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Michigan Long-Term Care Supports and Services Advisory Commission Meeting of July 27, 2009 Lansing, MI

- Agenda, Monday, July 27, 2009
- Single Point of Entry Demonstration, "*Highlights of Cost Effectiveness Evaluation*" – Eileen Ellis, Health Management Associates
- Project 2020, "*Building o the Promise of Home and Community-Based Services*" – Sharon Gire, Director, Office of Services to the Aging
- Project 2020 – Overview of the Proposal
- Logic Model Recommendation # 5 Health Promotion/Caregiver Support
- Background on Task Force Recommendation # 5
- Chronic Care Model
- Proposed Resolution – Assistive Technology
- Logic Model Recommendation # 7 Establish a New Quality Management System
- Public Comment

**MICHIGAN LONG-TERM CARE SUPPORTS & SERVICES
ADVISORY COMMISSION
MONDAY, JULY 27, 2009 FROM 10:00 – 4:00
AGENDA**

I. 10:00 A.M. Organizing Ourselves

- A. Introductions/Roll Call
- B. Review & Approval of May Draft Minutes
- C. Review & Approval of July Agenda

II. 10:15 A.M. SPE Evaluation Presentation

- A. *“Cost Effectiveness of Michigan’s Single Point Entry or Long-Term Care Connections Demonstration”* Final Report
– Eileen Ellis, Health Management Associates

III. AoA Grants and Update on Project 2020

- A. ADRC and the CLP Grants – OLTCSS Director Peggy Brey
- B. Project 2020 – OSA Director & Ex-Officio Commissioner Sharon Gire
- C. Commission Q & A

[12:30 LUNCH BREAK]

IV. 1:00 P.M. What Else is Happening

- A. Public Comment
- B. Logic Model Review: Task Force Recommendation on Chronic Care Management & Prevention
– Commission Workgroup Chair, RoAnne Chaney & OLTCSS PAT Lead, Nora Barkey
- C. Logic Model Review: Task Force Recommendation on Quality Management System
– OLTCSS PAT Lead, Pam McNab
- D. OLTCSS Integration & LTC Appropriations Updates
– OLTCSS Director Brey & Co. + Commissioners

[BREAK @ 2:30]

V. 3:00 P.M. What Needs to Happen

- A. Workgroup Updates: Chronic Care Management/Prevention Resolution on Assistive Technology
- B. Commission Action on Next Steps in State Budget Advisement & Advocacy = Resources for Activities – Commissioner Farmer
- C. September Commission Needs
- D. Other Commissioner Announcements & Adjournment

Single Point of Entry Demonstration

Highlights of Cost Effectiveness
Evaluation

Presented to:

LTC Supports & Services Advisory
Commission

July 27, 2009

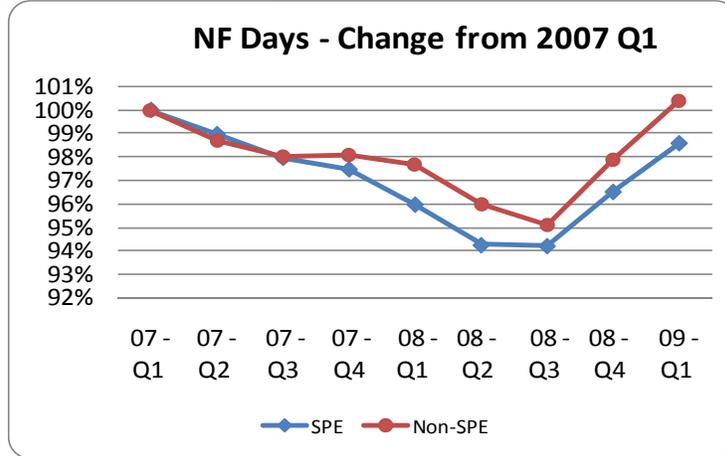
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Outline of Presentation:

- Differences in Long Term Care services & costs
- Differences in Level of Care Determinations
- Differences in transitions out of nursing facilities back to the community
- Potential future savings

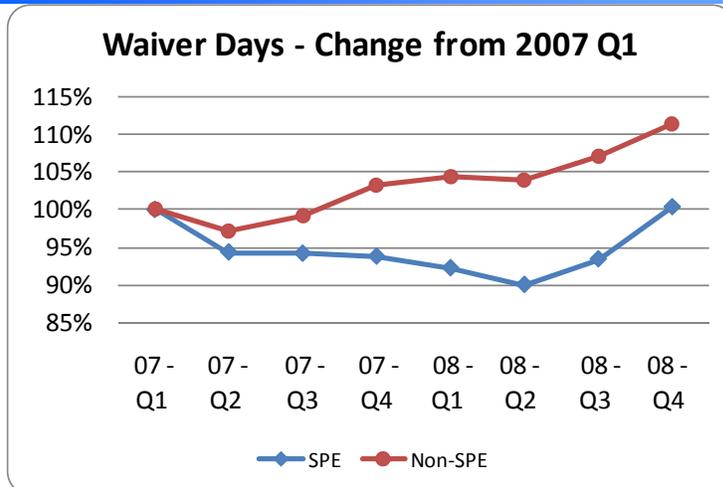
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Nursing Facility Days



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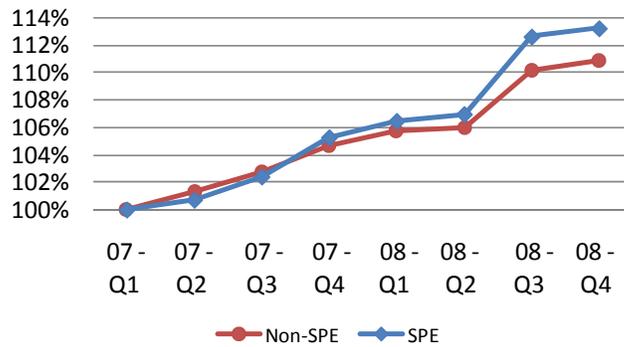
Waiver Days



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Adult Home Help Expenditures

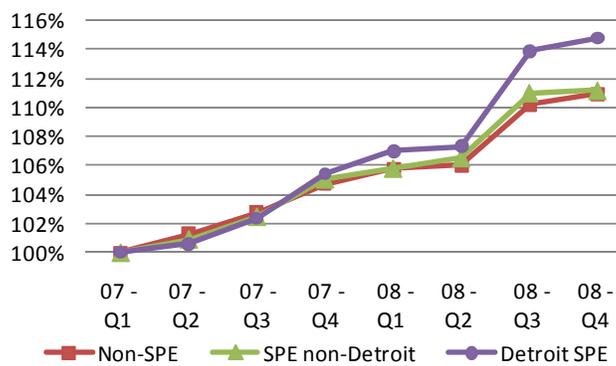
Adult Home Help Spending - Change from 2007 Q1



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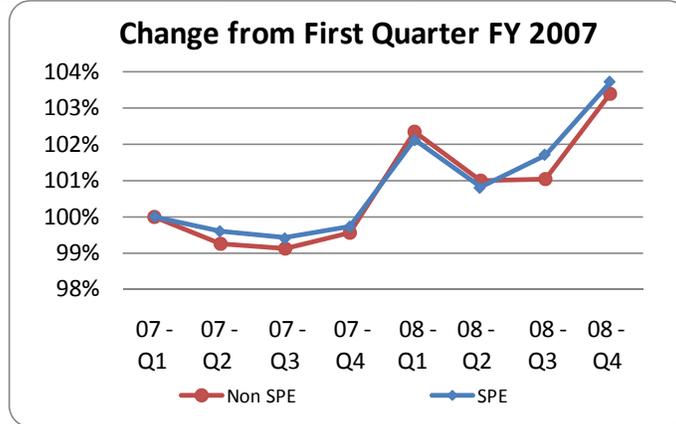
Adult Home Help Expenditures

