

**Living Long ~ Living Well
Long Term Care Conference
Greater Grace Temple Conference Center
July 22-23, 2004**

SUMMARY REPORT

Conference Purpose:

The conference was convened by the Detroit Area Agency on Aging (DAAA) on behalf of Detroit Mayor Kwame Kilpatrick's newly appointed "Dying Before Their Time Task Force." The conference served two major purposes: (1) to clearly define and validate the problem of minority health disparities and premature deaths in the Detroit urban area and (2) to involve stakeholders in the development of strategies for system and policy changes. A final report including the strategies will be referred to the task force for consideration and further exploration.

Conference Participants

Approximately 185 individuals attended the conference. Included were representatives of Governor Jennifer Granholm's Long Term Care Task Force, Mayor Kwame Kilpatrick's Dying Before Their Time Task Force, DAAA Board of Directors, service providers, local and state governmental agencies, MI Choice Coalition, DAAA Advisory Council, City of Detroit Senior Citizen Department, Michigan State Legislature, Detroit's medical community, universities, other senior citizens service agencies and seniors.

Expected Outcomes

Participants should acquire an understanding and knowledge of the problem of minority health disparities and the contributing factors and causes of premature deaths. Workshop participants should come away with defined system and policy changes needed to create change, as well as identified strategies to initiate action. All participants should be energized and challenged to push the agenda forward as a priority in their respective agencies, organizations, institutions and offices.

Living Long ~ Living Well Conference
Day 1
JULY 22, 2004

The first day of the conference was devoted to establishing a clear and consistent statement of the problem of minority health disparities and premature deaths of the elderly in the Detroit urban area. This was accomplished through presentations by five individuals noted for their work in these areas. They presented research findings, data and other information that clearly supported and defined the problem as it was stated in the previous "Dying Before Their Time Report" distributed by the DAAA.

SPEAKERS & PRESENTERS

Tene Ramsey: Executive Director, City of Detroit Senior Citizens Department was appointed to this position by Mayor Kwame M. Kilpatrick in January 2002. She started a Community Service Outreach (C.O.S.T.), where she and seven (7) other city departments go out into the community and give presentations at senior buildings located in the City of Detroit, recreation centers, community groups and nursing homes. She also developed a project called "We Work for Seniors" to address concerns of seniors and to ensure a high quality of life for seniors in the City of Detroit.

Paul Bridgewater: Executive Director, Detroit Area Agency on Aging. At the helm of DAAA, Paul Bridgewater has established one of the largest Holiday Meals on Wheels programs in the country, trained hundreds of seniors for computer technology jobs in the workplace, and implemented a local pharmacy assistance program that provides free prescription drugs. In addition, he created a region-wide Medicaid/Medicare counseling program for older adults, planned and implemented a Corporate Eldercare project, and started one of the most successful care management and home-care support services in the State of Michigan.

Herbert Smitherman, M.D., MPH, FACP

Dr. Smitherman is an Assistant Professor of Medicine in the Department of Internal Medicine at the Detroit Medical Center/Wayne State University School of Medicine. Dr. Smitherman's administrative duties for Wayne State University School of Medicine and Detroit Medical Center include, Co-Director of the Medical Office of Special Programs and the Director of the Center for Urban Health, Medical Director for the Detroit Medical Center and Wayne State university School of Medicine (DMC/WSU) Community Health Institutes.

Arline T. Geronimus, Ph.D.

Arline T. Geronimus is currently a professor in the Department of Health Behavior and Health Education, and Research Professor at the Population Studies Center at the University of Michigan. She is also affiliated with the Center for Research on Ethnicity, Culture and Health. Dr. Geronimus is a member of the Editorial Board of Human Nature and an Expert Consultant to the Centers for disease Control on Measuring Racial/Ethnic Discrimination in the National Children's Study. She has also served on NIH study sections, worked with the U.S. Civil Rights Commission, the Federal Reserve Bank of

New York, and the Aspen Institute's Roundtable on Comprehensive Community Initiatives to revitalize American cities.

David R. Williams, Ph.D.

David Williams is at the University of Michigan where he serves as the Harold W. Cruse Collegiate Professor of Epidemiology in the School of Public Health. He is also a Faculty Associate in the Center for Afro-American and African Studies and the program of Research on Black Americans. Previously, he was an Associate Professor of Sociology, Yale University, and Associate Professor of Public Health, Yale School of Medicine. He is the author of more than 100 scholarly papers in scientific journals and received an Investigator Award in Health Policy Research from the Robert Wood Johnson Foundation. He has been involved in the development of health policy at the national level in the U.S: In 1992, he was appointed, by the Bush Administration, to the Department of Health and Human Services' National Committee on Vital and Health Statistics. In 1993, he served as in an advisory capacity to President Clinton's Task Force on Health Care Reform. He has provided congressional testimony on racial disparities in health and served on the social science advisory panel for President Clinton's Initiative on Race. Dr. Williams has appeared on national television including ABC's Evening News, CNN, PBS, C-SPAN and the Discovery Channel. His research has been featured or he has been quoted in the national print media including the New York Times, Newsweek, Time, the Wall Street Journal, the Washington Post, Jet and USA Today.

Mary James, M.A.

Mary James joined the University of Michigan Institute of Gerontology as an assistant research scientist in February 2002. For nearly 25 years she held a variety of positions in Michigan State government, where she was instrumental in the development, administration, and evaluation of home and community based services for people who are elderly and disabled. Among her achievements are the establishment of a statewide 1915c Medicaid Waiver, known as MI Choice, and the companion state-funded Care Management program. During her tenure with the state, her interest in translating research into evidence-based public policy resulted in the creation of a statewide information system that supports profiles about the characteristics, expenditures, and outcomes of persons served in home care and nursing home settings.

