interested people hungry for current information about work and how it relates to a person’s disability.

The MIG is bringing Bryon MacDonald with the World Institute on Disabilities in California to Michigan in early May to present on Disability Benefits 101.org (www.db101.org). This is a California specific online tool to encourage and inform people about work. A core group of individuals will meet with Bryon to strategize whether a similar tool has application here in Michigan.

The MIG staff is preparing to submit a comprehensive grant for 2008-2010 based on recent resource mapping conducted and outreach efforts to community partners. Staff will be meeting with CTF members that wish to staff following the April meeting to share the major emphasis areas being considered and to gain feedback. Lunch will be provided.

Michigan FTW Enrollees March 2007



Freedom to Work Enrollment
By County
April 2007

County Code	County Name	Beneficiary ID		County Code	County Name	Beneficiary ID
1	Alcona	2		40	Kalkaska	3
2	Alger	1		41	Kent	84
3	Allegan	11		43	Lake	1
4	Alpena	1		44	Lapeer	7
5	Antrim	5		46	Lenawee	11
6	Arenac	4		47	Livingston	8
7	Baraga	1		49	Mackinac	2
8	Barry	4		50	Macomb	57
9	Bay	36		51	Manistee	5
10	Benzie	3		52	Marquette	8
11	Berrien	30		53	Mason	6
12	Branch	8		54	Mecosta	8
13	Calhoun	18		55	Menominee	4
14	Cass	3		56	Midland	14
15	Charlevoix	7		57	Missaukee	1
16	Cheboygan	1		58	Monroe	15
17	Chippewa	8		60	Montmorency	2
18	Clare	1		61	Muskegon	39
19	Clinton	3		62	Newaygo	9
20	Crawford	1		63	Oakland	84
21	Delta	10		65	Ogemaw	1
22	Dickinson	4		66	Ontonagon	1
23	Eaton	12		67	Osceola	4
24	Emmet	8		68	Oscoda	1
25	Genesee	26		69	Otsego	7
26	Gladwin	1		70	Ottawa	20
27	Gogebic	4		71	Presque Isle	1
28	Grand Traverse	20		72	Roscommon	5
29	Gratiot	5		73	Saginaw	7
30	Hillsdale	6		74	St. Clair	14

County Code	County Name	Beneficiary ID		County Code	County Name	Beneficiary ID
31	Houghton	5		75	St. Joseph	13
32	Huron	5		76	Sanilac	5
33	Ingham	38		78	Shiawassee	7
34	Ionia	4		79	Tuscola	3
35	Iosco	2		80	VanBuren	7
36	Iron	3		81	Washtenaw	41
37	Isabella	7		82	Wayne	81
38	Jackson	10		83	Wexford	2
39	Kalamazoo	58				
					TOTAL	964

MIG Status Report: Barriers to Employment – April 11, 2007

964 FTW Members arinit@michigan.gov

<i>Issue</i>	<i>Explanation</i>	<i>Potential Solution</i>	<i>Action/Timeframe</i>
<p>PAS/PCS Issue</p> <p>As of today Persons needing PAS/PCS to manage personal needs while at work cannot accomplish this.</p>	<p>Persons needing PAS/PCS to accomplish personal needs are limited at how long during the day they can be away from home. <u>Because they cannot take care of personal needs at work, they end up working less or choosing not to work at all.</u></p> <p>The FTW law itself prohibits the use of PAS/PCS in the work place, ie “FTW 106a (3) - ...and does not include personal assistance services in the workplace.”</p>	<p>-Work with MSA to draft language to amend the State Plan. This will be part of our Medicaid State Plan.</p> <p>-The State Plan Language will override the FTW Language.</p> <p>-Mike, Joe and Theresa will work with MSA</p> <p>-If no word on SPA by Friday, June 16, Ed Kemp will initiate contact with CMS to ensure the SPA process is moving.</p>	<p>-Submission expected by early April</p> <p><u>-May 11</u> Rough draft submitted to CMS on per Ed + Logan</p> <p><u>-May 23</u> Rough draft sent to Adrienne, MIG Grant Officer, for consideration</p> <p><u>-May23</u> Mike Head encouraged further MSA action</p> <p><u>-June 13</u> Ed Kemp has not heard back from CMS on the cursory review of the SPA. After the whole submission process is complete, which is expected early this fall, the Effective Date for the PAS piece is projected to be July 1, 2006.</p> <p><u>-June 23</u> Received email from Nancy Bishop that they have heard from CMS and the PCS State Plan</p>

			<p>Language is a go ahead with a few clarifications on areas not having to do with the workplace or the community.</p> <p><u>-July 11</u> Per Ed Kemp-MSA, an attestation letter stating that a state plan amendment allowing personal care services to be used at work will be submitted in July 2006, has been written. Sue Moran will sign and forward to the MIG for the 2007 Grant submission.</p> <p><u>-Aug 15</u> SP Amendment package is expected sent to CMS by the end of August. Notification will be sent to Joe when this occurs. Ed Kemp outlined next steps. 1) There will need to be a bulletin written for distribution. 2) Two issues still need to be resolved: a) # of evaluations necessary, and b) how the Mental Health</p>
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			<p>side might utilize this availability of PAS.</p> <p><u>-Sep 12</u> An amendment to increase the reimbursement rate levels for personal caregivers is being submitted to CMS. The amendment concerning PAS/PCS will have to wait till after a meeting with Mike Head, Paul Reinhardt, Pat Barrie, Irene Kazmerski, and others meet to discuss and resolve the mental health side of the issue.</p> <p><u>-OCT 10-</u> The PAS amendment was sent to CMS on September 28th. A draft bulletin for this policy has been created. Joe will send it to Ed Kemp with copies to Susan Yontz and Mike Head. CMS has 90 days to respond. MSA does not anticipate any additional issues. In the meantime we will continue the bulletin and policy</p>
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			<p>process.</p> <p><u>-Nov 14</u> We now have a SPA No. 06-16. CMS has sent back questions regarding the Home Help program itself not necessarily involving the PCA/PSA. A response will need to be prepared. Input will go through Mike Head to Ed Kemp. A meeting is planned to be scheduled to work on the response immediately after the Thanksgiving Holiday.</p> <p><u>-Jan 10, 07</u> Asked about how the State was doing on responding to CMS inquiries regarding PAS. Ed Kemp was not present at the meeting to give update and no one else had an update.</p> <p><u>-Feb 14, 07</u> According to Nancy Bishop of MSA, the responses to CMS questions were sent back to CMS, and we are expecting to hear back</p>
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			<p>from CMS by sometime late February. They have 30 days to respond back.</p> <p><u>-Mar 12, 07 CMS</u> responded to the responses from MSA and now appear to have one unresolved question about language in the State Plan Amendment (SPA) that notes that a “flat rate” is paid to adult foster care homes. This will need to be resolved before the SPA is approved by CMS. MSA notes that this will be very challenging to address.</p> <p><u>-April 11, 07 Ed Kemp</u> provided an update on the status of MSA’s response to CMS. CMS has informally approved all but one response. The remaining issue is in relation to personal care provided in an adult foster care facility. CMS is viewing this service as a bundled service and</p>
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			<p>that MSA is not reimbursing the provider of care. This is not an easy issue to resolve. Theresa will work with the MIG technical assistance staff to determine what other states are doing. This issue also affects the mental health system. This is a critical component to the existing grant and possible submission of the comprehensive grant.</p>
<p>Case Review/Earnings Level Issue</p> <p>Presently, after 12 months a person earning over SGA – upon their yearly DHS case review, the person is seen as “not” disabled, and kicked out of</p>	<p>DHS defers to PEM 260 for directive as to yearly review and PAM 815 as to guidance on the process of review. <u>DHS Diary Date set for automatic annual review of a person with a disability set at one year.</u> <u>The review looks at earnings, then disability.</u> The current FTW law supports this. The FTW law states</p>	<ul style="list-style-type: none"> -Working with MSA, and DHS – MRT Division. -Short term solution “interim update” to DHS proposed. -Long-term procedure being determined. - Need to review cases w/out considering disability. -Need to change procedure manual 	<ul style="list-style-type: none"> -MSA, DDS/MRT, SSA, & consultants from WI teleconferenced on Feb 9 to determine process -<u>Feb/Mar</u> Mi Job Concerns increased -<u>Mar/Apr</u> advised MSA of MI JOBS concerns - <u>April</u> MSA met with MI Jobs late in April -<u>May 16</u> Jackie & Theresa provide re-worked forms & created cover letter to MSA

<p>FTW because of earnings level.</p>	<p>eligibility standards in 106a (2) specifically “(a).... or would be found to be disabled except for earnings in excess of the SGA level as established by the U.S. SSA”</p>	<p>(PEM) manual to disregard earnings consideration in the case of FTW participants</p> <ul style="list-style-type: none">- Jackie & Theresa assigned to work with MSA & complement process-Theresa will assure that Linda does receive copies of the documents she needs (PEM 260 & 174).	<p>-MSA begins 10 day concurrence process and seeks DHS endorsement</p> <ul style="list-style-type: none">-Anticipate a July 1st implementation- <u>June 13</u> Linda stated that she needed the revised version of PEM 260 sent to her, and also PEM 174. Discussion as to process of creating a new form occurred. An ALJ letter was initiated to alert them of this issue so that they could kick it back to MSA and avoid unnecessary hearings.- <u>July 11</u> MSA will provide Jackie with changes from DSS. They will also provide MIG with the status of the policy and a timeline for implementation. MSA is going to look into pursuing a possible “interim waiver” of disability determination for freedom to work participants impacted by this problem. MSA will
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			<p>obtain a list of possible FTW individuals up for annual review and consider how this may be used to advise local offices so individuals do not receive notices about being ineligible.</p> <p><u>-Jul 19</u> MSA, represented by Logan Dreasky, and Linda Kusnier attended MI Job Coalition Meeting to go over the strategy that will be employed to effectively keep adverse actions from occurring in the case of persons whose DHS Medicaid case is up for annual review. At this time Logan explained that a query will be developed to identify the cases for review and a list would be compiled. As a pre-emptive strategy, once the cases are identified, the local office will be informed and the case will have the review date extended by 12</p>
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			<p>months. This will allow MSA enough time to come up with the appropriate policy to deal with the issue.</p> <p><u>-Jul 26</u> MIG Received email from MSA, who stated that with the assistance of DHS, they have developed the query to identify cases with current or upcoming review dates. The plan is to begin reviewing the cases at DCH beginning the week of August 7, 06. Any action extending the review dates will be completed by DCH.</p> <p><u>-Aug 15</u> No list yet, but should be complete soon. Staff from MSA will manually make the changes to review dates through December. The policy should be done by then. The new instruction to MRT will say to disregard income when making the medical review.</p>
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			<p><u>Sept 12</u> Joe stated frustration with lack of movement on this issue and underscored MIJobs coalition concerns. Logan and Ed suggested inviting Sue Moran and Steve Fitton to next MI JOBS meeting.</p> <p><u>Sept 13</u> Logan made a decision to have Linda Kusnier start reviews of all current FTW enrollees on 9/25. This will be completed by 9/29. She will review each enrollee, select those with Oct, Nov, Dec, Jan, Feb & Mar. review dates and move the review date forward 1 year. Linda will log this data and advise DHS so they are aware of the changes. This way it can be handled within MSA. Logan would have her start this next week, but she's out of the office on vacation.</p> <p><u>-Oct 10</u> Linda received the</p>
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			<p>printout for the AD-CARE consumers. The criterion for the printout was more extensive than just those on FTW who needed a review so the list was approximately 800 names. Only 4 individuals needed to have their review dates advanced ahead. About 80% of this list is coded as AD-CARE, and it appears on the surface, that there may have been miscoding errors. Some of these consumers had earned income above the AD-CARE level and likely should be in FTW.</p> <p><u>-Nov 14</u> Linda reviewed cases in September and the forwarded the re-determination dates as appropriate. There is a new Joint Manual Process that is slowing the process of getting the necessary new policy in place. Therefore, MSA will</p>
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			<p>continue to work with DHS to extend review dates as necessary. In January 2007, the topic will be brought up again to see where things are at that point.</p> <p>-<u>Feb 14, 07</u> This issue is still not resolved, therefore Linda is to push review dates forward for six months again. Logan will send Linda an email to see if she has been able to complete the process. If Linda cannot get to it before leaving for her time off work, Logan will ask Anne Bialke to complete the push forward of review dates process.</p>
<p>Unearned Income Issue</p> <p>Current FTW individuals receive or achieve unexpected</p>	<p><u>Some unearned income results as a direct benefit from working</u>, such as: unemployment, workers compensation, and working at higher earnings, thereby increasing the amount of SSDI check</p>	<p>-The benefits derived from working are received as unearned income, ie unemployment, comp pay, disability leave, etc.</p> <p>-The intent is not to be</p>	<p>-<u>Early March</u>... Advised Logan & Linda with outline of several different ways that unearned income may impact people, especially during period of non-employment. Joe and Theresa</p>

<p>unearned income, placing them in a status with unearned income above FPL.</p>	<p>received in the case of temporary layoffs or medical leave. <u>Other factors that could cause an unexpected rise in unearned income include the death of a parent, receipt of child support, or receipt of spousal support.</u> FTW Law 106a (2) (c) states, “The individual has unearned income level of not more than 100% of the current federal poverty guidelines.” Yet this seems to contradict with 106a (4) (c) which speaks to “temporary breaks in employment that do not exceed 24 months if temporary breaks are the result of an involuntary layoff or are determined to be medically necessary.” <u>Because of a person’s past work record, the amount of unearned income collected during these temporary breaks from employment</u></p>	<p>penalizing people who work - Theresa assisted by Joe, will develop list of items to be included in future inclusive FTW disregard for submission to Logan by June 30.</p>	<p><u>-Mid March...</u> Unemployment is being submitted as a disregard amendment to the Administrative Rules as State Plan supplement per Logan with CMS <u>-Early May</u> Logan noted that other factors impacting unearned income may be considered with a “broad” %’general disregard for current FTW participants -<u>Anticipate</u> discussing during June Ed/Logan mtg. <u>-June 13</u> Good news, the unemployment issue is now a part of the policy in print as of Program Policy Bulletin #2006-010, p6 of 11. Discussed the development of an inclusive disregard that would have items of unearned income that is received either directly or indirectly related to being a benefit of working. <u>-June 30</u> The list of</p>
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may actually bring a person above the FPL threshold and make them ineligible to participate in FTW.

unearned items with some policy language was developed by Theresa and then forwarded to Logan at MSA

-July 11 Members will review the suggested disregards and consider others. Ed Kemp of MSA suggested that we needed to get Mike Head to assist in seeking new administrative policy on disregards. Joe will follow up with Mike if the list is conclusive at the August meeting.

