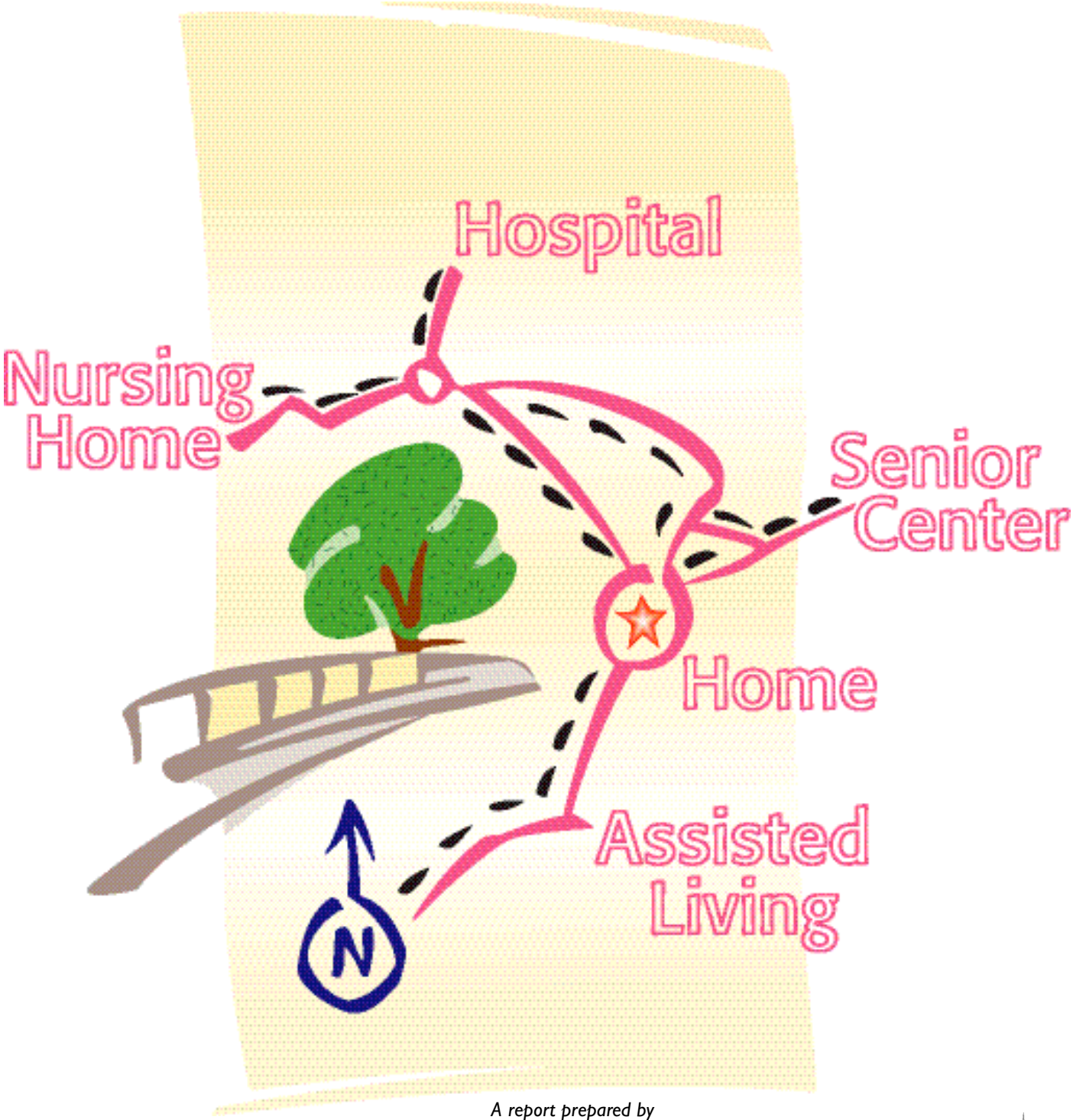
Long Term Care Task Force

Navigating thru the Options



A report prepared by

State Representative Paula Zelenko

and

House Democratic Leader Dianne Byrum

March 2004

LETTER FROM THE CHAIR

As a person who was quickly thrown into the long-term care system when my otherwise healthy father was hit by a tree limb and paralyzed from the neck down, I know firsthand the challenges one faces when trying to find appropriate long term care for a loved one. Although I later learned that many resources existed in my community that could have helped my brothers and I when making some tough choices, at the time that I needed the resources, I did not know of them. Unfortunately, for too many families around the State, the resources they need to make wise decisions on long term care for a loved one are either unknown or inadequate. The Long Term Care Task Force was charged with making recommendations as to both: improving the quality of long term care as well as expanding the resources available to families who are making long term care decisions.

I am grateful to House Democratic Leader Dianne Byrum for giving me the opportunity to chair the Task Force on Long Term Care. I had the great privilege to work with a number of Michigan's leaders in the field of long term care. Without their knowledge, dedication, and passion, this report would be lackluster at best. I appreciate the hard work of the staff for their commitment to coordinating schedules, tending to the details for the hearings, proofing, editing and getting this report to print in a timely manner. I thank my family for their input, reflection, and support through the months spent working on this report, especially my parents, because even in their death, they continue to teach me. Most importantly, I am grateful to the overwhelming number of people who testified about their experiences and recommendations at one of our 10 public hearings. Their stories and experiences are powerful and the recommendations within this report are a direct result of their commitment.

I learned much during my time chairing the Task Force on Long Term Care. We heard about many caring and loving people who selflessly care for our most vulnerable citizens yet earn less than those who work in fast food restaurants. I learned that without the countless volunteers who deliver meals to homebound persons, coordinate social activities in nursing homes, and many other important functions, services to seniors and disabled persons would be significantly less. I learned that for every Medicaid dollar that the State spends on in-home care, it spends $100 on care provided in a nursing home. Finally, more often than one might think, vulnerable citizens are taken advantage of with little recourse. These, and many more findings, are elaborated in this report. So to is my personal story on finding long-term care services for my parents.

Michigan's population is aging and living longer. As more of our citizens face challenges with health or disability, the need for better long term care planning and coordination is increasing at a rapid rate. It is my hope that the Michigan legislature, Governor Granholm, and local communities will turn the recommendations in this report into action. I am committed to championing long term care initiatives during my tenure in the Michigan legislature. With the help of the members of this Task Force, other leaders in long term care, compassionate community leaders, and bold law-makers, we can provide seniors and those with disabilities the quality, compassionate, cost-effective care that they deserve.

Paula K. Zelenko

State Representative Paula Zelenko

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Membership

Aldo Vagnozzi is a first-term State Representative from District 37, comprised of Farmington and Farmington Hills. Aldo Vagnozzi served as mayor of Farmington Hills for five years and on the city council for l2 years as well as the Farmington school board for four years. He currently serves on the Education and Senior, Health and Retirement committees. Aldo is active in the Michigan Campaign for Quality Care, a group trying to improve nursing home care.

Barb Buckbee is a retired educator, retiring from the Southwest Macomb Career Technical Education Consortium in June of 2002. During her tenure in the consortium, she was an administrator for career technical education, career development, counseling and special populations programs. She received her doctorate from Wayne State University. Barb's credentials include education and training in administration, counseling, secondary and elementary education especially in the areas of career technical education, career development, special education, and life management. Since retirement, Barb has continued to volunteer. Barb says, "I appreciated the opportunity to serve on the Long-Term Committee and Thank you for the experience."

RoAnne Chaney is a Health Policy Coordinator for the Michigan Disability Rights Coalition She is participating in the development of a public authority model for independent home care workers. Her areas of expertise are with long-term care, community integration, and meaningful consumer involvement.
RoAnne has experience in disability and health care issues in Michigan. Previously, she was a Senior Program Officer with Center for Health Care Strategies where she worked on Medicaid managed care issues. She was the Operations Director for the Michigan Disability Rights Coalition from 1997-2001 where she coordinated Michigan's Assistive Technology systems change project. RoAnne was also the Associate Director of the Ann Arbor Center for Independent Living for ten years where she and a team developed a collaborative interagency process to assist individuals with a variety of significant disabilities leave nursing home settings to live in the community. RoAnne has a Bachelor of Arts in Social Work and a Master of Public Administration from Eastern Michigan University.

Doris J. Silcox, Executive Director, Maple Heights Retirement Community in Allen Park. As the director, Doris oversees an eleven story high rise that houses 155 apartments. Before accepting the position as Executive Director, Doris was employed by American House as a manager. She also served on the Presbyterian Village of Westland, Board of Trustees . Prior to working in senior housing, Doris was employed for seven years by the City of Westland Senior Resources Department. Doris has dedicated her career to meeting the changing needs of older adults.

Jean Johnson
For the past eight years Jean Johnson has been the Director of the Burton Senior Center. Jean has a diverse knowledge of Long Term Health Care issues. While in nursing school she worked direct care for two paraplegic young boys, before making a career change starting her own business Jean worked for several nursing homes and for Bay Valley Community

Hospice. Always an advocate for Senior Citizens Jean found the perfect career move to the Burton Senior Center, under her leadership she has worked to utilize the talents of fifty-six volunteers to provide a full service Senior Center and has worked to improve the quality and accessibility of service for Senior Citizens. Jean is currently on the Advisory Board for the pilot MiCAFE food assistance program and the Genesee County Senior Winter Games. Jean is a member of the Michigan Association of Senior Centers and the Genesee County Senior Directors Association.

Lauren Essenmacher, Director of Council on Aging, Clare and Gladwin Counties since 1996, has been working with the Council since 1976, and during that time has worked to expand the Council' s scope of services to meet the needs of a growing mid-Michigan senior population. Since 1976, Essenmacher has also assisted the Gladwin City Housing Commission's Housing and City/County Transit programs in helping provide affordable, accessible housing and transportation to elderly, handicapped/disabled and low-income residents of Gladwin County. While in the capacity of Deputy Director, the Housing Commission, which administers Council on Aging as well as the Housing and Transit programs, received the Best Practices Award from the Department of Housing and Urban Development and the Department of Health and Human Services in 1994, for best utilization of federal dollars. Essenmacher has served on the Planning Committee of the Michigan Directors of Services to the Aging, and is currently on the Gladwin County Fair Board.

Mike Simowski has been the Executive Director of The Senior Alliance, Inc.(Area Agency on Aging 1-C) since 1999. He has been involved in the provision of services to older persons and their caregivers for three decades. Prior to his appointment at TSA, he was the Deputy Director at the Detroit Area Agency on Aging from 1986 to 1999. He also has held positions at the Detroit-Wayne County Area Agency on Aging and the Institute of Gerontology at Wayne State University

Nida Donar is a graduate of Highland Park High School. She received her Bachelor and Master of Social Work degrees from Wayne State University as well as a Certificate in Family and Couples Therapy.She was a federal food-law training specialist for Michigan Legal Services in the 1970's, and worked with a coalition that succeeded in bringing about mandated school lunch programs in Michigan schools. She was the Managing Director of the South East Michigan Coalition of Occupational Safety and Health in the 1980's. As the Executive Director of the Hunger Action Coalition of Michigan she organized a successful legislative campaign in 1995 to expand mandatory school breakfast programs in Michigan public schools.
Nida is currently the executive director of Citizens for Better Care, a statewide long-term care consumer advocacy agency. She also is a part-time instructor in the Wayne State University School of Social Work. She is a Eureka Fellow and on the state board of the American Civil Liberties Union and a board member of Legal Aid and Defenders Association. She is the recipient of the John Paul XXIII Community Service Award and the Mother Wattles Humanitarian Award.

Peter A. Lichtenberg, Ph.D., ABPP is the Director of The Institute of Gerontology and a Professor of Psychology, Psychiatry and Physical Medicine and Rehabilitation at Wayne State University. He received his bachelor's degree from Washington University in St. Louis, and his Master's and doctorate in Clinical Psychology from Purdue University. After his internship he completed a post doctoral fellowship in geriatric neuropsychology at the University of Virginia Medical School where he also became a faculty member. He is an active researcher and clinician, and was awarded the Garrett Early Career Award for his contributions to geriatric rehabilitation. He is a Fellow of both the American Psychological Association and the Gerontological Society of America. In 1999 Dr. Lichtenberg was awarded the outstanding achievement award from the national network Psychologists in Long Term Care. In 2001 Dr. Lichtenberg was awarded both the Distinguished Graduate Faculty Award and the Outstanding Graduate Mentor Award from Wayne State University. In 2002 he was awarded the Alzheimer's Advocate Award by the Michigan State Council for Alzheimer's Disease. Dr. Lichtenberg has been awarded over $10,000,000 in grant funding and has over 125 publications including 5 books, the latest ones being Handbook of Assessment in Clinical Gerontology and Interdisciplinary Handbook of Dementia: Psychological, Neurological and Psychiatric Perspectives Dr. Lichtenberg's research interests include disability, dementia and depression among African American elders.

Rep. Glenn S. Anderson represents the 18th House District, (Westland), and is currently serving his second term in the Michigan House. Rep. Anderson is the Democratic Vice-Chair of the House Transportation Committee and serves on the House Insurance and Financial Services Committee. Rep. Anderson was elected Democratic Caucus Chair by his colleagues for 2003 - 2004. Before his election to the House in 2000, Rep. Anderson served nine years on the Westland City Council after having served on various commissions. Rep. Anderson was named Legislator of the Year by the Michigan Association of Chiefs of Police in 2002. Rep. Anderson is both a Council of State Governments BILLD Fellow and Toll Fellow.