Change from First Quarter FY 2007



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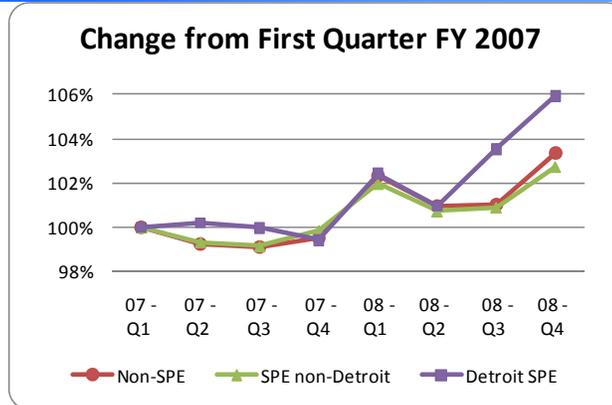
Aggregate Long Term Care Costs – Including Cost of SPE



In the short run, the increased adult home help costs outweighed the nursing facility and MI Choice waiver savings in the SPE counties.

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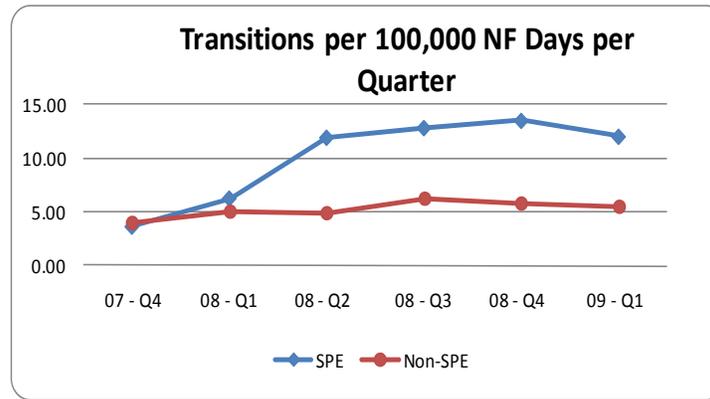
Aggregate Long Term Care Costs – Including Cost of SPE



The non-Detroit SPE areas have already achieved cost neutrality. In Detroit the SPE may have increased awareness of services such as adult home help for an already eligible population.

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Promising Trend - Transitions out of Nursing Facilities



Expected future savings are \$11.3 million per year if higher transition rate is maintained.

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Promising Trend: Level of Care Determinations

October 2008 to March 2009	
Percent Not Eligible	
Non-SPE Regions	
Nursing Facilities	0.29%
Waiver	4.78%
Total	1.24%
SPE Regions	
Nursing Facilities	1.04%
Waiver	7.39%
Total	2.87%

On an annualized basis, the NF difference represents a savings of \$6 million.

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Conclusions

- SPE was correlated with lower trends in nursing facility days and MI Choice waiver days of service.
- Adult home help costs were higher in the Detroit SPE area.
- As of September 2008 the SPE was not yet cost effective.
 - Note: for the SPEs outside of Detroit, cost effectiveness was already achieved.
- SPE led to some promising results related to transitions out of nursing facilities and lower rates of approval for entry to nursing facilities or the MI Choice waiver that could be expected to reduce future long term care costs.

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Project 2020

Building on the Promise of Home and Community-Based Services



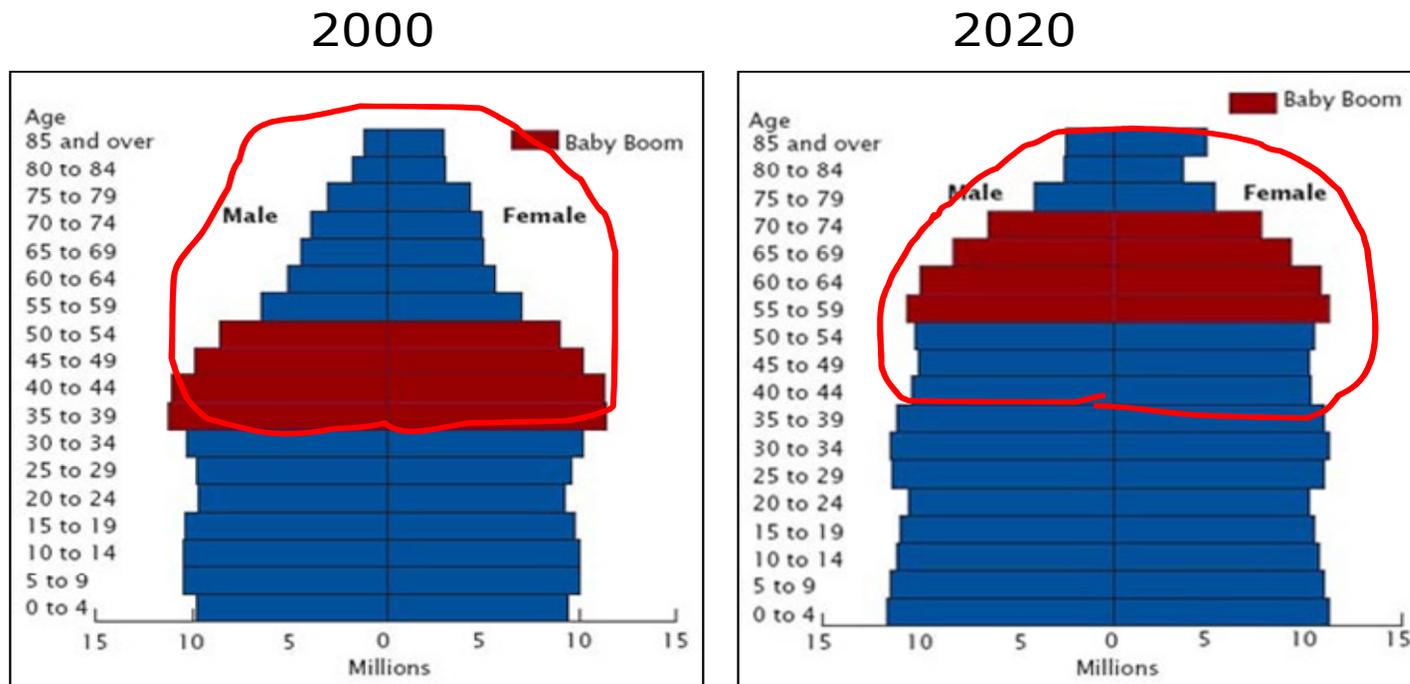
Background

- ▶ Winter 2007 meetings of NASUA and n4a
- ▶ Boards have met dozens of times to hammer out agreements
- ▶ Language in 2006 Reauthorization of Older Americans Act
- ▶ Seeking appropriations to match the authorizing language
- ▶ Using the past five years' worth of tested and proven best practices

NASUA/n4a Principles

- ▶ First, do no harm.
- ▶ Build on the current aging services network, not replace it.
- ▶ Encourage individuals' ability to live independently.
- ▶ Continue to serve the unique needs of rural, poor, minority, and disabled and aging populations.
- ▶ Support consumer-directed initiatives.
- ▶ Services should not be greater than the Medicaid waiver program.
- ▶ Encourage the increased use of technology to support efforts.
- ▶ Recognize that individuals, AAAs, SUAs, providers, and the federal government all have to contribute to make the program successful.