-Aug 15 Some discussion occurred. A recommendation was made by Tony to add VA and SSDI death benefits to the second list. Theresa will modify list and send it back to Logan. Also she will look more into the possibility of using a disregard by a percentage amount. Logan informed

			<p>us that these disregards would be for someone entering as well as already in the FTW eligibility category, because we cannot treat people differently.</p> <p><u>-Sept 12</u> Nothing has moved on this. Nothing we can do at this time. Need Plan of Action (PLN) on this. Per Ed Kemp there needs to be a meeting with Mike and others on this. Ed will put this on his Friday agenda with Steve Fitton.</p> <p><u>-OCT 10</u> The issue was discussed with Steve Fitton. Logan will provide Steve with rationale for each type of disregard before Steve will approve. Theresa provided Logan with some of the rationale that she had and has agreed to assist if needed.</p> <p><u>-Jan 10, 07</u> Theresa provided Logan Dreasky</p>
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			<p>with the top three disregards that would be most helpful to people with disabilities that are working and wish to remain eligible for FTW Medicaid. Logan Dreasky will move the list forward to Ed Kemp and Steve Fitton. A questioned rose about disregarding COLAs. Disregarding COLAs automatically seems to occur as a matter of policy within the department. Verification of this fact is necessary.</p> <p><u>-Feb 14, 07</u> Tony brought the issue of DAC status and additional unearned income to the group for discussion as a potential addition to our list of disregards. A DAC can be in FTW, then a parent passes away and now they can receive SSDI under that parent's record. Say that the parent SSDI amount puts their unearned</p>
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			<p>income over the FPL. Realizing that this is not income generated because of an individual's work record, but instead is based on their parents work record; we still do not want to punish a participant because of a rise in unearned income due to work. There seemed to be some debate as to how often; or if this would ever occur. The issue needs to be flushed out a little more. Bridget and Theresa will flush this out more for the next meeting.</p> <p>-April 11, 07 Key concerns of unearned increases that would potentially stop a person's FTW eligibility include COLA, increased SSDI check due to increased work, increased SSDI (DAC) or a Veterans payment due to a parent's death, as</p>
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			<p>well as worker's compensation. There was discussion regarding the ability to disregard unearned income for recipients vs. applicants. Per federal regulation, recipients and applicants must be treated the same, so any disregard for one applies to the other. MSA will pursue this with their administration. Two alternatives were raised: 1) allow unearned income to be part of Freedom Accounts. This will require a State Plan Amendment. 2) Revise the Freedom to Work law to not count unearned income in the eligibility determination and possibly require a flat rate premium (much like MIChild) as this would be easier and cheaper to administer.</p>
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<p>Aging Out Issue</p> <p>FTW participants approaching age 65+ accumulating resources, savings, retirement, etc. must now dissolve these resources in order to retain Medicaid eligibility.</p>	<p>FTW Law specifically states in 106a (2) (b) <u>“To be eligible, “the individual is at least 16 years of age and younger than 65 years of age.”</u></p> <p>Michigan’s Medicaid Buy-In Law is authorized under the TWIA, which has an age limit for participation of 16-65.</p>	<p>-One course of action could be to try to pass a Medicaid Buy-In under the Balanced Budget Act as other states are attempting to do. The Balanced Budget Act allows for all ages to participate but has other restrictions as to income earned and savings.</p> <p>-Theresa will discuss with NCHSD and look into which states either have done this or are about to accomplish the passing of both.</p> <p>-Theresa will follow up with NCHSD and/or Connecticut on this topic.</p>	<p>-NCHSD informed us that Connecticut is attempting to pass a BBA as of this year to address the “aging out” issue. Anticipate results from CT by early July.</p> <p><u>-July 11</u> Neither Theresa nor Joe has heard anything back from Connecticut on their progress. Theresa will make contact with Connecticut and other sources to look into this issue and possible resolutions.</p> <p><u>-July 13</u> Theresa received notification that Connecticut efforts to pass a MBI under the BBA have been successful. More details to follow.</p> <p><u>-July 17</u> CT did pass legislation allowing the state to cover persons who are 65 and older using the Balanced Budget Act. According to their policy analyst, Larry Carlson, their</p>
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			<p>proposed State Plan Amendment will add a Balanced Budget Act group to their Medicaid Buy-In. The BBA has no restriction of participation according to age. CT can now cover these individuals provided they meet the other provisions (disability, employment, and financial of their buy-in eligibility criteria.) CT. will be using 1902(r) (2) in order to extend the TWWIA income and asset limits to the BBA Group.</p> <p><u>-Sept 12</u> Theresa is working on a concept paper for this issue. Ed Kemp said he would like a copy of it sent to him and Logan for discussion purposes next time. He also said that we would need to draft Bulletin language for this issue. Theresa said she would add that to the concept</p>
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			<p>paper, and solicit Jackie's help with Bulletin language.</p> <p><u>-OCT 10</u> Theresa presented work plan on this issue, and is presently drafting concept paper outlining options to resolving this issue. Once a decision is made on a course of action, Theresa will draft the accompanying bulletin.</p> <p><u>-April 11</u> Joe noted that we need to have this on the agenda for May so it isn't forgotten. Per TTWWIIA regulations, a consumer is ineligible for Freedom to Work at the age of 65. It appears to be unfair to encourage a consumer to work only to have to loose all they have gained once they reach age 65. Connecticut has resolved this barrier using the Balanced Budget Act. Theresa will pursue Connecticut's language.</p>
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<p>Premium Issue</p> <p>The current FTW premiums fees are seen as “cliffs.” The variance in premium amount leaves big differences from one level to the next, which can be triggered by a simple .50 cents increase in pay.</p>	<p>The FTW Law allows for Medicaid Buy-In premiums to be on a sliding scale. Specifically the FTW Law states in 106a “(5) (c) “the Premium sliding fee scale shall have no more than 5 tiers.”</p> <p><u>An unintended consequence of setting the fee scale as MI did (using an SSI methodology for counting income) resulted in individuals having to earn around \$4,000 a month before paying the first level of premium, which was set at \$50.00.</u></p>	<ul style="list-style-type: none"> - Consider a MSA Administrative Policy Change in the existing current premium fee scale. -One Suggestion includes changing to a % scale for individual income level; or go from 100% FPL To 250% of FPL to begin paying premium. - Another possibility would be to switch to a sliding scale based on percentage of countable income. -Some states have premiums that start at the point of any earnings and/or may include unearned income 	<p><u>-Aug 15</u> It was suggested that we consider using % for eligibility into the program. And it should also be noted that % was suggested here as a way to make premiums smoother from one level to the next.</p> <p><u>-Sept 12.</u> It was suggested by Tony that we might want to look at and compile suggestions using different premium scales or methodology for premiums. Theresa will assist by providing an analysis from NCHSD on what other states have for their premium systems.</p>
<p>Marriage Penalty Issue</p>	<p>The issue of deeming is a problem for FTW</p>	<p>-This is a federal challenge within SSA</p>	<p><u>-Aug 15</u> A question was raised, why we couldn't use</p>

<p>The FTW participant's earnings are "deemed" to the spouse and the spouse becomes ineligible for Medicaid and other supports.</p>	<p>participants who have a spouse receiving supportive benefits, such as SSI, due to a disabling condition. A part of the working spouses' income is deemed to the other spouse. This results in the other spouses' benefits possibly being reduced or eliminated.</p>	<p>-The WIAG group meets in Chicago and this is a topic they are considering. Tony Wong, Karen Larsen, & June Morse participate.</p>	<p>the provisions in 1902 to specify this group individually, and make a State administrative rule that would eliminate the problem of deeming between spouses. Logan referred us to a piece of guidance issued from CMS that may be of help. More research to be done in this area. Sept 12 Tony is going to write up a possible state solution to this Federal problem using the 1902 (r) (2) provisions. He would like some feedback on a document he is preparing for the WIAG committee.</p>
<p>Part B Premiums Issue</p> <p>Some FTW persons become responsible to pay the Medicare premium for Part B without being</p>	<p>The state DHS policy FTW, PEM 174, clearly states,"a person eligible for medical assistance under FTW is not eligible for ALMB." FTW participants may be required to pay Part B costs when they achieve certain earnings levels.</p>	<p>-Theresa will further research potential implications of this factor within the FTW program -Consider whether a change in Administrative policy is needed</p>	<p>-<u>June13 MSP</u> premiums were discussed briefly as the issue also involves concurrently eligible for ADCARE. Linda concurred with Theresa's findings that people did not have to pay Medicare Part B premiums because of switching to</p>

<p>advised of this impact.</p>	<p>Currently Individuals are not made aware of this before switching to FTW.</p>	<p>-Need to develop method to inform participants that they may be required to pay their Medicare Part B premiums as they begin working.</p>	<p>FTW, but because of a rise in their income as a result of working. <u>-Jan 10</u> We acquired information at this meeting that there is a new sliding scale to part B premiums with costs starting at \$93.60 plus \$12.50 and with a scale going up from there. At this time there doesn't seem like there would be an impact for our current FTW participants, but that may change if and when we have participants in the higher income brackets.</p>
<p>Waiver Issue</p> <p>People are asking about being in FTW while using waivers.</p>	<p>People want to be able to remain within a waiver, work, and participate in FTW, but they have been told they can't. People prefer waivers because of the PSA/PCA services. Waivers have a higher income limit to be economically eligible than other Medicaid programs.</p>	<p>-Discussed with Pam McNabb & Jackie Tichnell. Eligibility would depend on slots and earnings? - Mike Head noted that FTW was an eligibility Category, whereas the MI Choice waiver is a Program Category. -May 18...Jackie</p>	<p>-Anticipate discussion of this topic during June Ed/Logan meeting. <u>-June 13</u> Logan and Linda acknowledged receipt of the overview memo from Jackie suggesting that a person may utilize both MI Choice Waiver and FTW eligibility at the same time. MSA will further review the</p>

	<p>FTW is an eligibility category and by using the “Freedom Accounts” a person should remain or be eligible for the MI Choice Waiver.</p>	<p>forwarded an overview of why we believe FTW should be able to work in conjunction with this waiver</p>	<p>memo, meet with Bob Orme, waiver policy analyst and make a suggestion to Ed on how to proceed. <u>-July 13</u> Both FTW and MI Choice are a Medicaid Eligibility. The issue appears to be in the interpretation of policies. MSA will discuss with both DHS and waiver agents. <u>-Aug 15</u> regarding a discussion on the term “Nursing Home Level of Care” and how this plays into people on the My Choice waiver using FTW. Some discussion needs to occur on the interpretation of long term care terminology and the interaction between the MICHoice Waiver and FTW. Ed will meet with Bob Orhm and others. <u>Sept 12</u> Per Ed Kemp, once meetings begin on SPEs needs to be set up with Bob Orhm and Ed</p>
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			<p>Kemp said that the topic of “Nursing Home Level of Care” NHLC could be one of the first issues to be discussed and resolved. We want the waiver agents to understand that NHLC can be delivered in the community. Remember Olmstead. And that in some cases people with that level of health needs still live active lives including working.</p> <p><u>-OCT10</u> Ed was not in attendance. Joe will check with him individually to see where things are on this issue.</p> <p><u>-Nov 14</u> Ed said Jim Schwartz will discuss and advise Waiver Agents that a person can be on both a MI CHOICE Waiver and FTW at the December Waiver general meeting.</p> <p><u>-Jan 10, 07</u>-Mike Head met with Ed in December to address this. Logan did</p>
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			<p>not know if this had formally been addressed. Joe will check with Ed. <u>-Feb 14, 07</u> We can now celebrate success on this issue. People can now participate in both the waiver and FTW at the same time. Joe presented a copy of a memo to the waiver agents giving them direction on the new policy.</p>
<p>Economic Earnings Issue</p> <p>SSDI recipients that are FTW enrollees remain discouraged from earning over SGA until a person can minimally replace their SSDI check. Ties into the Federal SSA action on SGA. People are unlikely to work in order to have less</p>	<p>People with disabilities work to make money just like anyone else. Individuals are commonly unwilling to accept work that won't minimally replace their check. <u>It costs PWD money \$ to work, in some cases people with disabilities incur large expenses in order to work.</u> In addition, individuals remain concerned of the future need of medical coverage. Some progress has been made in this area through</p>	<p>-Need to do research on what it would take to eliminate SGA and allow persons to wean off benefits slowly. -Work with the MI JOB Coalition and others working towards a solution to the issue of SGA - PWDS need to gain skills to qualify for a higher paying job, so they can earn enough to take the leap of faith off the system.</p>	<p>-Feb & April "Think Work" summits suggest growing effort by Mi Jobs Coalition to seek demonstration/pilot grant from SSA to disregard SGA as a standard for persons with SSDI.</p>

<p>\$ in their pockets.</p>	<p>the TWIIA and reinstatement of benefits provision within.</p>		
<p>Deductible Issue</p> <p>As of January 2004, PWD may have been put into Spend-Down eligibility category (now referred to as the Deductible Program) instead of being referred to the FTW eligibility category.</p>	<p>As of January 2004 through August 01 2005 (Prior to the institutionalization of the LAO2 prompt), PWD may have inadvertently been put into spend-down (now referred to as the Deductible Program) when applying for Medicaid benefits because of having earned income combined with unearned income that placed total earnings over the FPL. Some of these individuals should have been FTW participants.</p>		<p>- July 13 Concern was expressed as to what if anything can be done to capture persons who were missed.</p> <p>-Aug 15 Additional discussion occurred. No action</p> <p><u>-OCT 10</u> There was some discussion as to what/who this population is. Linda Kusnier is working on the December 2003 persons that were spend down prior to January 2004 and would have been FTW persons except for the implementation date. Tony was thinking this was the same group of persons. Logan will pursue with Linda</p>