Sondra Seely, RN, CRNH

Established the Cottage Hospice in 1976, which was the first of the current ten Hospices of Henry Ford programs, which include a program for terminally ill children, a grief support program for children and their families, and a hospice residence. Retired as Administrator of Hospices of Henry Ford, following 30 years of service, in Sept., 2003. Currently serving as consultant to Hospices of Henry Ford. Founding member of the MHPCO and board member since 1980. Assisted in developing state regulations. Currently MHPCO Chairperson of Education & Nominating Committee.

1983 - Joined several hospice professionals to review the hospice standards that were prepared by the Health Care Financing Administration in Washington, D.C.

1985 – Founding member of the Michigan Hospice Nurses Association.

1989 – Founding member of the Academy of Hospice Nurses.

1994-1997 – Founding member of Michigan Cancer Pain Initiative and Hospice Coalition of Michigan.

Other Current Affiliations – Michigan Long Term Healthcare Task Force; Michigan Alliance for Pediatric Palliative Services (MAPPS).

Boards served on: MHPCO, Madonna University Hospice Advisory Board, Michigan Cancer Foundation Hospice Board, Michigan Cancer Pain Initiative; Henry Ford Health System Hospice Advisory Board, Lutheran social Services/Heartline.

Wendy Williamson has been with Michigan Protection and Advocacy Service, Inc., an independent civil rights agency for people with disabilities, for the past three years. She is a Certified Social Worker with a background in disability rights, long-term care, mental health, alternatives to guardianship, and various clinical as well as civil rights issues.

Joanne L. Barr
Background includes 19 years as a General Motors employee. She earned an undergrad degree from Wayne State University in 1985 and a Juries Doctor degree from Detroit College of Law in 1989. She was appointed Magistrate in the 39th District Court from 1992 to 1999: concurrently had a law practice with a concentration in family law, probate, estate planning and elder law. Joanne's interest in long-term care resulted from caring for her brother and mother during their final illnesses. She organized the Macomb Court Chapter of the Michigan Campaign for Quality Care.

Lydia Rizzo is a retired high school librarian. In May 2002 the Ecorse Board of Education dedicated to her the media center of its new $23.5 million high school. She also received a Certificate of Special Congressional Recognition of outstanding support and dedication to Ecorse Public Schools. She was an organizer and coordinator of the Oakland County Branch of Michigan Campaign for Quality Care from 1998-2002. Lydia co-edited with Mike Connors the 400 page book The Michigan Long-Term Care Companion. She also has been a published writer on long-term care issues. In April 1999 the American Association of University Women Educational Foundation-Farmington Branch named a gift to the Educational Foundation in her honor "in appreciation of your significant contribution to the mission of the AAUW Educational Foundation."

Taraynn Lloyd is the Director of Community Relations at Borgess Visiting Nurse and Hospice in Kalamazoo. She has a leadership role in an organization that provides in-home health care and hospice services to more than 4,500 seniors in eight counties in southwestern Michigan. Taraynn also serves as a member of the Public Policy Committee of the Michigan Home Health Association.

Jan Osborn has worked as a Long-Term Care Ombudsman in northeast Michigan for 15 years. She is employed by NEMCSA, Region 9 Area on Aging. In addition, she and Nancy Turner started the Best Practices of Northern Michigan group six years ago. The group consists of about 40 staff members and other professionals from care facilities in the region. They meet on a monthly basis to share ideas about how best to serve the needs of older citizens.

Acknowledgements

A special thanks goes to the hundreds of members of the public who passionately testified before the Task Force with their thoughts on improving long-term care in Michigan. Their personal stories and hope make this report a very compelling document. We are also thankful to the media for covering our work before, during, and after each hearing.

Each member of the Long-Term Care Task Force should be recognized for their outstanding commitment to this project. Members took time from their busy schedules to travel around the State for meetings. Most often, they assumed the cost of such travels themselves. In addition, they gave of their personal time to assist in the writing of this report. Their knowledge, experiences, and devotion to improving long-term care in Michigan are evident in the solid recommendations put forth in the report.

There are several staff who deserve recognition for their support in the Task Force's work. **Kate Segal** drafted this report as well as provided minutes for each of the hearings. Without her hard work and knowledge on the topic, the report would not have been written. **Kim Ross** and **Meredith Andrews** coordinated the public hearings and outreach efforts. **Rik Hayman** coordinated the press efforts. **Bette Bigsby** provided support to **Representative Zelenko**, and many other staff to State Representatives assisted in finding hearing locations. **Tina Weatherwax-Grant** provided oversight to the entire project.

Finally, the following people provided the Task Force with insightful presentations, the information therefrom provides much of the statistics offered herein: **Teresa Pizana,** Michigan Office of Financial and Insurance Services, **Hollis Tumham**, Michigan Policy Director for the Paraprofessional Healthcare Institute, **Tom Czerwinski**, Western MI Area Agency on Agency, **Kathleen Kueppers**, Area Agency on Aging 1-B, **Maureen Mickus**, MI State University, **Roanne Chaney**, MI Disability Rights Coalition, **Suzanne Szczepanski-White,** A Friend's House, **Wendy Winkler**, MI Hospice, **Barb Selesky**, Frederic Timberview Living Center, **Betty Wargo**, Adult Foster Care Grayling, **Marilyn Heard**, Grayling Nursing Center, **Carol Elliott**, Northern MI Works, **Brenda Robeerts**, former Long Term Care Ombusman.

Executive Summary

Michigan's population is aging. By the year 2020, Michigan will see a 41.5 percent increase in the number of people who are 65 years old or older, or an estimated 1.7 million older Michiganians. By 2020, over 1 in 6 Michigan citizens will be 65 years old or older, and one out of every 50 will be 85 years old or older. Unfortunately, Michigan does not have a long term care system that respects individual preferences or rights, and high quality care is hard to find. Michigan ranks eleventh out of the fifty states for the use of restraints in nursing homes and for the number of residents with bedsores. In addition, high staff turnover, inadequate training, poor supervision, and low wages too often result in competent caregivers leaving the field. Consequently, Michigan's vulnerable adults, whether they live in nursing homes, assisted living facilities, or their own homes, too often receive poor quality care, or no care at all.

Complicating the long term care needs of Michigan's citizens is the fact that one-third of Michigan's elderly population is poor, or nearly poor. Michigan ranks thirteenth nation-wide for its number of elderly individuals who live in poverty. In contrast, Michigan ranks 26th among the nation's Medicaid programs for its spending on long term care.

Long term care is not just for the elderly, but also for those with disabilities who need services to assist them in their daily activities. In just three years, Michigan's disability population receiving Medicaid long term care services under the age of 65 grew by more than 17 percent and is expected to continue to increase. When one includes those over the age of 65, the disabled population increased more than 30 percent in the last three years. With the passage of the Americans with Disabilities Act and Supreme Court rulings confirming the right for disabled individuals to have community based care options, Michigan's long term care system will continue to include a diverse population and must do a better job of offering a wide array of services.

The State, through Medicaid, is the single largest payer of long term care services in Michigan. Increasingly, the State is questioned for the way this money is spent. Twenty-six states spend more than 40 percent of their long term care budget on community-based services. Michigan spends less than 30 percent on home and community-based services, with only 10 percent spent on the Medicaid MI Choice Home and Community Based Waiver. The vast majority of long term care funding in Michigan is spent on nursing home care. With 82 percent of Michigan's elderly population owning their own home, Michigan is paying for institutionalized care when 77 percent of residents report they would prefer to access support services in their own home (AAA Public Opinion Survey February 2003).

Transforming the long term care system in Michigan cannot happen overnight. But there are steps that Michigan must take now, and continue to take in order to provide all of Michigan's citizens with the long term care options and choices that are best for them. From the hearings this Taskforce held across the state, it is clear that families need to be better informed of the resources available to them when making long term care decisions. In addition, a cultural change -- from an institutional-based care system to

one based on consumer choice – is needed.

Members of this Taskforce represent a broad cross-section of long term care specialists and interests. From members advancing the rights of people with disabilities to those caring for consumers of long term care services, the Taskforce represented the entire spectrum of long term care. Yet even with these vast professional experiences, we each learned a great deal about the strengths and weaknesses of our current system. Most disturbingly, we note that when those working in the long term care field struggle to navigate their way through it, the experiences for others is understandably overwhelming.

From the hearings this Taskforce held across the state, it is clear that families need to be better informed of the resources available to them when making long term care decisions.

Hundreds of members of the public shared their personal stories in hopes of finding solutions or helping others bypass the challenges they endured in the long term care system. To that end, the Taskforce listened to their experiences, the frustrations of caretakers, the advice of experts, and the suggestions of professionals from all aspects of long term care to create this multifaceted list of recommendations for creating a long term care system in Michigan that respects an individual's dignity and provides appropriate choices for all individuals needing long term care services.

Recommendations:

Staffing

• Provide financial and other incentives to long-term care employers who do a good job of retaining direct care workers by providing positive working conditions including: affordable health care coverage, higher wages, career ladders, continual training, and other workplace innovations.

• Improve recruitment methods, and supervision practices, to attract and retain more direct care workers in all long-term care settings.

• Apply the public authority model used in other States (e.g. California, Oregon, and Washington) to better support the individual provider option; allowing individuals served through the Home Help program to select and employ their worker, via the "consumer-directed" care mode, while providing a source of worker supports and strengthening the recruitment of workers by new Home Help recipients.

• Develop outcome based measures for nursing home care that shifts the regulatory focus from measuring deficiencies to measuring quality.

• Increase direct care staffing ratios in nursing homes. Michigan should, at minimum, be meeting the national average of 4 hours per resident, per day. Facilities should be subject to strict penalties when these levels are not met.

• Embrace alternative nursing home models, including the Eden approach, that create great communities to live and work.

Training

• Michigan Works boards, community colleges, long-term care employers, disability and aging organizations, community foundations, and public and private entities should combine resources across the state and regionally to increase training opportunities for direct care workers and provide assistance with placing these trained individuals in jobs. Consideration should be given to combining training for family caregivers with direct care workers to maximize resources, particularly in rural areas of the state, and to promote the use of the most effective clinical practices throughout Michigan.

• Create a training infrastructure in Michigan where workers are paid during training sessions, and ongoing education is available for those wanting to climb a career ladder.

• Improve current training programs for all direct care workers in all long-term care settings by focusing not only on health and clinical aspects but also communications, problem-solving, and critical thinking. Insure that training is ***delivered*** from a

• Improve current training programs for all direct care workers in all long-term care settings by focusing not only on health and clinical aspects but also communications, problem-solving, and critical thinking. Insure that training is delivered from a platform of consumer's directing services and using adult-centered teaching methodologies.

• Ensure that those providing the training for entry level health care workers have adequate credentials and experience.

• Offer direct care workers training on dementia that emphasizes the nature of illnesses that produce dementia and successful approaches in providing supports and services to individuals with dementia. Training should also be offered on other challenging behaviors direct care workers may face as well as on how to handle residents with complex medical conditions.

`• Require sensitivity training, and retraining, on a regular basis that includes administrators and higher management. This includes developing and making available training for supervisors of direct care workers so those workers are better supported in their jobs.

Paying for Long Term Care:

• Medicaid long term care funding should follow the consumer. Medicaid funding should be permitted for the spectrum of long term care services, ultimately serving individuals' needs as they, their families, and care team see fit. This should begin immediately with pilot projects.

• Increase funding for, and the capacity of, the Medicaid MI Choice Waiver Program.

• Michigan should apply the principles of the Independence Plus model in its Home and Community Based waiver in order to strengthen the options for recipients to control and direct their care when they have such an interest and capability.

• Remove living accommodation restrictions on the Medicaid MI Choice Waiver Program. Individuals who financially and physically meet the Medicaid waiver eligibility requirements should be able to receive those services in subsidized housing, especially public housing facilities and licensed assisted living facilities, as well as their own home. A person's home should not be a barrier to qualifying for waiver services.

• Allocate funds from the nursing home quality assurance assessment fee to facilities

willing to make improvements including: increasing staff to patient ratios, reducing turnover among staff, providing health care benefits to staff and their families, improving the quality of life for residents, and enhancing consumer protection procedures.

• Pass the Long Term Care Insurance Model Act in Michigan. Michigan should pass legislation that provides incentives for Michiganians to save for their own long term care needs with the confidence that they are making sound investments.

• Include questions about long term care insurance on the test that insurance agents must pass before selling insurance products.

• Create a consumer guide to long term care insurance policies that includes a history of all companies' rate increases. Michigan should provide an unbiased consumer guide that informs consumers how to analyze their individual need for long term care insurance and of insurance companies' performance in the long term care market.

• Commission on Aging to promote the benefits of Long-Care Term insurance.

Protecting Long Term Care Consumers

• Increase access and visibility of Michigan's Long Term Care Ombudsmen. Improve access to Long Term Care Ombudsmen by requiring the State and local Ombudsmen's telephone numbers to be posted in all long term care facilities, and publicly promote the Ombudsmen's roles and responsibilities.

• Increase funding for Long Term Care Ombudsmen to advocate for all consumers of long term care services regardless of their age or place of residence.

• Increase training opportunities for local Ombudsmen and provide best practice models for improving community collaborations.

• Create a short guide to Long Term Care consumers' rights to be developed by the State Long Term Care Ombudsman.

• Create a webpage for the State Long Term Care Ombudsman that allows consumers to submit questions.

• Enhance the state's MISeniors.net website to be a thorough, state-wide entry-point referral service for long term care needs.

