DCHSC 2-24-14
Lynne Lindsay

House Appropriations Department of Community Health Subcommittee
February 24, 2014

Good morning Representatives. My name is Lynne Lindsay and I am a breast cancer survivor and advocate for the American Cancer Society Cancer Action Network.

Because of cancer research and improvements in diagnosis and treatment efforts, there is greater hope for people diagnosed with this disease today.

But if we don't do more to make sure Michiganders have access to these lifesaving screenings and treatments, that hope is out of reach for too many of us.

Just a few years ago, I never imagined I'd be one of 13 million survivors. I couldn't get cancer. I was young. I had plans for my future.

But on April 27, 2011, when I heard those terrifying words, 'you have cancer', I was determined to become one of the 13 million.

On March 30th of that year, I found a lump under my armpit. Having a medical background, the lump felt, too me, more like a cyst than cancer. But worried there was a very small chance it could be cancer, I decided to get it checked out.

In the back of my mind, I knew a cancer diagnosis could bankrupt me, because the health insurance plan I had signed up for didn't start for three more months. If this lump was cancer, how could I pay for treatment and what would I do if I couldn't pay the bills?

I called the health department to see if there was some way for me to get a free mammogram. I had heard about other women accessing these screenings for free, but had no idea where to turn.

That's when a caseworker told me about the Breast Cancer and Cervical Cancer Program here in Michigan. This program provides free breast and cervical cancer screenings for uninsured and underinsured, low-income women.

I made an appointment to get my screening right away. Still thinking the likelihood that this was cancer was extremely low.

A mammogram followed by a quick biopsy proved me wrong.

That's when I really started to worry about how I would pay for my treatment. I knew I was in for the fight of my life, I knew I was going to win, but I had no idea how I would afford it.

Fortunately for me, I quickly learned that because I was diagnosed with breast cancer through the Breast Cancer and Cervical Cancer Program, I would be able to access Medicaid for my treatment. This meant I had a fighting chance.

If I didn't have access to a mammogram through the Breast and Cervical Cancer Control Program, I don't know what would have happened. Time was of the essence for me and I needed treatment quickly.

See... my cancer was spreading very quickly. Faster than the doctors said they had ever seen before. When I first felt the lump, it was the size of a jelly bean. By the time I had my mastectomy, only 60 days later, it had spread to several spots in my breast and 12 lymph nodes, 11 of which had to be removed.

The surgery determined my breast cancer was stage three, grade three, a very aggressive form of breast cancer.

So I had to follow up surgery with 24 weeks for chemotherapy, nine months of Herceptin and 28 days of radiation treatment.

After this, I would have to take a drug called Tamoxifen for the next five years. A drug I'm still taking.

I'm here, today, to tell you that the Breast and Cervical Cancer Control Program truly saved my life. It was there for me when I had nowhere else to turn. It gave me hope and it gave me a fighting chance.

The Breast and Cervical Cancer Program only serves women and because of the elimination of state funds for Cancer Program, only 10 percent of eligible women can receive services through this program.

We can't continue on like this. I urge you to restore funding to the state Cancer Prevention Program through the Health & Wellness Fund.

Thank you for your consideration.

Lynne Lindsay

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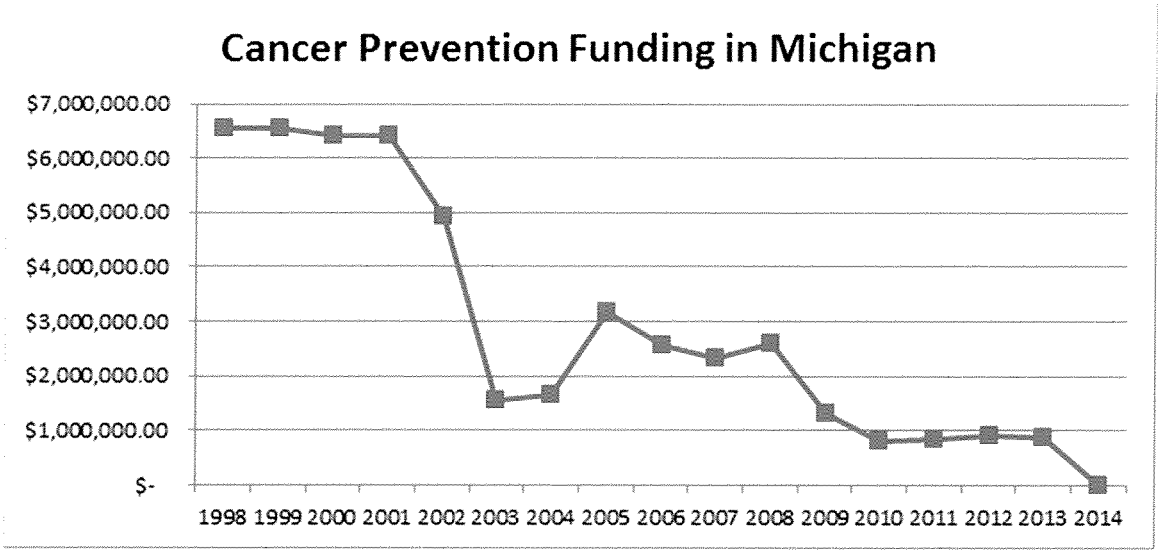
DCH SC 2-24-14
Karen Jennings

TESTIMONY
KAREN JENNINGS
HOUSE APPROPRIATIONS SUBCOMMITTEE ON COMMUNITY HEALTH
February 24, 2014



Good morning. My name is Karen Jennings and I am the Coordinator of the Ingham County Breast and Cervical Cancer Control Program (BCCCP) at the Ingham County Health Department in Lansing, Michigan. Ours is the second largest program in the state, and will serve over 2700 women in an eight (8)county region in FY14. This is a substantial decrease from the 4366 women we served in FY13. This decrease is a result of a funding from both the CDC and the State of Michigan.

I am here in support of reestablishing funding for the MDCH Cancer Section. Specifically, I'm here to speak with you about the Breast and Cervical

Program and the impact it has had on the women in our state.

The BCCC Program has provided free breast and cervical cancer screenings and diagnostic services to low-income women in Michigan since 1991 through funding from the Centers for Disease Control (CDC). Michigan has developed a model program, and consistently has met or exceeded the quality standards required by the CDC.

Michigan has supported this program with additional funding in past years which enabled us to screen more women in the 40 - 49 year range than allowed by the CDC funding. The CDC funding allows for only 25% of the total women screened to be under the age of 50. This year, without funding from the State, we have to restrict the number of the younger women. In my program, we know the total number of women who can be enrolled and screened between the ages of 40 and 49 each month. When we reach that threshold, we tell the women we cannot enroll them and to please call back on the first of the next month. Our phones are ringing when we walk in the door on the first and the 'slots' fill quickly. Women who asked to call back next month are often frustrated, angry, scared and confused.

The BCCCP program has many success stories. Over the duration of the program we have screened over 493,000 women, diagnosed nearly 4,200 breast cancers and 5,900 cervical cancers or pre-cancers. With the addition of the Medicaid Treatment Act in 2000, most of the women diagnosed through our program received Medicaid for their treatment.

Breast and cervical cancers can be successfully treated if detected early. Mammography has proven to be the best available tool to detect breast cancer at an earlier, more treatable stage. Both the American Cancer Society and Susan G. Komen for the Cure recommend routine annual mammograms for women beginning at age 40. Early detection not only saves lives, but it saves the state and its residents money as well. As much as $20,000 is saved in initial treatment costs for each breast cancer case that is detected early.

We are truly at an exciting crossroad with our program. We know that approximately 60% of the women we currently serve will meet the financial eligibility for the Healthy Michigan Program when it rolls out in April. Those women will no longer be eligible or need the services of BCCCP. However,

for poor women who don't meet the Medicaid eligibility, or those who have purchased a Bronze insurance plan that will not cover diagnostic services until a high deductible has been met or those who still do not have any health insurance, the BCCCP will still be needed.

Reestablishment of funding in the Cancer Prevention Program in the Health & Wellness Fund will allow us to serve these women who fall through the cracks. It will allow us to educate and reach out to those women still needing breast and cervical cancer screening. It will allow women to receive a diagnostic work-up if their insurance doesn't cover it.

The reality is that women are still dying from breast and cervical cancer. The BCCCP has made a significant impact in Michigan towards reducing those numbers. We are asking that the state continue to partner with us so that we may continue with the good work that we have established in Michigan.

Funding to the Cancer Prevention Program directly saves lives,promotes health, reduces the health

care burden on state residents, and acts as a magnet for federal funds.

The Cancer Program, like many other prevention programs, has continued to face cuts year after year. Last year the unthinkable happened - all funds for cancer prevention were eliminated in the Health & Wellness Fund! Senators, I urge you to take steps to get the state Cancer Program back to where it once was. Please restore $6 million to the Cancer Program through the Health & Wellness Fund over the next three years beginning with $2 million for FY 15.

I appreciate your interest and thank you for your time today.

MICHIGAN
ASSOCIATION
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House Department of Community Health Subcommittee of Appropriations
Testimony
February 24, 2014
Meghan Swain, Michigan Association for Local Public Health

Good afternoon, my name is Meghan Swain. I am the executive director for the Michigan Association for Local Public Health, representing the 45 local health departments in Michigan. I would like to thank Chairman Lori and committee members for this opportunity to make some brief remarks regarding Essential Local Public Health Services (ELPHS), a funding line item in the Department of Community Health budget.

The eight (8) mandated essential services include: food safety/protection, immunizations, hearing screenings, vision services, infectious disease, sexually transmitted disease control and prevention, on-site sewage management, and public/private water supply. All 45 local health departments carry out this work on behalf of the state.

For FY 2014, this committee was instrumental in restoring funding for the eight (8) Essential Local Public Health Services by $2M dollars. We thank you for that hard work.

We would like to continue strengthening the funding of ELPHS by requesting, at a minimum, an additional $2M dollars to bring the funding levels back to pre-Michigan recession times. Looking to the future of local public health funding, we would also like to address the 50/50 cost sharing formula provided in the Public Health Code (PA 368) or at least discuss adequate funding mechanisms instead of fluctuating cuts or restoration.

The Governor has been very clear about investing in Michigan and what the role of government is as a customer service entity for Michigan's 9.8 million citizens. Public health provides services every day to all the citizens from direct service delivery such as immunizations to silent service in safe water and food. Therefore, I would like to find ways to ensure local public health is a funding priority and seeking health in all policies.

We support Governor Snyder's budget proposal as it relates to fully restoring revenue sharing, ongoing investment in the 4x4 obesity plan, infant mortality reduction, expansion of Healthy Kids Dental in Kalamazoo and Macomb Counties, and the Healthy Michigan Plan.

