Michigan Long-Term Care Supports and Services Advisory Commission

RECOMMENDATIONS

April 11, 2014

1. Electronic medical records (EMRs) should be available to the consumer and all of their health providers. The record would include a complete history of all health-related services and providers, and the current health status of the consumer, including an accurate list of medications and all involved specialists and consults. The record could be accessed using multiple devices (computer, cell phone, etc.) and by any of the consumer's health providers (in/out of network). This would require ensuring all health system EMRs are compatible and that records would be automatically updated immediately after every provider visit. This initiative would enable a wide sharing of patient information to enhance informed health care decisions, medication reconciliation, and coordination and transitions of care.

2. Physician/nurses would make home visits to seniors and individuals with a disability who have high health risks and difficulty commuting to the provider. This is particularly true for rural regions.

3. The current array of Medicaid Long-Term Supports and Services (LTSS) is inefficient because the various programs are located in different state agencies (OSA, MDCH, MDHS, etc.), each with their own bureaucratic policy requirements and few incentives for streamlining and coordination of services across agencies to facilitate access for consumers. Silos need to be broken down and all LTSS and their various functions (funding, licensing, program design, auditing) should be housed in a single agency to reduce duplicate administrative overhead personnel and infrastructure costs, paperwork, and consumer confusion, and to improve efficiency and coordination between services.

4. All LTSS programs would be available from any provider, regardless of the consumer's health plan or the provider's affiliation with any health system. There should be no financial disincentive (higher patient pay contribution) for selecting a specific provider. There should be no higher co-pay for using an out-of-network provider.

5. There should be high transparency in the clinical outcomes such as health outcomes, hospital readmission rate, length of stay, avoidable medical error rate, infection rate in ICU, annual inspection citations, and patient satisfaction levels of all providers. The performance measures need to be objective and easily understood by consumers. This transparency facilitates an informed consumer making their preferred provider choices. Ironically, the consolidation of health providers into large regional health systems and the health plans narrowing of network providers has greatly reduced the choices available to consumers. Comparative shopping based on the transparency of clinical

performance metrics is subsequently unlikely or ineffective within large health systems that do not provide choice within their system or through options to use providers outside their system.

6. There should be a single eligibility process for individuals needing LTSS, similar to the current application form used for Medicaid eligibility.

7. Hospital discharge planning for seniors and individuals with a disability should include coordination with Home and Community Based Services (HCBS) for care at home as the first option, if at all possible, to create timely transitions to the most appropriate services. Currently, a set of discharged seniors are first sent to a nursing home (because it is available 24/7) where the senior is defined as inappropriately placed and temporarily housed until HCBS become available. A two-step process that benefits the hospital/nursing home provider community should become a one-step process that benefits the patient. This would improve quality of care and decrease problems associated with multiple transfers and associated costs.

8. The current labor force available to care for an increasing number of seniors and disabled who require LTSS is inadequate. The workforce, from physicians to personal care aides, needs to be dramatically enlarged, as well as qualified, to provide competent, safe LTSS in a respectful manner. At the high end of clinical training, more physicians need to be trained as geriatricians or receive additional training in care of older adults. This can be achieved with strategies such as increasing their reimbursement rate to reflect the complexity of, and time for, each case, establishing loan forgiveness programs, and requiring aging content in medical school curriculum and continuing education for practicing physicians.

The majority of paid (and unpaid) LTSS is provided by direct care workers and personal care aides (PCAs) who assist with daily tasks of living that allow people to stay in their own homes as long as possible. PCAs are in an excellent position to monitor client status and intervene before costly adverse events occur, yet, no federal competencies or training requirements exist for PCAs and many work without credentials. PCAs need substantially more training to competently address complex physical and mental challenges of their patients. There should be required, standardized, affordable PCA training requirements that cover all basic competencies: a viable career path with a recognized training certification process; a monitoring of career progress; increased pay for trained workers; incentives to employers for hiring trained workers; and job conditions that make PCA work a viable career choice, including guaranteed hours, health benefits, scholarships or cost-sharing for training, and support services such as provision of day care and transportation.

9. Expand the array of services available so that individuals have a broad range of care options and providers from which to choose that would meet whatever needs they have at any given moment, whether it is acute or LTSS. This requires changing the payment system so that money

follows the person, as well as improving respect, cooperation and coordination of care among the full range of providers and care delivery options.

An example of such an expansion would be to make MI Choice more available as a service option, and to have more than one MI Choice waiver agency in each region.

10. There should be a statewide, multi-pronged promotional campaign to increase the understanding of the aging process and the many positive social and economic contributions of an experienced and important segment of the Michigan population. Seniors' and disabled citizens' assets are substantial, underused and underappreciated for enriching the quality of life for the larger community. Seniors and persons with disabilities should have increased opportunities to participate more actively in paid employment, volunteer work, and other ways to engage in their own growth and continued personal development. Retirement should be redefined to embrace a continued, meaningful engagement in the larger community.

11. Patient initiative, autonomy, and independence trump all other decision makers or health care provider choices, regardless of residential setting (nursing homes, Adult Foster Care, MI Choice, Assisted Living). Trumping includes decisions regarding privacy in sleeping units, roommate selection, furnishing/decorating/sleeping and living units, control over their schedules and activities, access to food at all times, and visitors of their choice at any time.

12. Coordination and integration of services have been important components of many health plans and previous health reform efforts. It was previously the promise of primary care physicians, medical homes and now through use of navigators, helpers, integrators, supporters, facilitators, and others with similar titles. Health systems should coordinate and integrate services regardless of the mechanism used to assure this outcome. The best example of such a health system is Program for All Inclusive Care for the Elderly (PACE). It should be expanded and PACE-like options should be funded and provided by federally qualified health clinics.

13. Elderly, chronically ill individuals should receive "life-long" person-centered, LTSS from community, insurer, or provider based navigators to access appropriate, timely interventions, maintain optimal health, and live independently in the place of their choice.