• Create a state definition of "assisted living" and require all assisted living facilities to have standard contracts and qualified health professionals providing medical services.

• Create a statewide registry of certified nursing assistants, home health workers, home help workers, direct support professionals, personal care assistants, and other direct care workers working in both residential and home and community based services within the Department of Community Health. The registry should be accessible by all consumers.

• Urge the United States Congress to create an interstate registry of certified nursing assistants, home health workers, home help workers, direct support professionals, personal care assistants, and other direct care workers working in both residential and home and community based services.

• Require all long term care facilities' internal patient reports of abuse to be recorded in, or on, a patient's chart and to be made available to the patient and medical advocates.

• Permit the Long-Term Care Ombudsman and state surveyors access to all patient abuse reports at long term care facilities. Ombudsmen should have direct access to facility surveys and enforcement histories.

• Increase penalties for patient abuse. Currently, a victim of abuse can only receive $100.00 regardless of the severity of the abuse. Penalties should be adjusted to fit the crime, and should be exempt from Medicaid eligibility requirements. Revise sentencing guidelines for elder abuse to consider the number of people abused.

• Require posters in all long term care facilities that explain the rights of residents and that elder abuse is against the law.

• Create a misdemeanor charge for long term care staff, even temporary staff, who do not report abuse.

• Work with law enforcement to investigate complaints of elder abuse by health care employees in all settings.

• Counties should consider creating elder abuse task forces, similar to the one in Genesee County, to investigate and inform the public about elder abuse.

• Permit residents of long term care facilities to install video cameras or other electronic monitoring devices in their room.

• Increase penalties for guardian and conservatorship abuse.

• Require review standards and audits for all guardians and conservators.

• Prevent any agency, whether public or private, that is directly providing services to an individual from being a court appointed guardian for that individual, unless no other suitable agency or person can be identified.

• Amend the long term care facility inspection process to encourage state surveyors to randomly meet with residents and residents' families.

• Require state surveyors to review the financial records, including charges to patient accounts, as part of their annual evaluations of long term care facilities.

• Create sanctions for all long term care facility personnel who lie to a state surveyor.

• Fire regulations for assisted living facilities should be consistent state wide.

Family Supports

• Implement a uniform needs assessment tool to establish guidelines and a process by which seniors and the disabled are matched with appropriate services and placed in appropriate settings. This tool should also be used to assist families and caregivers in determining what care their loved one need and what options are available to them to meet those needs.

• Create a discharge check list that hospitals and families could use at discharge care conferences. Before leaving the hospital with a loved one, families should understand medication requirements, equipment options, assistance services, etc.

• Create a "tool kit" for families who are entering the long term care system for the first time to be distributed and developed by the State Long Term Care Ombudsman.

• Medical community should refer families to hospice services before the last few weeks of one's life.

Which Setting is Best for My Loved One?

"My dad was an outdoorsy type and had no poor health conditions other than some arthritis and he wore hearing aids. But that all changed on September 28, 2000 when my dad had an accident in the woods while cutting down a tree. A dead limb from an adjacent tree fell, striking him on the back of the head. In the hospital we learned that our family's very own Superman was paralyzed from the shoulders down. My dad was on a ventilator, but after a few weeks he was deemed stable enough to begin physical and occupational therapy. For a few minutes all of our spirits were lifted. But then, the hospital social worker handed me a list of physical and occupational therapy facilities and I was to tell her the next day where we were going to send dad from the hospital. One day? I was overwhelmed. What are my options? Where was I to begin?"

State Representative Paula Zelenko

Services for Those Still Living at Home

More and more families are becoming caregivers for their older relatives. In fact, eighty to ninety percent of all caregiving is provided by family members. That means that one out of every 4 working adults is also caring for an older family member. While there are many important public programs available for long term care needs, they represent only a small part of the long term care continuum. The average caregiver is a 43 year old female who is taking care of her 70 year old mother. Caregivers have to be parents, spouses, workers, and look after the house. They can't do it alone. These responsibilities are often physically, emotionally, and financially draining. Most caregivers are not trained for this responsibility and are easily overwhelmed. There are programs and services available to help family care-givers in almost all of Michigan's counties.

Adult Day Services

Adult Day Centers are wonderful programs for both seniors and their caregivers. They provide a place for functionally and/or cognitively impaired individuals who cannot, or should not, be left alone. Centers provide care in a structured, supportive group setting other than the client's home and provide a variety of health, social and other related support services. These services can be provided during any part of the day, but less than 24-hour care. Centers vary in their approach to caring for their clients with some centers offering social oriented programming and others basing their services on a medical model. Most often, adult day centers will provide a combination of the two, with personal care services and staff to serve other needs. Clients usually require some form of assistance and are unable to perform activities of daily living without it. Adult day service programs do require the client to be able to leave their home to receive services. This absence provides caregivers with a much needed break. Adult day services provide supports for the caregiver that can help extend the amount of time a caregiver can provide in-home services to their family member before having to place their loved one in an institutional care setting.

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Michigan does not regulate adult day service programs. However, the Commission on Accreditation of Rehabilitation Facilities (CARF) is an independent, not-for-profit accrediting body that does accredit adult day service providers. This is a voluntary accreditation program that adult day service providers seek and that is specific to adult day centers. None of Michigan's more than 140 adult day

centers are CARF accredited, but three centers in West Michigan have been accredited in Adult Day Service standards in specialized programs: two with a behavioral health population and one with the developmental disability population.

If an adult day service is affiliated with a healthcare organization, the program may also be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). JCAHO evaluates the quality and safety of care at health care organizations, but its accreditation standards are not specific to adult day services. Many insurance companies will require adult day service programs to be CARF or JACHO accredited for reimbursement.

While the state does not certify or license adult day centers, many centers do meet minimum standards of care in order to receive state funding from Area Agencies on Aging (AAA). Before an AAA can contract with a provider for services, the provider must meet state and federal requirements for quality and care as determined by the Michigan Office of Services to the Aging. Local AAAs are responsible for evaluating and monitoring local adult day services for compliance with the state standards.

One adult day service program that the Taskforce heard testimony about is A Friends House in Macomb County. A Friends House provides services for individuals with dementia including assistance with toileting and medications. Eighty percent of A Friends House clients have some form of dementia, and 60 percent require assistance with toileting and/or medications. These individuals do not need nursing care, but they do need assistance with many activities of daily living. A Friends House provides options for individuals wishing to be as independent as possible, for as long as possible, while still remaining in their homes.

A Friends House Director, Suzanne Szczepanski-White, reported that most caregivers who come to her center say "I wish I knew about you sooner."

Funding for adult day services varies. A Friends House receives state funding through its local AAA and has a mandatory cost share schedule with a sliding scale. The Medicaid MI Choice Waiver program also covers adult day services for qualifying individuals. Overall, adult day services cost approximately $56 a day, or anywhere from $5 to $8 an hour, paying more or less depending on the number of support services that are needed.

The biggest challenges facing adult day services are funding and underutilization. Testimony revealed that most centers are underserved and underutilized. A Friends House Director, Suzanne Szczepanski-White, reported that most caregivers who come to her center say "I wish I knew about you sooner." She testified that too often caregivers seek adult day services as a last resort, as a last step before nursing home care, or after their loved one is "too far gone" to be able to use adult day services for long. Director Szczepanski-White believes this is unfortunate because although older family members with dementia may not remember having been in the adult day center that night, they enjoy themselves while they are there and are happy when picked up by their caregiver.

To find an adult day service program in your area, contact the following:

Michigan Office of Services to the Aging
P.O. Box 30676
Lansing, Michigan 48909-8176
517-373-8230
website: miseniors.net

or
National Adult Day Services Association, Inc.
722 Grant Street, Suite L
Herndon, Virginia 20170
Toll Free Phone: (866) 890-7357 or (703) 435-8630
Fax: (703) 435-8631
E-mail: HYPERLINK "mailto:info@nadsa.org"

Michigan Office of Services to the Aging, Area Agencies on Aging

The Michigan Office of Services to the Aging (MOSA) is an independent agency within the Michigan Department of Community Health. The office was created in response to the federal Older Americans Act of the early 1970s. Michigan passed companion legislation, the Older Michiganians Act, in 1981 to further increase support services for Michigan's elderly population.

The goal of the Michigan Office of Services to the Aging is to provide supportive services to older adults and the frail elderly to allow them to remain in their homes. MOSA works in partnership with 16 regional Area Agencies on Aging (AAA) to provide indigent seniors with support services that are tailored to meet the needs identified in local communities. Through AAA and contracted providers, MOSA provides care management, information and assistance, meals, in-home services, legal assistance, guardianship, transportation, health promotion, and caregiver supports.

The goal of the Michigan Office of Services to the Aging is to provide supportive services to older adults and the frail elderly to allow them to remain in their homes.

Area Agencies on Aging are independent agencies designated by MOSA to oversee the MOSA services in local communities. State and federal funding is disbursed to regional AAAs from MOSA and is then distributed in the community based on that community's needs. Each AAA is required to have an Advisory Council of local seniors and other community members to determine how the state and federal funding will be used to assist the seniors in their community. AAA services are available to all individuals age 60 and over; however, priority is given to those seniors in the greatest social and/or economic need. In most communities, AAAs are the best information source for a variety of needs. As a result, they are a great starting point to contact when in need of assistance.

In most communities, AAAs are the best information source for a variety of needs.

In fiscal year 2002 MOSA, through their network of partners and providers, served more than 324,000 seniors (20 percent of the 60 years old and older population in Michigan) with $91 million in state, federal, and local monies. One fourth of those served in 2002 were 85 years old or older, and 70 percent were women.

Medicaid Home and Community-Based Waiver

The Home and Community-Based Waiver for Elderly and Disabled, or MIChoice, is an optional Medicaid program that states can implement as an alternative to institutional settings (nursing homes) for the elderly and for persons over the age of 18 with physical disabilities. The waiver refers to "waiving" Medicaid's usual requirement of funding care only in nursing homes and allows states to offer services to individuals with higher incomes. Michigan received approval from the federal government for its waiver program in 1992 and implemented it state-wide in 1998. In 2000, Michigan's MI Choice Waiver was renewed for an additional five years.

The waiver program provides living assistance to Medicaid-eligible persons still living in their homes. It is a preferable alternative for the elderly and disabled since they are able to independently stay in their homes, remain members of their communities, and preserve family and neighborhood ties. The waiver program covers 13 services, but on average, individuals uses only five. Services available under the waiver include: adult day care, respite care, chore services, homemaker services, transportation, home delivered meals, counseling, private duty nursing, emergency response system, personal care supervision, medical supplies and equipment, and home modification.

The Home and Community-Based Waiver provides living assistance to Medicaid-eligible persons still living in their homes.

Participation in the waiver program is determined by Medicaid eligibility. Individuals are limited to assets no greater than $2,000 (excluding their home and one car) and must have a monthly income at or below 300 percent of the Social Security Supplemental Income payment standard, or approximately $1690 per month. Once an individual qualifies for the waiver program, services are paid by state Medicaid funds and federal matching dollars. On average, the state pays approximately $1,151 a month for an individual to be in the waiver program, or less than $42 a day.

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In the past, 25 percent of individuals in the waiver program were young disabled adults. Now, less than 10 percent of younger adults make up the program. The program is extremely important to disabled adults because the waiver allows them the independence to remain in their community rather than isolated in an institutional setting. In addition to a reduction in the number of disabled adults able to participate in the waiver program, over the last several years the waiver program has cut the number of people that it serves from about 12,000 individuals to a little more than 6,000. State funding cuts have left the waiver program at about $100 million a year. This is in comparison to neighboring Ohio, which has more than 34,000 individuals in its waiver program.

Adult Home Help

The Adult Home Help Program provides personal care services to elderly, blind, and disabled persons to assist them in remaining in independent living situations. The program was created in 1981 with the intent to keep Michigan's citizens in their homes rather than in institutional care or adult foster care. Adult Home Help services are non-specialized personal care services provided through the Medicaid program to low-income Social Security Disability recipients or Medicaid-Only recipients who meet the program's eligibility requirements. Supplemental Security Income benefits (SSI) are paid to individuals who are poor and disabled, whether or not the individual has worked in the past.

The Adult Home Help program provides unskilled personal care services. These services cover Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Activities of Daily Living include assistance with eating, toileting, bathing, grooming, dressing, transportation, and/or mobility. Instrumental Activities of Daily Living include assistance with taking medication, meal preparation, laundry, housework, and shopping or errands.

The current "consumer-directed" aspect of the Home Help program is becoming more difficult to maintain as it is very hard for an individual to find a worker where they do not have a readily available family member.

The program is funded through the Department of Community Health budget, but is operated through the Family Independence Agency (FIA). FIA must complete an assessment of individuals wishing to enter the program to determine the level of services needed and it works with recipients to select providers when possible. In about one-half of the cases, services are provided by family members. In most other cases, individuals requiring this assistance attempt to engage friends or obtain referrals through the assistance of their FIA worker or the local Aging Services office. The large majority of Home Help workers are the directly employed by the individual receiving services. This aspect of the Home Help program, a feature called "consumer-direction", has been a central element of Michigan's Home Help program since its inception. This feature is highly valued by the individuals served because it gives them a strong degree of control over the quality and manner in which they are served, including the right to dismiss the worker and find another if things are not working out. In a small number of cases (10%), the beneficiary receives their Home Help services from a worker who is employed by a public or private home care agency.