We also support the Department of Community Health's strategic priorities, including but not limited to, implementation of an integrated chronic disease strategy, as it relates to public health initiatives, increasing immunizations rates, emergency preparedness and response at the local level, reducing health disparities, and comprehensive population health monitoring, which is done best with local reporting, improving outcomes for children and vulnerable populations, and strengthening the public health workforce, especially at the local level.

Again, I would like to thank the Chairman and committee members for this opportunity to speak on behalf of the 45 local public health departments and the Essential Local Public Health Services.

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What is Public Health?

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Public Health is a complex system which protects people from unsafe or hazardous conditions and provides methods of promoting good health and preventing disease. Partners in this system include state and local health departments; community health centers; colleges and universities; schools; federal agencies; federal and state legislatures; community organizations; the business community; and, of course, the public.

Public health functions are often grouped into three basic areas by the Institute of Medicine - **assessment, assurance,** and **policy development.** While these terms are not well known; many of the functions that are provided under them are probably familiar to most people.

Assessment functions include determining if a community has enough doctors, nurses and dentists; recording the number of births and deaths; tracking health trends; conducting laboratory analyses; and evaluating the effectiveness of programs. Assessment programs primarily serve as the mechanism to determine if the total health system is working as well as it should.

Assurance covers those activities that deal with making sure people's health needs are safely and effectively met. For example, government's role in regulating, through licensure and inspection, falls under this heading. Programs that provide education to both health care providers and the community are part of assurance as well. Finally, assurance includes providing medical, dental, and psychological services directly to the public.

Policy development pertains to the setting of goals for health services, developing performance standards, determining priorities for the allocation of resources, and planning for systems to meet identified health needs. Setting immunization standards for children is an example of public policy development.

The story of public health is one of success. The public can eat at restaurants anywhere in Michigan, access health care, breathe clean air, work in a safe environment, and live without fear of catching many diseases because our public health system is working.

A Longer Life and a Better Life

Without strong public health protection, living in Michigan could be very different. Less than 100 years ago, imagine: the average lifespan was just 47 years; no sewers and septic tanks, so water is unsafe to drink; no vaccinations, so almost everyone is sick and medical costs are even higher; no restaurant inspections, so food is unsafe to eat; kids don't have a safe place to play; people live next to toxic waste.

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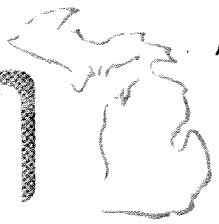
Local Public Health's Unique Role



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Local Health Departments (LHD) protect and improve community well-being by preventing disease, illness and injury and impacting social, economic and environmental factors fundamental to excellent health. The LHD is the foundation of the local public health system that comprises public- and private-sector health care providers, academia, business, the media, and other local and state governmental entities.

- ***Track and investigate health problems and hazards in the community.*** LHDs gather and analyze data on the community's health to determine risks and problems. This information drives specific programs and activities designed to control multiple threats: both communicable and chronic diseases; food, water, insect and other "vector-borne" outbreaks; biological, chemical and radiological hazards; and public health disasters.

- ***Prepare for and respond to public health emergencies.*** As a result of extensive and ongoing preparation, LHDs respond quickly and effectively to disease outbreaks and other public health events—they are trained extensively to respond to the increase of the incidence of diseases, natural disasters, and acts of terrorism. They coordinate delivery of drugs, supplies, and provisions to victims and populations at risk. They keep the public informed and serve as the network hub for community hospitals, physicians, and other health care providers.

- ***Develop, apply and enforce policies, laws and regulations that improve health and ensure safety.*** Acting on their knowledge about their community, LHDs create data-driven policies to meet health needs and address emerging issues. They help craft sound health policies by providing expertise to local, state and federal decision makers. LHDs also inform individuals and organizations about public health laws while monitoring and enforcing compliance.

- ***Lead efforts to mobilize communities around important health issues.*** With local and state government agencies, businesses, schools, and the media, LHDs spearhead locally organized health promotion and disease prevention campaigns and projects. They galvanize the community to tackle disease prevention and personal health care needs. LHDs also educate and encourage people to lead healthy lives through community forums; public workshops and presentations; and public service announcements.

- ***Link people to health services.*** LHDs connect people with personal health services, including preventive and health promotion services, either in the community or as close to the community as possible. They also advocate for development of needed programs and services in underserved populations and continuously monitor the quality and accessibility of public health services.

- ***Achieve excellence in public health practice through a trained workforce, evaluation, and evidence-based programs.*** LHDs recruit and develop skilled workers with expertise in core public health competencies. They ensure that public health workers update their knowledge and skills through continuing education, training and leadership development activities. They regularly evaluate the effectiveness of all programs and activities using evidence-based standards and strive to adapt successful interventions.

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Public Health – It's the Law

M. Swain
MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

State of Michigan Constitution – Section 51: Public Health and General Welfare

The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health.

Public Health Code – Act 368 of 1978 ~ Part 24 (State Department of Public Health)

Section: 333.2221 - Organized programs to prevent disease, prolong life, and promote public health; duties of department.
Sec. 2221. (1) Pursuant to section 51 of article 4 of the state constitution of 1963, the department shall continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs, including prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable population groups; development of health care facilities and agencies and health services delivery systems; and regulation of health care facilities and agencies and health services delivery systems to the extent provided by law.

Section 333.2224 - Promotion of local health services; coordination and integration of public health services.
Sec. 2224. Pursuant to this code, the department shall promote an adequate and appropriate system of local health services throughout the state and shall endeavor to develop and establish arrangements and procedures for the effective coordination and integration of all public health services including effective cooperation between public and nonpublic entities to provide a unified system of statewide health care.

333.2475 - Reimbursement for costs of services; equitable distribution; schedule; local expenditure in excess of prior appropriation.
Sec. 2475. (1) The department shall reimburse local governing entities for the reasonable and allowable costs of required and allowable health services delivered by the local governing entity as provided by this section. Subject to the availability of funds actually appropriated reimbursements shall be made in a manner to provide equitable distribution among the local governing entities and pursuant to the following schedule beginning in the second state fiscal year beginning on or after the effective date of this part:
(a) First year, 20%. (b) Second year, 30%. (c) Third year, 40%. (d) Fourth year and thereafter, 50%.
(2) Until the 50% level is reached, a local governing entity is not required to provide for required services if the local expenditure necessary to provide the services is greater than those funds appropriated and expended in the full state fiscal year immediately before the effective date of this part.

Public Health Code – Act 368 of 1978 ~ Part 22 (Local Health Departments)

333.2433 - Local health department; powers and duties generally.
Sec. 2433. (1) A local health department shall continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs, including prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable population groups; development of health care facilities and health services delivery systems; and regulation of health care facilities and health services delivery systems to the extent provided by law.

333.2451 - Imminent danger to health or lives; informing individuals affected; order; noncompliance; petition to restrain condition or practice; "imminent danger" and "person" defined.

Sec. 2451. (1) Upon a determination that an imminent danger to the health or lives of individuals exists in the area served by the local health department, the local health officer immediately shall inform the individuals affected by the imminent danger and issue an order which shall be delivered to a person authorized to avoid, correct, or remove the imminent danger or be posted at or near the imminent danger. The order shall incorporate the findings of the local health department and require immediate action necessary to avoid, correct, or remove the imminent danger. The order may specify action to be taken or prohibit the presence of individuals in locations or under conditions where the imminent danger exists, except individuals whose presence is necessary to avoid, correct, or remove the imminent danger.

333.2453 - Epidemic; emergency order and procedures; involuntary detention and treatment.

Sec. 2453. (1) If a local health officer determines that control of an epidemic is necessary to protect the public health, the local health officer may issue an emergency order to prohibit the gathering of people for any purpose and may establish procedures to be followed by persons, including a local governmental entity, during the epidemic to insure continuation of essential public health services and enforcement of health laws. Emergency procedures shall not be limited to this code.

333.2455 Building or condition violating health laws or constituting nuisance, unsanitary condition, or cause of illness; order; noncompliance; warrant; assessment and collection of expenses; liability; judicial order; other powers not affected.

Sec. 2455. (1) A local health department or the department may issue an order to avoid, correct, or remove, at the owner's expense, a building or condition which violates health laws or which the local health officer or director reasonably believes to be a nuisance, unsanitary condition, or cause of illness.

333.2492 - Status report; appropriation for development and implementation of evaluation and related training.

Sec. 2492. (1) At the end of the second full state fiscal year after the effective date of this part, the department shall report to the governor and legislature as to the status of required and allowable health services in relation to standards, costs, and health needs of the people of this state. (2) An amount equal to 1% of the estimated total expenditures for the required and allowable local health services shall be appropriated to the department annually for the development and implementation of evaluation and related training for local health departments and department staffs in the delivery of the required and allowable health services authorized under sections 2471 to 2498.

Essential Local Public Health Services (Mandated ~ Cost Shared Services)

M. Swain

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Michigan Public Health Code – Act 368 of 1978 ~ MCL 333.17015

Sec. 904: Allocations to local public health operations; contractual standards; distributions; report.

(1) Funds appropriated in part 1 for local public health operations shall be prospectively allocated to local health departments to support immunizations, infectious disease control, sexually transmitted disease control and prevention, hearing screening, vision services, food protection, public water supply, private groundwater supply, and on-site sewage management. Food protection shall be provided in consultation with the Michigan department of agriculture. Public water supply, private groundwater supply, and on-site sewage management shall be provided in consultation with the Michigan department of environmental quality.

(2) Local public health departments will be held to contractual standards for the services in subsection (1).

Food Protection - This service is intended to minimize the risk of foodborne illness to persons consuming food from licensed food service establishments. Secondary objectives include the satisfaction of reasonable customer expectations relative to sanitation, and protection of the environmental quality in the vicinity of food service establishments. Elements of this service include plan reviews, licenses and permits, inspections, complaint investigations, enforcement actions, and investigations of reported cases of foodborne diseases.

Private Groundwater/Public Water Supply - Works through education and regulation to assure the proper installation, operation, and abandonment of the water supplies serving private and public water supply users. This is accomplished through issuance of well permits for all water wells, inspection of well construction techniques, monitoring of water quality, and areas of known or suspected areas of contamination.

On-Site Sewage Disposal Management - Consists of the review of sites proposed for sewage disposal, issuance and/or denial of permits, sewage disposal system evaluations and inspections, plan review, review of proposals for alternative sewage disposal systems, investigations, and enforcement.