Shirley A. Lockery, Ph.D.

Shirley A. Lockery joined the University of Michigan faculty in 1990. As a social gerontologist, professor Lockery has worked extensively on health issues surrounding ethnic and racial minorities. Professor Lockery received numerous training grants and research awards, including a national Institute on Aging Minority Investigator Award with the Health and Retirement Study. She has authored and co-authored numerous refereed journal articles, book chapters, monographs, and book/film reviews. Professor Lockery served on the editorial board of *Gerontology* and *Geriatrics Education* and as consulting editor of *Health and Social Work*, associate editor of the *American Journal of Health Promotion*, and reviewer for the *Gerontologist*, *Social Work Education Journal* and the *Social Work and Health Care Journal*.

SUMMARY OF PRESENTATIONS

Moderator: Paul Bridgewater

Mr. Bridgewater noted that Mayor Kilpatrick's appointing of the Dying Before Their Time Task Force shows the effort and persistence he is putting into this issue. He explained the format for each day and the two purposes of the conference prior to introducing the presenters:

- **Day 1:** to gain a better understanding of the problem and causal factors through the research and data presented, and
- **Day 2:** to begin the discussion of how to create policy changes in the areas of Health and Aging.

PRESENTER: DR. HERBERT SMITHERMAN, M.D.

Dr. Smitherman and Dr. Lee Kallenbach, Ph.D. Wayne State University, presented findings from a health status research study that included five areas: mortality, hospital usage, morbidity, access to care, out-state findings and Detroit Area MI Choice. The catalyst for the Dying Before Their Time research included:

- The need to understand why the Detroit Area lost 23% of its senior population from 1990 – 2000.
- The need to determine factors associated with out-migration.
- The need to determine the role that health status played in the loss of senior population.

Mortality:

Detroit Area: The research revealed that the death rate for Detroit area older adults between the ages of 50 and 59 is over 122% higher when compared to the rest of Michigan, and it is 48% higher for seniors between ages 60 and 74. This high death rate accounts for the premature deaths of approximately 1,600 Detroit older adults per year and results in over one-third of the loss in our senior population between the years 1990 and 2000. Much of this excess death is due to conditions that can be controlled with proper medical treatments.

Out-state Findings: High mortality rates were found in nine Michigan cities outside of PSA 1-A which consist of Detroit, the five Grosse Pointes, Hamtramck, Harper Woods and Highland Park. Nine of ten non-PSA 1-A cities studied had excess mortality rates. Twenty percent of the state's 60+ population reside in Medically Under-served Areas (MUA). After PSA 1-A, at 25.28%, four area agencies on aging (AAA's) each have nearly 10% of the state MUA population and the remaining AAA's each have less than a 7% share.

Hospital Use:

The hospitalization rate for Detroit area seniors is 37% higher than seniors in other parts of Michigan. Hospital rates after age 75 are still 15% higher in PSA 1-A when compared to the rest of Michigan.

Morbidity:

Chronic illness plays a major role in the health status of Detroit seniors. The majority (89%) of Detroit seniors have at least one chronic illness. Nearly half (39%) have three or more chronic illnesses, such as hypertension, arthritis, heart disease, and diabetes.

Access to Care:

Poor access to primary care physicians and preventative health care play a key role in the health status of seniors. About 54.5% of Detroit area seniors live in a federally designated Medically Under-Served Area. This number of seniors living in Detroit area's Medically Under-Served Area represents over one fourth (25.3%) of the State's Senior Population Residing in Medically Under Served Areas.

MI Choice:

The MI Choice Waiver Program provides strong measurable benefits to seniors and the community.

Study Conclusion:

- Chronic illness, poor access to care and poverty cause too many seniors to delay medical treatment until their illness is at a more advanced stage.
- PSA 1-A's 23% senior population loss can be attributed to the following factors:
 - Poorer health status
 - Out-migration
 - Having a smaller replacement cohort
 - About 40% of the 43,816 senior population loss in PSA 1-A can be attributed to the high mortality rate.
 - Premature death is a state-wide urban issue.

Recommendations:

Dr. Smitherman recommended the following system and policy changes:

1. Focus on prevention as opposed to illness. The current focus is on building large centers to treat sickness, rather than prevention. Health care systems should focus on the following areas:

- Health education
 - Wellness promotion (emphasis on pharmacy support)
 - Community outreach
 - Increasing the number of primary care providers in the Detroit area
 - Urban planning which includes parks and green-ways to encourage physical activities.
 - Blend planning with health care and use data to drive planning
2. Medical schools need to move from a disease model to a prevention model.
 3. Current legislation does not demand that the health care systems use profits for prevention. This legislation should be changed.
 4. Align resources with need. There is an increase in the number of uninsured and the current policy allocates resources based on population rather than need. Allocate resources to Medically Under-Served Areas.
 5. Increase health promotions.

PRESENTER: ARLINE GERONIMUS, PH.D.

Dr. Geronimus presented on her research in the area of Racial Health Inequality in Detroit: The Role of the Weathering Conceptual Framework. This concept proposes that African-Americans experience early deterioration as a consequence of the cumulative impact of repeated experience with social economic or political exclusion. The everyday mechanisms for weathering include:

- Cumulative impact of persistent material hardship
- Cumulative exposure to environmental hazards and ambient or social stressors in residential and work environments
- Persistent psychological stress and high-effort coping (sympathetic arousal), increasing in young to middle adulthood as family leadership roles are assumed and obligations expand and compete
- Increased pressure to adopt unhealthy behaviors as a means to cope with growing stress, uncertainty, or persistent material hardship
- The early development and progression of chronic conditions and diseases (including practical, financial, and emotional difficulties associated with these)
- Increasingly deleterious impact of medical under service or differential treatment by health care providers in light of escalating health needs
- Internalized effects of stigma or frustration, anger, or rage at racial injustice.