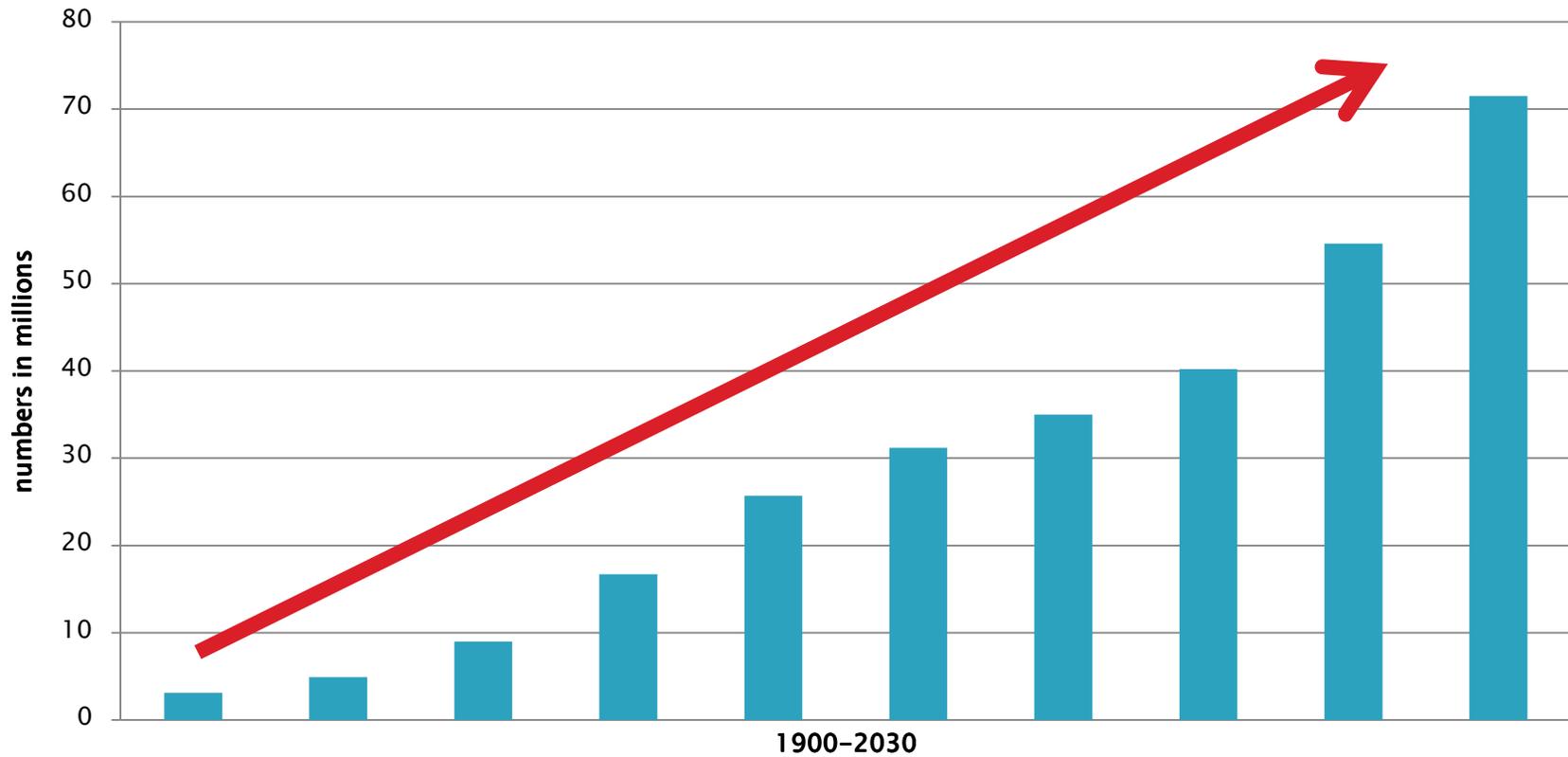
Changing Demographics



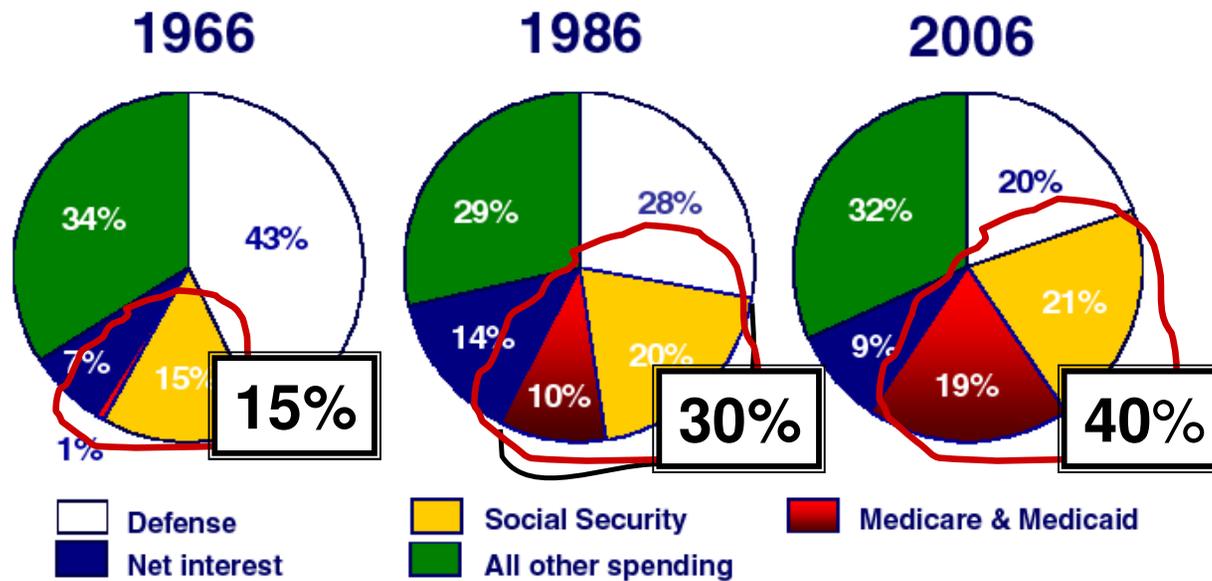
Source of charts: U.S. Census Bureau, "65+ in the United States: 2005," December 2005.