Hearing Screening - Includes screening of hearing problems, referral, and health education for the prevention of deafness and the amelioration of hearing problems. The primary focus of hearing services is preschool children (ages 3-5 years) and school-age children.

Vision Services - Includes screening, health education, and referral for the prevention of blindness and the amelioration of vision problems. The primary focus of vision services is preschool children (ages 3-5 years) and school-age children.

(Continued on other side)

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Michigan Public Health Code – Act 368 of 1978 (Concluded)

Sexually Transmitted Disease Control and Prevention - This program addresses disease transmitted through sexual contact, primarily syphilis, gonorrhea, Chlamydia, and HIV; the element targets the immediate effects and long-term sequelae, as well as prevention of the infections. Surveillance, screening, clinical services, sexual partner referral, and education are major program components.

Immunization - This program entails the provision of immunizations to the entire population, with special emphasis on pediatric populations, including proper storage, handling and distribution; the assessment of immunization levels to identify susceptible populations and to evaluate the effectiveness of immunization programs; and the assurance of complete immunization coverage among children enrolled in school, daycare or other preschool programs.

Infectious Disease Control - This program renders services that cut across the full range of infectious diseases, including the vaccine preventable diseases, the sexually transmitted diseases, human immunodeficiency virus (HIV) related disease, and tuberculosis. The activities of this program are directed toward preventing infectious disease, the gathering of information concerning the occurrence of infectious diseases, investigating cases and outbreaks of infectious disease, evaluating data and case information, offering treatment in certain instances, and instituting measures to control epidemics.

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Attachment A

MATRIX OF SERVICES OF LOCAL PUBLIC HEALTH

Services	Rule or Statutory Citation	Required =	Basic +	Mandated +	LPHO	Allowable	Notes
		1	1.A.	1.B.	1.C.	2	
Immunizations	PA 349 of 2004 – Sec. 218 and 904; MCL 333.9203, R325.176	X	X	X	X		
Infectious/Communicable Disease Control	MCL 333.2433; Parts 51 and 52; PA 349 of 2004 – Sec. 218 and 904; R325.171 et seq.	X	X	X	X		
STD Control	PA 349 of 2004 -- Sec. 218 and 904; R325.177	X	X	X	X		
TB Control	PA 349 of 2004 – Sec. 218	X	X	X			
Emergency Management – Community Health Annex	PA 349 of 2004 – Sec. 218 MCL 30.410	X	X	X			Basic Service under Appropriations Act and Mandated Service, if required, under Emergency Management Act.
Prenatal Care	PA 349 of 2004 – Sec. 218	X	X				
Family planning services for indigent women	MCL 333.9131; R325.151 et seq.	X		X			
Health Education	MCL 333.2433	X		X			
Nutrition Services	MCL 333.2433	X		X			
HIV/AIDS Services; reporting, counseling and partner notification	MCL 333.5114a; MCL 333.5923; MCL 333.5114	X		X			
Care of individuals with serious Communicable disease or infection	MCL 333.5117; Part 53; R325.177	X		X			(4) Financial liability for care rendered under this section shall be determined in accordance with part 53.
Hearing and Vision Screening	MCL 333.9301; PA 349 of 2004 – Sec. 904; R325.3271 et seq.; R325.13091 et seq.	X		X	X		
Public Swimming Pool Inspections	MCL 333.12524; R325.2111 et seq.	X		X			Required, if "designated"
Campground Inspection	MCL 333.12510; R325.1551 et seq.	X		X			Required, if "designated"
Public/Private On-Site Wastewater	MCL 333.12751 to MCL 333.12757 et. seq., R323.2210 and R323.2211	X		X	X		Alternative waste treatment systems regulated by local public health.
Food Protection	PA 92 of 2000 MCL 289.3105; PA 349 of 2004 – Sec. 904	X		X	X		

M. Swain

Services	Rule or Statutory Citation	Required =	Basic +	Mandated +	LPHO	Allowable	Notes
		1	1.A.	1.B.	1.C.	2	
Pregnancy test related to informed consent to abortion	MCL 333.17015(18)	X		X			
Public/Private Water Supply	MCL 333.1270 to MCL 333.12715; R325.1601 et. seq.; MCL 325.1001 to MCL 325.1023; R325.10101 et. seq.	X			X		
Allowable Services						X	This category would include all permissive responsibilities in statute or rule that happen to be eligible for cost reimbursement.
Other Responsibilities as delegated and agreed-to	MCL333.2235(1)					X	This category is NOT connected to express responsibilities within statute, but refers entirely to pure delegation by the department as allowed. In addition to general provision, the Code allows delegations for specified functions.

MATRIX DEFINITIONS

Name	Citation	Description
1. Required Service	MCL 333.2321(2); MCL 333.2408; R325.13053	Means: (A) a basic service designated for delivery through Local Public Health Department (LPH), (B) local health service specifically required pursuant to Part 24 or specifically required elsewhere in state law, or (C) services designated under LPHO.
1.A. Basic Service	MCL 333.2311; MCL 333.2321	A service identified under Part 23 that is funded by appropriations to MDCH or that is made available through other arrangements approved by the legislature. Defined by the current Appropriations Act and could change annually. For FY 2005: immunizations, communicable disease control, STD control, TB control, prevention of gonorrhea eye infection in newborns, screening newborns for 8 conditions, community health annex of the MEMP, and prenatal care.
1.B. Mandated Service	MCL 333.2408	The portion of required services that are not basic services, but are "required pursuant to this part [24] or specifically required elsewhere in state law."
1.C. LPHO	PA 349 of 2004 – Sec. 904	Funds appropriated in part 1 of the MDCH Appropriations Act that are to be prospectively allocated to LPH to support immunizations, infectious disease control, STD control and prevention, hearing screening, vision services, food protection, public water supply, private groundwater supply, and on-site sewage management.
2. Allowable Services	MCL 333.2403; R325.13053	"Means a health service delivered [by LPH] which is not a required service but which the department determines is eligible for cost reimbursement".
PA 349 of 2004		Fiscal year 2005 Appropriations Act for the Department of Community Health.

M. Swain

Suffering Public Health Departments Putting People at Risk

BY: Chris Kardish | December 17, 2013

After years of cutting public health, states are falling behind on vaccinating their residents and guarding against the possibility of disease outbreaks, food-borne illness and other threats, a new study released Tuesday concluded.

The Trust for America's Health and the Robert Wood Johnson Foundation rated states on 10 measures, including public health spending in recent years, the percentage of their populations receiving vaccinations for preventable diseases, how recently they've tested their emergency plans, whether they have the capacity to handle a surge in testing and whether they require medical facilities to report infections that arise from patients during their treatment.

Among the report's findings:
Two-thirds of states have decreased public health funding over the last two fiscal years, significantly impacting workforces and lab capacity. In total, 40,000 public health jobs have vanished in the last five years.
Only one quarter of states vaccinate at least half of their residents against the flu, despite Centers for Disease Control and Prevention recommendations that nearly all Americans get vaccinated.
More than half of public health departments didn't test emergency plans to deal with food-borne illness, an outbreak or biological weapon attack last year
Fewer than half of states require human papillomavirus vaccinations (HPV), education about the vaccine or funding for it, despite risks of cancer and scientific consensus against the conclusion that it increases sexual activity among the young adolescents who receive it.
Only two states and the District of Columbia meet the U.S. Department of Health and Human Services benchmark of providing whooping cough vaccinations to at least 90 percent of preschool children.
"There's been a widespread mistaken belief that we have... infectious diseases under control, and I think this has led to not just complacency but letting our guard down," said Tom Inglesby, director of the UPMC Center for Health Security.

The risks are real, the report's authors conclude. Food-borne and water-borne illnesses result in 128,000 hospitalizations and around 3,000 deaths each year, for example. Diseases that were considered either eradicated or no threat to the U.S., such as dengue fever and tuberculosis, which racked up nearly 10,000 cases in the U.S. last year, have been rebounding. And each year more than two million Americans develop antibiotic-resistant infections to diseases like Salmonella, and at least 23,000 die. Jeffrey Levi, the executive director of Trust for America's Health, put the cost of infectious diseases to taxpayers at $120 billion a year.

States received a point for meeting each objective measured. On a ten-point scale, a majority of states scored five or lower. New Hampshire performed the highest at eight. Seven states, including New York, North Carolina and Oregon, scored seven points. A total of 15 states scored five points, the most of any category. Georgia, Nebraska and New Jersey scored the lowest at two points.

The budget picture for public health in recent years has been bleak. A total of 33 states cut funding for public health over the past two fiscal years, some by as much as 30 percent. Sixty percent of state programs have laid off staff and more than 90 percent have lost staff through attrition. The report notes that public health is funded on a year-by-year basis, so it's especially vulnerable to the kinds of cuts that have been a staple of the years following the Great Recession. State public health departments also depend on funding from the federal government and the CDC, and both sources have decreased in recent years.

A recent National Association of State Budget Officers study put revenue growth at less than one percent in the next fiscal year. State spending is expected to increase 3.8 percent, and with so many competing demands following years of cuts, carving out space for public health is far from a given.

States should still take a hard look at their current levels of spending, ask what more they can do and whether they're spending existing support in the most efficient way, Levi said. For instance, providing vaccinations is now the responsibility of insurers under the Affordable Care Act, which frees up money in local health departments for other initiatives.

"Some of the delivery dollars that have been spent in the past can be reoriented to educate the public to take advantage," he said.

Find the full report here.

Public Health and the Leadership Imperative

Government leaders long ago took up the challenge of protecting the public from deadly diseases. New challenges are testing that resolve.

BY ELIZABETH K. KELLAR | JANUARY 15, 2014

Who thinks about the broad needs of our society? Private-sector leaders focus on the bottom line and their products. As individuals, each of us is consumed by our personal responsibilities, goals and challenges of daily life.

That's why it's so important for government officials to take a leadership role to advocate for future generations. Who else has the capacity and orientation to rally the public to make essential investments in infrastructure, education and the general welfare? Foresight may, in fact, be the most important skill set in the public leader's toolbox.

Take public health. A hundred years ago, cities faced massive public-health challenges, with high death rates from tuberculosis, bubonic plague, smallpox and malaria. Local-government reformers and the first city managers tackled these challenges with passion and rigor. When community leaders found evidence that strategic investments could dramatically improve public health, they built water and sewer systems and brought together community resources to tackle contagious diseases.

In 1923, for example, Louis Brownlow, city manager of Petersburg, Va., reported dramatic results after public and private agencies coordinated their efforts under the leadership of the city's health officer: The general death rate had decreased from 19.2 per thousand people in 1920 to 16.64 in 1922 and infant mortality had dropped from 189 in 1920 to 106 in 1922. "After two years it is almost impossible to discover ... what part of the health center work is done by the city, what by the Red Cross, the Kings Daughters, the Tuberculosis Society, [or] the Milk Fund," he wrote in the yearbook of the City Managers' Association.