Dr. Geronimus used a study of “Excess Mortality Among Blacks and Whites in the United States” as the basis for her presentation. Detroit was one of the 16 areas included in the study. The study found that the probability of survival to ages 65 and 85 are conditional on the survival to age 16. One-third of black girls and two-third of black boys who reach their 16th birthday do not live to their 65th birthday. In contrast,

nationwide, only 10% of girls and about 25% of boys do not live to age 65. The Central Detroit blacks are far worse than the Detroit whites. These statistics are not due to violence, homicide, or self-inflicted deaths. The main causes of death are chronic diseases such as cancer, cardiovascular diseases, hypertension and diabetes. All of these diseases are stress related.

Dr. Geronimus provided the data below from the research:

- The infant mortality rates and ratios by the age of the mother for whites and blacks in the U.S. and African Americans in Harlem.
- Ratios of very low birth weight for selected maternal ages in high poverty black communities in Michigan.
- The probability of surviving to ages 45, 65, and 85 for blacks and whites in the U.S., Central Detroit, Harlem, and Southside Chicago.

Conclusions:

- Even when income is similar, poor whites do a little worse than middle class blacks in the central Detroit area.
- Poor blacks in central Detroit do much worse than poor whites in other areas.
- There is endless evidence of cultural incompetence, and discriminatory practices on the part of the health care providers.
- There are misguided assumptions about the causes of poor health and the causes of under insurance.
- A person's health is affected by their cumulative experiences.
- Chronic and acute exposure to stress impacts the immune, metabolic and cardiovascular systems.
- Much of this excess death is due to conditions that can be controlled with proper medical treatments.

Recommendations for Public Health Systems and Policy Makers:

1. Change from a developmental approach to a weathering approach.
2. Understand the extent to which being a member of a stigma group relates to stress.
3. Address the belief by many Americans that Black Americans choose to be unhealthy.
4. Neutralize the face of racial stereotypes because only then will the health care system, providers and funding change.
5. Focus resources in areas most in need.

PRESENTER: DR. DAVID WILLIAMS, PH.D.

Dr. Williams' presentation provided an overview of the ways in which race and socioeconomic status (SES) combine to affect health status. His research found that there is a gap in health in early life, mid life and late life. For the 15 leading causes of death in the United States in 1999, Blacks had higher death rates than whites in 11

areas. Hispanics and American Indians have higher death rates than Whites in four categories.

Study Findings

- While socioeconomic status is a major contributor to racial disparities in health, race still matters for health when SES is considered. Race and SES are two related but not interchangeable systems of inequality. In national data, the highest SES group of African American women have equivalent or higher rates of infant mortality, low birth-weight, hypertension and overweight than the lowest SES group of white women.
- Health is affected not only by current SES but also by exposure to social and economic adversity over the life course. Personal experiences of discrimination and institutional racism are added pathogenic factors that can affect the health of minority group members in multiple ways.
- Race and Medical Care: Across virtually every therapeutic intervention, ranging from high technology procedures to the most elementary forms for diagnostic and treatment interventions, minorities receive fewer procedures and poorer quality medical care than whites. These differences persist even after differences in health insurance, SES, stage and severity of disease, and the type of medical facility are taken into account. Moreover, they persist in contexts such as Medicare and the VA Health System, where differences in economic status and insurance coverage are minimized. Racial disparities were found in treatment for heart disease, cancer, and cerebral vascular disease. There were also racial and ethnic differences found in administering analgesia.
- Minority Physicians: Although minority patients report a much higher level of satisfaction when treated by a minority physician. Most blacks are not treated by black physicians. In 1968, 2.5% of physicians in the United States were black. In 1999, 2.9% of physicians were black. Minority physicians are much more likely to practice in under-served areas and to practice in primary care settings.

Recommendations:

Knowledge of the extent of disparities and their causes is a prerequisite for the action listed below to be effective.

1. Address the broad determinants of health that are embedded in living and working conditions in an effort to improve health.

2. Reduce inequalities in health care including improved access to care and the quality of care, giving emphasis to the prevention of illnesses, providing effective treatments, and developing incentives to reduce inequalities in the quality of care.
3. Address underlying determinants of health including
 - Improving living standards for poor persons and households
 - Increasing access to employment opportunities
 - Increasing education and training that provide basic skills for the unskilled and better job ladders for the least skilled and
 - Investing in improved educational quality in the early years and reduce educational failure.
4. High schools and colleges need a concerted effort to increase the number of minority physicians.
5. We need to strengthen the capacity of community organizations to become actively involved in the identification and management of interventions. Partnerships are needed with government, industry and other private organizations.

PRESENTER: MARY JAMES, M.A.

Mary James' presentation focused on three key questions about the people in Detroit receiving care management services:

- What are the characteristics of Detroit home care users?
- How are Detroit home care users different from users in other regions?
- How have user characteristics changed from 2001 to the present?

The sources of data used were collected through the Office of Services to Aging Care Management Program and the Michigan Department of Community Health MI Choice Waiver Program. Both programs use Minimum Data Set for Home Care (MDS-HC) to assess needs and preferences for assistance.