Need for Action

Growth of Persons Age 65+



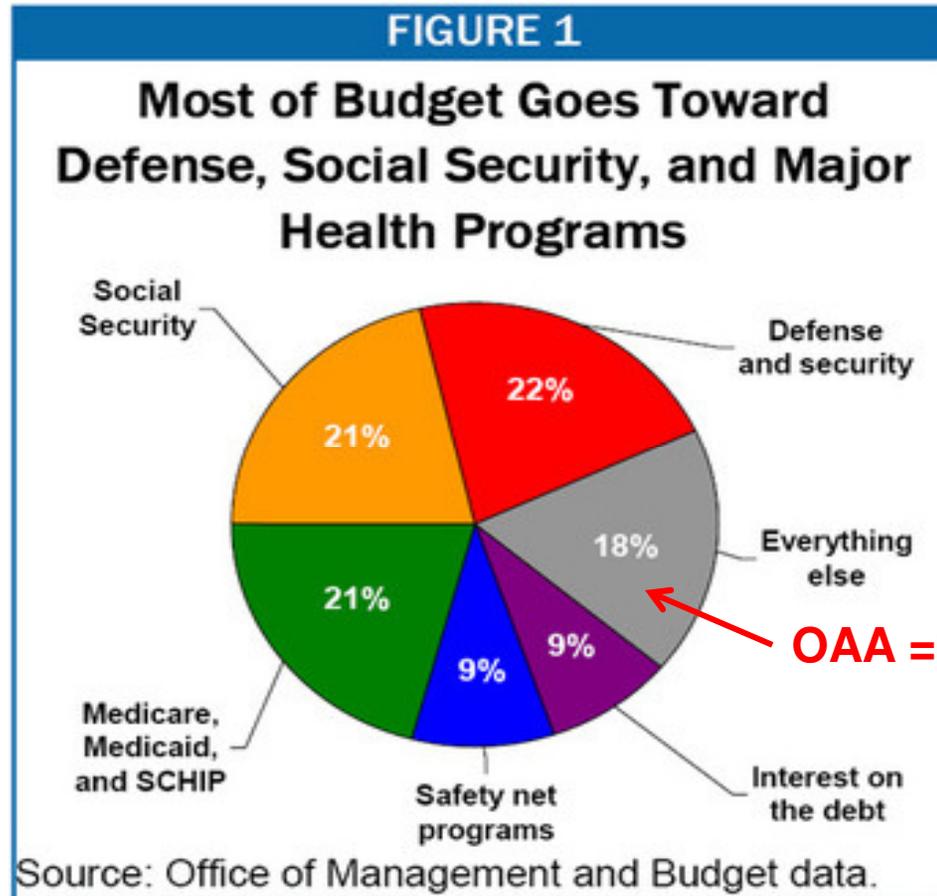
Composition of Federal Spending



Source: Office of Management and Budget and the Department of the Treasury.
 Note: Numbers may not add to 100 percent due to rounding.