<p>AD Care Issue</p> <p>PWDs that come in to apply for Medicaid and are working below 100% FPL are automatically referred to AD Care.</p>	<p>It is the policy of DHS to place eligible individuals into the most beneficial MA category for the person. Yet, <u>some individuals with disabilities who have jobs and are actively working are placed into ADCARE rather than FTW.</u> These individuals have a combined income below FPL. The benefit of placing working PWDs to FTW would increase the program enrollment numbers and bring more federal grant dollars to the state ultimately providing greater opportunities to individuals with disabilities.</p>	<p>-Take a look at DHS policy and procedures and determine if changes are needed. If so, make recommendations to MSA. Theresa and Jackie</p> <p>-Study the challenges of transferring working persons with disabilities from ADCARE to FTW to be sure that no harm would occur (recall that some would then need to pay the Part B premium of \$88.50/mo.)</p> <p>*People will only have to pay their Part B premium as their income rises above the poverty level. At that point they would no longer be eligible for ACARE or the Medicare subsidy</p>	<p><u>-June 13</u> Discussed briefly about the possibility of simply moving all eligible ADCARE people onto FTW to allow these individuals to take full advantage of the FTW program. Ed Kemp did not feel that anything would prohibit this from being done. Estimated time to completion, approximately two months per Ed Kemp</p> <p><u>-June 13</u> additional note Per Logan...when creating the hierarchy of Eligibility for the new bridges system FTW was placed above ADCARE. Additionally the new bridges system will allow targeted letters to be mailed to certain Medicaid eligible persons</p> <p><u>-July 11</u> MSA indicated that the actuarial division is concerned about moving AD CARE individuals to FTW. Joe will ask Mike to pursue this with Ed Kemp.</p>
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		<p>because they would be over income.</p>	<p>Ed is going to talk with the actuarial department as well. There was discussion about the issue of choice for persons “moving” from AD Care to FTW. Additionally it was also noted that consumers do need to be made aware that they have FTW, and what advantages for self sufficiency that offers to them. Possible methods of informing consumers once they are transferred to FTW were discussed.</p> <p><u>-Aug 15</u> Ed will get this topic on the agenda for his next meeting with Mike as the LTC department head, along with others. There are an estimated 74,000 ADCARE participants.</p> <p><u>-Sept 12</u> Estimate number of ADCARE beneficiaries with income from earnings is 6161. Ed Kemp will get this topic on the Friday agenda with Steve Fitton.</p>
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			<p><u>-OCT 10</u> Julie is to provide associated dollars with this group. MSA administration does support the concept of moving these 1consumers to FTW. Mike Head concerned about the timing. It is necessary to do this soon so that we can use this for future Medicaid funding... Logan will develop a plan to get this process done. The importance of educating consumers to make an informed choice was one again stressed.</p> <p><u>-Nov 14</u> Joe shared a draft memo to advise AD CARE participants. Joe will edit again and share it at the December meeting.</p> <p><u>-Jan 10</u> Joe submitted a letter collaboratively written with assistance of Jackie and reviewed by Theresa to go out to the 6000 + people that are being considered for transition</p>
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			<p>from ADCARE to FTW. The letter explains what FTW is and how it can benefit the individual. Most importantly, it will tell them where to get more information. Jackie suggested that it would be helpful if the letters sent out included the WIPA brochure. Discussion of transferring people over to FTW from ADCARE went on. There was lengthy discussion regarding the issue of married AD Care consumers. What is the impact on each of the partners? Currently, the FPL used for AD Care would be as a family of two (a higher level than family of one). The FTW person would need to have unearned income below 100% of FPL. Per Logan Dreasky, it was determined that this would not immediately impact the AD</p>
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			<p>Care spouse who would continue to be considered in a family of two under AD Care. There would be no initial impact, until there were more earnings in the AD Care group. If both people had unearned income below FPL and earnings (even very small earnings) then they'd both be FTW eligible and remain Medicaid eligible as long as they individually met FTW criteria. And it was also suggested to included with the letter an option of choice by saying "if you do not wish to participate in freedom to work Medicaid call (case worker or MSA?) The only challenge to this language is that written this way the letter requires an affirmative rather than a passive response from individuals if they do not wish to participate in FTW.</p>
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			<p>Next step Joe will work with Tony re: use of WIPA brochure/contact info, letter will be rewritten with the recent input and forwarded to Logan for his review... When approved, MSA will handle the mailing out of the letters.</p> <p><u>-Feb 14, 07</u> New draft of letter was submitted and did not include income grid. The new version was well received and will be our final draft for submission to be sent out along with a WIPA brochure, as the group decided that this was useful information to include.</p> <p><u>-March 14</u> Again the question was raised by Logan as to the viability of just switching all ADCARE consumers who have income from work over to the Freedom to Work category in one step. According to present state</p>
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			<p>DHS policy; putting people in the most advantageous Medicaid category for their benefit; procedurally the Freedom to Work is the most beneficial category for people with disabilities who work.</p> <p>-<u>April 11</u> Joe Longcor provided MSA with an official request to notify DHS of the transition of single working AD Care consumers to Freedom to Work. This will help increase the numbers of Freedom to Work consumers for the submission of the comprehensive grant. MSA will provide each county DHS with a list of possible consumers to transition. DHS will have to ascertain if the consumer is single, and if appropriate, change the coding to Freedom to Work. A complete case</p>
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			<p>review should not be required. If DHS Outstate Operations sends the list to each county with a due date, these should be completed in time for the comprehensive grant submission.</p>
<p>Freedom Accounts Issue</p> <p>FTW enrollees are not aware of Freedom Accounts and commonly don't know the benefits of utilizing these accounts to build savings or increase earnings.</p>	<p>The advantage to Freedom Accounts is that <u>PWDs can set aside income to save for things they need, and still qualify for Medicaid</u> benefits and medical coverage under the MA program.</p>	<p>-Determine how to build awareness among FTW enrollees to promote increased earnings & savings while retaining needed benefits.</p>	<p>- July 11 Logan Shared that MSA is working with DHS on the Bridges project and that the Bridges System has a "placeholder" to trigger the system designers to allow for Freedom Accounts in the new system. This would tell the system to automatically put savings into Freedom Accounts during the budget creation process by DHS workers. MIG needs to work with MSA on developing o process to handle this issue with DHS. Jackie, Theresa & Joe will meet on</p>

			<p>7/20/06.</p> <p>-7/20/06 Jackie, Theresa and Joe met and developed a plan to address this issue through creating a form and making changes to the PEMs.</p> <p>-Aug 15 Theresa reported that she has located within the PEMs a DHS Form that will serve the purpose of designating freedom accounts by consumers of DHS services. She also has drafted new PEM language and directions for the use of this form.</p> <p>Theresa is in the process of going through the PEMS to see where modifications need to occur to affected PEMs, and is drafting a memo on this to be submitted with the suggested changes.</p> <p><u>-OCT 10</u> Theresa shared a draft Bulletin announcing this policy. She provided Logan with a copy. MSA</p>
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			<p>will review and provide the office with comments. Tony suggested adding a section on consumer responsibilities and consequences to the bulletin and the brochure he is working on. Theresa suggested modifying DHS Form 503 Asset Verification Form to include designation for Freedom Accounts, creating a new DHS Form for FTW. A suggestion occurred to modify the FTW DHS Form since Freedom Accounts can also include money from income. Make it a similar but New Form with its own Form Number.</p>
<p>SSA 1619 transition to FTW</p> <p>Presently smooth transition to FTW is not assured.</p>	<p><u>Persons presently in 1619 status may earn or save their way onto FTW, but are fearful to take that leap because they are unsure that transition into FTW Medicaid will be a seamless process.</u></p>	<p>-Research possible ways to address MA policy to allow this transition to be seamless.</p>	<p>-TBD</p>

<p>Working from Home and HUD Housing</p>	<p><u>Persons living in HUD housing are told that they cannot engage in business activities out of their home.</u> This severely limits some employment opportunities for PWDs.</p>	<p>-Theresa will check HUD policy and also with a few contacts she has within the advocacy field that often helps PWDs with housing issues regarding subsidized housing.</p>	<p>-June 16 Ref Jackie Blankenship (MSHDA) thru Sue Eby (MDCH) thru Glen Ashley (MDDC-MDCH)</p> <p>HUD Regulations: 24 CFR 982.551 Obligations of Participant states (h) Use and occupancy of unit - (1) The family must use the assisted unit for residence by the family. The unit must be the family's only residence. (5) Members of the household may engage in legal profit making activities in the unit, but only if such activities are incidental to primary use of the unit for residence by members of the family.</p> <p>24 CFR 982.516 discusses family income and composition; and 24 CFR Part 5.609 discusses family</p>
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			<p>income; 24 CFR Part 5.611 discusses adjusted income</p> <p>HUD's Housing Choice Voucher Program Guidebook says this about income inclusions</p> <p>—</p> <p>"The net income from operation of a business or profession. Expenditures for business expansion or amortization of capital indebtedness shall not be used as deductions in determining net income. An allowance for depreciation of assets used in a business or profession may be deducted, based on straight line depreciation, as provided in Internal Revenue Service regulations. Any withdrawal of cash or assets from the operation of a business or profession will be included in income, except to the extent the</p>
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			withdrawal is reimbursement of cash or assets invested in the operation by the family."
Michigan First - Health Care Program	Does this new waiver have any impact on the Freedom to Work Program?		<p>-July 13 Jackie Tichnell contacted Susan Yontz. What we know so far is that it is an 1115 waiver, there is no draft available to share, and there is no template. Susan will let people know that we are interested in learning more information and she will get back to us.</p> <p>-August 8 Theresa has done some research into this and drafted a memo giving the message that from all materials so far there appears to be no adverse effects to FTW participants. This new MI health program may in fact offer health care to people with disabilities who wouldn't otherwise have access to health care.</p>

<p>FTW training in DHS offices (and elsewhere) to NOT include References to not being on a Spend Down/ Deductible.</p>	<p>The current training module used by DHS makes reference to FTW not being for people on the deductible Medicaid program.</p>	<p>The fact of people being on a deductible being the reason for exclusion from FTW is really not true. The qualifying eligibility criteria used for FTW is the same as for ADCARE eligibility, using an SSI category income breakdown.</p>	
<p>Issue regarding the use of or Lack of use of IRWEs by PWDS due to many systemic problems.</p>	<p>1. There are no clear rules or process available to the public or with in the SSA Department that persons can use as guidance in determining whether they have potential IRWEs. 2. When PWDS who are aware of the POMS or are working with a knowledgeable Social Worker and therefore they have a list of IRWEs to turn in. They are treated as if they are stealing or trying to get something they don't have a right to. 3. When PWDS are</p>	<p>There needs to be an administration process and documentation flow process put into place here. Along with an appeals process. The lack of these things clearly shows why the numbers are so low in people using IRWEs.</p>	

	<p>working with knowledgeable WIPAs etc. and turn in there IRWEs, they receive no correspondence or feedback from SSA. And on most occasions no one even applies the IRWES to the case. And if SSA does. SSA never tells anyone.</p>		
<p>FTW and Family Size Eligibility Issue</p>	<p>When FTW eligibility is considered for people with disabilities, we look at the individual. The issue of what is the individual is a member of a family of two and the working spouse is currently receiving Medicaid under ADCARE or some other category?</p>	<p>-We need to decide if we can look at family size relative to income eligibility. -We need to consider the impact on other people who now may be eligible where they were not before.</p>	<p>-<u>March 14, 07</u> Mr. Steve Fitton , and Mr. Paul Reinhart, and Ms. Jackie Doig were guests at the meeting this day to discuss this particular issue as it arose with a married disabled consumer who wished to be in the Freedom to Work category. Currently, he receives Medicaid through the ADCARE category. Between the consumer and his spouse their combined income is under the FPL income level for a family of</p>

			<p>two. Although the individual alone has unearned income above the FPL for an individual. The question was raised of whether or not to allow an individual who meets the 2 per person standard of unearned income less than 100% of FPL criteria into the FTW category. Paul supported it. Steve said he also would support it, but he would like to see some documentation on the implications of allowing this. Logan said that this would cause some issues with the way the law is written and with CMS and the State plan.</p>

Self- Determination in Long Term Care Project April 2007

As of this writing, April 17, 2007, there are 32 participants enrolled in Self Determination, including participants from the Detroit Area Agency on Aging. DAAA contracted with PAS as a fiscal intermediary. 45% of enrollees are ages 64+ and 55% are people with disabilities.

We will begin training the rest of the wavier sites, who were not Pioneers on Person Centered Planning and Self Determination. We will conduct two sessions in three regions over the summer. Session one, person centered planning is scheduled to occur in three regions in June – Southeast Michigan, Gaylord and Kalamazoo. Sally Burton Hoyle will be part of the training as well as the local Pioneer Site coordinators and participants.

There is a track on long term care being offered at the Self Determination conference June 11 & 12.

We are presenting two workshops at the AAA conference.

I am still finishing an operations manual, and the quality measuring tools.

We will be conducting a case audit to discover how the Pioneer Sites are implementing and documenting person centered planning.

We are also coordinating our work with the goals stated in the System Transformation grant regarding increased choice and control for participants in the long term care system, specifically focusing on person centered planning, participant directed services and individual budgets. This will include policies and practices along with training and information.

We have begun work on renewing the MI Choice waiver. A large area of focus is updating the service definitions and standards.

For more information contact me at 517.335.5671 munizt@michigan.gov

MQCCC Report to the Consumer Task Force Quarterly Report Through March 31, 2007

Limited Criminal History Check Project

The Home Help part is still on hold

Registry Update

Here are the stats as of March 31, 2007:

Topic	Current Number	Percent Increase from Last Quarterly Report
Providers responding to Brochure	4202	32%
Number of Introductory Sessions Held	176	21%
Total # of Providers at Introductory Sessions	1003	48%
Number of Approved Providers	624	53%
Number of Providers with Approval Pending	87	107%
Number of Providers Denied	51	24%
Number of Consumers Served	488	58%
Number of Referrals Made	3610	70%

Other

Three Dementia trainings were held this past quarter in Lansing, Grand Rapids and Southfield. We have 4 more scheduled – one each in Bay City, Holland, Highland Park and Detroit.

Two CPR trainings have been planned. They will be in Lansing.

There are 17 more Adult Abuse and Neglect Prevention trainings planned through the end of June 2007.

The Provider Agreement Policy Draft gave us an opportunity to speak with approximately 1500 people in January and February as well as receive correspondence from another 700 or so. We are still waiting on March's call numbers.