Summary of Findings:

- Detroit home care users are significantly more impaired as a group.
- Detroit caregivers provide more hands-on assistance for more hours per week.
- Detroit home care users rely on skilled home care for rehab.

Recommendations:

1. Review long-term comparative outcomes, examining access to physicians, emergency rooms, and Medicare skilled nursing beds.
2. Change waiver payment to link to acuity.

3. Provide support to caregivers.

PRESENTER: SHIRLEY LOCKERY, PH.D.

Dr. Lockery summarized the presentations from the earlier speakers, provided a synopsis of the Medicaid and Medicare programs' impact on disparities and recommended several systems and policy changes.

Summary of Findings Presented

- Health disparities between various ethnic groups persist through the entire life cycle. Black mortality rates are especially elevated for heart disease and cerebral vascular disease experienced, and exceed those for whites at any age beyond 44 years. The rates of heart disease and cerebral vascular disease experienced by Blacks at ages 45-54 are higher than those reported for other groups at ages 55-64. In addition, the rate of chronic disability is higher for Blacks and Native American; these differences are apparent very early in adulthood. The rate of chronic disability among Black and Native American men at ages 30-34 is not reached until decades later for Whites and Asians.
- Unequal Treatment: Confronting racial and ethnic disparities in health care: African Americans were 1.5 times more likely to be denied managed-care authorization in an urban emergency room. They were also less likely to receive medications for HIV and AIDS. Disparities in care were even more extreme for the senior citizens. African-American Medicare patients were almost four times less likely than their white counterparts to receive needed coronary bypass surgery and nearly two times less likely to receive treatment for prostate cancer. Older Black Americans were 3.6 times more likely to have their lower limbs amputated as a result as diabetes. More than 40% of non-elderly African Americans (1.25 million) had no health insurance in 2001-2002.

Medicare

Before gaining Medicare coverage, people with disabilities must first receive Social Security Disability (SSDI) for 24 months. Four hundred thousand of the 1.3 million American on Medicare are completely uninsured during this 24-month waiting period. Death rates among SSDI recipients are highest during their first 24 months of receiving SSDI. Current interpretation of federal law limits Medicare coverage of durable medical equipment, such as wheelchairs, to devices individuals need to function inside their homes.

Prescription Drugs

In 2002, Americans paid 67% more than Canadians for patented drug products. In 2003, total prescription drug costs for people with Medicare were \$95 billion (\$2,318 per person). In 2003, CBO estimates that 16% of people with Medicare (6.56 million individuals) had prescription drug costs exceeding \$4,000. On average, individuals with Medicare spent \$996 (43%) of these prescription drug costs out of pocket. By 2013, annual total prescription drug costs for people with Medicare are expected to grow to \$284 billion, for a ten year (2004-2013) total of \$1.8 trillion. Older Americans' social Security checks increased by 2.6% in 2002, but the average price of the 50 drugs used most by older Americans increased by 6%.

Recommendations and Proposed Policy Priorities

1. Consistent racial/ethnic data collection.
2. Effective evaluation of disparities – reduction program
3. Minimum standards for culturally and linguistically competent health services
4. Greater minority representation within the health care workforce
5. Expanded health screening and access to services (e.g. through expanded insurance coverage)
6. Establishment of state offices on minority health
7. Involvement of all health stakeholders in minority health improvement efforts.
8. Creation of a national coordinating body to promote continuing state-based activities to eliminate racial and ethnic disparities.
9. Utilization of an earlier age (less than 50 years) in data collection and reporting to create an accurate picture of health disparities.
10. A comprehensive Medicare Prescription Benefit with minimal out-of-pocket costs for all low-income seniors.
11. Support legislation for the import of safe, affordable medicine.

Dr. Lockery recommended the following Strategies for Creating a Healthy Community (MAP-IT):

1. Mobilize individuals and organizations that care about the health of your community into a coalition.
2. Assess the areas of greatest need in your community as well as the resources and other strengths that you can tap into to address those areas.
3. Plan your approach: Start with a vision of where you want to be as a community; then add strategies and action steps to help you achieve that vision.
4. Implement your plan using concrete action steps that can be monitored and will make a difference.
5. Track your progress over time.

Living Long ~ Living Well Conference
Day 2
JULY 23, 2004

Purpose

While the first day of the conference was devoted to develop a clear and consistent statement of the problem of minority health disparities and premature deaths, the second day of the conference was devoted to develop strategies for system and policy changes. The day began with 5 panel participants presenting on the five selected areas of Health Care, Long Term Care Services, Residential Care and Healthy Aging. After hearing from the panelist about the current trends, challenges in practice and systems and policy issues, 160 participants participated in workshops to develop strategies that will be referred to the Mayor's Dying Before Their Time Task Force.

PANEL PRESENTATIONS

I. PANELIST: NOBLE MASERU, PH.D, DIRECTOR OF DETROIT HEALTH AND WELLNESS PROMOTION

TOPIC: HEALTH CARE

This presentation was based on the results of seven focus groups conducted by the Detroit Department of Health and Wellness with the elderly in Detroit. The focus groups were conducted in response to the "Dying Before Their Time Report" distributed by the Detroit Area Agency on Aging.

The purpose of the focus groups was to determine the current status of participants, and what could be done to respond to their needs. The focus group results revealed:

- Problems within the community of acquiring & securing wealth. Ninety percent of the constituents are dependent on Social Security or some type of pension fund. 94% live on incomes of less than \$20,000 per year.
- Need for information on staying healthy.
- Inadequacies in the emergency service system.
- Need and concern for medical transportation; 35% needed need transportation.
- Need for personal care and assistance with developing an adequate care plan.
- Inadequacy and lack of community resources.
- Uninsured is an issue in the city.
- Satisfaction with organizations such as DAAA and Detroit Department of Senior Services in providing advocacy.