Similar results were reported in Beaumont, Texas, where City Manager George J. Roark wrote that he had hired "the best sanitary engineer" to improve the city's water supply. Consequently, by 1922 malaria had been reduced by 50 percent and tuberculosis in the milk supply had been eliminated.

Where are we today? Just as budget cuts during the Depression years threatened public-health efforts, new strains on health-department budgets threaten to reverse some of the gains of the past century.

Of particular concern is the impact on the public-health workforce. Research released in November by the Center for State and Local Government Excellence and the University

of Illinois at Chicago found that local health-department leaders are particularly concerned about recruitment and retention. Retaining funded positions has become especially difficult, and opportunities to promote well-qualified people are limited due to human-resources rules and regulations.

The study, funded by the Robert Wood Johnson Foundation (RWJF), reinforces worrisome state-level findings released last month by the Trust for America's Health and RWJF: Two-thirds of the states decreased public-health funding over the last five years, eliminating 40,000 public-health jobs, according to that report. And just two states and the District of Columbia have met the U.S. Department of Health and Human Services benchmark to provide whooping-cough vaccinations to at least 90 percent of preschool children.

These are serious issues, ones that simply don't lend themselves to private-sector or personal solutions. At the end of the day, we count on government to sound the alarm and assume leadership responsibility. If government lacks the wherewithal or the will to effectively address an issue as broad and important as public health, who will?

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M. Swain

Return on Investment Analysis: Local Public Health Funding

Strong Evidence for the Value of Population Health Investments

Michigan Association for Local Public Health

2013

Return on Investment Analysis: Local Public Health Funding

Strong Evidence for the Value of Population Health Investments

EXECUTIVE SUMMARY

The Michigan Association for Local Public Health (MALPH) is a member organization comprised of Michigan's 45 local public health departments. Each department seeks to carry out its statutory responsibility of preventing disease, prolonging life, and promoting public health through organized programs in its area of the state. These organized programs encompass eight vital public health operations: 1) immunizations, 2) sexually transmitted disease (STD) control, 3) infectious disease control, 4) hearing screening, 5) vision screening, 6) food safety inspection, 7) drinking water protection, and 8) on-site sewage management.

The State of Michigan has historically recognized the vital importance of public health services for the well-being of all Michiganders. The state has codified a cost-sharing formula into statute, so as to better share the responsibility of protecting Michigan's population health. Recent budgetary cutbacks have resulted in the state halting its obligation to fund half the cost of these activities. Although the economic recovery remains fragile, such drastic reductions in public health funding will harm the health and well-being of every Michigander. As this report will show, the essential services and other programs provided by local health departments across the state ALL have consistently strong returns on investment, ultimately saving money for patients, the healthcare system, and state government alike, while promoting the health of Michigan residents. Using data collected by local health departments and applying existing return on investment (ROI) research from scientific literature, this report estimates the ROI for the eight essential public health services. **In every instance, these services generate great value for the State of Michigan with ROIs ranging from 2 to 1 to as high as an astounding 162 to 1 (for vision screening).**

Table 1 – Summary of ROI estimates

Local Public Health Service	ROI (benefit per dollar invested)	Notes
Childhood Immunizations	$22 to 1	$88 Million saved in 2009
Flu Vaccinations	$11 to 1	$91 – $141 saved per vaccination (direct medical costs only)
STD Screening	$2.50 to 1	Through pelvic inflammatory disease prevention
Infectious Disease Surveillance	$2.00 to 1	Considering ONLY bacterial meningitis prevention
Hearing Screening	$112 to 1	From gains workers' future productivity
Vision Screening	$162 to 1*	From life-long disability prevention for kids
Food-borne Illness Surveillance	Epidemic Prevention	187 cases occurred in 2009 ($1.5 Million for treatment)
Drinking Water Protection and On-Site Sewage Management	Epidemic Prevention	Gastrointestinal outbreak, South Bass Island, Ohio

*The estimated ROI for vision screening based on use of Visual Acuity Screening (more robust). If Photoscreening is used instead, ROI drops to $142 to 1[20]

It is important to note that this report includes only a *sampling* of the activities of local public health departments. There are other services provided for which strong scientific evidence exists for significant ROI. While it is true that not all prevention or population health initiatives save money downstream (especially in the *clinical* realm), the public health services of local health departments focus on those services considered by scientists to be best practices. For this reason MOST local public health department activity creates significant ROIs.

It is also important to note that population (or public) health includes activities that are much broader than the eight essential services that local health departments are required to provide. Issues like motor vehicle accident reduction, obesity prevention, and air pollution mitigation all fall under the realm of public health. Most of these activities have demonstrated cost-effective returns on investments, while also improving people's health outcomes. Michiganders unknowingly rely, every day, on the professionals working to ensure our citizens' health at the systems-level. We must make it a priority to safeguard this first line of defense against disease.

Whoever wishes to investigate medicine properly should proceed thus: . . . first, consider the seasons of the year, and (their) effects . . . Then the winds. . .especially such as are common to all countries, and then such as are peculiar to each locality. We must also consider the qualities of the waters . . . (W)hen one comes into a city to which he is a stranger, he ought to consider its situation . . . and the mode in which the inhabitants live, and what are their pursuits, whether they are fond of drinking and eating to excess, and given to indolence, or are fond of exercise and labor, and not given to excess in eating and drinking[1].

-Hippocrates (c. 460 BC – c. 370 BC), the "Father of Western Medicine"

ESSENTIAL LOCAL PUBLIC HEALTH SERVICES
Michigan's First Line of Defense for Ensuring Health

Michigan's 45 local health departments play a vital role in protecting the health of Michigan residents at the population level. In fact, their role is considered so important that Michigan law requires the state to provide a minimum level of funding for eight basic health services. Michigan statute mandates local health departments to

> continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs, including prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable population groups; development of health care facilities and health services delivery systems; and regulation of health care facilities and health services delivery systems to the extent provided by law[2].

Local health departments have several more statutory responsibilities:

- Implementing and enforcing laws
- Utilizing statistics and research to protect the public health
- Investigating cause of disease and especially epidemics
- Planning, implementing, and evaluating public health education
- Preventing and controlling environmental health hazards, diseases, and health problems of particularly vulnerable populations
- Having power to perform such duties and exercising that power.

While these duties may seem vast, eight basic services have developed which fulfill the statutory responsibility of local health departments. These services are 1)immunizations, 2) sexually transmitted disease control, 3)infectious disease control, 4)hearing screening, 5)vision screening, 6)food safety inspection, 7)drinking water protection, and 8)on-site sewage management.[3] The state, recognizing that local health departments need resources to adequately provide such services, developed and codified a cost-sharing formula to fund the delivery of these services. **As of 1984, the state and local health departments were each required to fund half of these services.[4] Despite this requirement, the state has not funded local health departments for these services at the statutorily required level in more than 15 years**, leaving local health departments to scramble for supporting funds from other sources, either through fees or from local governing entities. Funding for these eight essential services in the Essential Local Public Health Services (ELPHS) appropriation has decreased since

2003, when ELPHS received $40.8 million. If ELPHS funding had been adjusted each year for inflation, ELPHS would currently be receiving $47.6 million. In fiscal year (FY) 2008–09, however, the ELPHS appropriation was $40.6 million for these mandated services ($35.5 million General Fund; $5.1 million School Aid Fund). If the state were meeting its statutory obligation, regardless of inflationary increases, ELPHS would have received $66.8 million in FY 2009-10.

While allocating funds can be difficult in times of economic contraction, funding for public health services are exactly the kinds of investments that have greater need during downturns in the business cycle, while simultaneously providing great return on investment for the state, as the following examples in this report will demonstrate. Adequately funding public health makes clear economic sense because local health departments create value for Michiganders with benefits that directly lead to better health and lower health care costs. Yet, public health funding makes even more sense when one considers the long-term economic impact. Without a healthy and productive workforce, Michigan cannot generate economic growth. Local health departments across the state work tirelessly to promote health at the population level. **Investing in local health departments leads to enormous "bang for the buck" now and in the future.**

Immunizations

Immunizations are one of the most important tools in fighting and eradicating deadly infectious diseases. The importance of vaccinations cannot be overstated. The fear of polio, measles, and diphtheria is almost non-existent now because of our local public health childhood immunization program. Seasonal outbreaks of new strands of the flu virus can be quickly quelled with well-organized vaccination campaigns. Local public health departments play a vital role in educating the public on the importance of vaccinations, tracking and reporting the number of people who have been vaccinated, and distributing vaccines for emergency outbreaks.

Michigan's local public health departments receive approximately $4 million from the state to provide a comprehensive, statewide vaccination program that includes vaccine administration, technical support to private providers, and surveillance and reporting through the Michigan Care Improvement Registry.

Childhood immunizations provided $22 in savings for every dollar invested

ROI for Childhood Vaccinations

Childhood vaccinations remain crucial in fighting the resurgence of deadly diseases. Routine childhood immunizations include DTaP (diphtheria, tetanus, and pertussis), Hib (Haemophilus influenzae type b), IPV (polio), MMR (measles, mumps, and rubella), and HepB (hepatitis B). In Michigan, more than 487,990 doses of these vaccines were administered by local health departments in 2012. Local public health departments record childhood immunizations so that children lacking proper vaccines can be easily identified. Health departments also work closely with schools and private providers to maintain appropriate vaccination coverage. The Centers for Disease Control and Prevention (CDC) reports that for every $1 spent on these childhood immunizations in 2001, $18.40 in savings were realized in direct and indirect

costs.[5] Today that would be about $22 saved for every $1 invested*. Taking into account *only* the childhood immunization program, the amount of money saved in 2012 with a $4 million investment would have amounted to more than $88 million.

ROI for Flu Vaccines

Local public health departments' responsibilities for immunizations are greater than just childhood vaccinations. When the H1N1 strand of influenza began spreading at alarming rates in 2009, local public health departments had the sole responsibility of acquiring and distributing vaccines to the most vulnerable populations in the most expedient manner possible. Research conducted in 2009 estimated the savings incurred as a result of H1N1 vaccinations. Each H1N1 immunization saves between $91 and $141 in medical costs, depending on when the vaccination is administered.[6]

In 2009, every dollar local health departments spent on H1N1 vaccinations provided up to $11 in direct and indirect savings.

