

Support, Implement, and Sustain Prevention Activities

Commission Workgroup
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LTCSS Advisory Commission Retreat
January 27-28, 2009

Progress

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

Members: 32 with regular participation of consumers, representatives from aging, disability network, public health and dementia and providers

Schedule: Bi-monthly

Progress

- **Priorities Established**
 - **Promote Use of Assistive Technology**
 - **Support Infrastructure for chronic care management programs**
 - **Support Family and Informal Caregivers**
- **Information Framework**
- **Partnership and Collaboration**

Changing Needs

| | |
|--------------------|-----------------------------|
| 1900 – 1950 | Infectious disease |
| 1950 – 2000 | Acute, episodic care |
| 2000 – 2050 | Chronic care |

Gerald Anderson, PhD – Johns Hopkins University

Chronic Condition Prevention Model

Primary Prevention: Targets People with major risk factors but no disease and Goal is to Prevent First Event



Secondary Prevention: Targets People with disease /conditions and Goal is to Prevent Recurrent Events and Control Disease

Health Promotion: Targets the Entire Population and Goal is to Prevent Risk Factor Development

Source: Centers for Disease Control and Prevention 2003.

Primary Care System in Crisis

- Fragmented, uncoordinated patient care
- Practices poorly designed to deliver chronic disease care
- Increasing expectations and demands from Payers and Purchasers
- Misaligned reimbursement system
- Shrinking primary care workforce

MI Primary Care Consortium

BACKGROUND

In 2005-06, 200+ MI health professionals developed strategic recommendations to resolve five system barriers to effective delivery of primary care:

- **Underuse of community resources**
- **Underuse of patient registries, other HIT**
- **Underuse of evidence-based guidelines**
- **Misaligned, unfair reimbursement system**
- **Practices poorly designed to deliver preventive and chronic care**

What wrong with current systems?

- **Ineffective Self-Management Support**
 - **The individual makes most of the decisions regarding his/her health, but generally the physician “prescribes” or “orders” the treatment plan.**
 - **Consumers must have information, skills, and confidence to make good decisions, but most people receive rushed admonitions to shape up instead of educational and supportive interventions that are effective.**

Self-Management Support

- **Emphasizes the person's central role as (shift of power)**
- **Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up**
- **Organize resources to provide support**

Chronic Care Model



Assistive Technology

- **Federal Grant which focuses on technology and community living**
- **MDRC AT initiatives**
- **LTCC with CIL using OT**
- **OSA Care Management and service standards**

Caregiver Support

- **Identification of Caregivers through TCare Assessment and plan**
- **Increased Caregiver services such as Savvy Caregiver**
- **Wraparound caregiver model- mental health funds**

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

Section One: Progress

Using a public health approach to prevention underlie the task force recommendations. The model recognizes the importance of well being and prevention and that care doesn't reside solely in the individual but within a web of interactions among the individual, family and community. A public health approach seeks long term solutions. Tools include use of population based surveillance and prevalence data to understand public impact and prioritize efforts. This approach underlies the priorities and activities undertaken.

Throughout the past year, the OLTCCSS staff participated in collaborative planning processes and program development to align activities in the various state departments in the areas of health promotion, care giver support and meeting the needs of persons with chronic conditions with the recommendations.

Health Promotion Workgroup

The *Commission Workgroup on Health Promotion* reviewed the Task Force Recommendations and identified three priority areas: Increase availability and use of assistive technology, identify and support care givers through increased use of care giver assessment and supports, and increase availability of and access to chronic care management.

Care giving

Together with stakeholders from the medical community, service providers, Medical Services Administration, Office of Services to the Aging, and Mental Health the OLTCCSS works with the Dementia Coalition Caregiver work group to develop consensus on goals and activities to improve supports and services to informal care givers. Progress has been made on these priorities:

Through development work for the Long Term Care Connection (LTCC), the OLTCCSS sponsored partnership in a research effort to further test the outcomes for care givers of the "T-Care" Caregiver Assessment and Planning model. As a result LTCC staff together with staff from a mix of providers including adult (day) programs, councils on aging and area agencies on aging was were trained and are currently providing support to care givers. This effort increased expertise of staff and contributed to the research base of knowledge developed by Rhonda Montgomery PhD as part of her project.

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Information on using the “Wrap Around Caregiver Model” was provided to LTCC supervisors, Options Counselors are active participants in team meetings in West Michigan and the Upper Peninsula.