Recommendations

The Department of Health and Wellness will:

1. Challenge systems to use and provide resources in innovative ways.
2. Get involved with the Detroit Public School system to have direct intervention.
3. Go into homes to provide services such as flu shots.
4. Work with other agencies. They have a partnership with Wayne State University.

II. PANELIST: TONI FLOWERS, UNDER-SERVED PROJECT MANAGER, MICHIGAN PEER REVIEW ORGANIZATION

TOPIC: LONG TERM CARE SERVICES

This presentation focused on culture in relation to health care problems and health disparities of the under-served. African-Americans comprise 90% of city of Detroit's population and they are more ill, have more disparities, greater barriers to access to care, and greater financial issues. The following list of way of exploring new strategies and best practices in transforming long-term care were articulated:

- Focus on culturally competent care; not merely recognizing differences between and among different ethnic groups, but being efficient in the ability to demonstrate and serve with the understanding.
- Change the way health care is delivered to a more 'patient-centered care.'
- Get new, fresh approaches from experts and from the workshop to explore some cultural concepts in transforming long term care.
- Address the crisis of shortage of nursing.
- Increase recruitment and provide special training for long term care workers.
- Increase pay scale to retain workers.

I. PANELIST: NIDA DONAR, EXECUTIVE DIRECTOR, CITIZENS FOR BETTER CARE

TOPIC: RESIDENTIAL CARE

The presentation provided information about voluntary and involuntary nursing home transfers and closures. Numerous studies have shown that nursing home closures and transfers are associated with depression, increased irritability, serious illness, and elevated mortality risk.

A study conducted over an eleven-month period (November 2002 –December, 2003) examined the impact of nursing home closures. Six nursing homes

remained open and there were three closures during the period. The study looked at 3 things:

1. The impact on residents from nursing home closures.
2. Identifying the factors that could have predicted those closures.
3. What kinds of recommendations could be made based on the findings.

Findings

- Sixteen residents of the three nursing homes that closed died.
- From the six nursing homes that remained open, the average number of deaths per month was one for two homes, two for one home, and three took residence in hospice residents.
- From one nursing home that closed, 13 percent of the people who had moved died.
- One nursing home was already in the process of becoming an emergency closure due to the lack of backup generators to provide air conditioning, lights and water; that closure only took eight hours and 104 people were transferred 8 months later, of which 10 percent died.
- One other nursing home closure took seven days, while the occupants were pressured to vacate in three or four days. Residents' families were not given options for new placements. After five months 7 percent of those residents had died.
- For all nursing home closures, residents were not given adequate time to find a place to move.
- Inconsistencies in regulation by state officials were found – citations were allowed to pile up until forced closures.

The study led to the following questions that are recommended for further exploration:

1. What structural changes are needed in the Bureau of Health Systems to address the need for an early warning system to address potential nursing home closures?
2. What changes are needed in the Bureau of Health Systems to efficiently act on complaints?
3. What additional services should be available to nursing home residents and their and families?
4. How can plans be developed and implemented in Detroit to provide licensed, affordable alternatives to nursing homes?

IV. PANELIST: RICHARD DOUGLASS, PH.D., EASTERN MICHIGAN UNIVERSITY

TOPIC: RESIDENTIAL CARE

Dr. Douglass presented on the subject "Residential Care with an Urban Twist: Can Residential Care Save Detroit's Dependent Aging?" Based on his work in this area, he made the following observations:

- The most critical issue regarding Residential care is the fact that most often it is privately paid.
- If you don't have the money, then you probably can't get any form of high quality, regulated, supervised residential care.
- In the inner cities, there is a subculture of informal "residential care" facilities that operate with a revenue stream that is defined by the Social Security checks that arrive in the mail every month.
- Dr. Douglass' fieldwork has found these places to be neglectful, often dangerous, and highly profitable to the owners.
- Unlicensed, informal "adult foster homes" supplement more adequate resources for many of the poor, the uninformed, the isolated, and the confused who may have, or may just be aware of a few options to this common entrepreneurial practice.
- Seldom are the senior housing complexes, retirement villages or other rewards of our society for the middle class and wealthy available for those who chose to stay, or were left behind in the urban centers.
- Without appropriate service in the continuum of care for the poor and under-served aging, we will continue to see higher levels of sickness, hospitalization, nursing home placement and mortality in the future.

Recommendations

1. Community education.
2. Cultural programs with specific and clear messages.
3. Programs with multiple entry points.

v. PANELIST: KAREN CALHOUN, VICE PRESIDENT, COMMUNITY HEALTH, GREATER DETROIT AREA HEALTH COUNCIL

TOPIC: HEALTHY AGING

Ms. Calhoun shared information about the Greater Detroit Area Health Council which brings the value of a diverse and influential membership of regional leaders to healthcare issues. Major program categories include restructuring Delivery, Value Purchasing, Planning and Community Health. Each area includes policy initiatives and individual programs and projects:

- The Community Health Division designs and implements community-based and work site initiatives to encourage consumers to make informed decisions on lifestyle behaviors and healthcare, and to improve access to health care, reduce health disparities and encourage health and wellness programs.
- Active for Life is a national demonstration effort to reduce sedentary lifestyles among individuals, 50 years and older in 9 cities as part of a 4 year, \$972,000 Robert Wood Johnson Foundation clinical trials grant (2002-2006).