The current "consumer-directed" aspect of the Home Help program is, however, becoming more difficult to be maintained, as it is very hard for an individual to find a worker where they do not have a readily available family member. Obtaining workers, even family members, is made even more difficult because the average hourly amount that FIA will allot for performing the tasks authorized for a recipient who directly employs their worker is around $6.00/hour. (Payments made to agencies who employ the worker are $10.00/hour or higher.) The effect of this low hourly amount on recruitment of workers is exacerbated by the use of the FIA "Reasonable Time and Task

Schedule". However, many advocates report that, because the amount of time allotted for each task is standardized, the actual amount of time required for providing the assistance is often greater in many individual circumstances, that the amount authorized. This results in the effective rate of pay for many workers being much less than the apparent hourly rate that is applied to the authorized time for conducting authorized tasks, meaning that the worker may be, in actuality, working for less than even minimum wage. Even for dedicated family members, giving up other employment to become the care-giver for their loved one may be financially impossible for them. When this aspect is extended to a shrinking labor pool of potential direct care workers, the viability of the program is threatened.

In fiscal year 2001-02, the Adult Home Help program provided assistance to more than 42,000 individuals for a total cost of $172.4 million. The average cost per recipient was $4,229 per year.

Assisted Living

Assisted living, as defined by the Assisted Living Federation of America, provides a person with housing, support services, personalized assistance, and specialized care. Usually, supportive services are offered 24 hours a day to meet the routine and changing needs of their clients. Individuals typically stay an average of three years in assisted living.

The recent growth of assisted living facilities in Michigan far outweighs that of nursing homes.

Assisted living began as an alternative to the institutional setting most common in nursing homes. Most often, assisted living is marketed as a home-like environment that is generally less expensive than institutional care. Consumers and their family members seek this service because it represents a quality of life that they do not see in nursing homes and other institutional settings.

The recent growth of assisted living facilities in Michigan far outweighs that of nursing homes. There are two types of assisted living facilities in Michigan: licensed and unlicensed facilities. Adult Foster Care homes and Homes for the Aged are licensed while most newer assisted living facilities are not.

Adult Foster Care

Adult Foster Care homes (AFC) are licensed facilities that provide room and board, personal care, and supervision to those who do not need continuous nursing care. Michigan has more than 5,000 AFCs across the state that provide assistance for adults, age 18 and older, in small, mostly privately owned facilities.

AFCs are regulated by the Office of Children and Adult Licensing in the Family Independence Agency. Each site is inspected by the state every two years for compliance with state regulations. AFCs are limited to a maximum of 20 residents by state regulation, but they are not limited in the type of resident they accept. AFCs can provide services for any adult 18 years of age or older including the mentally ill, developmentally disabled, physically handicapped, and the elderly.

Nationally, assisted living facilities cost approximately $83 a day. In Michigan, AFCs vary widely in their fees because it depends upon the services provided.

Nationally, assisted living facilities cost approximately $83 a day. In Michigan, AFCs vary widely in their fees because it depends upon the services provided. Medicaid does cover some individuals living in AFCs if they qualify for Supplemental Security Income benefits (SSI). SSI is a federal social security payment for individuals who are poor and disabled regardless of whether the individual has worked in the past. If an individual does not qualify for SSI benefits, then services in AFCs are private pay and not covered by traditional Medicaid or Medicare.

Homes for the Aged

Homes for the Aged provide room and board and supervised personal care to people 60 years of age and older and accommodate 21 or more residents. Homes for the Aged are licensed by the Office of Children and Adult Licensing in the Family Independence Agency and subject to inspections annually. Michigan has 192 licensed Homes for the Aged providing service to more than 14,500 individuals.

Homes for the Aged can provide personal studio apartments, shared rooms, or apartment-like settings for residents. However, all residents must be 60 years old or older to reside in a Home for the Aged. In addition, Homes for the Aged offer communal settings for their residents and have shared meals.

Homes for the Aged vary in their cost depending on the type of facility chosen and the services that are provided. Costs can be as low as $800 per month and as high as $3600 per month depending on the type of services offered. Traditional Medicaid and Medicare will not cover expenses in Homes for the Aged, but Medicaid will cover SSI beneficiaries. Thus, the primary source of funding for Homes for the Aged is from private pay individuals.

Unlicensed Assisted Living

As the population continues to age, more and more assisted living facilities are opening across Michigan. However, many of the new facilities are not licensed Adult Foster Care or Homes for the Aged facilities as we consider traditional "assisted living" facilities, but instead are unlicensed facilities. These facilities provide residents with independent living accommodations. In assisted living facilities, residents have a private room, bath, and kitchenette, and can choose to participate in communal activities offered by the facility or remain independent in their own accommodations.

In assisted living facilities, residents have a private room, bath, and kitchenette, and can chose to participate in communal activities offered by the facility or remain independent in their own accommodations.

Since assisted living facilities are not regulated, they can pick and choose the type of residents they will accept. Some facilities provide a full range of support services while others provide only basic additional supports. When a full range of support services are provided, those services are contracted directly with the resident and are not part of the room and board fee. In order to fall outside of Michigan's licensing requirements, the assisted living facility owner, and the operator of the support services cannot be the same entity. Although not licensed, the Contract Services Act of 1999 does require these facilities to outline, in a contract, the services they will be providing to residents.

Unlicensed assisted living facilities are funded through private payers and a limited number of Medicaid Waiver clients. Because unlicensed assisted living facilities contract for services outside of room and board fees, individuals living in assisted living facilities are eligible to receive waiver services if they qualify. However, most residents in newer, unlicensed assisted living facilities would not meet the income eligibility requirements for the Medicaid waiver and therefore, would have to privately pay for their services.

In a study conducted by Dr. Maureen Mickus, at MSU, 68 percent of unlicensed assisted living facilities provided assistance to residents with medications. However, only 28 percent of those facilities had a registered nurse (RN) employed at the facility.

The Taskforce heard testimony on both sides of the assisted living debate—whether to license all assisted living facilities or continue the status quo of both licensed and unlicensed facilities. In support of licensure, testimony was heard that unlicensed facilities provide services without properly trained and qualified staff administering those services; including medication dispensing and other health care delivery in Michigan. In a study conducted by Dr. Maureen Mickus at MSU, 68 percent of unlicensed assisted living facilities provided assistance to residents with medications. However, only 28 percent of those facilities had a registered nurse (RN) employed at the facility. Concern about the quality of care these residents are receiving and what protections are in place for residents when these facilities are unlicensed is prevalent.

Supporters of continuing the practice of unlicensed assisted living facilities in Michigan argue that these facilities can offer a greater variety of services and allow a resident to "age in place." The freedom from regulatory burdens allows facilities to change with new technologies and programming while still protecting the consumer through contracts and the ability to take their business elsewhere. Some reason that by allowing assisted living facilities to operate independently, facilities are better able to respond to individuals' needs and create innovative programming.

Nursing Homes

Long term care options have evolved over the years, but nursing homes are still the principal provider of 24-hour care. Nursing homes are environments for individuals who cannot live independently and require regular medical, rehabilitative, and supportive services along with room and board. Skilled nursing facilities provide 24-hour nursing services as directed by the patient's physician. Some individuals seek temporary nursing home care for their rehabilitation needs whereas others need long-term care.

According to Marilyn Heard, Executive Director of Grayling Nursing Center, there are 319 state and federal rules with which nursing homes must comply.

Nursing homes and skilled nursing home facilities are regulated by state and federal rules. According to Marilyn Heard, Executive Director of Grayling Nursing Center, there are 319 state and federal rules with which nursing homes must comply. Nursing Homes can be cited if they are not in compliance with these rules and face fines and other sanctions. Much of Ms. Heard's work is spent keeping up with regulations and preparing for inspections by the Bureau of Health Systems within the Michigan Department of Community Health.

Before a nursing home, county medical care facility, or hospital long-term care unit is eligible for Medicaid and Medicare it must be licensed by the state and meet Medicaid and Medicare certification standards. Medicaid, by far, is the largest payer of nursing home care; however, insurance and private money are also used to pay for nursing home care. In Michigan, there are more than 430 nursing homes costing an average of $5,000 a month to someone paying without Medicare or Medicaid assistance. The state through Medicaid pays an average of $3,256 per individual per month in a nursing home.

New Nursing Home Models

While much of the testimony heard by the Taskforce relating to nursing home care centered on problems with patient care, we also heard promising testimony about alternative care models. For example, the Eden Alternative and Wellspring model are part of a cultural change to alter the way in which long term care is delivered in institutions. The Eden Alternative turns the typical nursing home into a vibrant living and working environment. While traditional nursing homes focus only on a medical

model of treatment, the Eden Alternative prioritizes care, and emphasizes the importance of relationships between residents and staff.

The Eden Alternative prides itself on its staff training. Staff competency and satisfaction is paramount to the program. The Eden Alternative's Golden Rule is "as management does unto staff, so staff shall do unto elders." The Eden Alternative expounds that loneliness, helplessness, and boredom account for the majority of suffering within the long term care community. The program works to address these issues and believes the result will be an improved quality of life for elders and workers alike. A study conducted by the Institute on the Future of Aging Studies (IFAS) found that rates of staff turnover in facilities using the Wellspring model were lower than in traditional nursing homes. The study also found that Eden alternative facilities improved performance in federal surveys and had fewer citations. Costs were also offset when the staff worked better. When staff is more vigilant, they are quicker to observe issues and vocalize their observations. Overall, the study showed a better quality of life for residents, improved interaction between elders and staff, and better work environments for staff when alternative nursing home models were used.

Hospice

Hospice providers, and members of the Michigan Hospice and Palliative Care Organization (MIPCO), serve more than 27,000 patients a year in Michigan. This is just one quarter of the people that could be taking advantage of hospice services. Hospice programs provide patients and families with compassionate care when patients have life-limiting illnesses and treatment is no longer an option. Hospice services provide care for all symptoms of the illness, including pain management, as well as counseling for both the patient and the patient's family.

One of the greatest challenges in obtaining hospice care is getting a timely referral.

Even though both Medicare and Medicaid cover hospice services, as well as most insurance companies, Michigan residents continue to underutilize hospice services. An average stay is 46 days, with the median length of stay at 17 days. This is in comparison to the six months or more of services that most patients are eligible to receive depending on the course of the terminal illness. Hospice also offers one year bereavement services to family members after a patient dies.

One of the greatest challenges in obtaining hospice care is getting a timely referral. Many individuals testified that they wished they had known about hospice services before their crisis situation. In surveys conducted by the Michigan Hospice and Palliative Care Organization, families report being very satisfied with hospice services and willing to recommend it to others. However, they also reported frustration with the lack of timely referrals. Referrals for hospice care must come from a physician and are often discussed

at the very end of life rather than earlier in a terminal disease.

Once a referral has been obtained, hospice services can be provided in any care setting. Hospice will work with the patient and family to provide services in the environment most comfortable to the patient; whether that is in a home, nursing home, hospital, or hospice facility. In many cases, individuals want to remain in their own homes and hospice works with the individual and family to make this happen.

To find hospice services in your area, contact the:
Michigan Hospice & Palliative Care Organization
6015 West St. Joseph Highway, Suite 104
Lansing, Michigan 48917
517-886-6667 or 1-800-536-6300
www.mihospice.org

The Hands That Help – Workforce Issues in Long Term Care

"After weeks of physical and occupational therapy, my dad was finally able to go home with care-giving from my mother and family. But the strain of caregiving on my mother was taking its toll—she began to experience mini strokes and spent a few days in the hospital before returning home with her own health care needs. I then had two parents at home unable to care for themselves. We needed someone in their home to take care of Dad since Mom could barely care for herself. After 64 interviews, we finally found a wonderful caregiver. She came to the house five days a week for eight hours a day. She took charge, knew who to call for help and kept my two brothers and me in line as to who needed to do what and when. Without her knowledge and assistance, we would not have been able to keep Mom and Dad in their home."

State Representative Paula Zelenko

Professional Staff

Studies have shown that with increased staffing ratios, errors and patient injuries are reduced. However, there is a shortage in Michigan of direct care workers in home care, nursing home care, and other long term care settings. Even though one out of every five health care workers in Michigan is an unlicensed direct care worker, Michigan is facing a widening gap between those who need care and those who are providing care. Long term care work is labor intensive and without adequate wages, benefits, training, support, and supervision; thus it is a field with a high turnover rate.

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Ms. Barbara McGregor of Warren testified that she relies on home health care. She has had three closed head injuries and she has Parkinson's disease and needs the assistance home health care provides. Many of her caregivers work for just a couple of months before leaving for another job. Her last caregiver just moved to Colorado where she is still provides home based care, but making better money. Ms. McGregor sees first hand that her direct care workers are not getting the wages they need, so she has to supplement their wages in order to keep them. Unfortunately, with her limited income, her little extra is still not enough.

Most home care aides in America receive poverty-level wages, little training, and no health coverage -- conditions that result in nearly 100 percent turnover. The high turnover in direct care staff is difficult on both the elderly and disabled, whether they receive that care in their own home or in an institution. In every sector of long term care, the job turnover rate is three times larger than the average turnover rate in all industries. This significantly jeopardizes the quality of care. When staff leave a long-term care job, there is a break in the services provided, and limited resources must be

used to train new workers instead of improving the wages of remaining workers or the quality of care for recipients.

Nadine Mitcham of Westland testified that the shortage of certified nursing assistants in southeast Michigan has pushed some facilities to use temporary staff. Unfortunately, temporary staffs are unfamiliar with residents' needs and preferences as well as various facility protocols. Ms. Mitcham wants reduced dependence on pool staff, resulting in a more stable, safer, and humane environment for patients.