Chronic Care Management and Palliative Care

With input and support from staff from the Office of Long Term Care Supports and Services that focused on the Task Force recommendation, the Michigan Department of Community Health (MDCH), Division of Chronic Disease and Injury Control pursued and was awarded a five-year grant from the Centers of Disease Control and Prevention. The focus of the grant is to build capacity within the state for a coordinated, public health approach to health promotion for people with disabilities. As part of the capacity building, a Disabilities Health Unit within the Division of Chronic Disease and Injury Control has been established to: 1) collaborate with key stakeholders, 2) develop a strategic plan and initiate programming to prevent secondary conditions, and 3) better the health of people with disabilities in the state of Michigan.

Janet Olszewski, the Director of MDCH, has named an advisory council, who, along with other stakeholders, has been charged with developing and implementing a strategic plan promoting the health of persons with disabilities across four dimensions:

- 1) improving access of people with disabilities to health screenings and healthcare services
- 2) promoting management by people with disabilities of their own health and behavioral risks
- 3) improving the effective response of health professionals to people with disabilities about their health needs
- 4) integrating the needs of persons with disabilities into existing health promotion activities.

These dimensions reflect the priorities in the Task Force recommendations on health. The process has significant consumer involvement. The initiative will result in improved access and health outcomes for persons with disabilities.

The work of the “Healthy Aging” collaboration, a partnership between the MDCH Division of Chronic Disease and Injury Control and Office of Services for the Aging (OSA), is another effort that moves the state toward implementation of strategies identified in Recommendation Five. The initiative focuses on mobility, quality of life, healthy lifestyle, evaluation, and policy recommendations.

The OLTCSS included requirements and training to assure the Options Counselors at the Long Term Care Connection (LTCC) demonstration have the communication skills to understand individuals’ goals and target assistance to consumers to support use of evidence based health promotion and prevention programs.

The OLTCSSs also facilitated efforts to increase access and understanding of palliative care and end of life planning for the LTCC staff.

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During FY 2008 LTCC staff provided referrals and explanation on chronic disease self management, health promotion activities and end of life care to XXXnumber of callers.

Section Two: Next Steps

Health Promotion Workgroup

The OLTCSS provides support and input to the *Commission Work group on Health Promotion*. (See Section Three of this document for complete list of strategies for Recommendation 5) The work group develops recommendations for the commission based on the education and sharing that occurs at the meetings.

Caregiver

The Office of Services to the Aging received an Alzheimer Disease Demonstration Grant to provide the evidence based “Savvy Care giver” program to caregivers in six Area Agency on Aging Regions. The OLTCSS through its participation in the Dementia Coalition Work Group on Care giving acts in an advisory capacity to the grant and undertakes activities to support this important initiative.

The OLTCSS committed funds for FY 2009 to support increased availability of the T-Care caregiver assessment and planning service for caregivers. This effort will increase the capacity of the Information and Assistance service providers and home and community based providers to conduct care giver assessment and will increase the number of providers trained to partner with care givers to develop a support plan to meet the care giver’s needs. The anticipated outcome is improved well being, improved physical and emotional health and delay unwanted institutional placement.

The Mental Health and Substance Abuse agency allocated block grant funds to several new wrap around model programs for FY 2009. The Wrap Around model material will be revised to encourage use by additional Options Counselors and Care Managers.

Health Promotion and Chronic Care Management

Health promotion is defined as the process of enabling people to increase control over their health and to improve it. This process requires personal participation and supportive environments. To be successful it is necessary the professionals and referral network is informed and engaged and there is awareness and available programming,

DCH will support development of infrastructure to increase access to evidence-based health promotion programs including Chronic Disease Self Management (PATH), Fitness for Life, Matter of Balance is planned.

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The OLTCSS efforts to expand understanding and use of person centered planning which will include support for training on stages of change and motivational interviewing skill development will result in increased utilization of health promotion programs.

The OLTCSS , in recognition of the significant impact of dementia on individuals, care givers, and the provider system will participate in a collaborative effort to seek funding so that expert consultation on dementia is available to professional and family care givers.

Finally, opportunities to increase use of assistive technology through changes to MSA and OSA policy are being identified. Recommendations will be made to the Commission.

Assessment Process

The OLTCSS plans to make efforts to develop a common core assessment provided through a person centered planning process. Changes to the assessment process that incorporating practices that support control and self management and improving coordination across providers will result in improved service and outcomes for all but will particularly benefit persons with multiple chronic conditions.