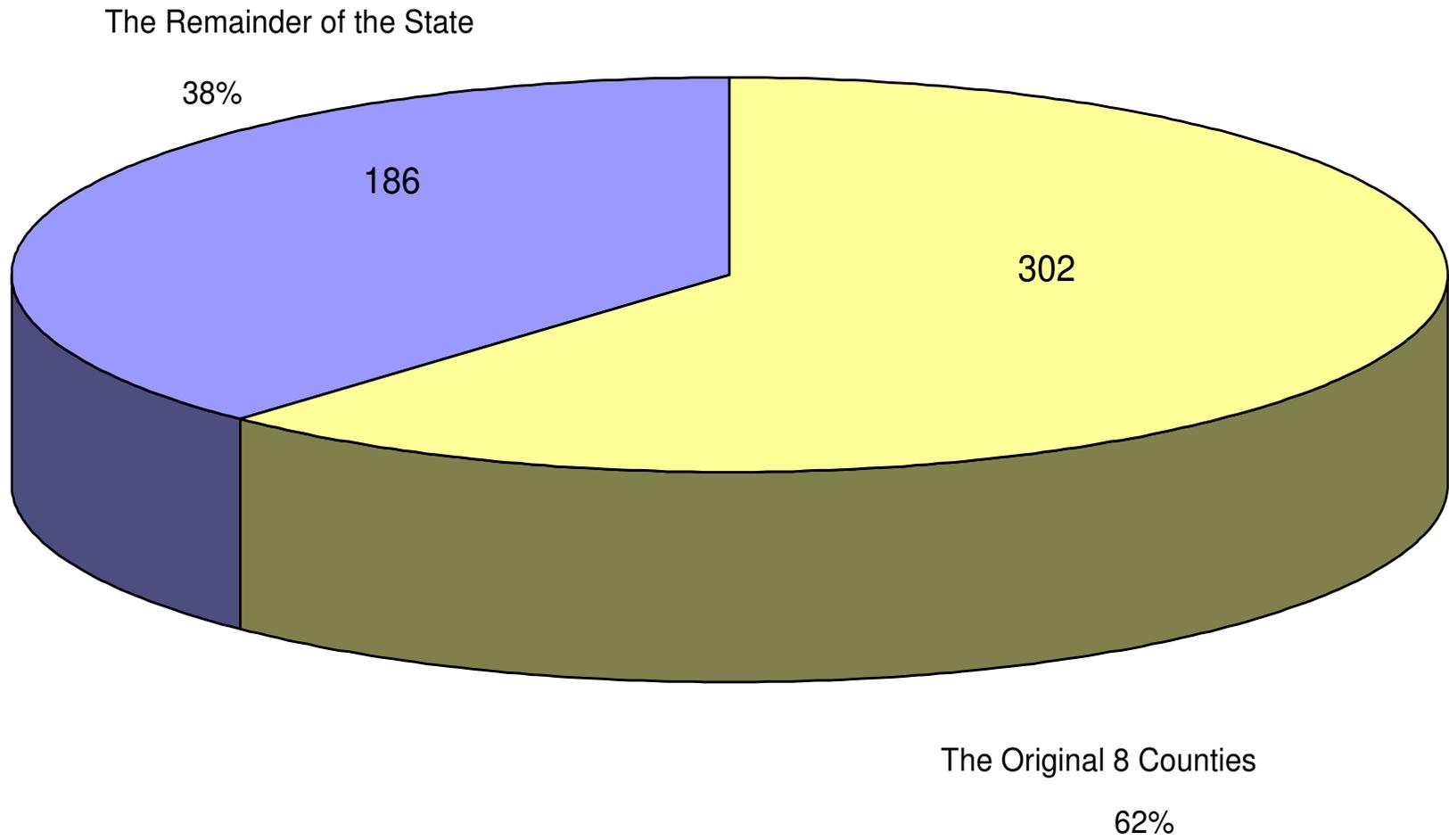
Emergency Provider meetings continue with attendance by DHS Central Office staff, DCH/MSA staff, QC3 Board members and DHS frontline staff.

We received a clean audit report for FY 06. The Management letter included some recommendations including a more formal budgeting policy and adoption of the proposed financial accountability policy. The adoption of those policies took place at the March Board meeting.

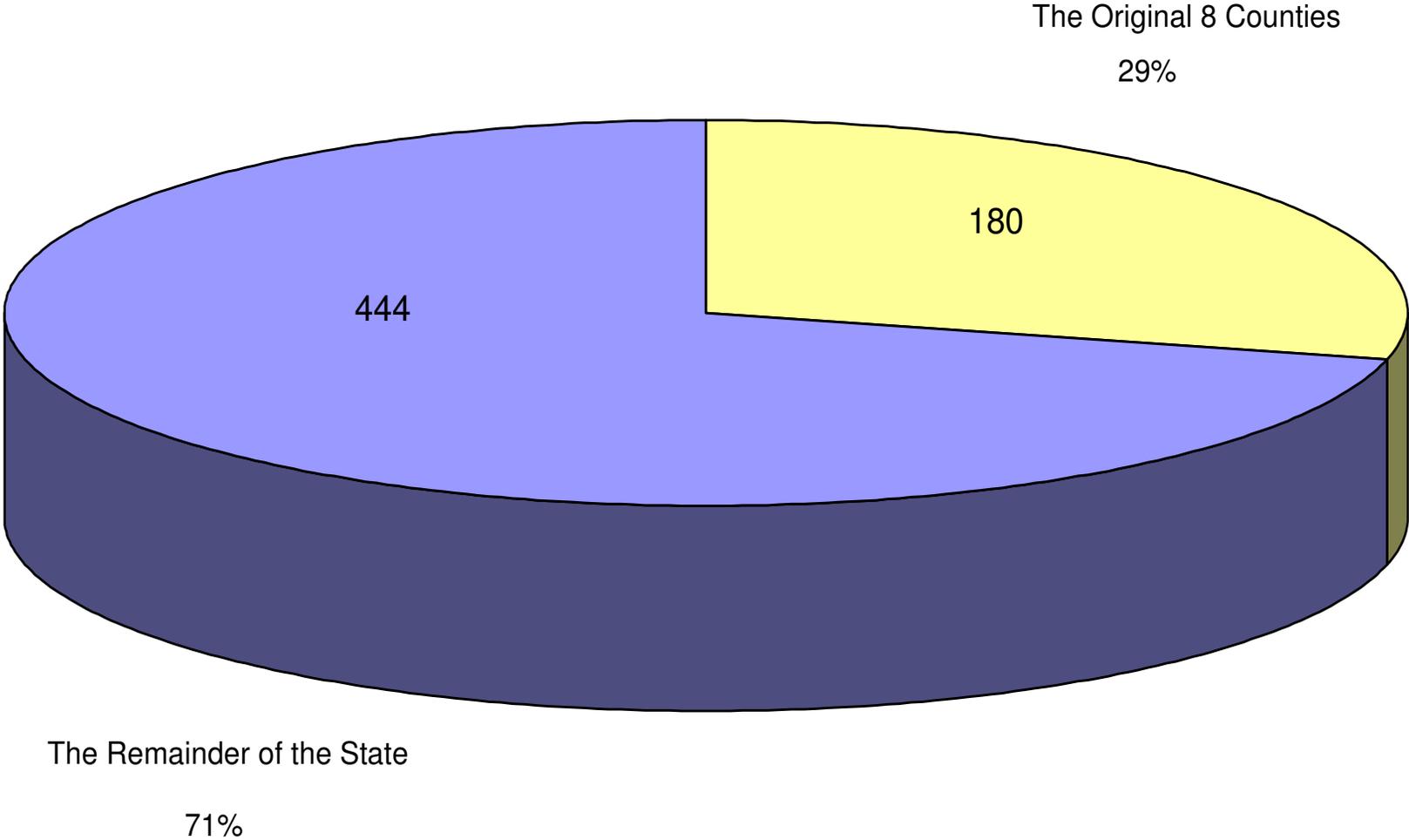
We are receiving assistance (free) from two MSU Ph. D. candidates on provider recruitment and retention. Both students have an extensive background in personnel and recruitment as well as personal commitments to home and community based long term care services. We are quite lucky they chose us.

Finally thanks to the Medicaid agency for being willing to pursue a technical assistance grant on workforce issues. While MI did not get the full grant, we did receive an intermediate level grant to look at why some counties have more providers than consumers and vice versa.

488 Consumers as of March 07



624 Providers as of March 07



County Activities for March

COUNTY	Registry Management Associate	Date of Brochure Mailing	Date of DHS Meeting	# Responding to Brochure	Date of Upcoming Orientations	# of RSVPs for Upcoming Orientation	# of Orientations Held	Total # of Providers at Orientation	# of Approved Providers	# of Providers Approval Pending	# Pending for referrals more than 2 mths	# of Providers Denied	# of Orientation Walk outs	# of Consumers	# of Referrals made	# of referral letters sent or calls made	# Inactive due to enough work	# Inactive does not wish to be on registry	# Inactive other	Removed from registry		
1	ALCONA	CJ	05/12/06	09/19/06	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0		
2	ALGER	Brandy	08/15/06	08/15/06	1		1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	Provider wishes to work in Marquette ONLY
3	ALLEGAN	Brandy	07/21/06	08/02/06	13		2	6	3	0	1	0	0	2	8	3	1	0	1	0	0	New provider responses - never done HH before
4	ALPENA	CJ	05/12/06	07/11/06	5		1	2	2	0	0	0	0	1	1	1	0	0	0	0	0	The Provider that attended was from Montmorency County.
5	ANTRIM	CJ	05/12/06	04/20/06	1		2	2	2	0	0	0	0	1	1	1	0	0	0	0	0	
6	ARENAC	Sarah	02/06/06	03/06/06	25		1	7	2	0	0	0	0	1	3	1	1	0	1	3		
7	BARAGA	Brandy	06/28/06	07/13/06	3		1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Provider didn't show
8	BARRY	CJ	02/13/06	01/26/06	9		1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	
9	BAY	Sarah	02/06/06	03/06/06	111		5	39	24	1	0	1	4	37	279	58	2	1	1	5		
10	BENZIE	CJ	05/12/06	04/05/06	4		1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	
11	BERRIEN	Brandy	06/28/06	07/18/06	45	05/15/07	2	7	3	0	0	1	0	0	0	0	0	0	3	0		
12	BRANCH	Brandy	08/25/06	09/14/06	10		1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	
13	CALHOUN	Brandy	06/28/06	06/08/06	28	04/24/07	1	3	2	0	1	0	0	0	0	0	0	0	0	0	0	
14	CASS	Brandy	06/28/06	07/27/06	7	05/24/07	1	2	0	0	0	0	0	0	0	0	0	0	1	0	0	1 Provider has not phone no. - inactive
15	CHARLEVOIX	CJ	05/12/06	04/25/06	1		1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	
16	CHEBOYGAN	CJ	06/28/06	05/02/06	3		1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
17	CHIPPEWA	Brandy	06/28/06	07/11/06	5		1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	
18	CLARE	CJ	03/06/06	04/06/06	14		1	3	6	0	0	0	0	2	10	2	0	0	0	0		
19	CLINTON	CJ	07/01/05	09/20/05	12		2	7	2	0	1	0	0	2	6	2	0	2	0	1		
20	CRAWFORD	CJ	05/09/06	04/26/06	6		1	2	2	0	0	0	0	2	4	2	0	0	0	0	0	
21	DELTA	Brandy	06/28/06	07/12/06	9		1	4	1	0	1	0	0	0	0	0	1	0	0	0	0	
22	DICKINSON	Brandy	06/28/06	07/13/06	7		1	3	0	0	0	0	0	0	0	0	1	0	2	0	0	
23	EATON	CJ	07/01/05	02/15/06	20		5	4	4	1	0	0	0	6	22	6	0	2	0	0	0	

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24	EMMET	CJ	06/28/06	04/25/06	5		1	2	2	0	1	0	0	0	0	0	0	0	0	0	0	waiting for MI DL/ID - moved to GT	
25	GENESEE	Sarah	07/01/05	11/29/05	318		10	78	49	7	0	2	3	54	479	90	2	0	7	13			
26	GLADWIN	CJ	03/06/06	04/06/06	13		1	6	5	0	0	0	0	1	5	2	0	0	0	1	0	moved	
27	GOGEBIC	Brandy	07/21/06	08/16/06	4		1	3	1	0	0	0	0	0	0	0	1	0	1	0	0		
28	GRAND TRAVERSE	CJ	05/12/06	05/25/06	12		1	6	5	0	1	2	0	0	0	0	1	0	0	0	0		
29	GRATIOT	CJ	02/13/06	09/20/06	4		1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	Provider not from Gratiot	
30	HILLSDALE	Tanya	05/12/06	06/27/06	7		2	2	2	0	1	0	0	0	0	0	0	0	0	0	0	0	
31	HOUGHTON	Brandy	06/28/06	07/13/06	7		1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
32	HURON	Sarah	03/06/06	05/30/06	6		1	1	1	0	0	1	0	1	1	1	0	0	0	0	0	0	
33	INGHAM	CJ	07/01/05	08/01/05	139		16	61	40	0	3	2	3	86	744	173	7	2	1	3	0	Includes Tri. and Shiawassee and Livingston	
34	IONIA	CJ	02/13/06	02/07/06	35	04/03/07	4	2	5	4	0	0	0	10	31	10	0	0	0	0	0	0	
35	IOSCO	CJ	05/12/06	09/12/06	3		1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	
36	IRON	Brandy	07/21/06	07/13/06	7		1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
37	ISABELLA	Sarah	04/06/06	05/08/06	9		1	1	2	0	0	0	0	2	11	3	0	0	0	1	0	0	
38	JACKSON	Leesa	04/14/06	04/19/06	24		3	10	3	0	3	4	0	1	3	1	0	0	0	0	0	0	
39	KALAMAZOO	Brandy	05/12/06	05/16/06	69	03/29/07	5	2	24	8	0	3	3	5	2	7	2	0	0	7	0	1 Provider denied due to no ID. Wants to attend next LS.	
40	KALKASKA	CJ	05/12/06	04/20/06	3		1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	Tried 2x to meet with provider for intro session
41	KENT	Ian	06/28/06	06/14/06	182	05/07/07	4	42	36	5	5	1	2	19	209	40	1	0	1	0	0	0	
42	KEWEENAW	Brandy	06/28/06	07/13/06	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
43	LAKE	CJ	04/03/06	07/27/06	3		1	2	1	0	0	1	0	2	6	3	0	0	0	0	0	0	0
44	LAPEER	Sarah	06/28/06	07/27/06	16	04/19/07	2	1	7	3	0	0	0	1	5	1	1	0	0	0	2	0	0
45	LEELANAU	CJ	05/12/06	05/25/06	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
46	LENAWEE	Leesa	05/12/06	06/13/06	15		1	2	1	0	0	0	1	1	2	1	0	0	0	0	0	0	0