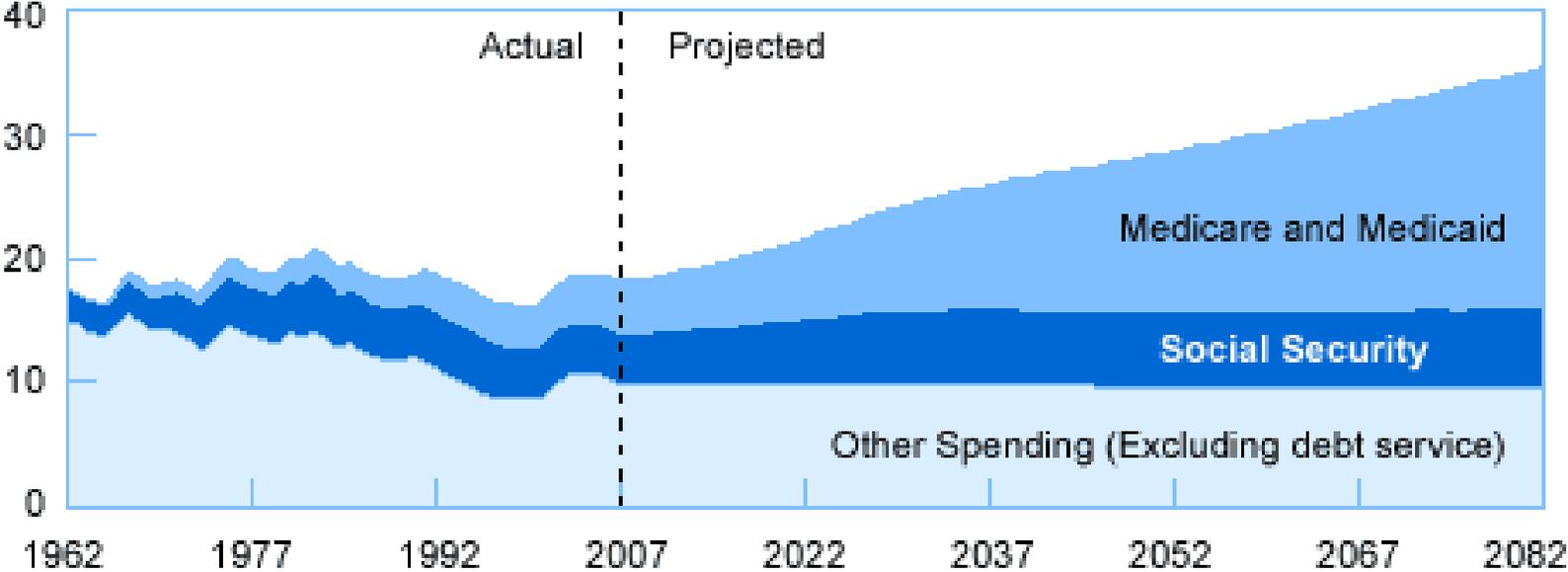
Spending on Older Americans Act

Total Spending
\$2.73 Trillion

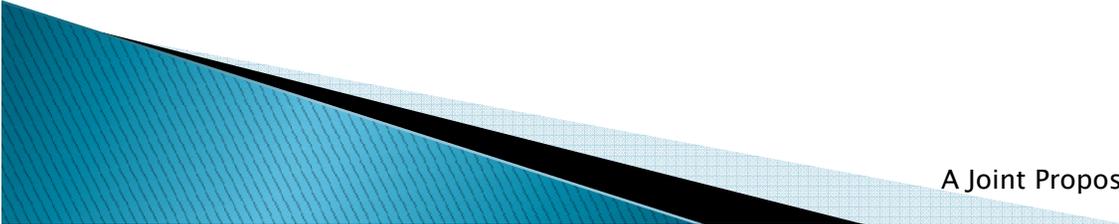


OAA = 0.066%

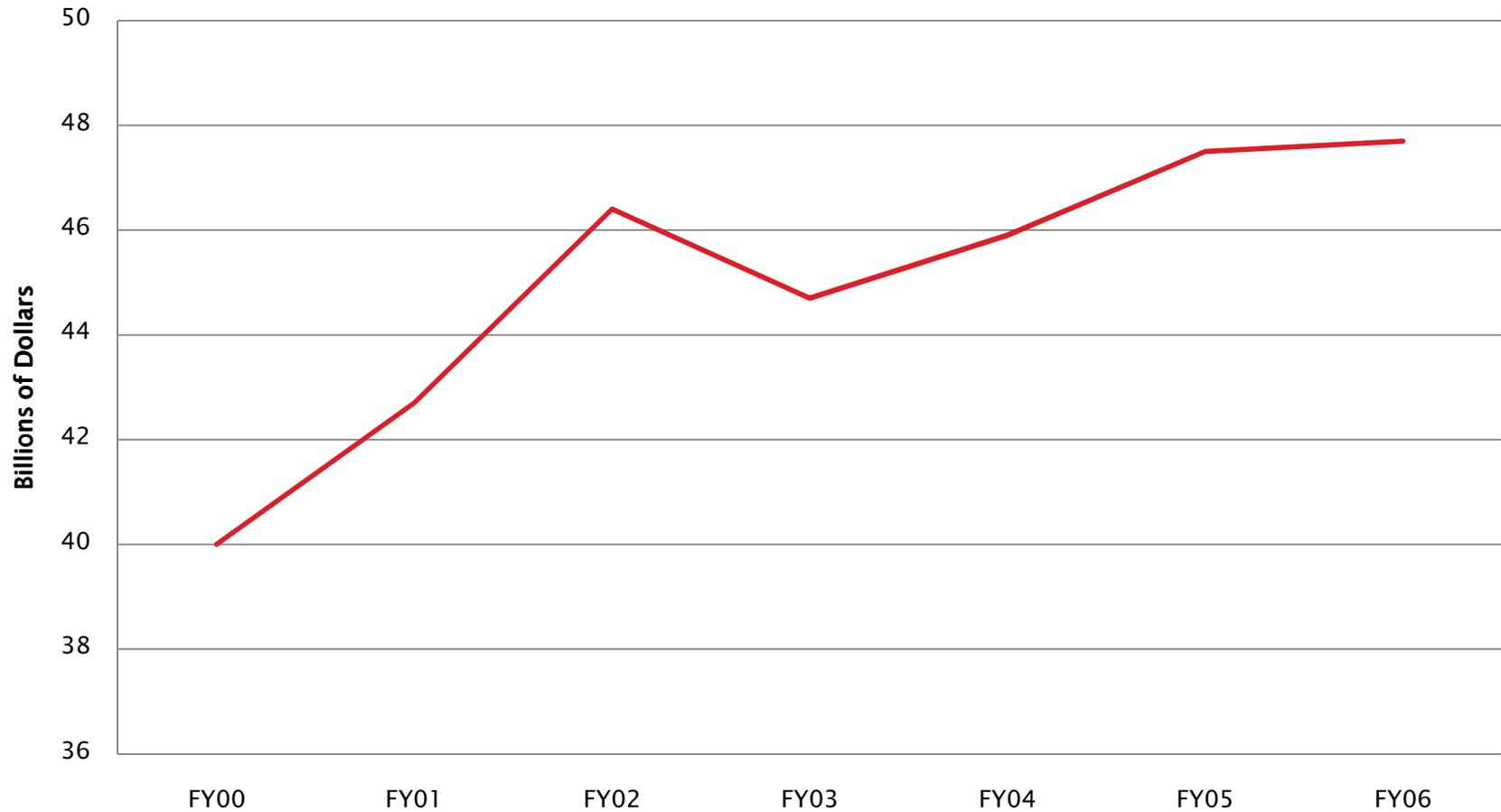
Percent of Gross Domestic Product



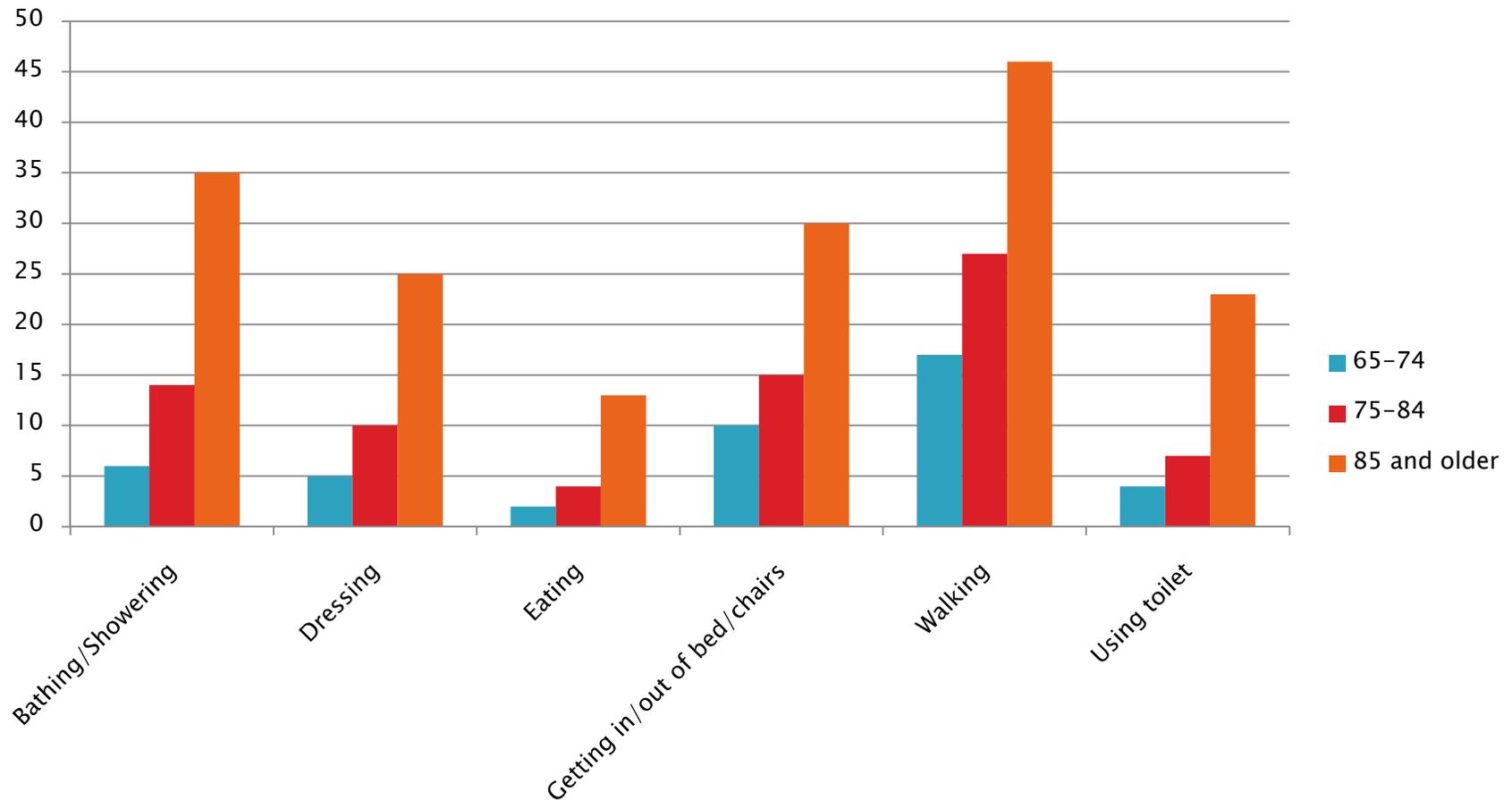
Source: Congressional Budget Office, June 2008



Medicaid Nursing Facility Spending



Percent of Individuals with Limitations in Activities of Daily Living by Age Group



The Aging Services Network

▶ Who Do We Serve?

- 27% of consumers are poor
- 33% of consumers live in rural areas
- 20% of consumers are minority
- 52% of older persons report having a disability

▶ Who Are We?