Rachelle Uken, a local long term care ombudsman in Grand Rapids, testified that residents in one local nursing home have to wait thirty minutes to an hour for their call light to be answered.

When facilities are understaffed, residents suffer. Rachelle Uken, a local long term care ombudsman in Grand Rapids, testified that residents in one local nursing home have to wait thirty minutes to an hour for their call light to be answered. On occasions when the staff is really short, Ms. Uken said staff will just turn the call lights off and tell residents that they'll come back when they aren't as busy. Ms. Uken also shared stories of residents having meals taken away uneaten because there wasn't sufficient staff available to help them eat.

Recipients and advocates from across the state testified to the need for additional staff in nursing homes. Ms. Uken's experiences were reflected in testimony from numerous cities throughout the state with the same result—residents not getting the care they needed. Michigan law requires not less than 2.25 hours of nursing care per resident per day. The industry average in Michigan is 3.3 hours, but this is well below the national average of 4 hours. The law equates to only one nursing care personnel for eight patients in the morning, one caretaker for 12 patients in the afternoon, and one caretaker for 15 patients at midnight. Each nursing home must also have a registered nurse available seven days a week, eight hours per day. These levels have not been changed in more than 30 years.

Because of lower staffing levels, Michigan nursing homes average 10 deficiencies per home per inspection compared to the national average of only eight per home. Although studies have shown that errors lessen with additional staff, most nursing homes in Michigan are not moving toward improvement in this area of patient care.

Wages

The average wage for a Michigan direct care worker is $9.27 per hour, compared to the average Michigan worker wage of $17.31 per hour. This low wage is not competitive with most other entry-level jobs. In order to be considered self-sufficient (requiring no government assistance) a single worker with two children needs to earn $16.52 per hour. Since the long term care environment cannot offer this level of pay, the positions are unattractive to workers needing one job to support a family. In addition to low wages,

many direct care workers do not have health benefits for themselves or their families. Even when employers do offer health benefits, research shows that 70 percent of direct care workers can not accept the coverage because the premiums are too high.

The average wage for a Michigan direct care worker is $9.27 per hour, compared to the average Michigan worker wage of $17.31 per hour

Competent, caring direct care workers are leaving the field, and thus their clients, because of the low wages. Ms. Sharon Zils of Grand Rapids was a direct care provider working in the Home Help program through Family Independence Agency from 1988 to 1995. She started at just $5.00 an hour and when she left in 1995 she was still only making $6.50 an hour. Now, she is a private duty care provider for people who can afford to pay her directly. This larger income allows her to meet her family's needs. She testified that she won't work in a nursing home because she has a low tolerance for people who don't do their job; a symptom of under paid staff she claims. She testified that even though she doesn't normally favor tax increases, she believes there is a very big need to attract and keep good direct care providers.

Training

Besides low wages and the physically demanding work, direct care jobs are also unattractive because of the lack of training and supervision that typically accompany them. Michigan's training requirements for a certified nurse assistant (CNA) are lower than most other states. Michigan currently only requires 75 hours of caregiver training for nurse-aide training as required by federal law, but most other state programs require an average of 120 hours. Home health aides who are employed by certified agencies are tested after taking the CNA training course. There is little or no training required or offered in most other long term care settings across Michigan.

Michigan Works in northern Michigan created a basic healthcare training program to meet the shortage of direct care workers in its service area.

Many individuals seeking direct care jobs do not have the skills to provide the basic services required of the job. As a result, expanded training options need to be created. Michigan Works in northern Michigan created a basic healthcare training program to meet the shortage of direct care workers in its service area. A committee created an introductory health curriculum designed to teach potential employees basic life and health care skills in hope that employers would then provide additional training. The program was a huge success and serves as a model for other Michigan Works offices.

This northern Michigan training course, which was only 60 hours, met funding requirements by the Workforce Investment Agency and Work First programs. Training began with a math and reading comprehension test so that instructors would know the skill levels of the students. The trainees also took a work readiness inventory that

measured their ability to be employed. The inventory looked at transportation, childcare, and other funds needed to get to the training and later, to get to work. Referrals came from agencies and through advertisement of the program.

The first 10 hours of training were taught by Michigan Works staff. The second 10 hours were taught by an appearance work team, who concentrated on issues such as time management, conflict resolution, courtesy, confidentiality, legal issues, clerical skills, diversity, wellness, leadership, stress management, work ethics, and patient rights and responsibilities. The thought was that even if the trainees did not go into healthcare, they would still gain valuable skills for other jobs. The latter 35 hour section focused on body functions, including: CPR, basic nutrition, basic vital signs, body mechanics, Maslow's hierarchy of death and dying, an overview of aging and dementia, body systems, anatomy and physiology, medical terminology, and sensitivity training. If there had been more time, they report they would have done job shadowing. Instead, they visited facilities as a class.

The U.S. Geriatric Congress for Long Term Care reports that 65 percent of long term care clients have dementia.

A reoccurring need heard by the Task Force from public testimony was that all training programs for direct care workers need to pay more attention to the needs of people with dementia. The U.S. Geriatric Congress for Long Term Care reports that 65 percent of long term care clients have dementia. For these clients, there is a huge turnover in workers (100 percent), mostly because of the stress involved. Caregivers need help managing the stresses of the job as well as time management skills to work with these individuals. With the increasing number of people affected by some level of dementia, it is important that the group of employees having the most contact with these patients, namely, direct care workers, have adequate training and knowledge to work with these patients. Many health professions encourage and require continuing education to ensure patient safety and professionalism in the field; members of the public testified that direct care workers should not be treated any differently.

As our State becomes more diverse, so too does its aging population. Long term care staff at all levels, need to be sensitive to the traditions and values of other cultures, religions, and families. Rosemary Antone from the Chaldean American Ladies of Charity highlighted this point when she testified to the difficulties that residents who do no speak English have in nursing homes. Many residents who cannot communicate with staff are sometimes put into dementia units simply because they do not speak the language. Her organization volunteers in area nursing homes and other long term care facilities to help interpret for residents, but it is not enough. With cultural training, Ms. Antone asserted that staff would be better able to work with non-English speaking patients.

Sunu Jain of Macomb County testified that his mother faces numerous barriers to quality

care in her nursing home because she often slips into speaking only Hindu and is a vegetarian. Mr. Jain's mother was suffering from malnutrition because she usually could not get a vegetarian meal in the nursing home. Many times her only option was to eat the side dish, and more often than not, it was a small helping of mashed potatoes.

Sunu Jain of Macomb County testified that his mother faces numerous barriers to quality care in her nursing home because she often slips into speaking only Hindu and is a vegetarian.

Training is needed for supervisors of direct care workers. Whereas the turnover rate of workers approaches 70 percent, the turnover rate for supervisors is 15 percents. Many direct care workers report that one of the reasons for leaving their position is poor supervision.

Family Caregivers

While much attention is paid to professional caregivers, eighty to ninety percent of all the caregiving in this country is provided by family members. It is important to remember that although there are many publicly funded programs that are very important to long term care, in actuality, they represent only a part of the whole long term care picture.

The average caregiver is a 43 year old female taking care of her 70 year old mother. One out of every four working adults is a caregiver for an older family member. These caregivers need support services or they burn out. Caregivers often have to be a mother, father, wife, husband, worker, child care provider, housekeeper, cook, etcetera as well as a caregiver. These responsibilities cause high stress for caregivers. Ms. Ardith Thompson of Bay City testified first hand how difficult it is to be the sole caregiver. She took care of her father in her home, but the stress of caring for her father, and trying to work to help pay the bills, quickly overwhelmed her. She had to turn to a nursing home to provide her dad's care. She testified that classes and community resources may have helped her take care of her father and deal with his basic needs as well as help her manage the stress of being his sole caregiver.

While much attention is paid to professional caregivers, eighty to ninety percent of all the caregiving in this country is provided by family members.

In 2000, the federal government passed the National Family Caregivers Support Program as part of the reauthorization of the Older Americans Act. The National Family Caregivers Support Program uses Area Agencies on Aging to expand caregiver programs including respite, education, and other resources in the community. Ms. Mary Ferry of Holland knows first hand how support services can help a caregiver. Ms. Ferry testified that her 23 year old daughter has muscular dystrophy and was in a wheel chair by the time she was in the sixth grade. Her daughter couldn't even sit up. Ms. Ferry was her daughter's caregiver for years until she received support services from the Medicaid waiver. This program has changed her

family dynamics. Her daughter is now in college and she doesn't have to worry about running home from work each day to care for her. Most importantly though, Ms. Ferry reported that she can now concentrate on being her daughter's mother and not her caregiver. Drawing the lines between mother and caregiver was important to her because she never had adequate resources to be both.

Recommendations:

Staffing

• Provide financial and other incentives to long-term care employers who do a good job of retaining direct care workers by providing positive working conditions including: affordable health care coverage, higher wages, career ladders, continual training, and other workplace innovations.

• Improve recruitment methods, and supervision practices, to attract and retain more direct care workers in all long-term care settings.

• Apply the public authority model used in other States (e.g. California, Oregon, and Washington) to better support the individual provider option; allowing individuals served through the Home Help program to select and employ their worker, via the "consumer-directed" care mode, while providing a source of worker supports and strengthening the recruitment of workers by new Home Help recipients.

• Develop outcome based measures for nursing home care that shifts the regulatory focus from measuring deficiencies to measuring quality.

• Increase direct care staffing ratios in nursing homes. Michigan should, at minimum, be meeting the national average of 4 hours per resident, per day. Facilities should be subject to strict penalties when these levels are not met.

• Embrace alternative nursing home models, including the Eden approach, that create great communities to live and work.

Training

• Michigan Works boards, community colleges, long-term care employers, disability and aging organizations, community foundations, and public and private entities should combine resources across the state and regionally to increase training opportunities for direct care workers and provide assistance with placing these trained individuals in jobs. Consideration should be given to combining training for family caregivers with direct care workers to maximize resources, particularly in rural areas of the state, and to promote the use of the most effective clinical practices

throughout Michigan.

• Create a training infrastructure in Michigan where workers are paid during training sessions, and ongoing education is available for those wanting to climb a career ladder.

• Improve current training programs for all direct care workers in all long-term care settings by focusing not only on health and clinical aspects but also communications, problem-solving, and critical thinking. Insure that training is delivered from a platform of consumer's directing services and using adult-centered teaching methodologies.

• Ensure that those providing the training for entry level health care workers have adequate credentials and experience.

• Offer direct care workers training on dementia that emphasizes the nature of illnesses that produce dementia and successful approaches in providing supports and services to individuals with dementia. Training should also be offered on other challenging behaviors direct care workers may face as well as on how to handle residents with complex medical conditions.

• Require sensitivity training, and retraining, on a regular basis that includes administrators and higher management. This includes developing and making available training for supervisors of direct care workers so those workers are better supported in their jobs.

How Can I Afford to Pay for Long Term Care?

"Dad was soon to be released from the rehabilitation hospital. Besides being a quadriplegic, he had no other health problems so there was no need to keep him in the hospital. But, he still needed 24 hour around the clock care, so we were faced with either finding a facility to transition him at before bringing him home or finding home health care for him. Dad was only 64 years old and wasn't Medicare eligible for another three months. He didn't have a brain injury, so he wasn't eligible for the quadriplegic facilities close to home. And, Mom and Dad's monthly income was $6.00 a month over the limit for the one Medicaid Waiver slot that had become available in Genesee County. The cost of private pay home health care was expensive but the closest nursing home that could accommodate my dad's needs was in Detroit and almost twice as expensive as having someone care for him in his home. Mom made the executive decision that she would care for Dad herself with the help of my brothers and me."

State Representative Paula Zelenko

As Michigan's population ages and an increasing number of individuals and families are looking for long term care options, how much that care will cost is many times a deciding factor. The annual cost of nursing home care in 2002, for room and board alone was $5,043 a month. Home care options vary greatly, but can average anywhere from $13 to $15 an hour for a home health aide and $18 to $20 per hour for skilled nursing care.

The middle class and especially the "near-poor" are often left struggling with long term care costs.

Nationally, Medicaid pays for 49 percent of nursing home care and private payers pay for 45 percent of the care. In Michigan, Medicaid pays for 69 percent of nursing home care. In this payer system, low income families have the assistance of Medicaid and higher income families have the ability to pay out of pocket for these expenses. However, the middle class and especially the "near-poor" are often left struggling with long term care costs. In fact, 43 percent of respondents in a Public Opinion Survey for Michigan Area Agency on Aging Association in 2003 stated that they are not confident in their ability to pay for nursing home care when they may need it.

With the high cost of long term care, even families that try to save for their long term care needs often come up short. Mr. Anthony Messina of Livonia testified about how quickly a family's retirement savings can be wiped out by long term care services. Mr. Messina's aging, middle class parents worked hard throughout their lives and they thought they had accumulated enough money to take them through their last years.

However, Mr. Messina's father became ill and then his mother developed a condition in which she was no longer able to walk. For the last two years, Mr. Messina's parents were able to private pay for his mother's care at approximately $5000 a month. His parents never intended to file for Medicaid because they wanted to be, and remain, independent. However, their money ran out faster than other funding could be found. He was finally forced to help his parents apply for Medicaid because the nursing home bills were piling up.

Medicaid

Michigan's investments in long term care are out of balance. In fiscal year 2004, Michigan will spend more than $1.1 billion a year in Medicaid funds on nursing home care, and $100 million a year on the Medicaid Home and Community Based Waiver option.