Section Three: The following “Strategies/Action Steps” and “Benchmarks” were taken from Michigan Medicaid Long-Term Care Task Force Report, May 2005.

Strategies/Action Steps

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

1. Convene a broad-based coalition of aging, disability, and other organizations.
2. Review community resources and needs (including prevention, chronic care, and caregiver supports).
3. Identify existing local, culturally competent strategies to address prevention, chronic care needs, and substance abuse.
4. Develop and support programs to address prevention, chronic care, and caregiver supports.
5. Promote the use of culturally competent caregiver training on injury prevention, rights and benefits, and person-centered planning.
6. Develop wrap-around protocols for caregiver/consumer support needs.
7. Develop a public health caregiver support model.

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8. Create initiatives and incentives to support caregivers.
9. Identify and promote the use of elements of established models for chronic care management and coordination (e.g., Wagner or ACOVE model).
10. Create incentives for implementing culturally competent chronic care models and protocols.
11. Develop and implement chronic care protocols, including, but not limited to:
 - a. medication usage.
 - b. identifying abuse and neglect, caregiver burnout/frustration.
 - c. caregiver safety and health.
12. Promote the use of Assistive Technology (AT) for consumers and direct care workers/caregivers as a prevention tool.
13. Investigate grant opportunities to pilot chronic care management models.

Benchmarks

1. Needs assessments are conducted and gap analysis reports are completed and reviewed.
2. Local and statewide groups complete plans to address local health and wellness gaps.
3. Executed contracts in place with local existing entities, which are broad-based (including the aging and disability community) to address gaps.
4. Completed workgroup report evaluating progress, outcomes, and identifying next steps.
5. Every local region has a program in place to train caregivers that is culturally competent to the needs and culture of the informal caregiver.
6. Consumer supports are increased and better utilized.
7. Caregiver needs screening incorporated into Medicaid-funded screening instruments.
8. Upon retrospective review address caregiver, needs.
9. Registries completed with processes in place for ongoing updates.
10. Legislative and administrative initiatives are in place and used.
11. Increase in the number of primary and LTC providers trained and adopting the best chronic care and culturally competent models.
12. Medical schools and nursing/ancillary healthcare programs expand their curricula to include chronic care.
13. Increased numbers of students graduating from schools with established chronic care curricula/programs.

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14. Increased number of providers using screens and protocol-driven interventions.
15. Increased use of assistive technology as reflected in the person-centered plan.

| Goal: Support, Implement and Sustain Prevention Activities (Recommendation 5) | | | | | | |
|---|--|------------------|--|---|--|-----------------|
| Objective | Activity | Output | Outcome | Indicator/measure | | Responsible for |
| Promote the Use of assistive Technology | | | # of persons who remain independent through use of assistive technology increases 5% | # persons using assistive technology (in waiver, in care management, in Home Help, etc) | | |
| | Regular commission workgroup meetings to share information to increase awareness | MDRC power point | | | | |
| | Disseminate assistive technology information through committee | | | | | |
| | Create plan to increase resources for assistive technology | | | | | |
| | Implement plan | | | | | |
| Support infrastructure for chronic care management programs | | | | | | |
| | Regular commission workgroup meetings to share information to increase awareness | | | | | |
| | Promote use of self management programs | | | | | |

1 Goal: a focus of accomplishment supported by a series of objectives needed to realize it. Operational objective: short-term goal whose attainment moves an organization towards achieving its strategic or long-term goal.

| Goal: Support, Implement and Sustain Prevention Activities (Recommendation 5) | | | | | |
|---|--|--|---------|--|-----------------|
| Objective | Activity | Output | Outcome | Indicator/measure | Responsible for |
| | Use CDC cost calculator to estimate and compare cost of chronic disease and cost of prevention | | | | |
| Support Caregivers | Commission support for caregiver assessment | Commission vote | | | |
| | Identify care givers | Programs conduct TCare assessment and make referrals | | # of care givers identified | |
| | Staff is trained and provides T Care assessment | | | | |
| | Staff is trained and provide T Care care giver support plan | | | # of caregivers report decrease stressed, increased capacity to continue care giving, delayed NF placement | |
| | | | | | |

2 Goal: a focus of accomplishment supported by a series of objectives needed to realize it. Operational objective: short-term goal whose attainment moves an organization towards achieving its strategic or long-term goal.