- 56 State Units on Aging
- 629 Area Agencies on Aging
- 244 Title VI Native American Aging Programs plus 2 Native Hawaiian organizations representing 400 Tribes
- Thousands of Service Providers

Components of the Proposal

Component of Program	Service
Person-Centered Access to Information	Provides assistance, access, counseling and awareness of long-term care services and supports
Evidence-Based Disease Prevention and Health Promotion	Targets scientifically proven interventions to reduce chronic disease and disability to affected elderly individuals
Enhanced Nursing Home Diversion Services	Provides consumer directed community care to individuals at high risk of institutionalization

Number of Recipients

Component of Program	Eligibility Criteria	Estimated Number of Recipients (5 years)	Estimated Number of Recipients (10 years)
Person-Centered Access to Information	Anyone interested in Long-Term Care	40 million	105 million
Evidence-Based Disease Prevention and Health Promotion	Individuals 60 or older or who are at risk of falls, have chronic illness, etc.	1.2 million	4.1 million
Enhanced Nursing Home Diversion Services	300 percent of SSI with assets not in excess of \$25,000	124,000	172,000

Federal Net Change

Components of Program	Estimated Federal Net Change (5 years)	Estimated Federal Net Change (10 years)
Person-Centered Access to Information	\$322.4 million	\$1.1 billion
Evidence-Based Health Promotion and Disease Prevention	\$158 million	\$665.8 million
Enhanced Nursing Home Diversion Services	\$111.8 million	\$618 million

Person-Centered Single-Entry Point Systems

	Federal	State	Total
Outlays	\$600 million	\$200.1 million	\$800.2 million
Savings	\$1.7 billion	\$1.3 billion	\$3.0 billion
Net Change	\$1.1 billion	\$1.1 billion	\$2.2 billion

** Over 10 years*

Evidence-Based Health Promotion and Disease Prevention

	Federal	State	Total
Outlays	\$234.3 million	\$149.6 million	\$997.6 million
Savings	\$1.5 billion	\$0	\$1.5 billion
Net Change	\$665.8 million	-\$149.6 million	\$516.2 million

** Over 10 years*

Enhanced Nursing Home Diversion Services

	Federal	State	Total
Outlays	\$7.8 billion	\$4.7 billion	\$12.5 billion
Savings	\$8.4 billion	\$6.4 billion	\$14.8 billion
Net Change	\$618 million	\$1.7 billion	\$2.3 billion

** Over 10 years*

How would it work?

Component	State's match	Roll-out
Person-centered access to information	25 percent	First year
Evidence-based disease prevention & health promotion	15 percent	First year
Enhanced nursing home diversion services	States would receive a capped grant based on calculating the states' (FMAP + 5) * number of potential eligibles	Phased in over 3 years

Other Components

- ▶ Technology Grants (examples of some uses)
 - To build web portals for ADRCs
 - To develop on-line training programs for disease management
 - To build health information exchanges for community centers
- ▶ Technical Assistance
 - State and community level specific, tailored technical assistance
- ▶ Evaluation

What's Next?



Transforming & Modernizing America's Health Care System

- ▶ **Protect Families' Financial Health**
- ▶ Make Health Care Coverage Affordable
- ▶ Aim for Universality
- ▶ Provide Portability of Coverage
- ▶ **Guarantee Choice**
- ▶ **Invest in Prevention and Wellness**
- ▶ Improve Patient Safety and Quality Care
- ▶ **Maintain Long-Term Fiscal Stability**

A Call to Action: Health Reform 2009

- ▶ **Individual Responsibility**
- ▶ Strengthening the Employer-based system
- ▶ Guaranteed Access to Affordable Coverage
- ▶ **Strengthening Public Programs**
- ▶ **Focusing on Prevention and Wellness**
- ▶ **Addressing Health Disparities**

How Can You Help?

- ▶ Learn more about 2020, visit our blog and websites
- ▶ Join our listservs to stay continuously informed
- ▶ Contact your Congressional delegation
- ▶ Send letters, emails, and phone calls to key Congressional members
- ▶ Ask your member of Congress to co-sponsor the legislation
- ▶ Work with your state legislature

For additional information



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PROJECT 2020

Building on the Promise of Home
and Community-Based Services

Overview of the Proposal

(S. 1257/H.R. 2852)

Project 2020's Goal:

Provide the resources to implement consumer-centered and cost-effective long-term care strategies authorized in the 2006 reauthorization of the Older Americans Act. Empower the Aging Services Network to implement these strategies through a three-pronged program encompassing person-centered access to information, evidence-based disease prevention and health promotion activities, and enhanced nursing home diversion services.

Even before the first baby boomer turned 60 years old in 2006, national spending for long-term care, especially under Medicaid, was placing significant strain on federal and state resources. In 2008, there are already more than 52 million Americans over age 60. By 2020, almost one in six individuals will be age 65 and older. The fastest growing segment of the aging population is individuals over 85, the most vulnerable older adults who tend to need long-term care and whose numbers are expected to double by 2020. These demographic trends make our current strategy for financing long-term care costs through the Medicaid and Medicare programs unsustainable.

The National Association of State Units on Aging (NASUA) and the National Association of Area Agencies on Aging (n4a), conscious of the financial pressures facing states and the federal government, have developed an incremental, coordinated national long-term care strategy that will generate savings in Medicaid and Medicare at the federal and state levels while enabling older adults and individuals with disabilities to get the support they need to successfully age where they want to—in their own home and community.



Overview of the Proposal, *page 2*

The strategy, which has evolved from long-term care initiatives of the U.S. Administration on Aging (AoA), the Centers for Medicare and Medicaid Services (CMS), HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE) and others, was incorporated into the reauthorized Older Americans Act (OAA) in 2006.

The strategy builds on the historic role of State Units on Aging (SUAs), Area Agencies on Aging (AAAs) and Title VI Native American aging programs (Title VIs). It is a comprehensive and integrated approach to enabling the elderly and individuals with disabilities to make their own decisions, to take steps to manage their own health risks, and to receive the care they choose in order to remain in their own homes and communities for as long as possible, avoiding unnecessary and unwanted institutionalization.

AoA, in cooperation with SUAs and AAAs, has been testing best practices in community-based long-term care that have been demonstrated to reduce the need for more expensive institutional care and prevent "spend down" to Medicaid for people of all ages with disabilities. n4a and NASUA have embraced these proven strategies as requirements for infrastructure development and participation in this program. This three-pronged approach will allow communities to provide services to this growing population at a lower cost to consumers and to Medicaid and Medicare. The key elements of this approach include:

- 1. Person-Centered Access to Information**
- 2. Evidence-Based Disease Prevention and Health Promotion**
- 3. Enhanced Nursing Home Diversion Services**

NASUA are seeking funding to support federal outlays of \$2.5 billion over the next five years to be administered through the Aging Services Network of State Units on Aging and Area Agencies on Aging.

Funding will be administered by AoA through disciplined, performance-based grants that will have conditions of participation designed to ensure that the components are implemented in ways that have been proven to work best at the community level. The program seeks to build on and enhance—not supplant—the current system and network of SUAs and AAAs/Title VIs.

Overview of the Proposal, *page 3*

For consumers, this program will empower individuals to make informed decisions and to better conserve and extend their own resources using lower cost evidence-based programs, including consumer-directed options for care in the community.

According to our initial estimates, the program has the potential to reach over **40 million Americans** and will **reduce federal Medicaid and Medicare costs by approximately \$2.8 billion** over the first five years of the initial investment requested, resulting in a net savings to the federal government of nearly \$250 million.

The program would also generate significant savings for state governments. Financial performance is expected to improve in years five through ten of the program, as all systems reach full scale operations nationally, with the **net federal savings over ten years reaching over \$1.1 billion.**

Program Components

Person-centered access to information—

Due to the fragmentation in public programs and information asymmetry, too many individuals currently lack access to quality information on community-based long-term care services. This long-standing condition is a significant factor in over-utilization of institutional care.