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47	LIVINGSTON	CJ	07/01/05	01/30/06	6		1	1	1	0	0	0	0	2	10	3	0	0	0	0	with Ingham.
48	LUCE	Brandy	06/28/06	07/12/06	2		1	1	1	0	0	0	0	1	1	0	0	0	0	0	Provider did not work out.
49	MACKINAC	Brandy	05/12/06	05/02/06	2		1	0	0	0	0	0	0	2	0	0	0	0	0	0	Leesa she was a Union Steward but told me she was referred by Kim Stardevant
50	MACOMB	Sarah	7/1/05 & 3/06/06	09/20/05	136	05/09, 05/10, 05/31	n/a	6	56	24	1	0	2	6	62	561	113	2	1	5	6
51	MANISTEE	CJ	05/04/06	04/05/06	7		1	1	0	0	0	0	1	0	0	0	0	0	0	0	Provider never returned application
52	MARQUETTE	Brandy	07/21/06	08/15/06	13		1	3	4	0	0	0	0	0	0	0	0	0	0	0	
53	MASON	Brandy	07/21/06	08/02/06	4		1	2	1	0	0	0	0	0	0	0	0	0	0	1	0
54	MECOSTA	Brandy	05/12/06	04/18/06	12		1	5	1	0	0	1	0	0	0	0	0	0	0	3	0
55	MENOMINEE	Brandy	06/28/06	07/12/06	11		1	8	3	0	0	0	0	1	2	1	0	0	5	0	
56	MIDLAND	Sarah	02/06/06	03/08/06	15		1	5	1	0	0	0	0	1	5	2	0	0	0	0	
57	MISSAUKEE	CJ	05/12/06	04/05/06	7		1	4	6	0	0	0	0	1	5	2	0	0	0	0	
58	MONROE	Leesa	05/12/06	06/22/06	8		1	2	1	0	0	1	0	0	0	0	0	0	0	0	
59	MONTCALM	Brandy	05/12/06	02/07/06	33		3	*17	10	0	0	0	0	4	17	4	1	0	4	0	* 1 provider from Ionia
60	MONTMORENCY	CJ	06/28/06	08/24/06	4		1	1	1	0	0	0	0	0	0	0	0	0	0	0	Provider didn't show
61	MUSKEGON	Brandy	05/12/06	05/04/06	57	04/27/07	4	2	13	8	0	0	2	0	1	5	1	0	0	2	1 provider contact info no longer valid.
62	NEWAYGO	Brandy	08/15/06	07/27/06	21		2	6	2	0	0	3	0	4	7	3	0	0	1	0	
63	OAKLAND	CJ	07/01/05	11/15/05 & 1/5/06	253		14	71	44	2	2	5	5	79	527	133	2	1	4	11	Pendings: 3-Ref and 1-waiting for MI DL
64	OCEANA	Brandy	07/21/06	08/02/06	15		1	5	3	0	0	0	0	0	0	0	1	0	1	0	
65	OGEMAW	CJ	05/12/06	05/10/06	9		1	4	3	0	0	0	0	0	0	0	0	0	0	0	
66	ONTONAGON	Brandy	07/21/06	08/16/06	7		1	5	3	0	0	1	1	1	2	1	0	0	0	0	
67	OSCEOLA	CJ	03/06/06	04/18/06	10		1	3	2	0	0	0	0	0	0	0	0	0	1	0	

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68	OSCODA	CJ	06/28/06	08/24/06	3		1	1	1	0	0	0	0	1	1	1	0	0	0	0	
69	OTSEGO	CJ	05/29/06	09/19/06	22		1	10	6	0	1	0	0	8	45	10	1	0	1	0	
70	OTTAWA	Brandy	05/12/06	05/24/06	11		1	7	5	1	0	1	1	2	7	2	1	0	0	0	1 response not a provider and not interested.
71	PRESQUE ISLE	CJ	06/28/06	07/11/06	2		1	1	0	0	0	0	0	0	0	0	0	0	1	0	
72	ROSCOMMON	CJ	05/12/06	05/23/06	8		1	3	1	0	0	0	0	1	3	1	0	0	0	0	
73	SAGINAW	Sarah	02/06/06	11/15/05 & 1/5/06	231		4	69	52	7	0	3	1	35	271	50	0	0	1	12	
74	ST. CLAIR	Sarah	06/28/06	07/27/06	44		2	11	7	0	1	0	0	4	35	8	0	0	1	1	
75	ST. JOSEPH	Brandy	06/28/06	06/20/06	4		1	3	0	0	0	0	2	0	0	0	0	0	1	0	
76	SANILAC	Sarah	03/06/06	06/07/06	10	04/25/07	2	4	3	0	0	0	0	0	0	0	0	0	1	0	
77	SCHOOLCRAFT	Brandy	08/15/06	08/15/06	3		1	1	0	0	0	0	0	0	0	0	0	0	0	0	Provider decided the registry wasn't for him
78	SHIAWASSEE	CJ	01/30/06	01/30/06	26		4	20	6	0	0	0	1	1	2	1	1	0	0	1	with Ingham.
79	TUSCOLA	Sarah	03/06/06	06/07/06	10	04/17/07	2	9	3	0	0	0	0	1	6	2	0	0	0	0	
80	VAN BUREN	Brandy	06/28/06	06/20/06	29		2	7	3	0	0	2	2	7	27	10	0	0	0	0	
81	WASHTENAW	Leesa	07/01/05	09/21/06	72		5	33	16	0	3	2	1	11	58	14	1	0	1	0	
82	WAYNE	Allyson & Leesa	11/12/06	09/12/06	1857	04/04/07	30	18	263	170	62	25	10	6	22	169	33	0	1	2	0
83	WEXFORD	CJ	05/12/06	04/05/06	18		1	7	4	0	0	0	0	2	7	2	1	0	0	0	
TOTALS					4202		47	176	1003	624	87	53	51	46	488	3610	800	30	10	62	60
Change from February Report					+414		+20	+5	+49	+58	-23	+13	+5	+2	+45	+477	+87	+4	0	+8	0

67 Counties have approved providers

17 Counties without approved providers.

**Person-Centered Planning
for Community Based Long-Term Care**

**Practice Guideline
Review Draft March 2007**

“Person-Centered Planning is a process for planning with and supporting the individual receiving services. The process builds upon the individual’s capacity to engage in activities that promote community life and honors the individual’s preferences, choices and abilities.”

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**Person-Centered Planning for Community Based
Long-Term Care
Practice Guideline
March 2007**

“Person-Centered Planning is a process for planning with and supporting the individual receiving services. The process builds upon the individual’s capacity to engage in activities that promote community life and honors the individual’s preferences, choices and abilities.”

I. Purpose

This document provides guidance and technical assistance on how to successfully implement the Person-Centered Planning process with individuals participating in the MI Choice Medicaid waiver program and other community based long-term care services. The Person-Centered Planning process is a contract requirement for MI Choice waiver agents, which provide community-based long-term care services to people who are aging or have disabilities.

The Michigan Department of Community Health, Office of Long-Term Care Supports and Services has convened a discovery and training process for MI

Choice waiver agents and the long-term care community as a whole to identify exemplary practices in Person-Centered Planning. This policy and practice guideline is an outcome of that process.

The Person-Centered Planning process ensures that individuals who need long-term care supports and services have a method for identifying their goals and preferences and the necessary supports and services. The process enables individuals to maintain their lives in the community, increase or maintain their quality of life, and address health and welfare issues.

In the Person-Centered Planning process;

- Individuals know their options,
- Individuals make their own decisions,
- Individual decisions are driven by their life goals and priorities,
- Individuals have the support of allies in planning, developing and implementing their supports and services.

II. Person-Centered Planning Process (PCP)

Definition

Person-Centered Planning is a method used to assist individuals in planning for how they wish to obtain the supports and services they need and want within the context of how they live their lives at home in their communities. The individual directs the planning process with a focus on what he or she wants and needs.

PCP is individualized, designed to respond to the desires and preferences expressed by the individual. As a process for planning and supporting the individual, it builds upon the individual's capacity to engage in activities that promote community life and honor the individual's preferences, choices and abilities. The process also can quickly adapt to changing needs and desires.

Often, individuals select allies to become involved in the Person-Centered Planning process; these allies may include family, friends, professionals, or caregiver staff. The involvement of allies is the choice of the individual; some people will choose not to involve any of their allies or will invite only one or two people to participate. Professionals, who have

traditionally been involved in the planning and delivery of services, may have a role in the Person-Centered Planning process and their recommendations and assessments may be used in the planning process. The supports coordinator must be involved because he or she is responsible for authorizing the service plan. However, the development of the service plan, including the identification of possible supports and services and providers, is based on the expressed needs and desires of the individual rather than the recommendations of the professionals. The individual's choices drive an ongoing process of setting goals (such as where they want to live, how they want to connect with others, the activities in which they want to participate) making plans, selecting supports and services, evaluating progress and outcomes, and revising or setting new goals. The goals and identified supports and services are incorporated into a service plan that includes both paid supports and services (such as MI Choice waiver services) and unpaid support (such as support provided by a spouse) that shapes service delivery implementation and is revised as needed.

III. Background

A. Shifting to a Person-Centered Model

The role of long-term care services is to assist individuals in meeting their health and welfare needs. Historically, long-term care service delivery has been based on the medical model, which focused on treating the health condition of concern. Medical professionals made decisions about treatment and service settings. The setting for long-term care was typically the nursing home. Federal regulations favored this approach. Recently, other community alternatives became more available.

B. History of Person-Centered Planning in Michigan

The movement toward person-centered planning has been growing in Michigan for the past two decades. Originally, person-centered planning was developed as a method for working with persons with developmental disabilities to identify their dreams, goals and preferences.

As the concept was introduced in Michigan in the late 1980s and early 1990s, the independent living

philosophy was incorporated into the Person-Centered Planning process so that the individual could use the planning process to develop the life he or she chooses in the community with work, meaningful activities, friends and relationships and other means of community involvement, just like everyone else. In 1996, legislation was passed that required individuals receiving supports and services in the public mental health system to develop an individual plan of services using a Person-Centered Planning process. In the last ten years, individuals with developmental disabilities and/or mental illness have used this process to pursue their goals to live, work and be involved in the community with the support they need and want.

C. Person-Centered Planning in Long-Term Care

The philosophy of Person-Centered Planning has been embraced statewide as the method for individuals who need long-term care to plan for supports and services to enable them to maintain their lives in their homes, neighborhoods and community and to maintain or obtain connections with other community members. The Michigan Medicaid Long-Term Care Taskforce was appointed by Governor Granholm in 2004 to: “examine and

report on the current quality of Medicaid long-term care services in Michigan and make recommendations for improvement in the quality of Medicaid long-term care services and home-based and community-based long-term care services provided in Michigan.” The final Taskforce report identified Person-Centered Planning as a central policy recommendation. It recommended:

“Use Person-Centered processes and tools to assess and match the individual's needs and desires across a continuum of LTC services based on demonstrated need, effective individualized management and care planning.”

In addition, its seven other recommendations focused on individual choice and control by making available: a continuum of long-term care options, increased awareness and information, options for arrangements that support self-determination, and a well-compensated workforce.

D. Person-Centered Planning and Self-Determination

Person-Centered Planning is a method for identifying an individual's needs and desires and make meaningful choices regarding their lives, self-determination is the belief and value that individuals who need supports and services have freedom and authority to manage their individual budget and directly employ or contract with their service providers. All people who are receiving MI Choice waiver services have the right to develop their supports and services through the Person-Centered Planning process. By the end of 2007, individuals receiving services from any waiver agent in the state also will be able to choose to participate in the Michigan Self-Determination in Long-Term Care program, which enables individuals to choose and employ their own providers, including personal care workers, and to manage the individual budget authorized by the waiver agent.

IV. Implementation of Person-Centered Planning

A. PCP Values and Principles

Person-Centered Planning is an individualized process designed to respond to the expressed needs/desires of the individual.

- Each individual has strengths and the ability to express preferences and to make choices.

The individual's choices and preferences shall always be honored and considered if not always included in the plan due to health and welfare concerns or budgetary restraints.

- Each individual can contribute to the community, and has the ability to choose how supports and services may help them meaningfully participate in and contribute to the community.
- Person-Centered Planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals and desires.
- A person's cultural background shall be recognized and valued in the planning process.¹

¹ Adapted from Person-Centered Planning Policy and Practice Guideline, Michigan Department of Community Health, October 2002.

B. Essential Elements for Person-Centered Planning

There are a number of methods available to accomplish Person-Centered Planning, including, but not limited to: Individual Service Design, Personal Futures Planning, MAPS, Essential Lifestyle Planning, Planning Alternative Tomorrows With Hope. This Guideline does not endorse any particular method or model. Regardless of the model used or whether a formal model is used at all, the following characteristics of Person-Centered Planning are essential to the process of planning with an individual and his/her allies.

- 1. Person-Directed** The plan for the individual is the individual's vision of what he or she would like to be or do. The plan is not static, but rather it changes as new opportunities and challenges arise.
- 2. Capacity Building** Planning focuses on an individual's gifts, talents and skills rather than deficits. It builds upon the individual's ability to engage in activities that promote a sense of belonging in the community.

3. Person-Centered The focus is continually on the individual for whom the plan is being developed and not on fitting the person into available slots in a standard program. The individual's choices and preferences must be honored. If the individual does not communicate verbally, the process accommodates him or her to ensure that the individual's choices and preferences are honored. Guidance on Behavior as Communication is provided below.

4. Network Building The process brings people together both to support an individual (by involving allies in the planning process and honoring their role in individuals' lives) and to support the larger community (by involving community members and by providing a mechanism for individuals receiving services to connect with one another and with community members as desired).

5. Outcome-Based The plan focuses on increasing any or all of the following experiences, which are valued by the individual:

- Growing in relationships or having friends
- Contributing or performing meaningful activities

- Sharing ordinary places or being part of their own community
- Gaining respect or having a valued role that expresses their gifts and talents
- Making choices that are meaningful and express individual identity
- Addressing health and welfare needs
- Planning for end-of-life support, when necessary.