To receive Medicaid coverage for long term care services, individuals must meet asset and income limitations. Medicaid will allow an individual to keep their home and one car, but it doesn't take into consideration the assets needed to pay taxes, home insurance, and upkeep on a home or vehicle.

The Task Force heard from several people how the spend-down requirements make it very difficult for individuals to afford personal expenses and other needs particularly for those in a nursing home. An individual in a nursing home who receives Medicaid receives only $60 a month for personal expenses, and an SSI beneficiary only receives $44 a month. Ms. Kaye Curodeau from Flat Rock testified that when her mother was in the nursing home on Medicaid, she only received $60 a month for clothing and all of her personal care needs. Ms. Curodeau said a new shirt and a haircut would exhaust this. The biggest challenge was paying for cable out of that money. Ms. Curodeau stated that nursing home residents rely on their televisions, especially since some of them can't get out of their beds. For many, this is their only exposure to life outside of their room. The fees for cable and telephones are full price, and as such, too expensive for most residents. The problem increases when residents are moved to different rooms in the nursing home, because in many cases, residents also have to pay a fee reconnecting.

The Medicaid program expends about $100 million a year on the Home and Community Based Waiver program. The demand for this program far outweighs its funding. The Home and Community Based Waiver program spends an average of $42 a day for care in a person's home whereas Medicaid pays approximately $118 a day for nursing home care. The Taskforce heard much testimony on the waiver program. Many complained about the numerous restrictions on where the waiver can be used, and for what services, thus hindering individuals' ability to have Medicaid cover their long term

care needs in their home or at a facility of their choosing. Others complained that the program has not accepted new clients in over a year. Finally, others simply pleaded for its expansion.

Ms. Sheila Hall of Gladwin, Executive Director of the Gladwin City Housing Commission, testified that the Michigan Waiver needs to be expanded to not only apply to more individuals in their own homes, but also to more individuals in public housing facilities. She noted that residents in senior housing cannot always qualify for a waiver because they have too many needs; however these needs are much more expensive if they are met in a nursing home.

The waiver program also helps the young disabled population remain in their homes. Remaining in their own homes is a priority for this population. With the help of the Medicaid waiver program and additional funding through the Family Independence Agency, Mr. Eric Thomas of Flint has been able to move into his own home. He has since started a record label and writes articles for magazines. Mr. Thomas uses a wheelchair after being shot twice in the spine in 1997 at the age of 25. He was rendered a quadriplegic, but after extensive rehabilitation, his parents were able to bring him home. At first he only received a couple of hours of care, but eventually this was increased to 10 hours. His mom received payment to provide five hours of care for him and with help from the Disability Network he also received Family Independence Agency funding and the Medicaid waiver for another 10-15 hours of care. Remaining in his home is critical to Mr. Thomas. He stated that he would rather die than go into a nursing home. Mr. Thomas credits his success to the assistance he receives from his workers through the Medicaid waiver. He knows first hand how vital the waiver program is for young people like him.

Ms. Sheila Hall, Executive Director of the Gladwin City Housing Commission, testified that residents in senior housing cannot always qualify for a waiver because they have too many needs.

Medicare

Many people have the misconception that the federal Medicare program will pay for their long term care needs. However, Medicare will only pay for up to 100 days of skilled nursing care per benefit period. And this care is only if the patient was in the hospital for three days prior to being transferred to a skilled nursing facility and the patient continues to meet the qualifying criteria on a day to day basis. Medicare defines skilled care as care that can only be administered by a registered nurse (RN.)

Medicare is a federal health insurance program for people who are 65 years of age or older, or for anyone who has been disabled for 24 months. Medicare Part A insurance helps pay for inpatient skilled nursing care in a Medicare participating skilled nursing home. Of the 100 days of skilled care that Medicare will pay for, it pays 100 percent of

the cost of the first 20 days of care. For the next 80 days, Medicare requires the individual to pay a $105 co-pay per day. In order for a patient to continue to receive Medicare coverage for skilled nursing home care, the patient must show improvement and meet other qualifying conditions.

It is possible to qualify for both Medicare and Medicaid programs when one's income is low enough. At that time, Medicaid will pay for a wide variety of medical services, including many that are not covered by Medicare.

Long Term Care Insurance

Recognizing the limits of Medicare coverage and the income restrictions for Medicaid, it is important that a family plan for their expected long term health care costs. Since Medicare is not likely to cover all expenses, and many middle and upper income families do not want to spend down their assets, they can benefit from long term care insurance.

Long term care insurance is still in its infancy compared to most other types of insurance coverage. However, it can be an asset to families when paying for home help care and skilled nursing home care. Early long term care insurance policies had limited coverages; the policies typically covered only long term care given in a skilled nursing home. These earlier policies did not offer coverage for intermediate or basic care needs and there was no coverage for home health care. When companies did begin to offer policies with home health care benefits, it was a separate policy that had to be purchased in addition to a long term care policy for nursing home care. At that time, purchasing all of the extra policies for a continuum of care needs was very expensive. The earlier policies also had the same restrictions as Medicare which required a three day hospital stay before the policy would begin to cover nursing home care. These early policies were very limited and were not responding to the changing long term care system. Not surprisingly, less than 2 percent of Michigan's population has a long term care insurance policy.

Long term care insurance can be an asset to families when paying for home help care and skilled nursing home care.

Earlier long term care policies were also hampered because the value of the policy could not be protected. If an individual bought a policy for a certain amount of coverage, there were no protections in place for that policy to increase with inflation. If someone bought a long term care insurance policy 40 years prior to needing it and did not change the policy, chances were very high that by the time they needed it (if they could in fact meet the restrictions to activate the policy) the coverage would last for only a short time—far less than the amount needed for their care.

In 1992, Michigan added Chapter 39 to its insurance code to reform long term care insurance policies in Michigan. Under the new law, long term care insurance policies have to include coverage for intermediate and basic care at a level comparative to their nursing home coverage. It also requires that long term care insurance policies include home health care and offer inflation protection at a minimum of 5 percent compounded. This ensures that the policy will at least keep up with inflation. Insurance companies can still offer other types of inflation coverage, but they must at least offer the 5 percent increase. Chapter 39 also eliminated the three-day hospitalization stay requirement. Unfortunately, Chapter 39 did not grandfather in policies that were written prior to 1992, so some policies still are not adequate to meet the purchasers' long term care needs.

Another change that helped the long term care insurance market is the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Part of the new HIPAA regulations allow a policy holder to deduct their long term care insurance premiums from their taxes. It also gives tax incentives to employers for offering long term care policies. These changes were intended to get more people interested in investing in long term care insurance.

Long term care insurance policies have to include coverage for intermediate and basic care at a level comparative to their nursing home coverage.

According to Ms. Pizana with the Office of Financial and Insurance Services, long term care insurance is a young product; it is feeling the pains of growth. There have been continuous and significant increases in premium rates as insurance companies realize their initial pricing was inadequate to cover long term costs. Part of this increase is due to the inexperience of the insurance companies in accurately estimating the amount needed in their reserves. When a policy holder pays his/her premiums, part of the money goes into a reserve for future expenses, and a portion is used for current expenses. This system is to ensure that when a policy holder needs to collect on the policy, there is money in the insurance company's reserves to cover the expenditures. Unfortunately, misjudgment on the part of insurance companies has led to inadequate reserves and large jumps in premiums to cover expenditures. Insurance companies originally thought that many people would lapse their long term care coverage and a certain percentage would decide that they no longer need the coverage, thus freeing up money to stabilize the insurance company's reserves. However, according to Ms. Pizana, people hang on to their long term care insurance more than any other type of insurance coverage. This leaves insurance companies with very low reserves and large payouts.

Another problem facing the long term care insurance market is the inexperience of the sales force. Agents do not always know the real details of long term care policies and may misinform buyers. Unlike other types of insurance, there are no specific requirements for insurance salespeople to meet before they sell long term care insurance policies.

While agents have to pass a test before selling insurance, there are no questions pertaining to the long term care insurance market included. The Task force heard testimony that some of the questions on the insurance test should include long term care policy information.

Ms. Chris Nettleton, Michigan Office of Financial and Insurance Services, testified that more information on LTC for both agents and consumers is needed.

Ms. Janet Miesiak of Allen Park has been selling long term care insurance, and only long term care insurance, for the past three years. Ms. Miesiak commented that if an insurance agent has a health license then s/he can sell long term care insurance. She also agrees that some of the agents do not seek to know the policies well. She stated that some agents choose not to sell it correctly, but most problems can be addressed with education.

Ms. Chris Nettleton, Michigan Office of Financial and Insurance Services, addressed the lack of public information on long term care insurance policies. If insurance companies were to disclose details of their long term care policies then consumers would have the tools to compare the products they are buying. She believes that many seniors are approached by agents to purchase policies, but some of these individuals would be better off putting the money in the bank because the premiums are too high for their income. However, since many agents aren't aware of this and don't know the policies well enough to explain them, seniors have been misled. She testified that more information for both agents and consumers is needed.

The Long Term Care Insurance Model Act would hold companies accountable and make them base their rates on actuarial data to curb significant jumps in premiums.

While the changes made to the Insurance Code in 1992 went a long way in updating Michigan's long term care insurance market, there are still obstacles to purchasing long term care insurance. Ms. Nettleton discussed the need for Michigan to pass the nationally recommended Long Term Care Insurance Model Act. This act would require the agent to certify that the rates are actuarially sound, and how many rate increases there will be over the lifetime of the policy if an individual purchases a long term care policy. These increased consumer protections would inform the buyer of the potential costs of the policy. There should be a set limit on the number of rate increases an insurance company can make on a policy. Ms. Nettleton stated that the model act allows three increases before the insurance company would be subject to review and potentially removed from the market. The Long Term Care Insurance Model Act would hold companies accountable and make them base their rates on actuarial data to curb significant jumps in premiums.

The Long Term Care Insurance Model Act would also require a non-forfeiture benefit that would allow an individual to get at least part of their premiums back. Right now, if an individual can no longer afford the long term care insurance premiums, or decides

s/he doesn't want the policy anymore, s/he doesn't get any money back. This current situation makes purchasing long term care insurance a risky investment for some.

Ms. Nettleton encouraged the Task force to include older policies in all new legislation. One of the biggest complaints she receives from consumers is that they cannot get their benefit unless they spend three days in the hospital. When Michigan passed long term care reforms in 1992, it did not grandfather in the older policies. As a result, many individuals cannot use the benefit they have paid for because they were not hospitalized for three days.

Long term care insurance can be a part of a financial plan for many people, but it is not the answer for all, cautioned Ms. Nettleton. When purchasing any insurance, especially long term care insurance, it is important to look at the individual's needs—an individual should not sacrifice food in order to make premium payments. The needs of individuals and their situations need to be taken into account before buying long term care insurance.

Many people are still unaware that long term care can cost upwards of $50,000 a year for basic care.

Ms. Nettleton also discussed the need for greater public awareness about the cost of long term care. Many people are still unaware that long term care can cost upwards of $50,000 a year for basic care. That figure does not include doctor visits, hospitalizations, or medications. Federal law does provide for tax incentives for employers to offer long term care insurance, but it hasn't been the catalyst it was thought it would be. Michigan state employees do have a long term care insurance plan option that they pay for themselves, but they can get a group rate keeping the premiums lower. Many larger employers are moving this way, but more education is needed on how to purchase the best product.

Recommendations:

- Medicaid long term care funding should follow the consumer. Medicaid funding should be permitted for the spectrum of long term care services, ultimately serving individuals' needs as they, their families, and care team see fit. This should begin immediately with pilot projects.

- Increase funding for, and the capacity of, the Medicaid MI Choice Waiver Program.

- Michigan should apply the principles of the Independence Plus model in its Home and Community Based waiver in order to strengthen the options for recipients to control and direct their care when they have such an interest and capability.

• Remove living accommodation restrictions on the Medicaid MI Choice Waiver Program. Individuals who financially and physically meet the Medicaid waiver eligibility requirements should be able to receive those services in subsidized housing, especially public housing facilities and licensed assisted living facilities, as well as their own home. A person's home should not be a barrier to qualifying for waiver services.

• Allocate funds from the nursing home quality assurance assessment fee to facilities willing to make improvements including: increasing staff to patient ratios, reducing turnover among staff, providing health care benefits to staff and their families, improving the quality of life for residents, and enhancing consumer protection procedures.

• Pass the Long Term Care Insurance Model Act in Michigan. Michigan should pass legislation that provides incentives for Michiganians to save for their own long term care needs with the confidence that they are making sound investments.

• Include questions about long term care insurance on the test that insurance agents must pass before selling insurance products.

• Create a consumer guide to long term care insurance policies that includes a history of all companies' rate increases. Michigan should provide an unbiased consumer guide that informs consumers how to analyze their individual need for long term care insurance and of insurance companies' performance in the long term care market.

• Commission on Aging to promote the benefits of Long-Term insurance.

Stop that Felon from Preying on Others

"My Dad and mother both passed away in January of 2003; however, that isn't the end of my story. During the last few days of my mother's life, one of the many health care workers we had in our home got a hold of my mother's checking account number. The worker made several electronic telephone transactions and even identified herself as me to pay off her debts to a collection agency. She spent more than $3,000 of my mother's money in just a couple of days and she has yet to be found."

State Representative Paula Zelenko

Representative Zelenko is not alone. Identity theft and other crimes against vulnerable adults are a real threat to older Americans. Recognition of elder abuse is fairly recent and the federal government, along with some states, is now recognizing and punishing crimes against older Americans. It is estimated that 2.5 million people are victims of some form of elder abuse each year. Unfortunately, only one out of every 14 incidents is reported to authorities. Victims are most often older women, around 75 years of age, and in 32 percent of cases, the abuse is committed by a family member.