- Motown in Motion is a promotional campaign encouraging individuals within the 7 county region become and remain physically active at least 30 minutes most days of the week to reduce sedentary lifestyles and risks against cardiovascular disease, obesity and diabetes.

The City of Detroit's population is burdened with indicators that suggest alarming levels of obesity, asthma and diabetes. The following summary describes the status of Detroiters as related to these health conditions:

- Detroit has the largest African American population and highest rate of overweight and obesity in the State of Michigan.
- Health-related and economic costs are associated with overweight and obesity. In 2000, the estimated cost of obesity rose to \$117 billion of which \$61 billion account for direct costs for prevention, diagnostic and treatment services; indirect costs of \$56 billion address wages lost illness, disability and death (MDCH, 2003).
- Diabetes was the sixth leading cause of death for Detroit residents in 2000. National studies suggest approximately 20,120 Detroit adults have diabetes and are unaware of it.
- Detroit has the highest number of Preventable Hospitalizations (2897) per 10,000 (in 2000) as compared to the Metropolitan Detroit region. Also, the community coverage mix (in 2000) of Detroit's 951,000 population reflects 31.5% Medicaid eligible, 11.9% Medicare eligible, 21% uninsured and 35.5% commercial coverage. The public healthcare provision is highest in Detroit, and commercial coverage is lowest as compared to the tri-county region and State of Michigan.
- The nation's population is aging. In the nation, baby boomers represent the majority of the population. By 2022, it is estimated that 20% of the population will be over 65.

The Health council is finalizing its plan to encourage healthy lifestyles in the region.

WORKSHOPS

I. Health Care Workshop

Outcomes

Long-term Outcomes:

- Reduce preventable hospitalization.
- Increase proportion of seniors with primary care visits (Medicare).
- Reduce mortality.

Immediate Outcomes:

- Improve/increase health literacy.

Strategies

Set up a standardized education delivery system

- Churches
- Senior centers
- Block clubs
- Neighborhood city halls
- Media advertising
- Television, radio, print
- Recreation centers
- Wellness centers
- Block clubs
- Elder service casino tax
- State lottery for senior health and wellness education (state law allows it for education).
- Liquor/tobacco tax
- Millage tax
- Goods & services tax (co-pay on insurance - \$1.00 or less)
- Border crossing tax (1 cent per car)
- \$1.00 contribution per member from AARP for healthcare education for seniors
- Co-pay insurance

Outcome

- Improve quality of life for seniors

System and Policy Changes

- Coordinate and plan services for seniors.
- Develop a regional healthcare coordinating body.
- Involve intergenerational programs.

Strategies (Try not to re-invent the wheel)

- Bring major funders to the table on a regular basis.
- Collaboration/coordination and planning among city departments, and community and faith-based organization and services.
- Develop a set of senior health indicators used to drive system change and obtain funding.

Outcome

- Reduce healthcare disparities.

System and Policy Change

- Medicare and Medicaid physician/provider reimbursement for education.

II. Long Term Care Services Workshop

Outcome

- Person-Centered Services and Funding.
- Older adults, caregivers and other consumers will be informed of their rights to high quality and responsive health and long term care and receive person-centered services supported by public and private resources that promote consumer choice in the least restricted setting.

System and Policy Changes

- Require service providers to inform older adults of their rights prior to nursing home placement or home and community-based care.
- Move funding (money) with the client in the least restrictive status.
- Educate older adults, family members and consumers on long term care options.
- Promote client-driven service delivery systems that promote consumer choice.

Strategies

- Support the pending informed choice legislation.
- Conduct workshops to educate consumers on long term care options and consumer rights.
- Allocate funding based on need.

Continuum of Care

- Expand and improve the continuum of care for older adults to insure that they have access to services that support wellness, independent living and self-autonomy.

System and Policy Changes

- Implementation of a statewide single point of entry and common assessment tool that can be easily integrated on the local level.
- Promotion of 211 and an information and assistance resource and referral database for older adult services including the use of a live human response and not voice mail.
- Expansion of Medicaid Waiver and Care Management Services and integration with Adult Home Help.
- Bundling of home care services to encourage quality service provision with the least intrusion into the homes of the consumers.
- Expansion of community-based services through the strengthening of natural support systems of the elderly.
- Develop a background check and registry system that is shared among providers (national level registry, not just statewide).
- Increase the accountability and quality of services through standards and best practices.

Strategies

- Make cultural competency training available for service administrators; home care workers, staffs in institutional settings and health care professionals.
- Promote the use of service delivery models that support eliminating language as well as cultural and literacy barriers between service providers and clients.
- Encourage MI Choice Coalition and other groups to create training partnerships and alliances to support increased wages, training and support as well as recognition of long term care workers.
- Encourage the nursing home industry to increase salaries and wages, fringe benefits, training and other incentives that support quality care.

Outcome

- Wellness Alternatives.
- Integration of health and social services of the long-term care continuum to support health promotion and disease in home and community settings.

System and Policy Changes

- Create stronger partnerships between the social and health agencies to support wellness programs associated with health education including good nutrition and physical activity.
- Support disease management intervention in home and community settings that are directed to the elderly and family caregivers.
- Seek additional funding to lessen health disparities between older adults in the Detroit area and the remainder of the state.

Strategies

- Support the reduction of the mortality rate by implementing healthy aging programs in home and community settings within the continuum of care to.
- Use care managers and home care workers to monitor nutrition, medication use and elder abuse.
- Use nurse practitioners, parish nurses and trained health advocates to reach isolated, disabled and chronically ill in order to link them to health and human services.
- Advocate for additional funding and resources, including city or county millage.