6. Community Accountability The service plan will assure adequate supports when there are issues of health and welfare, while respecting each individual and according him or her dignity as a participating member of the community.²

7. Presumed Competence Person-Centered Planning is based on the premise that everyone has preferences that can form the foundation for how they want to live their life and what their dreams, goals and desires are. The focus is on these preferences instead of on an individual's disabilities, deficits, or level of capacity. In fact, all individuals are presumed to have the capacity to actively participate in the planning process. As described below, it is incumbent

² Items #1-6 were adapted from resolution adopted by the Howell Group of Michigan, October 1994

on the supports coordinator and the individual's allies to find a method to communicate with the individual and discern his or her preferences.

8. Information and Guidance When an individual is planning for arrangements that support self-determination, the Person-Centered Planning process must address the individual's need for information, guidance and support. Information and guidance may relate to the Person-Centered Planning process, options for supports and services, or it may directly relate to a particular need of the individual (such as what living situation would best meet the individual's needs and desires, what activities does the individual wish to pursue, strategies to build or rebuild and maintain relationships, the implications and consequences of a particular choice, or ways to become involved in the individual's community). Information and guidance is essential during the planning process, but also may be needed as service and supports are implemented.

Options should be drawn as broadly as possible from the ranges of long-term care services and generic community supports. Individuals must learn about options in ways that are useful to them. For some

individuals, it may be sufficient to provide a written description of services at the beginning of the Person-Centered Planning process or when seeking information about an option. Other individuals may need to learn about options through explanation, observation or experience. The individual may need to try an option before making a decision. The timing for the learning and decision-making processes might need to be closely aligned.

9. Participation of Allies For most people, the Person-Centered Planning relies on the participation of allies chosen by the individual because of their commitment to support him or her. Most people living in their community already have the involvement of family members, friends, peers; an individual may choose these people as their allies. Individuals may also have important relationships with paid personal assistance workers or other professionals. Each individual's situation and relationships are unique. Some people will want to seek out allies; others will choose to use the Person-Centered Planning process without them. The individual determines who is an ally and may exclude family members or friends for various reasons.

The participation of allies is important for broadening the planning input and sources of support. Allies can help individuals explore their options, articulate their vision of a desirable future, make choices for the future and find ways to solve problems. Chosen allies can be very helpful to the individual and to the supports coordinator in assisting and supporting the individual on a continuing basis as needs arise. Together, the individual and his or her allies learn together and invent new courses of action to make the vision a reality. Individuals who cannot identify family members or friends to participate should be offered support for cultivating allies who can provide this very critical assistance.

10. Documentation The planning results should be documented in ways that are meaningful to the individual and useful to people with responsibilities for implementing the plan. The individual should be aware of and approve all distribution of planning documentation.

V. Practical Considerations in Person-Centered Planning

A. *Planning for Health & Welfare*

The service plan and Person-Centered Planning process must balance health and welfare issues with the individual's right to make his or her own choices. Specific issues of health and welfare must be examined and addressed so that an individual will not find himself or herself in a situation where he or she is at imminent risk. The supports coordinator is responsible for ensuring that issues of health, safety and welfare specific to the individual are brought up, discussed and resolved through the Person-Centered Planning process. Solutions must assure the health and welfare of the individual in ways that support attainment of his or her goals while maintaining the greatest feasible degree of personal control and direction.

Typically, an important need is for a workable back-up system to provide support in the event that providers are unable to be present for a work shift or duty. There a variety of ways to structure a back-up plan and an individual, with his or her supports

coordinator and allies, can develop a back-up plan that meets the needs of the individual.

An individual may choose to address a sensitive health and welfare issue privately with the supports coordinator, rather than within a group planning process. Regardless of how it is done, the supports coordinator has an obligation to ensure that all health and welfare issues are addressed. When the individual makes a decision contrary to the support coordinator's or another professional's recommendation, the supports coordinator must ensure that the individual has information about all available options, document the individual choice, and revisit the issue as needed.

Sometimes, an individual's choices about how their supports and services are provided cannot be supported by the MI Choice waiver program, because the choices pose an imminent risk to the health and welfare of the individual or others. However, these decisions are made as part of the planning process in which the individual and their allies talk about the issues. Often the discussion leads to better alternatives that both meet the individual's needs and satisfy their dreams and goals.

B. Person-Centered Planning and Aging

The Person-Centered Planning process was originally developed and implemented with people with developmental disabilities. Often these were young people who were planning their whole life: the type of work or meaningful activities in which they would participate, where they would live, how they would develop friends and relationships.

Unlike younger people, older individuals have a whole lifetime of choices behind them. They have established a residence, chosen a career or life activities, found hobbies or other meaningful activities, developed friendships and relationships. Even when a person is unable to communicate because he or she has developed an incapacity, this lifetime of choices can be used to discern preferences and priorities. When a person is unable to communicate, life choices can be identified from the individual's surroundings (the presence or absence of photos; or the display of artwork, crafts, collections or awards).

Often, planning with older people focuses on how they can maintain or accommodate their current life. For example, an individual may need personal care or environmental modifications to be able to stay in his or her lifelong home. A person who no longer has the strength or energy to pursue their lifelong hobbies may choose to explore new pastimes.

When a person is in the later stages of life, the challenge may not only be preserving and extending the sources of joy. The individual may need support with a source of frustration or sadness—for example, grieving a deceased spouse or healing a broken or strained relationship with a family member or friend.

For individuals who are dealing with end of life issues, the planning process may involve where an individual wants to die, who they want to be with them, or who they don't want to be with them when they die. Other issues to consider could be; what kind of life-sustaining treatment they want or do not want, and what measures they need to make them as comfortable as possible. The planning process may include a variety of ways to help an individual come to terms with the dying process and obtain needed closure.

C. Behavior as Communication

Supports Coordinators ensure that the individual has the chance to ask questions and the options and choices clearly explained and thoroughly discussed. If the individual needs help understanding something or communicating thoughts, the individual, with his or her allies and/or supports coordinator must determine the best way to facilitate the individual's participation in the discussion.

People with disabilities communicate in a variety of ways. Some people use technology, others use hand signals, some use their voice, and others use picture systems. Some people can only signal yes or no using movement of their head, a hand, or another part of their body.

All people communicate through their behavior; for individuals who do not have other means of communication, behavior may be the primary means of communication. For many people who use behavior to communicate, their behavior may be seen as negative (they may yell, throw an item they do not want, throw a tantrum, or become aggressive).

Supports Coordinators and allies must learn to interpret an individual's behavior to determine what he or she may be communicating. Some behavior communicates emotions such as fear, discomfort, anger, or dislike. Other behavior communicates that the individual has a certain need or request or may want a certain solution or result. The behavior is unique to the individual. Efforts must be made to understand the communication and to find positive methods for the individual to communicate.

D. Involvement of a Designated Representative

Sometimes, a person may wish to choose to designate an ally to help him or her in the planning process. An individual who does not have a guardian may designate another person to help him or her with the Person-Centered Planning process and in implementing the supports and services chosen in that process. Selecting a personal representative may be done formally, by executing a power of attorney, or informally, by asking the representative to serve. Through the Person-Centered Planning process, the individual and his or her allies may determine the best person or persons to serve as representative. A representative must be able and willing to honor the choices and preferences of the individual and support

him or her to take as active role in the process as possible. In the event a personal representative is working counter to the individual's interests, the supports coordinator is authorized to address the issue and work with the individual to find an appropriate resolution.

E. Individual Monitoring and Evaluation of Progress and Outcomes

Just as the individual chooses his or her goals and the supports and services needed to achieve them, the individual should also evaluate progress toward those goals and the outcomes of the service plan. The supports coordinator can support the individual in this evaluation process (evaluation questions and surveys include standard ones required by the waiver agent or individual ones developed by the individual during the Person-Centered Planning process); they can be simple or lengthy. Evaluation may lead to reconvening the Person-Centered Planning process to modify the service plan or resolve a challenge that has arisen.

F. Independent Facilitation

An Independent Facilitator is a person chosen by the individual to guide him or her through the Person-Centered Planning process. An independent facilitator may be a family member or friend or may be an advocate recommended by a friend, provider or supports coordinator. Whether an independent facilitator is used and whom the individual chooses for independent facilitation is up to the individual.

The individual may use an independent facilitator if he or she wants or needs to have someone that assists the individual and advocates for the individual's dreams and goals. Some individuals find it helpful to have a person involved who is outside of the waiver agent and does not make decisions to authorize supports and services and funding. Other individuals like having assistance in arranging the details of the meeting or leading the meeting. An independent facilitator can do one or all of these tasks.

The independent facilitator helps the individual with the pre-planning activities for the Person-Centered Planning process. These activities include who will be involved, the topics to be discussed, and the individual's goals and objectives. When the

individual chooses to involve an independent facilitator, the supports coordinator may not be involved in the pre-planning process. The facilitator serves as the individual's advocate throughout the process, making sure that his or her needs and concerns are heard and addressed.

VI. The Steps of Person-Centered Planning

A successful Person-Centered Planning process puts individuals in charge of their own lives and planning, focuses on strengths, skills and/or life accomplishments, and acknowledges and honors individual preferences. A supports coordinator supports, guides, informs and assists the individual in learning about the Person-Centered Planning process and assures that the individual controls the Person-Centered Planning process. The planning process is not a single meeting. The individual may have a meeting every year, or more often, if needed. The individual may call a Person-Centered Planning meeting every time his or her wants and needs change.

Step #1 – Initial Contact & Getting Started

The Person-Centered process begins as soon as the individual enters the long-term care system and continues as the individual seeks changes. A supports coordinator chosen by the individual helps him or her navigate through the full array of services, supports, settings, and options. The supports coordinator ensures that the individual is provided with information regarding choices the individual can make. The supports coordinator provides information on the option for independent facilitation. Even if the individual chooses an independent facilitator, the supports coordinator is involved in the Person-Centered Planning process and authorization of supports and services paid for by the waiver agent.

Often individuals enter the long-term care system in a medical or other crisis. In those situations, immediate steps are taken to resolve the crisis and stabilize the individual's situation. Person-centered planning can begin only after the crisis is resolved.

Step #2 – Pre-Planning

Individuals must have opportunities to prepare for Person-Centered Planning process. This includes understanding the purpose, key aspects of the process (e.g. roles of the meeting participants, discussion

questions for the meetings), and the options under consideration. The individual can choose to do a pre-plan with his or her supports coordinator, an independent facilitator or a trusted ally or allies. Preparation should occur in ways that are effective for the individual, which may include a planning meeting or meetings, role-playing or practice sessions, written information or other methods.

- **Scope of the planning** The individual determines the scope of the planning. Person-Centered Planning generally asks the person to think broadly about dreams, goals and priorities. However, an individual can choose to talk about a specific topic, or challenge or even what is working or not working in his or her daily life. Both can improve an individual's quality of life and ability to maintain a life in the community.
- **Relationship between Person-Centered Planning and service plan** One implication of the broad scope of Person-Centered Planning is that it informs service or care planning; that is, the individual's life plans should give direction to supports and services that the individual needs in order to realize his or her goals. The Person-

Centered Planning process is also the way the individual determines the type of supports and services he or she needs that are authorized and paid for by the waiver and who will provide the services and supports. This plan is called a service plan. The purpose of the plan is to help the individual to be as independent and self-sufficient as possible and build ways for them to participate in their community as desired. These supports and services include Medicaid covered services, waiver services, and services available from other government programs. The service plan must contain the date the service is to begin, the specified scope, duration, intensity of each service and who provides the service. The individual's plan may also include informal supports that family and friends provide, as well as supports and services from other government programs.

- **Individual control over the planning process as well** The individual's choices include choosing the meeting participants, participant roles (e.g. who will facilitate), location, schedule, and meeting agenda. The site and time of the meetings should accommodate the individual and key allies. The agenda should include issues the individual wants

to discuss; it should also exclude issues the individual does not want to discuss.

Topics for pre-planning

In pre-planning, the individual should think about and choose:

- the dreams, goals, desires and the topics the individual wants to talk about at the meeting
- likes and dislikes, what the individual would like more or less of in his or her life, and what the individual seeks to change
- fears or concerns the person identifies as topics for discussion.
- topics the individual does not want talked about at the meeting
- who, among their friends, family members, professional providers, staff, and fellow community members the individual wants to invite to participate in the Person-Centered Planning process
- where and when the meeting will be held
- who leads the meeting and the discussion. The individual may want to lead the discussion. The individual may want their supports coordinator to facilitate the meeting or they may want to

- select an independent facilitator to lead the discussion
- who records in writing what happens at the meeting

Topics for a Person-Centered Planning meeting

These will vary, depending on the individual, but could include:

- What are the individual's goals and dreams for the future or how do they want to live his or her life?
- What does the individual want more or less of in his or her life?
- Who does the individual want to spend time with?
- What new things would the individual like to do or learn?
- What are some great things others should know about the individual?
- What help and assistance does the individual need?
- What things could get in the way of the individual's dreams and goals?
- What does the individual like to do in his or her free time?
- What supports and services does the individual need to achieve his or her goals and dreams?

- What activities is the individual interested in? (job, hobbies, recreational activities, or volunteer opportunities)
- What health and welfare needs does the individual have?

Step #3 – The Person-Centered Planning Process

The planning process is not a single meeting. The individual may have a meeting every year, or more often, if needed. The individual may call a Person-Centered Planning meeting every time his or her wants and needs change.

A Person-Centered Planning meeting may begin with all of the participants introducing themselves and sharing why they are participating in the meeting. The meeting may start with what is currently working and not working for the individual. Or the individual may start by sharing his or her hopes, dreams and desires for the future. Everyone gets to know the individual better and helps the individual with developing his or her plan to the extent help is asked for by the individual. The individual talks about what may get in the way of achieving his or her goals. It may be a physical or health issue or a skill that the individual wants or needs to learn, or a type

of assistance or support that the individual needs. Health and welfare issues are also discussed.

After all of the issues are discussed, the individual and their allies work together to determine what supports and services the individual needs to achieve their goals and dreams and who can help the individual do so. These include the paid supports in the individual's service plan, and the unpaid supports such as the help the individual's friends, family members and other allies provide the individual. The plan may be completed in a single meeting or it may evolve over several sessions.

If the individual is unhappy with his or her service plan, the individual must let their supports coordinator know. The individual has the right to reconvene the Person-Centered Planning process or to appeal through the Michigan Department of Community Health Fair Hearing Process. The waiver agent also has a dispute resolutions process.

VII. Organizational Components for Implementing Person-Centered Planning

Shifting from traditional service delivery methods to developing and implementing service plans through the Person-Centered Planning process requires a change in the organization's orientation. Instead of fitting individuals into existing programs, available supports and services must be adapted to meet the needs and desires of the individuals. The following characteristics are essential for organizations responsible for providing supports and services through the Person-Centered Planning process.