It is estimated that 2.5 million people are victims of some form of elder abuse each year.

Crimes against vulnerable adults can come in many forms, but typically fall into one of three main categories: abuse, neglect, or exploitation. Elder abuse, neglect, and exploitation are defined by Adult Protective Services as follows: elder abuse is harm, or threatened harm, to an adult's health or welfare caused by another person; elder neglect is defined as harm to an adult's health or welfare caused by self-neglect or the conduct of a person responsible for the adult's care; and elder exploitation is the misuse of an adult's funds, property, or personal dignity by another person. Whether these crimes are committed by a family member or another individual or in the home, nursing home, or other long term care setting, elder abuse is against the law. These definitions protect disabled adults as well.

Older Americans are more vulnerable to crime regardless of their ability to care for themselves because they are often easy to target. Seniors are typically home more than younger families and in some cases of financial exploitation are more willing to listen to the stories of exploiters. Sometimes, seniors may not want to admit to their children or others that they have made a mistake in hiring a certain helper or in helping someone who they thought was in need. In cases where a family member causes the abuse, seniors are even more vulnerable.

Unfortunately, crime against older Michiganians is on the rise. In 1999, overall crime in Michigan was down 5 percent, while crime against individuals over the age of 65 increased. Neglect cases increased by 36 percent, fraud by 8 percent, stolen property increased by 17 percent, and non–aggravated assault was up by 18 percent.

Michigan does have laws protecting older adults including increased fines and prison terms for individuals who commit crimes against vulnerable adults. Older adults are also protected by the federal Older Americans Act. In the Older Americans Act, the federal government created the Long Term Care Ombudsman Program whose primary responsibility is to be an advocate for the rights of nursing home residents and to be a regular presence in long-term care facilities to facilitate relationships with residents, employees, and the administration of each facility. The original Older Americans Act identified 10 key rights of older persons include the right to:

- adequate income,
- the best possible physical and mental health,
- suitable housing,
- full restorative services,
- employment without age discrimination,
- retirement in health, honor, and dignity,
- participation in civic, cultural and recreational activities,
- opportunities for community service,
- immediate benefit from research,
- and freedom and independence.

When the Act was reauthorized in 1992, Congress added protections for vulnerable adults from abuse, neglect, and exploitation as well as new funding. Most recently, Congress called on states to foster greater coordination with law enforcement and the courts to protect vulnerable adults.

As almost 70 percent of the nation's nursing homes, and 62 percent of Michigan's nursing homes, are for-profit entities that receive billions of dollars in federal Medicaid and Medicare funding annually, the original intent of the Long Term Care Ombudsman was to ensure that the concerns of nursing home residents were being addressed in a timely, convenient manner to the resident without getting involved in the court system. The argument was that the Ombudsman would be an objective third party who could monitor care, and resolve problems, without requiring the resident to seek an attorney and pay costly court costs.

In 1999, overall crime in Michigan was down 5 percent, while crime against individuals over the age of 65 increased.

In addition to the federally mandated State Long Term Care Ombudsman, Michigan has also created local long term care ombudsmen to provide advocates for nursing home residents at the local level. Rochell Ukonn of Grand Rapids is a local ombudsman with Citizens for Better Care and testified that ombudsmen serve an important role of advocating for the quality of care that residents deserve. She stated that many residents can't, or are too afraid to, address their concerns directly. She and other local ombudsmen help ensure that these residents' rights are protected.

Funding for the long term care ombudsman program comes from federal and some state sources; however, the funding is limited. The State Long Term Care Ombudsman program receives approximately $1 million a year for its work on behalf of all nursing home residents. Local ombudsman programs are funded through the AAA and the amount of money dedicated to their service depends on the community. With more than 430 nursing homes across Michigan, these resources are stretched thin.

To assist ombudsmen in advocating for the rights of nursing home residents, Michigan has supplemented the rights under the Older Americans Act with specific nursing home residents' rights. These rights center around an individual's right to respect, privacy, and dignity including the right to receive information about one's medical care, help plan one's treatment, and complain without retaliation.

Even with Michigan's Nursing Home Resident's Rights, abuses are still occurring. Monika Jackson Strobe of Novi testified about the horrific treatment her husband received in a nursing home. She told the Task force of the many abuses her husband suffered in a nursing home for seven and a half years. She told of how her husband's toenail was ripped out and no one bandaged the foot or could explain how it happened. Ms. Strobe has an entire book documenting the abuses against her husband. However, because there were never witnesses to her husband's mistreatment, the administration and local law enforcements ignored her complaints. She was especially frustrated with the staff who were able to tell her what happened to her husband, but were too afraid of retributions to tell the administrators.

Although Ms. Wilder only put in what was necessary to cut the monthly payment to the nursing home for her mother's care, money was frequently transferred in and out of that account.

Joanne Barr of Fraser testified that she called the police to investigate the nursing home's treatment of her mother. However, when the staff was questioned, they said it was spontaneous and the investigation was stopped. The staff said her mother had been hurt in a lift. When she spoke with the police, they wanted to know what she was complaining about—they told her she was lucky to have her mother in this nursing home.

In her testimony, Jean Wilder of Belleville described how she found out that large sums of money were transferred in and out of her mother's account. Although Ms. Wilder only put in what was necessary to cut the monthly payment to the nursing home for her mother's care, money was frequently transferred in and out of that account. She asked that nursing homes be held accountable for their finances.

While there are a patchwork of protections for Michigan's seniors and vulnerable adults, a comprehensive guide to understanding those rights does not exist. Over the years,

laws have been amended and new additions made, but there is neither a comprehensive code outlining seniors' rights nor an easy to understand, condensed document. The Task force repeatedly heard in testimonies that such a document would be helpful.

Americans with Disabilities Act

The Americans with Disabilities Act of 1990 (ADA) has been the most significant advancement of rights for people with disabilities in the United States. The ADA guarantees the rights of people with disabilities to be active participants in society in everyday life. It was designed to protect people with disabilities in employment, public services, public accommodation and services operated by private entities, transportation and telecommunications.

The ADA was derived from a collection of older laws intended to protect the rights of people with disabilities (i.e. the Architectural Barriers Act and the Individuals with Disabilities Educational Act). The act impacts more than 43 million Americans with disabilities, along with anyone who has a close involvement with someone with a disability, or those who have been ill-treated as a result of helping someone with a disability. Since its introduction in 1990, the act continues to provide equal opportunity for all in employment, public services, public accommodation, telecommunication, and other areas as interpreted by the courts.

The ADA guarantees the rights of people with disabilities to be active participants in society in everyday life.

Over the years, the Americans with Disabilities Act has proven difficult to interpret. The laws are broadly written, and oftentimes, questions regarding protections under the ADA have been evaluated on a case-by-case basis through the court system. One significant ruling by the United States Supreme Court was in 1999. This decision, *Olmstead v. L.C.,* 527 U.S. 581, stated that the ADA does consider unwarranted institutionalization as a form discrimination against people with disabilities. With this decision, disabled individuals can now practice their right to chose home and community based care over institutional care. Implementation of this decision, though, has not been immediate and many people with disabilities are still in nursing homes or other institutionalized settings when community based options would better serve their needs.

The ability to choose community based services over institutionalization is significant in the lives of people with disabilities, especially young adults. For Anna Dusbiber of Ann Arbor, it has meant the ability to attend Eastern Michigan University and hold a part-time job. Without receiving supportive services at her home, she cannot get out of bed and get ready for school or work. With her home care workers, she is planning on graduating from college in the next two years.

With the funding limitations on the MI Choice waiver program, not everyone in

Michigan has the ability to chose home and community based service options. According to the National Council on Disability, Michigan's spending on nursing facility services is considerable, and the number of nursing facility beds per 1,000 people in the state far exceeds the national average. With the vast majority of state and federal funding supporting nursing home care in Michigan, people with disabilities who cannot afford to private pay have few options available to them for community based supports and services.

However, in 2002, seven individuals filed a lawsuit against the state of Michigan because they were denied access to the MI Choice waiver program, but were eligible. The suit alleged that because the State closed the MI Choice waiver program to individuals who otherwise would be eligible for the program, the State was in violation of the Americans with Disabilities Act as clarified in the Olmstead decision. In January 2004, the State settled the suit and agreed to changes in the MI Choice waiver program. Specifically, the settlement calls for the State to spend not less than $100 million in FY 2004 for the MI Choice waiver program, but also make a good faith effort to increase the appropriation to $150 million; create educational materials about long term care options and community resources for consumers; publish and use a uniform eligibility checklist for all Medicaid long term care services; maintain waiting lists for the MI Choice waiver program; provide funding for transitional nursing home patients to community based options; and the State must create a Medicaid Long Term Care Task Force to develop options for expanding community based care and overall improving long term care.

The ability to choose community based services over institutionalization is significant in the lives of people with disabilities, especially young adults.

The lawsuit settlement will begin to move Michigan toward more community-based care options. The increased funding will help additional individuals find assistance in their community rather than in nursing homes, but Michigan will still only spend a fraction of its long term care dollars in community-based settings.

Enforcement

With State and federal laws to protect people with disabilities and the elderly, there are mechanisms in place to help ensure that individuals are protected. In most instances, formal complaints can be made directly to the Michigan Department of Community Health. However, in situations of immediate danger, the police should be the first agency to contact.

When nursing home residents' rights are violated, nursing homes can be fined by the state and the resident may be entitled to a payment or reimbursement of their costs incurred. However, in most cases, the resident is only paid $100 by the nursing home.

In cases of abuse or with severe injuries, $100 is meaningless compared to the pain and suffering the resident has endured. But, any amount higher than this could mean the temporary loss of Medicaid coverage for a resident if this $100 pushes one assets above the Medicaid eligibility window. In this current system, a resident is the victim twice. Monika Jackson Strobe, of Novi, testified that $100 was an unacceptable payment from a nursing home for the abuses patients like her husband suffered. Marty Adrian from Bridgeport agreed, testifying that stiffer penalties are needed. She stated that $100 is not enough of a deterrent for nursing homes to address the abuses she has witnessed.

Monika Jackson Strobe, of Novi, testified that $100 was an unacceptable payment from a nursing home for the abuses patients like her husband suffered.

In licensed assisted living facilities, the FIA is required to investigate reports of abuse and exploitation of the elderly. The FIA also investigates the Adult Home Help program to ensure that consumers are receiving the care and services they need. Diane Frankowski of Grayling testified that while the FIA does investigations, her job as a caseworker has become increasingly more difficult. Ms. Frankowski testified that with the state's early retirement plan implemented under former Governor John Engler, many FIA adult caseworkers have been overloaded and in some cases children's service workers are now conducting adult investigations, limiting the oversight for both children and adults. She further testified that the State has decreased the contact requirements to once every six months in order to handle the new caseloads. Ms. Frankowski testified that she believes this is a very big risk. Because many adults in her caseload have the right to hire their own caregivers, newer caseworkers are simply saying "okay" to the consumer's choice. While they have the right to hire their own caregivers, Ms. Frankowski testified that it is still important to ensure that the individual is hiring a competent worker and is not being manipulated by family members who are after money, or individuals who do not put the care of the consumer first. With the 20-25 percent increase in the state's population over the age of 60, Ms. Frankowski wants to ensure that there are resources in place to protect adults.

While a nurse as a health professional is required to report abuse direct care aides who provide a significant amount of the patient care to nursing home residents are not required to report abuse.

In situations of abuse, Michigan does mandate certain health professionals to report abuse to authorities. However, it does not mandate long term care facility employees to report abuse. While a nurse as a health professional is required to report abuse, as well as a human service professional, the direct care aides who provide a significant amount of the patient care to nursing home residents are not required to report abuse. Without these individuals being required to report abuse, and with the inability for residents, or their advocates, to obtain copies of internal nursing home incident reports, Michigan's long term care consumers may not be adequately protected. Furthermore, when an individual fails to report as required, under Michigan law, the individual is only subject to a fine, and/or potential civil liability. However, in

many states, failure to report elder abuse is a misdemeanor.

Jane Wilder of Belleville testified about the abuse her mother suffered in a nursing home. She said she called the police to file a complaint, but the police told her that her information was not consistent with the nursing home's report. Ms. Wilder would like to see mandated reporting of the so called "incidents" in nursing homes, and would like the ability to install a video camera in her mother's room so she may see for herself what happens to her mother when she can't be there. She testified that she is tired of consistently being told that the nursing home has no idea how her mother could have gotten hurt while in their care.

The Genesee County Elder Abuse Task Force includes mental health agencies, law enforcement, the prosecutor's office, senior advocate groups, and other parties interested in curbing elder abuse and coordinating ways to address it.

Coordination of community agencies is vital to combating elder abuse. In Genesee County, community leaders and activists have joined forces to form the Genesee County Elder Abuse Task Force. This Task Force includes mental health agencies, law enforcement, the prosecutor's office, senior advocate groups, and other parties interested in curbing elder abuse and coordinating ways to address it. This coordinated, county-wide approach is working to increase the awareness of elder abuse throughout the county, improve the response to incidents of elder abuse by appropriate agencies, promote the coordination of services for abused adults, and develop community strategies to prevent elder abuse. The Task Force began in June 1999 and has created an Adult Abuse Protocol for Genesee County which establishes coordination between law enforcement agencies and Adult Protective Services on how to respond to elder abuse. The Task Force also sponsors legislative forums on Elder Abuse.