Through the use of a single entry point system, such as the Aging and Disability Resource Centers (ADRCs) developed by the AoA and CMS, the Aging Services Network will provide individuals and their families with streamlined, comprehensive and reliable information that will help consumers make informed decisions about their long-term care. ADRCs integrate outreach, information, and options counseling for home and community-based long-term care in the community. Forty-three states currently receive AoA grant funding to initiate ADRCs in their states. This component builds on the current nationwide network of SUAs and AAAs, as well as complementary programs such as AoA's Eldercare Locator.

Overview of the
Proposal,
page 4

Evidence-based disease prevention and health promotion—

Health and behavioral science has developed significant interventions for evidence-based disease prevention and health promotion that result in improved health and well-being of elderly participants, and do not require application through expensive medical and health care settings. Through this program component delivered at the community level, the Aging Services Network will assist individuals with interventions such as falls prevention, physical activities, nutrition counseling, chronic disease self-management and medication management.

Enhanced nursing home diversion services—

At any given time, a small, but critical, population of elderly individuals is at high risk of losing their independence and financial stability through nursing-home entry and spend down to Medicaid eligibility—individuals who would prefer to remain in the community if possible. Eligible individuals participating in this program component will be pre-screened and receive intense case management through the single point of entry system to help coordinate personalized services and supports that will allow them to remain in their homes.

This needs-based portion of the program will provide home and community-based services such as home-delivered meals, homemaker services, personal care, medical transportation, home modification, assistive technology and adult day care. These traditional services provided by the Aging Services Network, when coupled with case management and the flexibility of consumer-directed models of care, provide an excellent alternative to nursing home care.

Targeting Recipients

These initiatives do not create a new entitlement program but rather seek to serve more people in the community while helping to alleviate fiscal pressures on Medicaid and Medicare. The work of single point of entry information systems is to reach out to all consumers and caregivers who have the need for information on long-term care

Overview of the Proposal, *page 5*

before they make irreversible decisions, ideally including younger adults who need to prepare in advance for their future long-term care needs. It is expected that the ADRCs will provide information, options counseling and referral to individuals who can and will finance their own care, as well as to those who may be eligible for support through the full array of programs available in the community.

Fully funding the ADRC is a critical component of the program, filling the gaps created by the currently limited nature of the programs in the states. This component will: 1) provide consumers information about and access to the full range of long-term care options potentially available to them, and 2) overcome the fragmentation and inconsistency in information, processes, standards and other fundamental elements of access to long-term services and supports. Consumers and caregivers who need access to information regarding long-term care options will be served by a truly person-centered single entry point system. This program component is designed to help all who ask for assistance, regardless of age, regardless of income and regardless of complexity of care needs.

Participants in the evidence-based disease prevention and health promotion component will be targeted for disease management programs directed to their actual conditions and potential risk factors. Over time, services will be offered widely to elderly individuals and those with disabilities through evidence-based health interventions in an effort to reach those for whom the evolution of disease and negative impact of chronic disease can be delayed or avoided and/or those individuals who are at risk of sustaining injuries due to falls, thus suppressing costs even more.

The program component providing enhanced nursing home diversion services will be available to individuals who are at the same level of clinical need as Medicaid waiver eligibility but who have assets in excess of Medicaid financial eligibility, not exceeding an average of \$25,000. (For most states this is equivalent to six months of nursing home care.)

These individuals fall outside of Medicaid eligibility, but due to their limited income and assets, they are the most likely to become Medicaid-eligible shortly after any institutionalization. While most

Overview of the
Proposal,
page 6

states have effective home and community-based waiver programs for individuals who are Medicaid eligible, only in very rare cases are they able to serve individuals whose assets are not below the \$2,000 threshold. Older people with moderate incomes just above eligibility standards are routinely admitted to nursing homes, exhaust their assets, and become Medicaid eligible. Once these individuals have entered a nursing home setting, it becomes nearly impossible to return them to the community.

Shared Responsibility

Slowing the growth in the demand for Medicaid and Medicare services for the elderly will require a shared effort by federal, state, and local government entities. Funding for both the single entry point systems and the evidence-based chronic disease prevention programs would be funded through existing AoA grant mechanisms. States would continue to support the single entry point effort with 25 percent match and the evidence-based programs with a 15 percent match. Grants for the single entry point program and the evidence-based health promotion program would begin immediately upon passage of the legislation.

The grants for the enhanced nursing home diversion services component would be offered in three phases, with states best positioned to advance system changes being awarded grants first, followed by states that need additional time to prepare. The program would be administered through a series of competitive grants to the states. States would not be competing against one another, but rather against a set of performance-based criteria.

In order to ensure the success of the program and that both states and the federal government share in the expected savings, states would receive an enhanced Medicaid Federal Medical Assistance Percentage (FMAP) equivalent to an increase of 5 percent in return for their participation in the nursing home diversion portion of this program. Technical assistance is planned for SUAs and AAAs to help them prepare for and implement each of the three facets of the program. A careful performance-based evaluation of the effort is also considered key to the success of the initiative.

Overview of the
Proposal,
page 7

Estimated Savings

Analysis has shown that these three components, when implemented across the country, effectively coordinated with existing activity of SUAs and AAAs, and targeted and managed properly, will cost less in the aggregate than if the aging services community maintains the current patchwork approach to services. This program will have all states engaged in implementation within three years of passage. Since federal savings, or “offsets,” will be garnered by Medicaid and Medicare, this program is more than budget neutral and therefore in accordance with “pay-as-you-go” rules.

The estimated gross federal savings for the program over five years total \$2.8 billion. The initiative will also generate significant savings to the states, which with favorable match rates will realize savings at even higher rates. This is a significant aspect of the program, given the added fiscal pressures being put on states related to Medicaid long-term care financing. It is estimated that the total number of individuals who will be assisted under this initiative is just over 40 million individuals, most of these with little or no direct financial support through the ADRC information, assistance and options counseling services.

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Project 2020: Building on the Promise of Home and Community-Based Services

Components of Program	Targeted Recipients	Estimated Number of Recipients (5 years)	Estimated Federal Savings (5 years)	Estimated Number of Recipients (10 years)	Estimated Federal Savings (10 years)
Person-Centered Access to Information	Provides information to anyone interested in long-term care	39.6 million	\$535.1 million	105.3 million	\$1.69 billion
Evidence-Based Disease Prevention and Health Promotion	Targets scientifically proven interventions to reduce chronic disease and disability to affected elderly individuals	1.2 million	\$392.4 million	4.1 million	\$1.51 billion
Enhanced Nursing Home Diversion Services	Provides consumer-directed community care to individuals at 300% SSI with approximately \$25,000 in assets	124,196	\$1.86 billion	171,755	\$8.44 billion
Total Number Served		41 million		110 million	
Total Federal Savings			\$2.787 billion		\$11.65 billion
Total Federal Outlays (includes administration and technical assistance costs)			\$2.546 billion		\$10.50 billion
Total Federal Net Savings			\$241 million		\$1.14 billion

Based on calculations prepared by The Lewin Group, April 2009.

Project Action Team Recommendation # 5 - Goal: Support, Implement, and Sustain Prevention Activities through (1) Community Health Principles, (2) Caregiver support, and (3) Injury control, Chronic Care Management, and Palliative Care Programs that Enhance the Quality of Life, Provide Person-Centered Outcomes, and Delay or Prevent Entry in the LTC system.