III. Healthy Aging Workshop

Outcome

- Access to Information.
- The population at large would have access to healthy living information in a culturally relevant and linguistic manner so that quality of life is improved for all citizens.

System and Policy Change

- Develop a central database to inform individuals of providers and also to maximize utilization of available resources.

Strategies

- Through the use of various mediums increase community at large understanding of healthy living.
- Medium would be appropriate to address specific target groups e.g. print, radio, television, etc.

Outcome

- Development of a broad-based agenda.

- Eliminate or reduce health disparities in our community so that the people can live fuller, healthier lives.

System and Policy Change

- Make the issue of health care a higher priority.
- Make the formation of a broad based coalition to distribute health care funding a priority.

Strategies

- Engage community stakeholders to eliminate, identify and focus on barriers.
- Develop a community agenda that embraces all segments of the population in order to address critical issues such as barriers, access and the uninsured.

Outcome

- Community Outreach.
- Change attitudes, behaviors and cognition so that all individuals exhibit greater self-determination in obtaining a healthier lifestyle.

System and Policy Changes

- Redirect funding and system priorities to support healthy living.

Strategies

- Develop a culturally competent workshop within communities that would address issues such as the hard to reach population e.g. isolated, illiterate, immobile, homebound, indigent, etc.
- Promote healthy living across all ages.
- Initiate a community-wide call to action and campaign to ensure that all people are informed so that change can take place (“Love Your Neighbor”).

III. Residential Care Workshop

Outcome

Housing with Supportive Services

- Residents Living Longer
- Pre and Post surveys
- Improvement of Residents Quality of Life scale
- Measures of health and services utilization
- Retention of residents in service area of DAAA

System and Policy Changes

- Money needs to follow the person when moving from nursing home to community.
- More money from more sources to supplement employee's salaries.
- Streamline and standardize eligibility for all state and federal programs determined by the state.
 - An incentive for state compliance.
 - Mandatory 21-day turnaround time for eligibility determinations.
- Accessible senior home repair program
 - Revise current system for allocation of money.
 - Gear home repair programs more toward seniors.
- Revise HUD policies to allow for innovations.
- Better, user-friendly, affordable transportation.
 - Without transportation, seniors cannot live independently.
- Integrated quality assurance and outcomes.
- Training and education for caregivers.
- Raise caregivers salaries under Medicaid reimbursement.

Strategies

- Focus group (some participants have offered their services immediately).
- Advocate to make senior issues a top priority
 - If necessary, with special legislation.
- Provide Pre and Post evaluation surveys for quality of services.
- Provide a quantitative measure of health and services utilization.
- Partnership between community developers and social service agencies and service providers (housing).
- Work through MSHDA to provide innovation at a local level.

Outcome

Available long term care facilities

- Reverse the out migration
 - Bring people back into the city.
 - Be proactive instead of reactive.

System and Policy Changes Needed

- Bonus for facilities investing in the city.
- Review of certificate of need process.

Strategies

- Carefully study transformation of old facilities; building of new facilities.

- Pilot projects / demonstration models.

Outcomes

Senior Friendly

- Cultural and SES sensitive services and input processes.
- Reducing health care costs.
 - Shorter hospital stays
 - Knowledge of eligibility for support services provided prior to discharge

System and Policy Changes

- Single system with multiple points of entry
 - Gives better information and eligibility to services
 - Phone
 - Internet
- Licensed, standardized process for assisted living
 - Currently, Medicaid Waiver cannot be used in licensed facilities.
- City lighting issues
 - Streetlights being out make neighborhoods unsafe for seniors.

CONCLUSION

The Detroit Area Agency on Aging and the Detroit Senior Citizens Department on behalf of the Mayor's ***Dying Before Their Time Task Force*** express their appreciation to all participants in the conference. Their work, time and effort helped to create this report, which will serve as a reference and support to move the agenda of "Minority Health Disparities and Premature Deaths" forward. The strategies identified above will be referred to the "Dying Before Their Time Task Force."

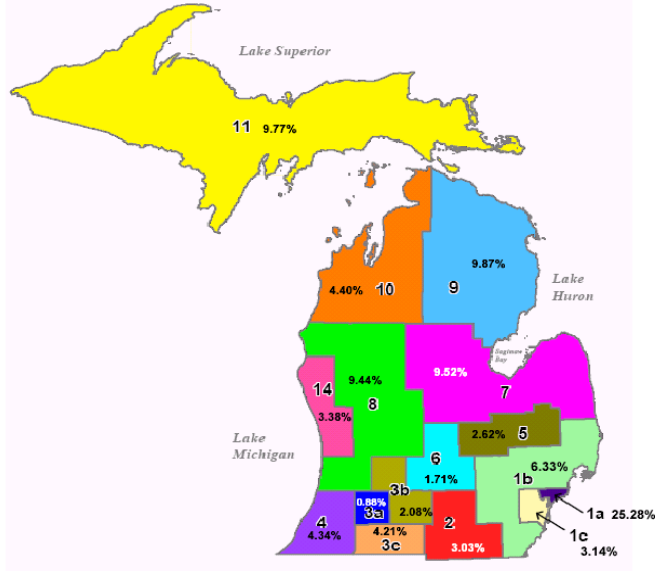
APPENDIX A

Population Loss

Year	Total Population	Population 60+	% Chg. Total	% Chg. 60+
1970	1,653,065	270,940		
1980	1,320,898	224,257	-20.1	-17.2
1990	1,130,565	191,424	-14.4	-14.6
2000	1,052,946	147,806	-6.9	-22.8