In 2009, 1,483,233 people in Michigan received the H1N1 vaccine. Local health departments received $19 million in federal emergency funds to coordinate the H1N1 vaccination program. The cost for each vaccination averaged $13, and every $13 invested in this program saved up to $141. Accordingly, every dollar invested in this program saved up to $11 in direct and indirect costs. Without a doubt, money spent on immunizations provides substantial economic returns.

Sexually Transmitted Disease Control

Local public health departments are required to provide screening for a variety of sexually transmitted diseases (STDs). Such screening is vital for the early treatment of infections and prevention of epidemics. Unfortunately, Michigan has seen an uptick in the number of reported STDs,[7] paralleling a nationwide trend of increasing STD rates.[8] In FY 2012, 63,874 cases of STDs were reported in Michigan, up from 60,892 in 2011. With early treatment, many of these can be easily cured without causing further health problems. The majority of STD screenings are for Chlamydia, gonorrhea, syphilis, and HIV.

Chlamydia and gonorrhea are two of the most common bacterial STDs occurring today, with Chlamydia the most frequently reported. Both Chlamydia and gonorrhea can lead to a number of serious health problems for women, including pelvic inflammatory disease (PID). PID is an infection of the uterus that can lead to serious health consequences including infertility, ectopic pregnancy, abscess formation, and chronic pelvic pain. The CDC recommends annual Chlamydia and gonorrhea screening for all sexually active women under the age of 25.

During fiscal year 2012, local public health departments conducted 42,739 screenings for Chlamydia and gonorrhea for both men and women. Of those, 5,983 (14%) received positive test results. Identifying people with STDs allows infected individuals to be treated, conditions like PID to be prevented, and lowers the risk that other people get infected. Early detection leads to better medical care and lower disease rates.

* Throughout this report, cost estimates are adjusted based only on the consumer price index and assume all other factors have remained the same.

Each dollar allocated for STD screening realized $2.50 in savings.

From the total ELPHS funds for FY 2008–09, $5.7 million was disbursed among local health departments for STD screening. It costs less than $30 for each test. The economic impact of STD screening has been thoroughly studied, indicating significant savings. In 1998, researchers in Baltimore determined that up to 40% of untreated Chlamydia cases progress to PID.[9] A similar study in 2000 determined that up to 40% of untreated gonorrhea cases can progress to PID.[10] Treatment costs for PID averaged $3,60011 in 1998; adjusted for inflation, each case would have cost about $4,800 in 2009. If 40 percent of the Chlamydia and gonorrhea cases identified and treated for women in Michigan in FY 2008–09 had gone undetected and progressed to PID, the costs associated with these diseases alone would have been about $14.5 million. Therefore, each dollar allocated for STD screening through ELPHS realized at least $2.50 in savings.

Infectious Disease Control

Local public health departments are the only central tracking source in the state for infectious disease incidence—all new cases of infectious disease are reported to local health departments for monitoring and investigation. Effective surveillance prevents or mitigates serious disease epidemics. The State of Michigan maintains a list of reportable diseases, including influenza, meningitis, and measles. Many of these diseases can impact vast portions of the population if and when they spread uncontrollably. Such outbreaks would have a hard to predict, but certainly large, fiscal impact on the state as medical expenses spike and economic losses ensue. Local health departments enter new diagnoses into a statewide tracking system each week; this tracking system allows for real-time monitoring and response to outbreaks. **In fiscal year 2012, there were approximately 83,500 cases of individual reportable diseases of more than 100 reportable disease types state-wide.**

Tracking reportable disease at the local level ensures proper identification and follow-up of diseases. Local health departments ensure that those affected receive appropriate treatment; track other people with whom infected individuals may have had contact in order to vaccinate, treat, quarantine, and educate them; and investigate and stop outbreaks. This surveillance helps public health authorities monitor incidence of reportable diseases, measure trends, assess and develop prevention and control strategies, and target at-risk populations for treatment. While surveillance is vital to control the spread of disease, it is also important to detect sudden changes in disease occurrence and distribution, so health professionals can understand why those changes occur. Once the sources and causes of disease are identified, adverse health outcomes can be prevented.

The CDC defines a reportable disease as one for which regular, frequent, and timely information regarding individual cases is necessary for the prevention and control of disease.[12] While many diseases on the list are of relatively little concern to many today (e.g., leprosy, plague, and polio), some are illnesses that continue to lower many people's quality of life. Meningococcal disease, commonly called meningitis, is one such illness. Meningitis is an inflammation of the tissue surrounding the spinal cord, and can be either viral or bacterial. Bacterial meningitis is more serious than viral meningitis, but neither can be definitively diagnosed without extracting tissue from the spinal column—a very costly procedure. Bacterial meningitis

can be treated with antibiotics; viral meningitis, although less serious, cannot be treated with antibiotics. Due to the difficulty of determining what type of meningitis a person has, antibiotics may be precautionarily administered until test results are available. If practitioners know about an increase in viral meningitis, they can treat for viral meningitis, instead of immediately ordering more expensive testing and treatments.

A study of a 1991 meningitis outbreak in Rhode Island estimated direct medical costs for 408 persons diagnosed to be more than $585,000.[13] Because of the difficulty of diagnosing meningitis, at least 359 patients were admitted to a hospital, although better coordination and communication about symptoms and diagnosis between the providers, public health officials, and hospitals could have prevented hospitalization. Only ten of these cases were bacterial infections; the overwhelming majority of cases were viral. On average, cost estimates for treating a person with bacterial meningitis are $8,145.[14] The authors of this study conclude that a more focused community response might have cut costs considerably because patients with viral meningitis do not benefit from expensive testing and treatment, like head CTs or antibiotics[15].

Hearing Screening

Hearing screening for school-age children is standard practice in the United States. The Individuals with Disabilities Education Act of 2004 requires states to identify children with disabilities, including hearing loss. Michigan requires that children be screened at least once between the ages of three and five, and every other year up to the age of ten. Local public health departments fund the cost of the screenings in conjunction with the state. Some children pass an initial screening, but are still at risk for hearing loss that fluctuates, is progressive, or is acquired later in development. Hearing loss can affect a child's ability to succeed in school, and early intervention has been proven effective in minimizing the negative effects on learning. Hearing loss can also be an indicator for more serious disorders, including Hunter's syndrome, a neurodegenerative disorder.

In fiscal year 2012, local public health departments received $5.125 million for hearing and vision programs. In 2012, local health departments conducted 447,217 hearing screenings[16]. Three percent of children screened were referred for follow-up. Early intervention for children with hearing loss has proven to significantly improve future development. Children with mild to moderate hearing loss, on average, achieve one to four grade levels lower than children with normal hearing.[17] With appropriate management, teachers and allied health professionals can bridge the achievement gap.

Every dollar invested in hearing screening saves $112 in future work productivity.

Untreated hearing loss costs about $250,000 in a lifetime. According to a 1993 study by the Marion Downs Center, children who do not require special education save a school system as much as $348,000 during a 12-year education. The lifetime costs of profound hearing loss, according to the Downs study, can total as much as $1 million.[18]

75 percent of that amount is attributable to lost work productivity. On average, 0.3 percent of children have hearing loss.[19] This would translate into 1342 of the children screened by local public health departments in Michigan in the 2011-12 school year. If these children receive assistance early, the overall

cost of hearing loss could be significantly reduced and could result in future work productivity savings of $280 million. Therefore, each dollar spent on hearing screening (with appropriate intervention) can save $112 in future work productivity.

Vision Screening

Local public health departments provide vision screening for school-age children. Health departments partner with the state to pay for vision screenings. Children are screened at least once between ages three and five years and every other year beginning with first grade, then through the ninth grade. Common eye conditions, such as decreased visual acuity and amblyopia, or "lazy eye," can be detected with routine screenings and prevented by early treatment with eye care specialists.

Local health departments screened 564,019 children for vision problems in 2012; more than 56,900 children were referred for follow-up and treatment, or 10 percent of children screened. For FY 11-12, local public health departments received $2.6 million for the vision screening program.

> **Every dollar invested in vision screening saves $162.**

Vision screening provides demonstrable cost savings. A study conducted in 2003 determined that all visual screening programs had a significantly positive benefit-to-cost ratio—the benefits of screenings exceeded the costs of screenings by a wide margin. Every dollar spent on childhood visual acuity screenings saves up to $162.20.[20] This finding would predict that the screening program in 2012 offered a benefit to the state of more than $421 million with an investment of $2.6 million.

Food Safety Inspection

Local health departments work with the Michigan Department of Agriculture and Rural Development (MDARD) to ensure the safety of food served in restaurants. The local health departments are responsible for the following activities:

- planning reviews
- conducting inspections
- processing license applications
- enforcing policies
- investigating complaints
- investigating foodborne illness outbreaks

MDARD provides evaluation, consultation, and training services to sanitarians in local health departments. In 2012, 194 full-time equivalent (FTE) inspectors conducted more than 85,586 inspections; 67 percent of those were routine inspections and the rest were follow-up or temporary food service activities. Each inspector conducts an average of 487 inspections annually.[21]

Local public health departments are responsible for investigation and follow-up when a suspected foodborne illness outbreak occurs. In Michigan, this is defined as an incident involving two or more cases, not in the same household, of people who have ingested a common food and have similar symptoms. In 2012, 109 potential foodborne illness outbreaks were identified. Of those, 30 were classified as probable foodborne illness outbreaks comprising 613 illnesses. Norovirus was confirmed as the cause of three outbreaks, clostridium perfringens caused two outbreaks, and salmonella was the confirmed cause of another three outbreaks, resulting in 187 cases of disease. The number of confirmed outbreaks and illnesses is low,

however, due to indeterminate conclusions from investigations. The cost of these illnesses can range from the price of a simple medical visit to more severe cases that result in hospitalization and even death. Research on the cost of salmonella suggests that in 1999 a physician visit for salmonella infection cost $315.[22] Adjusted for inflation, that medical cost would be $408 in 2012. For more severe cases, researchers estimate costs for salmonella to be $5,460,23 and for clostridium perfringens to be $6,400.24. That would work out to between $7,000 and $9,600 per case. These costs are for medical care only and do not take into account the cost to society from lost worker productivity.

The food inspection program is funded jointly by the state and through local fees and taxes. In 2012, the state allocated $7.8 million with the remainder of the $30.1 million program cost coming from local fees and taxes. Based on the number of illnesses identified and investigated with confirmed or probable cause (613 illnesses, using an average cost of $8,300 per case), **medical costs can be estimated to be more than $5 million. In the absence of state inspections and investigations that prevent outbreaks from occurring in the first place, these medical costs would be much higher.**

The state's investment to ensure food safety through local inspections and enforcement has provided enormous savings by guaranteeing timely inspection and follow-up. These measures prevent foodborne illness outbreaks and limit the impact when outbreaks do occur. This service protects the health of Michigan residents; moreover, food safety vigilance safeguards Michigan's tourist economy, allowing it to thrive.