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

Project Action Team Recommendation # 5 - Goal: Support, Implement, and Sustain Prevention Activities through (1) Community Health Principles, (2) Caregiver support, and (3) Injury control, Chronic Care Management, and Palliative Care Programs that Enhance the Quality of Life, Provide Person-Centered Outcomes, and Delay or Prevent Entry in the LTC system.

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

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

Project Action Team Recommendation # 5 - Goal: Support, Implement, and Sustain Prevention Activities through (1) Community Health Principles, (2) Caregiver support, and (3) Injury control, Chronic Care Management, and Palliative Care Programs that Enhance the Quality of Life, Provide Person-Centered Outcomes, and Delay or Prevent Entry in the LTC system.

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

Background on Task Force Recommendation #5

When the Long Term Care Commission was convened, it started a workgroup, the Health Promotion and Caregiver Support, to further Recommendation #5 of the Michigan Medicaid Long-Term Care Task Force Report. Members of the Workgroup include both commission and non-commission members who are consumers, representatives from relevant state departments, and advocates from statewide non-profit organizations.

Recommendation #5 included 13 Strategies and Action Steps to implement the recommendation. The recommendation is: “To Support, Implement and Sustain Prevention Activities through (1) Community Health Principles (2) Caregiver support and (3) Injury Control, Chronic Care Management, and Palliative Care Programs that Enhance the Quality of Life, Provide Person-Centered Outcomes and Delay or Prevent Entry into the LTC System.”

The Health Promotion and Caregiver Support Workgroup began meeting in August 2007. Its first order of business was to review the 13 strategies/action steps within the recommendation and identify the best way to implement them or their underlying principles. The PAT Recommendation #5 Logic Model Chart (attached) reflects the work of the Workgroup to date on the recommendation. The Prevention Project Action Team (PAT) from the Office of Long-Term Care Supports and Services supports the Workgroup’s activities. This summary describes the current status of the Recommendation #5 Strategies/Actions Steps from the Task Force Report.

#1. Convene a broad-based coalition of aging, disability and other organizations.

Action: The Health Promotion and Caregiver Support Workgroup is a broad-based coalition of organizations and individuals. Its activities are described under Objective #1.

#2. Review Community resources and needs (including prevention, chronic care and caregiver supports).

Action: The review of community resources and needs is embedded within all four objectives.

3. Identify existing local, culturally competent strategies to address prevention, chronic care needs, and substance abuse.

Action: This strategy is incorporated into Objective #2. Prevention and chronic care needs are explicitly addressed. Substance abuses issues are implicitly addressed within prevention and chronic care.

4. Develop and support programs to address prevention, chronic care, and caregiver supports.

Action: Support programs to address prevention, chronic care and caregiver supports are addresses with Objective #2 and #3

#5. Promote the use of culturally competent caregiver training on injury prevention, rights and benefits, and person-centered planning.

Action: This strategy is Activity #1 under Objective #2.

#6. Develop wrap-around protocols for caregiver/consumer support needs.

Action: This strategy is Activity #2 under Objective #2.

#7. Develop a public health caregiver support model.

Action: This strategy is Activity #5 under Objective #2.

#8. Create initiatives and incentives to support caregivers.

Action: This strategy is Activity #3 under Objective #2.

#9. Identify and promote the use of elements of established models for chronic care management and coordination (e.g., Wagner or ACOVE model).

Action: The use of the Wagner and PATH models are promoted and implemented in Activity #2 under Objective # 3.

10. Create incentives for implementing culturally competent chronic care models and protocols.

Action: This strategy is Activity #1 under Objective #3.

#11. Develop and implement chronic care protocols, including, but not limited to:
a. medication usage.
b. identifying abuse and neglect, caregiver burnout/frustration.
c. caregiver safety and health.

Action: All three of these items are implicit in the Chronic Care Management strategies, activities, and protocols under Objectives #2 & #3.

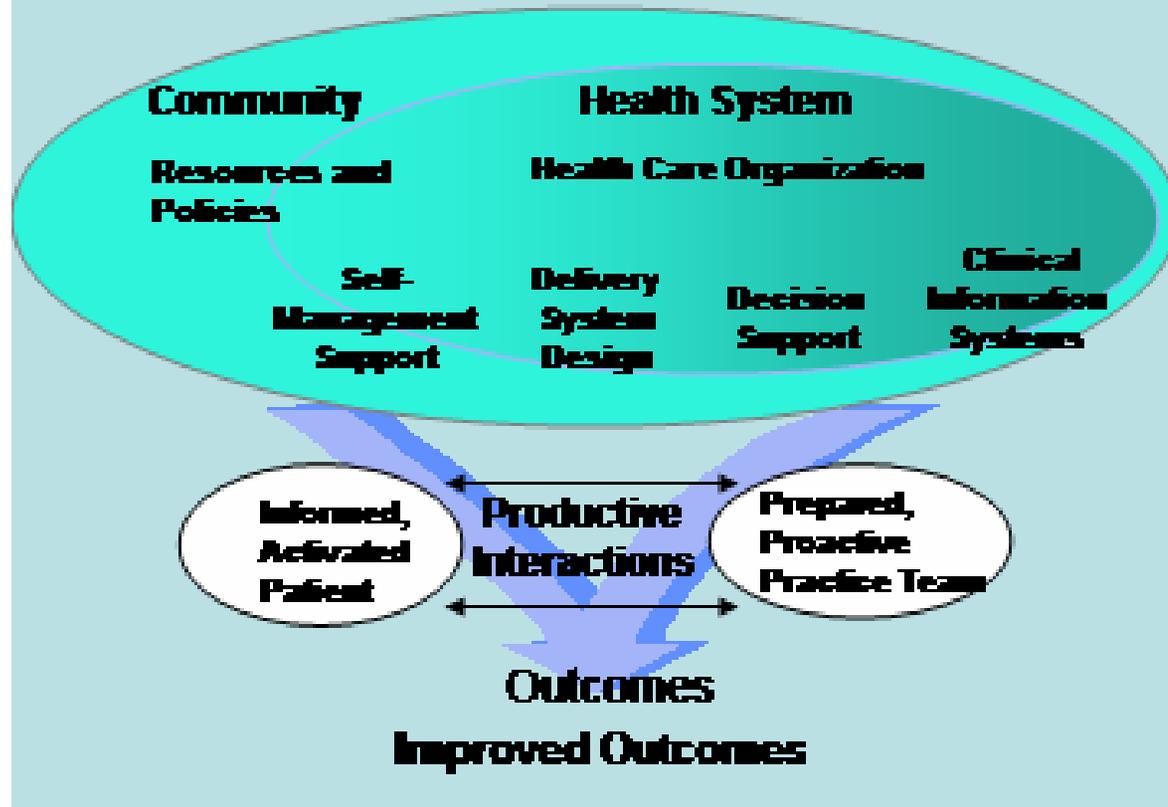
#12. Promote the use of Assistive Technology (AT) for consumers and direct care workers/caregivers as a prevention tool.

Action: This strategy is encapsulated in Objective #4

#13. Investigate grant opportunities to pilot chronic care management models.

The workgroup has noted that this strategy has been accomplished in part through the funding that Carol Callahan received to coordinate implementation of the Wagner Model within the state and the workgroup is considering what other actions need to be taken regarding this strategy.

Chronic Care Model



Proposed Resolution

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

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

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

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

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

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

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

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

Sources:

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

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Task Force Recommendation Seven: Establish a New Quality Management System
 To ensure LTC services across the spectrum are consumer centered
 7/27/2009 Long Term Care Commission

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

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

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

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

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