A. *Person First Language*

Person first language puts the person before the medical, physical or mental condition and maintains the emphasis on the humanity and dignity of the individual. For example, instead of *arthritic person*, the appropriate term would *person with arthritis*.

Using person first language is an important first step in reorienting the organization toward the individuals and their needs and desires. Instead of viewing individuals through the narrow scope of their condition or disability, the needs of the whole individual, as well as his or her support system, are identified and addressed.

B. Person-Centered Orientation

The focus must continually be on the individual for whom the plan is being developed and not on plugging that person into available slots in programs. Waiver agents have the responsibility to avoid unintended and detrimental consequences of their involvement, such as individuals becoming disempowered by deferring to professional decision-making, or families becoming displaced by service providers. The general strategy for avoiding these consequences is to presume competence and capacity by the individual, allies and the community, and to only provide assistance when the current situation leaves unmet needs. Just as the language for individuals receiving services has changed, the term supports coordinator has replaced terms such as care manager or case manager to identify the change in role from one who is managing or directing care to one who is supporting an individual to self direct their supports and services.

C. Training, Mentoring and Support for Staff

The staff should have training and supervision to ensure that they have the knowledge and capacity to meet their PCP responsibilities. These responsibilities may include: providing information and guidance to

individuals receiving or seeking supports and services, facilitating the planning meetings as requested by the individual, suggesting creative strategies to address the needs and desires of the individual, and monitoring the effectiveness of the Person-Centered Planning process and service implementation. Training in the tools and methods of Person-Centered Planning process is critical in giving supports coordinators the background to support a variety of individuals and provide a unique response to each individual; peer mentoring and support may be helpful to develop support coordinator capacity in this area. In addition, support coordinator positions should be designed to accommodate this new role. For example, caseload size must allow for sufficient personal contact, authority to make decisions in support of the individuals' choices, flexible hours and minimal competing duties. Staff performance reviews should include consideration of how well the staff person contributes to Person-Centered Planning, supports individual choice and helps realize individual goals. Staff performance evaluation should include Person-Centered Planning performance.

D. Community Resource Development

Information on community resources must be available to all staff and individuals. Waiver agents must map community resources and options for community involvement and participation in which individuals express interest must be investigated. The waiver agent must work with other community and government organizations to resolve barriers and advance common aims. This collaborative may include developing resources to meet unmet needs and developing collaborative agreements to resolve barriers and ensure effective resource utilization.

E. Information and Guidance

Each waiver agent must have an organizational commitment to provide information and/or experiences that sufficiently inform an individual of her or his options. Upon initial screening and eligibility determination, supports coordinators must provide individuals and their allies with written information about the right to the Person-Centered Planning process. Supports coordinators may also ensure that individuals have tools to successfully use the Person-Centered Planning process, develop individual quality service expectations that address preferences and evaluation of personal outcomes and goals, and implement arrangements that meet their

needs. The supports coordinator must offer additional information and support to the individual and directly address concerns that the individual may have either over the phone or in a face-to-face meeting. Continued assistance is available throughout the planning process, which continues and evolves as each individual receives waiver services. This commitment should be met through multiple and flexible means of providing information. These might include alternative forms of communication (e.g. Braille, sign language, audio-recorded documents), hands-on experiences with options and peer support from individuals who have experience using the same supports and services. Individuals and their allies are provided with telephone numbers to contact supports coordinators when new needs emerge that require the assistance of the supports coordinator or the reconvening of the Person-Centered Planning process.

F. Evaluation and Quality Management

The effectiveness of both the person-centered planning process and the outcomes of that process must be evaluated. The approach to evaluation and quality management must collect and use data,

including feedback from individuals on their views of the success of the Person-Centered Planning process and how the process impacts both the service plan development and service plan utilization. Data must be sought through multiple methods such as mail, phone or in-person surveys, focus groups, and other feedback loops.

Measures on the effectiveness and success of the person-centered planning process include whether: the individual invites allies important to them to participate in the process, the individual decides who will run person-centered planning meetings, the individual chooses meeting topics and the time and location of the meeting, and the individual's wants and needs are included in the service plan. A short written survey to evaluate the planning process must be provided to the participant with the authorized service plan; follow-up must be offered to assist the individual in completing the survey in the way that works best for him or her within 30 days of completion of the planning process.

Evaluation of the outcomes of the person-centered planning process include how the services and supports in the plan impact on the individual's ability to realize personal choices, maintain or increase

individual's quality of life, and assist in achieving his or her dreams and goals. Data should also be collected and analyzed to assess the impact of the Person-Centered Planning process on individual choices—both realized and not realized, barriers to realizing choices and achieving goals, and efforts to resolve barriers and assess participant quality of life. This data should be collected and analyzed using the Participant Outcome Status Measures (POSM) Quality of Life Assessment at least annually.

This quality management process and resulting data is used to improve services and make decisions that lead to better lives for individuals. The goal is to develop a sense of the success of PCP from the individual's viewpoint. Individual preferences are identified in through the Person-Centered Planning process and the evaluation and quality management process needs to reflect the success of supports and services to both include and address these preferences. This management information should be considered in organizational planning, including allocating resources.

After person-centered planning has been implemented over a period of time, the service plans

and individual budgets when reviewed across the system can provide useful information about what supports and services are being used by individuals and how resources are being allocated. Such an evaluation is valuable source for information on individual preferences that can provide guidance on how financial and other resources may be allocated in the future and what community capacity and relationships need to be developed.

VIII. Glossary

Allies Friends, family members and others that the individual chooses to assist him or her in the Person-Centered Planning process. Allies participate because of their commitment to supporting the individual, not because participation is one of their job duties. The individual determines who is an ally. Allies *may* include family members, friends, or advocates. Allies are not paid professionals (even though professionals may be very committed to supporting the individual).

Arrangements that support self-determination

Methods for an individual to accomplish self-determination in his or her life.

Independent Facilitator A person the individual chooses to guide and support him or her through the Person-Centered Planning process.

Independent Living The term used for both the philosophy and the movement that all people with disabilities, including people with significant disabilities, can maintain a life in the community—with work or other activities, a home, and personal relationships—if they have the right supports and services.

Service Plan The plan of supports and services for an individual that will be authorized and paid by the waiver agent.

Medicaid A government program that provides funding for supports and services authorized by the waiver agent.

Person-Centered Planning Process a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and honor the individual's preferences, choices and abilities.

Self-Determination The belief and value that individuals who need supports and services have the freedom to define their lives, make meaningful choices regarding their lives and have the opportunity to direct the supports and services they need to pursue their lives.

Waiver Agent The agency that authorizes the individual's service plan.

Supports Coordinator A person who works for the waiver agent and works with an individual to develop and authorize a service plan. The supports coordinator also provides other assistance and support to the individuals they serve.

Long Term Care Connections Logic Model Action Plan (Draft March 19, 2007)

The goal of the project is to establish ADRCs to serve as a comprehensive resource on long term care and provide information and assistance in accessing services, planning for long term care financing and delivery, benefits outreach and proactive choice counseling for the general population.

The Michigan Long Term Connections Provides comprehensive, reliable, unbiased information to consumers, caregivers, and providers on accessing long term care services. Original Grant Goal #1: Offer consumers the opportunity to explore a wide range of long-term care options in order to develop individual plans of care based on informed choice Original Grant Goal #6: ADRC/SPE operations demonstrate cultural competency				
Activities/Process	Outputs	Measures	Outcomes	Outcome Measures
Develop outreach standards.	Standards	Local outreach efforts use standards	Outreach campaign reaches economically and culturally diverse populations.	% respondents in RDD survey familiar with MILTCC
Develop marketing plans for each MILTCC site.	Marketing plans	Activities planned for local outreach	MILTCC is a recognized source of LTC Information.	<i>Total number and percentage of population served based on census figures for new and repeat contacts</i>
Implement outreach activities to market LTCC to community partners and consumers.	Presentations Media Releases	<i>Number and types of outreach activities</i>	Community partners refer consumers to MILTCC.	<i># of Contacts to MILTCC by referral source</i>
Develop policy regarding distribution of materials advertising the services of particular providers.	Provider material policy	Description of excluded materials	Consumers find the information they receive to be reliable.	Response to consumer survey questions
Develop/collect consumer education materials	Consumer education materials	Materials	The information shared with consumers is comprehensive. The information shared with consumers is unbiased. <i>Can we come up with an operational definition of 'unbiased'?</i>	Servicepoint records
Develop provider resource information template for Servicepoint	Resource database	Standard information is documented on all providers	Consumers were linked with resources within their region.	
Develop standards for resource information in Servicepoint	Resource information standards	Standards	Consumers considered information to be culturally appropriate.	

Items in italics refer to ADRC-MDS/SART Data Elements

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Create, maintain, and update resource database according to standards.	Resource records	# of resources Types of resources	Consumers receive information in a timely way.	
Train staff on information in the resource directory. Train staff on consumer education materials available through MILTCC.	Training materials	<i># of trainings</i> <i>Type of training</i>	MILTCC staff are knowledgeable about the resources available in the directory. MILTCC staff are knowledgeable about the available consumer education materials.	Response to training evaluation survey
Provide information and materials educating consumers on how to evaluate providers in meeting long term care needs.	Consumer Education Materials	<i># of information packets mailed to consumers</i> <i># hits on consumer guide webpage per month</i>	Consumers have the information they need to apply for, evaluate, and select long term care services. Consumers find the LTC information provided by MILTCC useful when making choices.	Response to consumer survey questions.
Provide information to consumer about planning and self determination with long term care services.	Consumer education materials	# of informational brochures provided # of face to face conversations # hits on web site	Consumers have the information they need about planning for long term care services. Consumers have the information they need to make their own decisions.	Response to consumer survey questions
Connect consumers to community experts to provide information related to special needs of consumers. Distribute special needs guides to appropriate consumers.	Resource directory referrals Mailings	# referrals # and type of consumer guides available #of guides mailed to consumers	Primary and secondary consumers with special needs have the information they need about specialized resources. Primary and secondary consumers with special needs find the information they received useful	Response to consumer survey questions

Items in italics refer to ADRC-MDS/SART Data Elements

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		# of hits on website (if available)	when making choices.	
Connect consumers with education providers and resources regarding health, chronic disease, and elder safety.	Resource directory referrals	# of referrals # of resources available	Primary and secondary consumers have the information they need about activities and behaviors that contribute to better health.	Response to consumer survey questions
Distribute information related to optimizing health, managing chronic disease, and elder safety.	Mailings	# of guides mailed # of hits on website (if available)	Primary and secondary consumers find the information they received about optimizing health, managing chronic disease, and elder safety useful when making choices.	
Conduct caregiver assessments to determine needs	Caregiver assessments	# of assessments completed Types of needs articulated	Caregivers feel their needs are understood by MILTCC staff. Caregivers feel involved and supported by MILTCC staff.	Response to caregiver survey questions
Connect caregivers with resources related to their needs and roles.	Resource directory referrals	# of resources available Types of resources available	Caregivers have the information they need about the caregiving role, how to support the primary consumer, and how to protect their own physical and mental health.	
Provide caregivers with special information related to their needs and roles.	Mailings Face to face Phone calls	# of guides mailed # of hits on website (if available)	Caregivers find the information they received useful when helping their loved one and themselves.	

Items in italics refer to ADRC-MDS/SART Data Elements

Long Term Care Connections Logic Model Action Plan (Draft March 19, 2007)

The goal of the project is to establish ADRCs to serve as a comprehensive resource on long term care and provide information and assistance in accessing services, planning for long term care financing and delivery, benefits outreach and proactive choice counseling for the general population.

The Michigan Long Term Connections Project works towards a goal of seamless efficiency in assisting consumer and families with long term care needs.

Original Grant Goal #2: Faster access to services through streamlining the multiple eligibility and assessment processes

Activities/Process	Outputs	Measures	Outcomes	Outcome Measures
<p>Convene Interagency Workgroup to share information and discuss ways to develop shared assessments to avoid duplication in Level of Care determination for consumers.</p> <p>Review carefully</p> <p>Describe other activities, e.g. 'Develop and implement electronic universal assessment'</p>	<p>Electronic universal assessment</p> <p>Note: which are performed by everyone or selected agency</p>	<p><i>Flow Chart of clinical eligibility process pre and post MILTCC</i></p>	<p>There is a shared understanding of process across the long term care system (i.e., MSA, OSA, DHS, DCH).</p> <p>Level of Care determinations are completed in a timely manner.</p> <p>Level of Care determinations are processed accurately.</p> <p>Note: Do we want to define a level of accuracy? Is there any way to know this?</p>	<p>Response to stakeholder survey questions</p> <p>Response to consumer survey questions</p> <p>Time to assessment completion is improved from baseline measures. Is this feasible?</p>

Items in italics refer to ADRC-MDS/SART Data Elements

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The Michigan Long Term Connections Project works towards a goal of seamless efficiency in assisting consumer and families with long term care needs.				
Original Grant Goal #2: Faster access to services through streamlining the multiple eligibility and assessment processes				
Activities/Process	Outputs	Measures	Outcomes	Outcome Measures
<p>Convene Interagency Workgroup to share information and discuss ways to develop shared functional modular assessments to avoid duplication for consumers.</p> <p>Review carefully</p> <p>Include more description of activities, e.g. ‘Develop and implement functional modular assessment process’</p>	<p>Modular Assessment</p> <p>Collaborative Assessment protocol</p> <p>Note: which are performed by everyone or selected agency</p>	<p><i>Flow Chart of clinical eligibility process pre and post MILTCC</i></p>	<p>There is a shared understanding of process across the long term care system (i.e., MSA, OSA, DHS, DCH).</p> <p>Functional assessments are completed within mandated timelines.</p> <p>Consumers feel assessments are completed in a timely manner.</p>	<p>Response to stakeholder survey questions</p> <p>Response to consumer survey questions</p> <p>Time to assessment completion is improved from baseline measures. Is this feasible?</p>
<p>Convene Interagency Workgroup to share information and discuss ways to develop shared assessments to avoid duplication in financial eligibility determination for consumers.</p> <p>Review carefully</p> <p>Include more description of activities, e.g. ‘Develop and implement universal, multi-purpose financial assessment process’</p>	<p>Electronic multi-purpose financial eligibility determination</p>	<p><i>Flow Chart of financial eligibility process pre and post MILTCC</i></p>	<p>There is a shared understanding of process across the Long term care system (i.e., MSA, OSA, DHS, DCH).</p> <p>Financial eligibility paperwork is completed within mandated timelines.</p> <p>Consumers feel financial eligibility is assessed in a timely manner.</p>	<p>Response to stakeholder survey questions</p> <p>Response to consumer survey questions</p> <p>Time to paperwork completion is improved from baseline measures. Is this feasible?</p>