Drinking Water Protection

Working collaboratively with the Michigan Department of Environmental Quality (DEQ), Local Public Health Departments implement drinking water protection programs including the Private and Type III Public Drinking Water Program (P-III) and the Noncommunity Public Drinking Water Supply Program (NCWS). **Approximately half of Michigan's population obtains their drinking water from groundwater source wells.**

In drinking water protection programs, local public health departments conduct pre-drilling site reviews to identify potential sources of contamination in the vicinity of the proposed drilling site. Well permits relay information regarding known and potential sources of contamination, well construction requirements, and water sampling. This "multiple barrier" approach effectively addresses the proper installation of safe drinking water supply wells. In 2012, local health departments conducted 12,598 pre-drilling site reviews and issued 13,171 well construction permits. In the same year, local health departments performed 6,247 post-construction final well inspections. Local health department staff, in cooperation with DEQ Environmental Health Section staff, worked directly with Michigan Registered Water Well Drilling Contractors to provide technical and regulatory guidance. During 2012, an initial well construction code conformance rate of 98.7% was accomplished in the P-III Program.

In the NCWS Program, local health departments also implement routine sanitary survey visits and continuously track federally-mandated water quality sampling requirements. Some examples of NCWS include schools, industries, restaurants, and campgrounds. Michigan has over 9,700 NCWS.

During 2011, there were 1008 Michigan NCWS water systems that were cited for at least one drinking water standard or monitoring violation, which would yield a combined compliance rate of 89.7 % on a state-wide basis. Local health departments then worked with these water suppliers to assure that appropriate water samples were collected or system corrections were made. Utilizing the Environmental Protection Agency's Enforcement Response Protocol, as reported in the federal Electronic Targeting Tool (ETT), the final drinking water quality and monitoring compliance rate for 2011 was 99.8% for the NCWS Program.

On-Site Sewage Management

Nearly one-third of Michigan's homes and businesses are served by On-Site Wastewater systems and the health of Michigan citizens requires that the state's groundwater and surface waters be protected. Effective systems for sewage disposal and vigilant testing of groundwater are two of the most important methods to protect Michigan's waters. Properly disposing of sewage has proven throughout history to protect populations from serious infectious illness, a dramatic public victory that has saved millions of lives. Diseases such as cholera and typhoid that were capable of destroying entire cities are no longer problematic in the United States. Local health departments work with the DEQ On-Site Wastewater Program to survey and approve potential sewage systems within their communities. While quantifying the value of effective sewage disposal and clean drinking water is difficult, the near eradication of diseases such as cholera and typhoid has contributed to the economic success of developed nations.

Public health efforts have made cholera and typhoid outbreaks a things of the past. However, health officials must still be vigilant against other infections, like *E. coli*. In Michigan, some bodies of water have been impaired due to lack of public health oversight, even though our vast reservoirs of quality freshwater set Michigan apart from the rest of the nation, providing a natural competitive advantage.

Many recommendations for protecting the watershed focus on the responsibilities of the local health department to (1) enhance and maintain ongoing water quality monitoring, (2) establish education programs for septic system owners, and (3) institute preventive and corrective action steps for nonfunctional septic systems. Protecting water resources keeps citizens safe, but also affects many sectors of our economy, including agriculture and tourism.

In 2012, local health departments issued almost 11,000 permits for residential septic systems, in addition to conducting 20,000 inspections and performing over 16,500 land evaluations for future sewage systems. Of the 11,000 systems that were permitted by local health departments, nearly 5,000 were permitted to correct failing systems that were impacting public health and the environment.

Historically, where local geology, waste disposal practices, well construction practices, and water sampling frequency have not been routinely monitored or have not been addressed in a coordinated manner, serious water-borne illness events affecting hundreds and in some cases thousands of people have occurred. **The 2004 water-borne illness outbreak at South Bass Island, Ohio in Lake Erie** is one example where the Centers for Disease Control (CDC) concluded that poor well construction practices, poor waste disposal practices, a vulnerable hydro-geologic setting, and lack of routine water sampling **resulted in**

1031 individuals contracting Campylobacter, Salmonella, Giardia, or Norovirus. In addition, E. coli, Clostridium perfringens, Cryptosporidium and Arcobacter butzleri were isolated from various water systems on the island.[22] Similar geology and similar remote, but extensive, residential and recreational communities exist in many parts of Michigan. Local health departments, through their drinking water and on-site waste water management programs, are on constant guard to proactively identify and prevent water-borne illness. Overall, Michigan invests almost $9.3 million annually in support of local health department efforts to ensure clean drinking water and appropriate sewage management. The money saved by preventing just one epidemic far exceeds the costs of these activities.

CONCLUSIONS

Our health departments' ability to (1) administer vaccinations, (2) monitor the spread of disease, (3) screen for STDs, identify (4) hearing and (5) vision deficiencies, (6) protect against foodborne illness, and (7) ensure the safety of drinking water and (8) sewage disposal all undoubtedly contribute to the health and safety of our communities. Communities with lower risk of contracting life-threatening illnesses enable Michigan's residents to contribute to the state's economic growth.

As demonstrated for each of the eight mandated public health services, the investment made by the state provides real economic value and saves money in both direct medical expenses and indirect costs from lost worker productivity. Based on the examples in this report, one can safely predict that every dollar invested in local public health activities creates significant cost savings for the state, while producing better health for Michiganders. Let us also remember that, in preventing and controlling epidemics and identifying and removing environmental hazards, public health *saves lives*. Unfortunately, the efforts of local health departments often go unnoticed by the general public and policy makers, alike. These are investments—in lives and in dollars—that Michigan cannot continue to neglect. **Without a doubt, strengthening local health departments strengthens Michigan**.

NOTES

1 Hippocrates. *On Airs, Waters, and Places*. (Translated by Francis Adams). From http://classics.mit.edu/Hippocrates/airwatpl.mb.txt

2 Michigan Compiled Law, 333.2433.

3 Although on-site sewage inspection and drinking water inspections are considered separate programs, discussion of these two areas will be grouped because they are administered so closely together.

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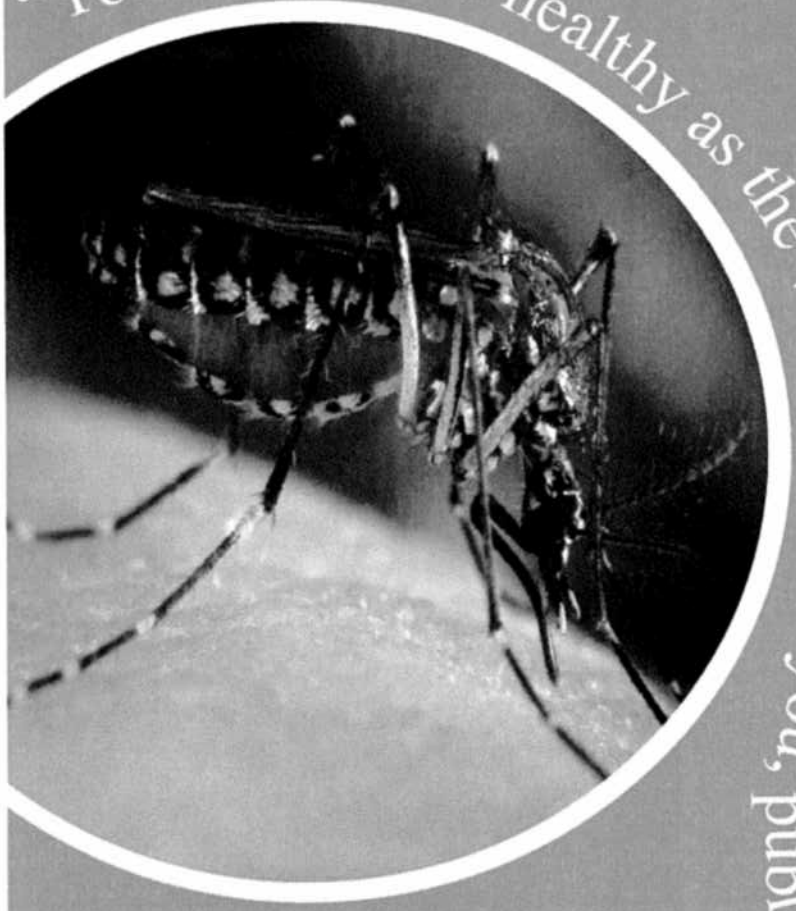
Cover Photo - http://images.nationalgeographic.com/wpf/media-live/photos/000/356/cache/smart-traveler-michigan-road-trip_35682_600x450.jpg

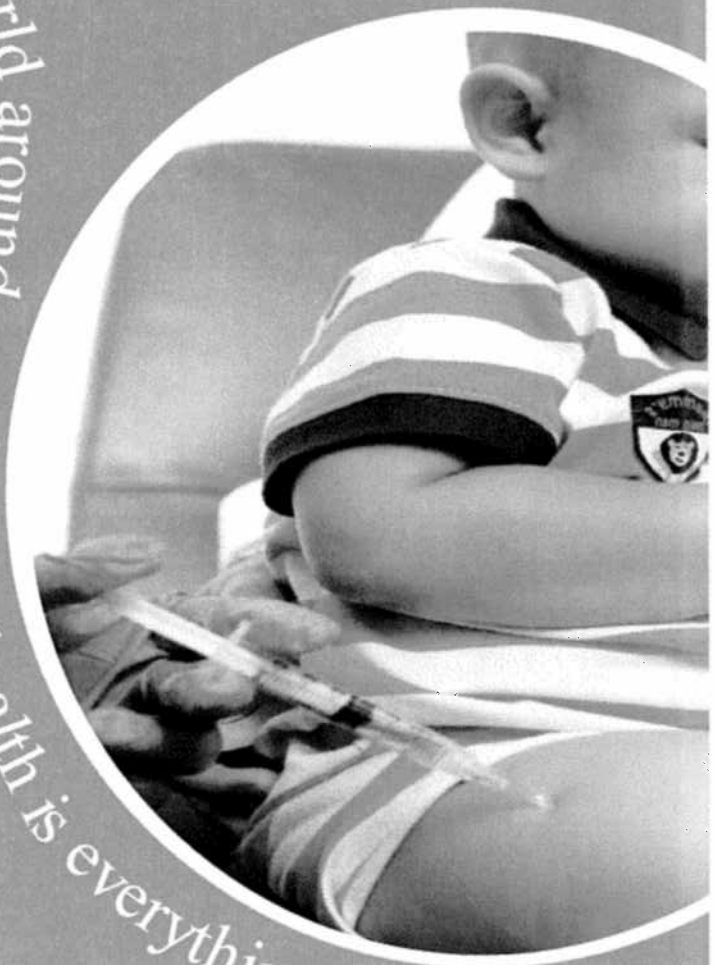
M. Swain

Year In Review

2013

"You are only as healthy as the world around you; public health is everything to everyone."





MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

2013 Year In Review

A Summary of the 8 Essential Services

- Food Protection
- Drinking Water
- On-Site Sewage
- Hearing Screening
- Vision Services
- STD
- Immunization
- Infectious Disease

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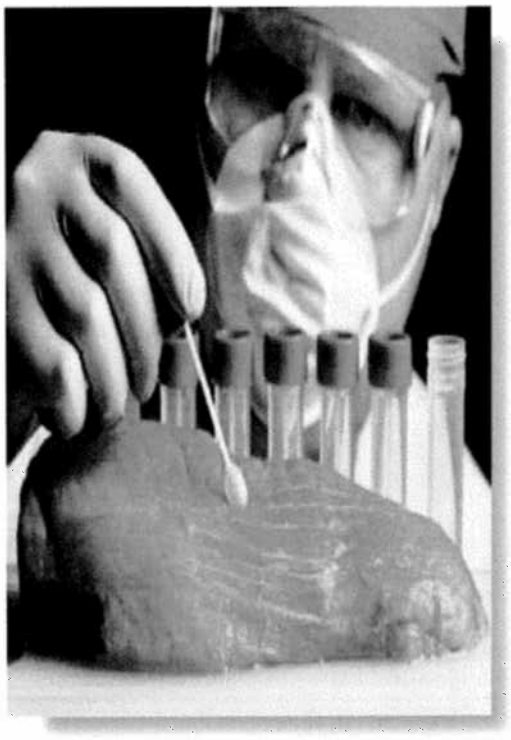
Public Act 368 of 1978

Public Act 368 of 1978 mandates 8 Essential Local Public Health Services (ELPHS) including food service sanitation, drinking water and public water supply, on-site sewage disposal treatment, vision screenings, hearing screenings, sexually transmitted disease services, immunizations, and communicable disease services. The Public Health Code states these programs will be cost shared between the state and locals; however, the present funding distribution is 67% local funds and 33% state funding. It is critical to understand Public Health touches the lives of every Michigan resident multiple times each day. While local health departments (LHD) share common goals of providing safe water, clean air, and protecting the public's health and environment, they individually specialize in implementing strategies that fit the needs of their jurisdiction.

From FY12 to FY13, LHDs remained flat from the ELPHS. The Executive Director from Michigan Association for Local Public Health, Meghan Swain, stated, "Yes, challenging financial times require innovation and creativity, but food, water, environment, and health still need to be protected!" Public health reduces health care costs in often seamless and almost invisible ways. Assuring adequate funding to promote, prevent, and protect your food, water, health, and environment requires a strong and sustainable investment in public health.

Food Service Sanitation



One of the most fundamental responsibilities of public health is the surveillance and monitoring of the food supply from the farm to the table. Both the state and local health departments are responsible for protecting the public through education, licenses, routine inspection of all food service establishments, and the investigation of potential foodborne illnesses. Most of the consultation and field work is performed by the health department and reported to the Michigan Department of Agriculture and Rural Development (MDARD). In FY12, 85,586 food operation inspections were completed by local health departments and a total of 15,795 follow-up inspections were completed to ensure that unmet standards in the initial inspection were corrected.

Local health departments are the last line of defense to ensure that safe and wholesome food reaches the customer and are often the first entities to be contacted to investigate a foodborne outbreak. A total of 109 foodborne illnesses outbreaks were reported in FY12. Through education of food service operators and licensing, local health departments are able to help prevent foodborne illnesses.

	FY11 (Oct.1,10-Sept.30,11)	FY12 (Oct.1,11-Sept.30,12)
Food Operation Inspections (includes temporary)	85,603	85,586
Follow-up Inspections (ALL)	15,234	15,795
Foodborne Illness Outbreaks	92	109

Drinking Water and Public Water Supply

Drinking Water Supply:

The availability of safe drinking water is a basic principle of public health. Water can contain biological, chemical, radiological, or physical components that can cause detrimental acute or chronic health effects, following consumption. To reduce the public's exposure to these potentially harmful agents, local health departments administer Drinking Water Protection Programs that regulate and monitor single family residential water systems and over 9,600 non-community public water supply systems. These programs provide public health protection through inspection and sampling of water supply systems, specification or approval of well design and location, contaminated well rehabilitation, administration of abandoned well plugging requirements, and by providing the public with educational materials related to safe water supply maintenance.

Currently, publicly-owned and private water wells provide drinking water for about 50% of Michigan's residents.

Local health departments administer the Private and Type III Public Water Supply Program under the provisions of Part 127 of Act 368 P.A. 1978, the Michigan Groundwater Quality Control Rules. They issue permits, review drilling and plugging records, and conduct final inspections to assure wells are installed in conformance with construction and location standards and that abandoned wells are properly plugged. The Michigan Department of Environmental Quality (DEQ) reported that in 2012, on a compiled, state-wide basis, LHDs achieved a final well inspection rate of 47.4 percent, and documented the plugging of 5,992 abandoned wells.

Private & Type III Public Water Supply Program	FY11 (Oct.1,10-Sept.30,11)	FY12 (Oct.1,11-Sept.30,12)
Permits Issued	12,140	13,171
Final Well Inspections Conducted	6,418	6,237
Abandoned Wells Plugged	6,000	5,992

Local health departments administer the Noncommunity Public Water Supply (NCWS) Program under the provisions of Act 399 P.A. 1976, the Michigan Safe Drinking Water Act. LHDs issue permits for new NCWS wells, which includes ensuring proper isolation to protect from potential contamination, conduct sanitary surveys of NCWS and oversee and enforce federal and state drinking water monitoring and reporting requirements. In 2011, The DEQ reports 90 percent of Michigan's noncommunity drinking water systems were in compliance, by meeting water quality monitoring and reporting requirements and not experiencing a Maximum Contaminant Level Exceedance.

Noncommunity Public Water Supply Systems	FY10 (Calender Year)	FY11 (Calender Year)
Total Number of Regulated Systems	9916	9753
Total Number of Systems with a Violation*	1806	1008
Percent of Systems with a Violation	18.5%	10.5%

*Calender year data is from the Annual Report on Michigan Public Water Systems Violations report. This report is not yet available for 2013.

Public Bathing Beaches and Swimming Pools

Public Bathing Beaches:

It is necessary to monitor Michigan surface waters that may contain for example, E.coli which is a potential human health risk from partial and total body contact. Local health departments voluntarily monitor the beaches in Michigan. The Public Health Code requires that if a local health department tests a public bathing beach that they are to notify the public, local officials, and the DEQ of the results. Owners of the public bathing beaches must post a sign that states whether or not the bathing beach has been tested, and if so where to find the results. The availability of funds increases the number of counties where beaches can be monitored. In 2012, only 57 out of the 83 counties monitored at least one beach within their county.

	2011 (Calender Year)	2012 (Calender Year)
The Number of Beaches Monitored in Michigan	410	418
The Number of Beach Monitoring Inspections (including follow-up inspections)	4,844	5,609

Public Swimming Pools:

DEQ requires a permit when building a public swimming pool. DEQ records indicate that LHDs made 7,625 pool inspections in 2011 and 7,522 in 2012. Multiple inspections for a pool occur from follow-up inspections due to a violation.

	2011 (Calendar Year)	2012 (Calendar Year)
Licensed Pools Inspected	5,482	*5,373

*The Public Swimming Pool program runs on Calendar year. Not all inspection reports were received and entered as of Jan. 6, 2013 for the 2012 Calendar Year. This number is the projected total inspections that include pending inspection reports.

On-Site Sewage Treatment Management

To protect and enhance the quality of surface and groundwater resources and to prevent adverse impact upon the public health by reducing sources of water contamination, it is necessary to have management identify system defects and health hazards. Local health departments, through performing site evaluations and inspections, issue permits to both public and commercial facilities. The permits detail the construction of the septic tank to prevent damage to property and injury to plant or animal life and secure remedial actions. Once a septic system is installed, a final inspection is conducted to assure that the system is installed in compliance with the permit. In both FY11 and FY12, almost half of residential and non-residential permits issued resolved failures of existing systems.

	FY11 (Oct.1,10-Sept.30,11)	FY12 (Oct.1,11-Sept.30,2012)
Residential Septic Permits	9,973	10,742
Residential Septic Failures Corrected	4,822	4,655
Non-Residential Septic Permits	640	563
Non-Residential Septic Failures Corrected	258	218

Hearing and Vision Screening

The Michigan Public Health Code requires screening during preschool for ages 3-5 and in schools during grades K, 2, and 4 (Hearing) and grades 1, 3, 5, 7, and 9 or in conjunction with driver's training (Vision). The Michigan Department of Community Health (MDCH) Hearing and Vision Program services are provided at no cost (FREE) by local health departments in collaboration with local schools and preschool centers, including Head Start. A total of $5.125 million was allocated to the MDCH Hearing and Vision programs costing on average in FY12 $5.58/child for a hearing screening and $4.17/child for a vision screening.