APPENDIX B

Percent Population 60+ Residing in a Medically Underserved Area
By Area Agency on Aging PSA



APPENDIX C

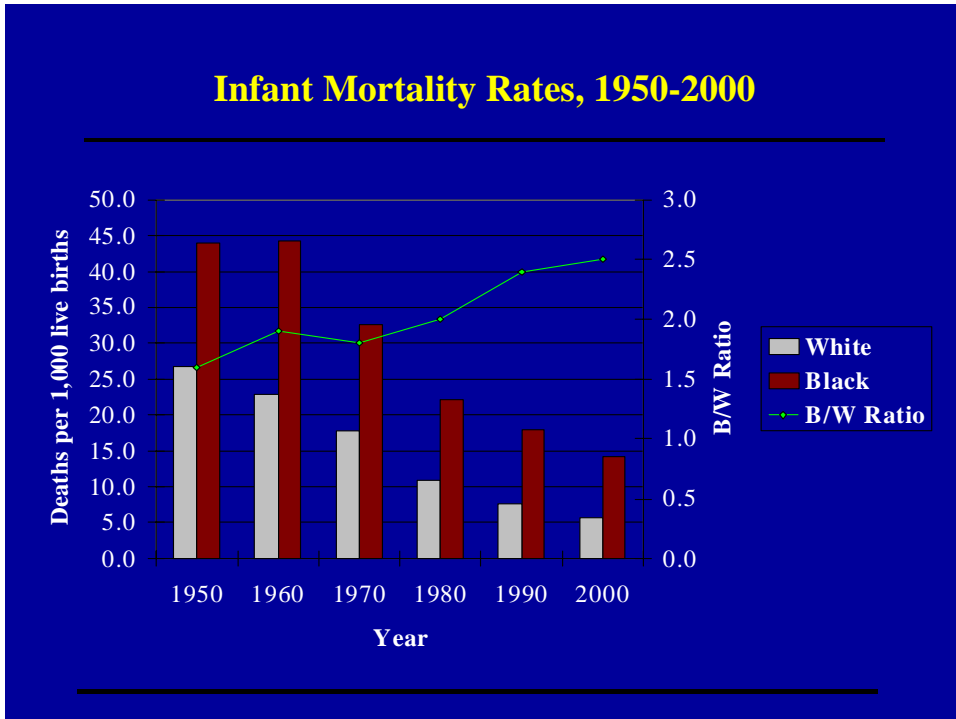
Probability of Survival to Ages 65 and 85 Conditional on Survival to Age 16 Women and Men in Selected Populations*

Men				
Survival to Age:	U.S. Whites	Central Detroit**Harlem†	Southside Chicago‡	
65	.77	.45	.37	.40
85	.23	.09	.08	.07
Women				
65	.87	.69	.65	.66
85	.42	.29	.25	.23

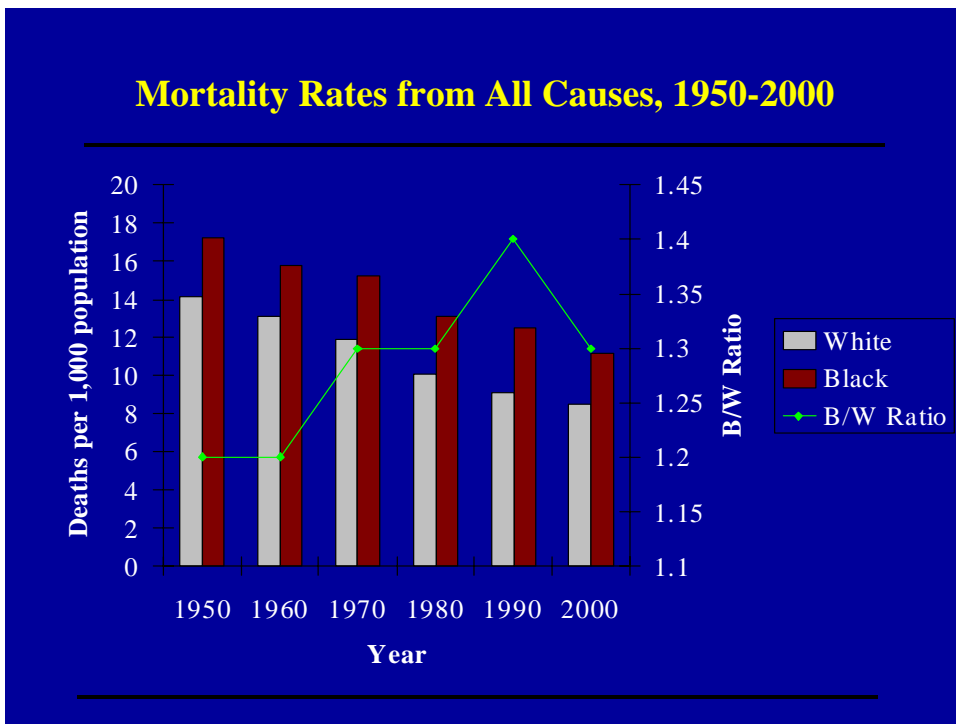
Source: Geronimus et al. *Demography* 2001; 38(2):227-251.

APPENDIX D

Infant Mortality Rates from 1950-2000



Mortality Rates from all Causes from 1950-2000



APPENDIX E

Excess Deaths for Black Population

Year	Avg.No/Day	Avg.No/Year
1940	183	66,900
1950	144	52,700
1960	139	50,900
1970	198	72,200
1980	221	80,600
1990	285	103,900
1998	265	96,800

TOTAL Premature Deaths, 1940-1999 = 4,272,000

Levine et al. 2001