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The Michigan Long Term Connections Project works towards a goal of seamless efficiency in assisting consumer and families with long term care needs.				
Original Grant Goal #2: Faster access to services through streamlining the multiple eligibility and assessment processes				
Activities/Process	Outputs	Measures	Outcomes	Outcome Measures
<p>Build relationships with providers representing special constituencies to discuss opportunities to work together and to build resources for consumers.</p> <p>Are other activities going to take place, such as developing provider training opportunities?</p>	<p>MOUs with representatives from agencies</p> <p>New resources for consumers</p>	<p># of MOUs</p> <p>Listing of partner groups</p> <p>Listing of new resources</p>	<p>MILTCC staff and partners understand the specialized needs of consumers.</p> <p>Consumers with specialized needs receive the support they need to connect with appropriate services and supports.</p>	<p>Response to staff survey questions</p> <p>Response to stakeholder/partner survey questions</p> <p>Response to consumer survey questions</p>
<p>Develop strategy to share Servicepoint consumer information with contracted providers, if feasible.</p>	<p>Servicepoint consumer information</p>	<p>(Listing of Shared data fields)</p>	<p>Providers use Servicepoint.</p> <p>Consumers do not experience duplicate requests for information.</p>	<p>Servicepoint records</p> <p>Response to consumer survey questions</p>
<p>Promote flexibility to allow co-location of agency staff and geographic deployment within MILTCC region.</p>	<p>Location of MILTCC staff</p>	<p>Percentage of central and decentralized staff</p>	<p>Consumers are able to access multiple services in the same location.</p> <p>Consumers feel that MILTCC offices are conveniently located.</p>	<p>Length of time to record/assessment completion. Is this feasible?</p> <p>Response to consumer survey questions.</p>

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Long Term Care Connections Logic Model Action Plan (Draft March 19, 2007)

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The Michigan Long Term Connections Project facilitates Access to Services through the use of appropriate information, assistance in determining eligibility and options counseling.

Original Grant Goal #1: Offer consumers the opportunity to explore a wide range of long-term care options in order to develop individual plans of care based on informed choice

Activities/Process	Outputs	Measures	Outcomes	Outcome Measures
<p>Staff at MILTCC sites learn about community needs assessment tools and strategies.</p> <p>Complete community needs assessment / environmental scan.</p>	<p>Listing of tools and strategies</p> <p>Community report</p>	<p>Evaluation of assessment.</p> <p>Summary of resources, needs, challenges, & success.</p>	<p>Board members and MILTCC staff feel the results of the needs assessment are accurate and useful.</p> <p>The board and MILTCC staff use results to make decisions and to inform planning.</p> <p>The results of the needs assessment are used to communicate gaps to officials.</p>	<p>Response to board survey questions.</p> <p>Response to staff survey questions.</p>
<p>Develop standards for information and assistance, and Options Counseling</p> <p>Train staff in standards, procedures, and protocols to assist consumers.</p> <p>Train staff in I&A, Options Counseling, financial eligibility determination, and functional assessment.</p>	<p>Standards</p> <p>Training manuals</p> <p>Training plan</p> <p>Trainings</p>	<p>Listing of standards</p> <p># of trainings held</p> <p>#of staff trained</p> <p>Staff satisfaction with training</p>	<p>Staff understand the material presented.</p> <p>Staff feel they can apply the information to their work.</p> <p>Staff serve consumers in a way that is consistent with their training.</p>	<p>Response to staff training survey question.</p> <p>Response to consumer survey questions.</p> <p>Response to stakeholder/partner survey questions.</p>

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			Staff demonstrate cultural competence when serving consumers. Consumers and providers trust the expertise of MILTCC staff.	
Consumer calls are received and addressed appropriately. NOTE: do all calls go through an operator first or do some I&A people answer phones?	Case records	<i>Total # of Contacts made to MILTCC</i> # providers, consumers, caregivers calling # of people who received each type of service. # people with completed and open calls	Consumers and providers felt they came to the right place for information and assistance. Consumers would use the MILTCC services in the future as needed.	Response to consumer survey questions. Note: Calls coming into the MILTCC may be completed by I&A counselors or Options Counselors. Many of the same measures will be used regardless of who completes the call.
MILTCC staff provide consumers with the information and assistance they desire. Factual information is used to develop referrals.	Case records	<i>Total #Individuals receiving I&A</i> # and types of information delivered to consumer based on I&A request # of referrals made by I&A counselor by type of service & funding type # repeat calls	Consumers received information that was specific to their needs. Consumers receive the information and assistance they need to access the services they desire. There is more overlap here with the Information	Response to consumer survey questions.

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			goal – we can repeat outcomes here, but I don't think it's necessary.	
MILTCC staff provide options counseling to consumers who seek it.	Case records	# consumers engaging in options counseling	Consumers receive the counseling they need to access the services they desire. Consumers develop a trusted relationship with the options counselors. There is overlap here with the 'Consumer driven' outcome.	Response to consumer survey questions.
MILTCC staff complete necessary paperwork for financial eligibility determination for those consumers who seek it.	Case records	<i>Total # Individuals receiving Financial Eligibility Assistance</i> <i>#of financial eligibility determinations for those over and under age 60</i> <i>#enrolled in Medicaid or other programs</i> <i>Institutional Care</i>	Consumers who wanted financial eligibility assessment received the assistance they needed to successfully complete the necessary paperwork within mandated timelines.	Response to consumer survey questions Case records
MILTCC staff provide Level of Care determination to consumers who seek it.	Case records	<i># of Level of Care Determinations for those over 60 and under 60</i>	Consumers who wanted LOC determination	Response to consumer survey questions.

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		<i>(Initial, Change in condition, Recertification)</i>	received the assistance they needed to successfully complete the assessment processes within mandated timelines.	Case records
Consumers are monitored through follow up	Case records	# of follow up calls from consumer to MILTCC # of follow up calls from MILTCC to consumers Timing of follow up calls Number of consumers who chose various follow-up options	Consumers received what they needed to connect with services and live in their residence of choice. Consumers received what they needed to address new needs through follow up calls.	Response to consumer survey questions.
Target individuals at risk for lack of choice in community based care setting due to unstable community placement due to precipitous care event, eminent hospital discharge, lack of knowledge and choices, or current placement in nursing home setting.	Identification of targeted individuals.	Number of consumers transitioning from one setting to another	Consumers in targeted populations receive the information, assistance, and counseling they need to access the services they desire and live in the residence of their choice.	Response to consumer survey questions.

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<p>The Long Term Care System is a consumer driven system allowing consumers the desired level of control over their residential setting and care choices.</p> <p>Original Grant Goal #4: Consumer's voice is integrated into ADRC/SPE organizational governance</p> <p>Original Grant Goal #5: Person-centered planning and consumer direction are the basis for individual planning</p>				
Activities/Process	Outputs	Measures	Outcomes	Outcome Measures
The Consumer Advisory Board meets and makes recommendations.	<p>Consumer Advisory Board Membership</p> <p>CAB attendance & meeting records</p> <p>CAB recommendations</p>	<p># of members and consumer group they represent</p> <p>Attendance lists & minutes</p>	<p>Consumer Advisory Board input is valued and acted on.</p>	<p>Response to Consumer Advisory Board survey questions.</p> <p>Response to staff survey questions.</p> <p>Response to Governing Board survey questions.</p>
Consumers are active members of MILTCC Governing Boards.	<p>MILTCC Governing Board membership</p> <p>Staffing strategy to facilitate primary consumer participation.</p>	<p># of primary and secondary consumer members on MILTCC Governing Board</p> <p>Attendance lists & minutes</p>	<p>The decisions of MILTCC Governing Boards reflect consumer input.</p> <p>Consumers feel that their participation on the Board is supported.</p>	<p>Response to Governing Board survey questions.</p> <p>Response to staff survey questions.</p>
PCP policy guidelines are developed and disseminated to MILTCC staff.	Policy guidelines	# guidelines disseminated	Staff understand PCP guidelines.	Response to staff survey.
MILTCC staff are trained in Person Centered Planning.	Training	# of staff trained in PCP process	Trained staff understand PCP principles.	Response to staff training survey.
Person Centered Planning is practiced by MILTCC staff.	Case records	Specified below...	PCP approaches are used when assisting consumers.	<p>Response to consumer survey questions.</p> <p>Some type of observational method?</p>

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MILTCC staff determine the needs of the primary and secondary consumer.	Case records	Needs articulated & by whom	Consumers feel that their needs are understood.	Response to consumer survey questions.
MILTCC staff determine the resources and assets of the consumer.	Case records	Resources and assets articulated	Consumers feel that their resources and assets are understood.	Response to consumer survey questions.
MILTCC staff support self-determination	Case records	# of consumers who are interested in self-determination and level of control preferred	Consumers feel that their goals for self-determination are understood and supported by MILTCC staff. Consumers are satisfied with their level of self-determination and control in decision making and care management.	Response to consumer survey questions.
MILTCC staff identify the preferences of the consumer.	Case records	# of times Consumer preferences are articulated and recorded in consumer records	Consumers felt satisfied that their preferences were understood and supported. Consumers had what they need to access the services they preferred. Preferences that were frequently unmet were	Response to consumer survey questions.

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			used to influence MILTCC planning.	
MILTCC staff provide consumers with options to choose from that are appropriate to their needs and preferences.	Case records	# and type of options presented to consumers	Consumers received options to choose from that fit their needs and preferences. Consumers had what they needed to access the services of their choice.	Response to consumer survey questions.
MILTCC staff act as consumer advocates.	Case records	# and type of advocacy provided to consumers	Consumers received the advocacy they needed to access services. Creative solutions to meet consumers' needs and preferences were identified.	Response to consumer survey questions. Response to staff survey questions.
MILTCC staff facilitate future planning.	Case records	# of Consumers assisted with developing future plans.	Consumer feels future needs are understood and supported. Consumer is satisfied with the future planning they receive.	Response to consumer survey questions.
MILTCC staff maintain contact with the consumer through follow-up.	Case records	# and time frame of follow-ups	Consumer is satisfied with follow-up activity.	Response to consumer survey questions.

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The Michigan Long Term Care Connections Project strives for effectiveness in program implementation				
Activities/Process	Outputs	Measures	Outcomes	Outcome Measures
Staff are hired and trained in sufficient numbers to adequately serve consumers and their families.	Case records Staffing records Staff satisfaction	<i>Number of FTEs by job category</i> <i>#new contacts by job description at MILTCC</i> <i>#repeat or existing contact/clients by job description</i> Response to staff survey questions	Consumers are served within MILTCC timelines. Consumers feel they are served in a timely manner. Consumers do not feel rushed to make decisions.	# of consumers served within timeframes Response to consumer survey questions
Conduct time studies to determine amount of time needed for each function performed at MILTCC site.	Time study report	<i># of minutes and hours per client for services</i>	Staff feel they have adequate time to serve the needs of consumers.	Response to staff survey questions
Study functional staffing models.	Models	<i>#hours in specialized activity</i> <i># of staff in specialty function by specialization</i> <i>Use of specialty staff</i> <i># of staff cross trained</i> <i>Use of cross-trained staff</i>	MILTCC sites have a plan for surge capacity. What does this mean? Consumers with special needs have access to specialty staff.	Response to staff survey questions

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A grievance process will be developed.	Grievance Procedures	# consumers utilizing grievance procedures	Consumers are satisfied with how their grievances are handled.	Response to consumer survey questions
MIS workgroup will be convened. Servicepoint will be developed and modified to track callers, consumers and resources, and produce data reports. Staff will be trained in entering data in Servicepoint. Remote data input capability will be developed for staff offline.	List of fields needed for data management and reporting in Servicepoint Training Fields needed for remote data entry	Inclusion of fields in software Training attendance Fields and forms for uploading	Servicepoint contains the necessary fields. Staff understand how to use Servicepoint. Data are recorded and reported accurately. Information technology supports MILTCC sites' business model for consumer tracking. What does this mean?	Accuracy of data reports Response to staff survey questions
Data software (Servicepoint) will be used to manage consumer information	Case records Resource database	Level of missing data Data quality	Staff consider Servicepoint data reliable and valid. Staff report satisfaction with Servicepoint.	Response to staff survey questions
A Continuous Quality Improvement process will be developed to track challenges and success. MILTCC staff will review QA protocols and procedures regularly.	CQI plan QA protocols and procedures CQI measures	Reporting on CQI measures	MILTCC sites use data from CQI process to make improvements.	Response to staff survey questions Response to board survey questions

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<p>CQI measures will be developed and implemented.</p> <p>MILTCC will share QA information with governance and stakeholders.</p>				
<p>A strategy to track the LTC costs by individual will be developed and implemented.</p>	<p>Report describing strategy</p>	<p>To be defined</p>	<p>The costs of various care options can be compared.</p>	<p>To be determined</p>
<p>The long term care system will assess its effectiveness in serving consumers.</p>	<p>Evaluation</p>	<p># of people served through MILTCC</p> <p>Evaluation results</p>	<p>Consumers felt the process was an effective means of meeting their priority needs.</p> <p>Consumers received what they needed to use public and private funds to access services.</p> <p>Consumers feel MILTCC has had a positive impact on their lives.</p> <p>Consumers feel they can actively participate in their LTC planning.</p>	<p>Response to consumer survey questions</p>

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The Michigan Long Term Care Connections System seeks to improve system capacity through evaluation of system change and consumer success in accessing services.				
Activities/Process	Outputs	Measures	Outcomes	Outcome Measures
The capacity of the LTC system to meet consumer needs and preferences will be determined.	Needs assessment reports Unmet needs and preferences documented in case records Unmet needs and preferences documented in evaluation	Unmet needs and preferences identified by consumers, staff, and partners Reasons for unmet needs and preferences	LTC system uses information collected to adjust and adapt to meet consumer needs and preferences. Unmet needs and preferences decrease over time.	Response to staff survey questions Response to partner survey questions
Stakeholder groups will receive information about evaluation results.	Reports Presentations	# of presentations of evaluation results # reports disseminated Audiences reached	LTC system uses evaluation results to inform decisions.	Response to staff survey questions Response to partner survey questions

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