Recommendations:

- Increase access and visibility of Michigan's Long Term Care Ombudsmen. Improve access to Long Term Care Ombudsmen by requiring the State and local Ombudsmen's telephone numbers to be posted in all long term care facilities, and publicly promote the Ombudsmen's roles and responsibilities.

- Increase funding for Long Term Care Ombudsmen to advocate for all consumers of long term care services regardless of their age or place of residence.

- Increase training opportunities for local Ombudsmen and provide best practice models for improving community collaborations.

- Create a short guide to Long Term Care consumers' rights to be developed by the State Long Term Care Ombudsman.

- Create a webpage for the State Long Term Care Ombudsman that allows

consumers to submit questions.

• Enhance the state's MISeniors.net website to be a thorough, state-wide entry-point referral service for long term care needs.

• Create a state definition of "assisted living" and require all assisted living facilities to have standard contracts and qualified health professionals providing medical services.

• Create a statewide registry of certified nursing assistants, home health workers, home help workers, direct support professionals, personal care assistants, and other direct care workers working in both residential and home and community based services within the Department of Community Health. The registry should be accessible by all consumers.

• Urge the United States Congress to create an interstate registry of certified nursing assistants, home health workers, home help workers, direct support professionals, personal care assistants, and other direct care workers working in both residential and home and community based services.

• Require all long term care facilities' internal patient reports of abuse to be recorded in, or on, a patient's chart and to be made available to the patient and medical advocates.

• Permit the Long Term Care Ombudsman and state surveyors access to all patient abuse reports at long term care facilities. Ombudsmen to have direct access to facility surveys and enforcement histories.

• Increase penalties for patient abuse. Currently, a victim of abuse can only receive $100.00 regardless of the severity of the abuse. Penalties should be adjusted to fit the crime, and should be exempt from Medicaid eligibility requirements. Revise sentencing guidelines for elder abuse to consider the number of people abused.

• Require posters in all long term care facilities that explain the rights of residents and that elder abuse is against the law.

• Create a misdemeanor charge for long term care staff, even temporary staff, who do not report abuse.

• Work with law enforcement to investigate complaints of elder abuse by health care employees in all settings.

• Counties should consider creating elder abuse task forces, similar to the one in Genesee County, to investigate and inform the public about elder abuse.

• Permit residents of long term care facilities to install video cameras or other electronic monitoring devices in their room.

• Increase penalties for guardian and conservatorship abuse.

• Require review standards and audits for all guardians and conservators.

• Prevent any agency, whether public or private, that is directly providing services to an individual from being a court appointed guardian for that individual, unless no other suitable agency or person can be identified.

• Amend the long term care facility inspection process to encourage state surveyors to randomly meet with residents and residents' families.

• Require state surveyors to review the financial records, including charges to patient accounts, as part of their annual evaluations of long term care facilities.

• Create sanctions for all long term care facility personnel who lie to a state surveyor.

• Fire regulations for assisted living facilities should be consistent state wide.

I'm taking care of Mom—Where can I go for help?

In 2000, my life was turned upside down trying to decipher the long-term care system I share my story with you, not so you will feel sorrry for me, but so that we can all begin to address the real needs that I have shared. I was no different than the majority of people who are not tied to the long-term care community: I was not aware of the assistance, guidance, and direction that I would quickly need in a time of crisis. It is my goal to bring about greater awareness of what is needed in our long-term care system, to promote the resources that are currently available, and to develop legislation that will get us all on the road toward providing better long-term care options."

State Representative Paula Zelenko

Ms. Maureen Chabot of St. Clair Shores, experienced firsthand the difficulty of navigating the long-term care system. Ms. Chabot was in the process of trying to find care for her 82 year old mother. She said that her mother needs some assisted care, but she can still do a lot by herself. The previous day, she had gone to the seventh place to look for care for her mother. She said that the amount of money that is charged in assisted living facilities is just astronomical. She had gone to one site, but there were additional fees for services beyond the high cost of room and board. Then she discovered that they only take seniors who can come and go on their own, not those with dementia or Alzheimer's disease who may wander. Ms. Chabot's mother's retirement money was from her home that she sold, money which would have been gone, she claimed, in just two years, if she had put her mother in one of the homes she found. She testified that most people are not educated on how to address her family members' long-term care needs and she didn't know who to turn to for help.

Ms. Maureen Chabot of St. Clair Shores testified that most people are not educated on how to address their family members' long term care needs.

Unfortunately, Ms. Chabot's experience is not unique. The Task force heard from many individuals whose first encounter with the long-term care community was during a crisis situation. This makes it difficult to research options and make decisions that are in the best interest of loved ones. One way to ensure that individuals have the information they need to make care decisions is to have a screening tool designed to help place individuals in the most appropriate setting for their care needs, regardless of their ability to pay. A comprehensive assessment often is needed to help consumers and families choose the appropriate level of care. Once they know what services they actually need, individuals and families can make informed decisions on care.

Another suggestion to help individuals and families make long-term care decisions is to have informed personnel at Michigan's hospitals who can help plan the next stage of care. These individuals would have care conferences before a person needing long-term care services could be discharged from the hospital. The conference would allow the health care providers, the family and a social worker to discuss with the patient what

medications, equipment and services would be needed once s/he left the hospital. The Task force heard from several families on how difficult it was to find appropriate placements for their loved ones, or the necessary equipment and support, if they were returning to a home with only a day's notice or less.

Task force members also heard testimony that individuals and families need a centralized access point to go to for information and local long-term care resources. Laurie Sauer, from Hillman, testified to the need for a central entry point. If everyone needing long-term care assistance knew they could call a toll free number and be directed appropriately, making long-term care decisions would be much easier. She suggested the Area Agency on Aging network could coordinate this role. There are many organizations across Michigan dedicated to advocating on behalf of consumers and educating Michigan citizens on their rights and options in long-term care. Many of these organizations are listed below.

There are many organizations dedicated to advocating on behalf of consumers and educating Michigan citizens on their rights and options in long term care.

long-term Care Ombudsman

Michigan's long-term Care Ombudsman is the voice of the resident in licensed long-term care facilities, including nursing homes, adult foster care homes, and homes for the aged. The long-term Care Ombudsman and her designees are consumer advocates and help investigate and resolve complaints made by or on behalf of nursing home residents or residents in other licensed facilities. long-term Care Ombudsmen staff also assist family members with resident rights' issues, financial concerns, guardianship and nursing home placements.

Michigan long-term Care Ombudsman
Michigan Office of Services to the Aging
P.O. Box 30676
Lansing, Michigan 48909-8176
http://miseniors.net
1- 866-485-9393

Adult Protective Services

It is against the law to abuse an elder adult. Adult Protective Services is a public service mandated by Public Act 519 of 1982. This critical program involves coordination and support from mental health, public health and law enforcement agencies; the probate courts; aging network and community groups; as well as the general public. The program is under the Family Independence Agency and its staff is charged with investigating allegations of abuse, neglect or exploitation, and with providing protection to vulnerable adults. Once a complaint is received by Adult Protective Services, investigations must begin within 24 hours.
To report abuse, call the Adult Protective Services Hotline at 1-800-996-6228.
For more information, contact your local Family Independence Agency office.

Area Agencies on Aging (AAAs)

Area Agencies on Aging provide a variety of in-home and community services that enable adults, 60 years old and older, to continue living independently at home or a chosen residence for as long as possible. AAAs can provide all seniors and their families with resources on where to turn for needed services at home or in the community. AAAs also offer services to poor, vulnerable adults that include: care management, information and assistance, meals, in-home services, legal assistance, guardianship, transportation, health promotion, and caregiver supports.

Area Agencies on Aging
Michigan Office of Services to the Aging
P.O. Box 30676
Lansing, Michigan 48909-8176
http://miseniors.net

Centers for Independent Living

Centers for Independent Living (CILs) are non-profit, consumer-controlled, community-based organizations that provide services and advocacy for individuals with disabilities. Michigan's CILs are an excellent first-contact for information regarding disability issues and for outreach and recruitment activities. They provide information and referral services including barrier free housing information, employment services, and social security and other supportive funding information; community advocacy including working with employers to provide job accommodations, legislative advocacy, and education on the Americans with Disabilities Act; individual skills development including job readiness training, rehabilitation assessments, and school-to-work transitions; and peer support including matching newly disabled individuals with disabled mentors and support groups.

To find a Center for Independent Living near you, visit the Michigan Community Service Commission or visit HYPERLINK "http://www.michigan.gov/mcsc/0,1607,7-137-6118_22503_23185-62985--,00.html" http://www.michigan.gov/mcsc/0,1607,7-137-6118_22503_23185-62985--,00.html.

or

Michigan Association of Centers for Independent Living (MACIL)
1476 Haslett Road
Haslett, MI 48840
517-339-0539
517-339-0805 Fax

Citizens for Better Care

Citizens for Better Care (CBC) is a non-profit consumer advocacy and information organization for long-term care consumers and their families. CBC provides regional ombudsman services in nursing homes, adult foster care, homes for the aged, and licensed "assisted living" facilities; family council development; family support services; elder abuse prevention education; state and federal legislative and policy advocacy; quarterly newsletters and many publications; training of long-term care professionals; and participation in consumer coalitions.

Citizens for Better Care
4750 Woodward Ave., Suite 410
Detroit, MI 48201
Ph: 313-832-6387 or 1-800-833-9548
FAX: 313-832-7407
HYPERLINK "http://cbcmi.org" http://cbcmi.org
HYPERLINK "mailto:info@cbcmi.org" info@cbcmi.org

Elder Law of Michigan

Elder Law of Michigan is nonprofit organization that works to protect the rights and dignity of older individuals and their families in Michigan. The organization provides professional staff, including lawyers, social workers, legal assistants and trained volunteers to help Michigan's seniors and families with pension counseling, legal advice and information, advocacy for low-income seniors, and information on long-term planning.

Elder Law of Michigan
221 North Pine
Lansing, MI 48933
517-485-9164
517-372-0792
HYPERLINK "mailto:info@elderslaw.org" info@elderslaw.org
Legal Hotline: 1-800-347-5297

Eldercare Locator

The United State's Administration on Aging provides a national, toll-free directory assistance called the Eldercare Locator. The Eldercare Locator helps people locate aging services in every community throughout the United States. The toll-free directory promotes awareness and improves access to state and local community programs and services for the aging. The free assistance is also available on the web and uses ZIP code information to locate local services. Individuals using the Eldercare Locator can connect to more extensive information for a variety of services including: Alzheimer's hotlines,

home delivered meals, transportation, legal assistance, housing options, adult day care and respite services, home health services, and long-term Care Ombudsman services.
Eldercare Locator
National Association of Area Agencies on Aging
1-800-677-1116
www.eldercarelocator.org

Michigan Campaign for Quality Care
The Michigan Campaign for Quality Care is a grassroots consumer group seeking better care, better quality of life, and better choices for Michigan's long-term care consumers. The Campaign is engaged in legislative and administrative advocacy, public education efforts, media campaigns, and other advocacy efforts for the long-term care consumers of Michigan.

Michigan Campaign for Quality Care
Nadene Mitcham, Chairperson, HYPERLINK "mailto:deanpol@earthlink.net" deanpol@earthlink.net, 734-422-5863
Carole Newburry, Secretary, cjnewb@mei.net
Alison Hirschel, Statewide Coordinator, HYPERLINK "mailto:hirschel@umich.edu" hirschel@umich.edu, 517-324-5754

Michigan Hospice & Palliative Care Organization
The Michigan Hospice & Palliative Care Organization (MHPCO) provides education to both consumers and professionals to increase awareness and understanding of the philosophy and principles of hospice and palliative care.

Michigan Hospice & Palliative Care Organization
6015 West St. Joseph Highway, Suite 104
Lansing, Michigan 48917
HYPERLINK "mailto:mihospice@mihospice.org" mihospice@mihospice.org
http://www.mihospice.org
517-886-6667 or 1-800-536-6300

Michigan Protection and Advocacy Service
Michigan Protection and Advocacy Service (MPAS) promotes, expands and protects the human and legal rights of persons with disabilities by providing them with information and advocacy. MPAS can assist individuals with discrimination in education, employment, housing, and public places; abuse and neglect; Social Security benefits; Medicaid, Medicare and other insurance; housing; Vocational Rehabilitation; HIV/AIDS issues; and many other disability-related topics. MPAS provides information and referrals

to help individuals understand their rights, technical assistance on disability related issues, legal representation to eligible individuals, and training, outreach and seminars to consumers, parents and families on many topics from rights under the Americans with Disabilities Act to managed care.

Michigan Protection and Advocacy Service
4095 Legacy Parkway, Suite 500
Lansing, MI 48911-4263
Phone: 1-800-288-5923 or 517-487-1755
FAX: 517-487-0827
For additional locations, visit HYPERLINK "http://www.mpas.org" www.mpas.org.

Recommendations:

• Implement a uniform needs assessment tool to establish guidelines and a process by which seniors and the disabled are matched with appropriate services and placed in appropriate settings. This tool should also be used to assist families and caregivers in determining what care their loved ones need and what options are available to them to meet those needs.

• Create a discharge check list that hospitals and families could use at discharge care conferences. Before leaving the hospital with a loved one, families should understand medication requirements, equipment options, assistance services, etc.

• Create a "tool kit" for families who are entering the long-term care system for the first time to be distributed and developed by the State long-term Care Ombudsman.

• Medical community should refer families to hospice services before the last few weeks of one's life.