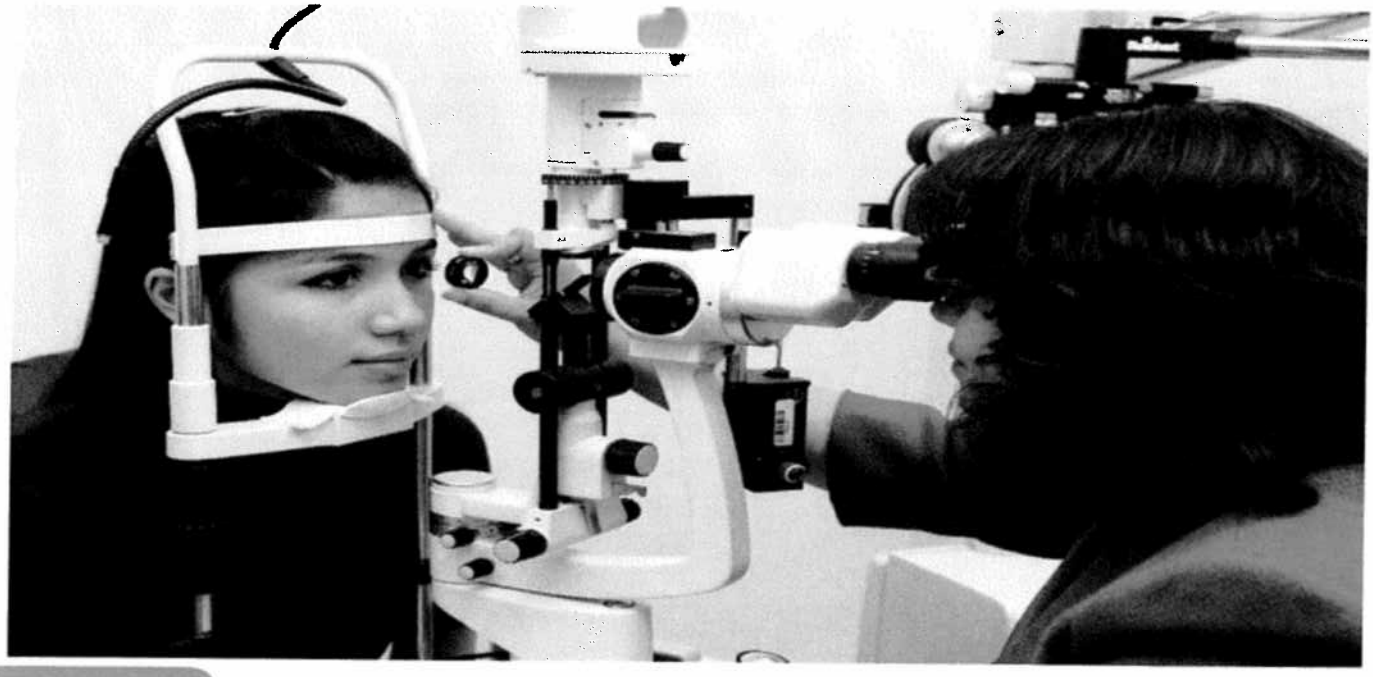
Hearing

	FY11 (Oct.1,10-Sept.30,11)	FY12 (Oct.1,11-Sept.30,12)
*Preschool Screenings	91,616	81,531
*Preschool Referrals	3,639	2,911
*School Screenings	360,277	332,250
*School Referrals	12,513	11,976

Vision

	FY11 (Oct.1,10-Sept.30,11)	FY12 (Oct.1,11-Sept.30,12)
*Preschool Screenings	135,757	89,735
*Preschool Referrals	10,448	5,955
*School Screenings	470,552	474,284
*School Referrals	52,540	51,388

* Not all hearing and vision screening and referral reports were received and entered as of March 21, 2013 for the 2012 Calendar Year.



Sexually Transmitted Disease (STD) and Human Immunodeficiency Virus (HIV)

Cases of STDs are required under the Public Health Code to be reported to local health departments to ensure appropriate care is provided and to execute a quick follow-up for priority cases. Patients and their sex partners treated early avoid the high costs associated with managing complications and preventing the spread of infection. All local health departments are mandated to provide STD services to persons presenting for care. Outreach and education are also provided by local health departments through schools and other community settings.

STD:

STDs, including chlamydia, gonorrhea, and syphilis result in excessive morbidity, mortality, and health related costs. In recent years, due to shrinking resources, there have been a decreasing number of STD clients seen in local health department clinics. Local health departments are forced to prioritize their services to those at highest risk from limited capacity which in turn demonstrates a high number of positive rates.

	FY11 (Oct.1,10-Sept.30,11)	FY12 (Oct.1,11-Sept.30,12)
*# of Chlamydia Cases	48,870	47,939
*# of Gonorrhea Cases	12,830	12,587
*# of Early Syphilis Cases Reported	394	411
**# of Syphilis Tests (by LHD STD clinic)	37,552	34,864
**# of Gonorrhea and Chlamydia Tests (by LHD STD clinic)	50,967	42,739
Positive Rate for Gonorrhea and Chlamydia Tests (by LHD STD clinic)	14.8%	14.0%

*The number of cases represents the morbidity within each jurisdiction. This is based on the county of residence of the infected individual. 80% of cases from local health departments come from non-LHD providers (private docs, ERs, urgent care, etc.) Local health departments conduct follow-up on these cases for treatment, risk education, and partner elicitation.

** The number of tests, per jurisdiction, represents the number of clients that were tested in that jurisdiction's STD clinic. It is NOT based on the client's county of residence. It is a reflection of clinic activity.

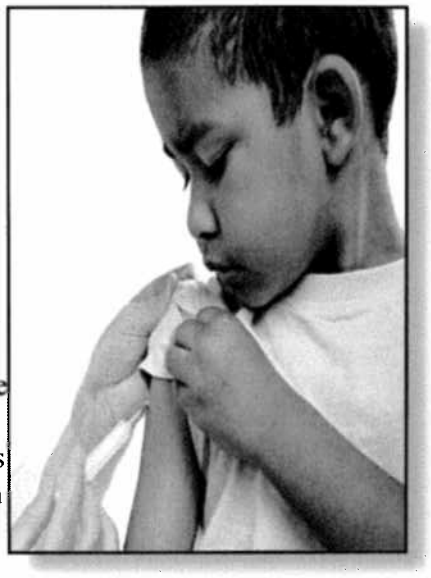
HIV:

The Centers for Disease Control and Prevention (CDC) "core" funding is the primary source of funding supporting HIV testing in local health departments. CDC has issued a funding formula that cut Michigan HIV Prevention program by $1.7 million (22%) for FY12. This formula has immediate and serious negative implications for Michigan. By 2014, when the CDC funding formula is fully implemented, Michigan losses will total up to $2.1 million, which represents a reduction of 33% of our current funding level that covers HIV testing, prevention for positives, health education and risk reduction for high risk negative individuals, and community-level interventions.

Michigan will also lose up to $883,000 (35%) of the award that supports HIV testing in health care settings in FY12. This award supports the implementation of standard of care HIV testing in health department STD clinics.

	FY11 (Oct.1,10-Sept.30,11)	FY12 (Oct.1,11-Sept.30,12)
New Cases of HIV diagnosed at Local Health Departments	146	131
HIV Tests Conducted at LDH	47,412	41,627

Immunization



Vaccinations are considered one of the 10 great public health achievements of the twentieth century. Vaccines dramatically reduce infectious disease in Michigan by protecting both the individual and the community. LHDs play a critical role in protecting Michigan's citizens against vaccine-preventable diseases. LHDs worked with the Division of Immunization to process over $86 million in Vaccines for Children (VFC) and public funds and helped to monitor the distribution of this vaccine to VFC providers serving underinsured and uninsured children and adults in Michigan. In addition to providing vaccines to the most vulnerable, LHDs also play a significant role in healthcare provider immunization service delivery systems and consumer education about vaccines. LHDs provide VFC compliance visits, quality assurance visits through the Assessment, Feedback, Incentives, and eXchange (AFIX) program and office education for physicians, nurses and medical assistants through Immunization Nurse Education (INE) trainings.

The following 2012 data points illustrate the instrumental role LHDs play in the prevention of vaccine-preventable diseases in Michigan:

	2012
Public Vaccine Management and Oversight	$86 million (1,780,540 doses of vaccine)
VFC Compliance Visits	1,088
Provider (AFIX) Quality Assurance Visits	1,016
Education (INE) Visits	492
Doses Administered by LHDs in MCIR	487,990

Infectious Disease

Reports of infectious diseases from local health departments, physicians, and laboratories are collected and aggregated at the county level to monitor the health of the population and to provide the basis for preventive actions. In fiscal year 2012, there were approximately 83,500 cases of individual reportable diseases and conditions, which was about one thousand fewer than the prior fiscal year. These numbers do not include the many non-reportable diseases and conditions such as head lice, strep throat, stomach flu, or influenza-like illnesses which are also captured in the Michigan Disease Surveillance System. Notable decreases were seen in FY12 in the number of West Nile Virus and Shingles cases reported down 82% and 35% respectively.

Local health departments provide various communicable disease services such as childhood immunization clinics, animal bite consultations and sexually transmitted disease treatments. In addition, local health departments serve on the frontline of communicable disease outbreak investigations, to minimize the local impact of disease transmission and to implement control measures to prevent future outbreaks.

For a complete list of reportable diseases in Michigan for 2011 as required by the Michigan Public Act 368, go to: http://www.michigan.gov/documents/Reportable_Disease_Chart_2005_122678_7.pdf

	FY11 (Oct.1,10-Sept.30,11)	FY12 (Oct.1,11-Sept.30,12)
Total cases of reportable disease	84,245	83,462

"In today's world, it is shortsighted to think that infectious diseases cannot cross borders."

Senator Ron Wyden - Oregon

Tuberculosis (TB)

TB is a contagious bacterial infection that is spread through the air and attacks the lungs, but may spread to other organs. In 2011 (Calendar Year), 170 active TB disease cases were reported by Michigan health departments, and provisional data for 2012 indicates 149 total active cases. The standard of care for treating tuberculosis is directly-observed therapy which involves a LHD staff member meeting in-person with the patient to deliver each dose of medication and watch the patient consume each dose.

The average period of treatment for TB is 6 months, although complications such as other concurrent diseases or drug-resistant TB may extend this period up to 24 months. Some TB patients require intensive case management to assure completion of treatment. Examples include patients who are homeless or substance-addicted, where the health department may need to coordinate assistance for housing, food, or substance abuse rehabilitation in order to assure the patient's compliance and completion of therapy.

Because TB is transferred through the air, the LHD must also track the number of "contacts" with whom the TB patient has been in close or frequent contact (e.g. family, friends or coworkers). These contacts require evaluation to determine if they were infected with TB. Identifying and properly managing contacts to TB patients is very time and resource intensive. Patients with active TB disease provide sputum specimens for microbiological testing. One such test is referred to as a "smear," and patients who are sputum-smear positive are more likely to transmit disease than those who are sputum-smear negative. Therefore, contacts to sputum-smear positive patients are given the highest priority for evaluation and follow-up. 2011 preliminary data shows 706 people were in contact with a sputum-smear patient.

Types of TB Cases for Investigation

	2010 (Calender Year) Active Case: Sputum smear +	2011 (Calender Year) Active Case: Sputum smear +
Cases for Investigation	59	53
Number of Contacts	1,071	706
Evaluated	870	619
TB Disease	6	11
Latent TB Infection	140	122
Started Treatment	103	101
Completed Treatment	56	68

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

DCH SC 2/24/14
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2014 MDCH Budget
House DCH Subcommittee on Appropriations
February 24, 2014

Chairman Lori, and subcommittee members. I bring greetings from Jackson County. My name is Richard Thoune. I am the Director of the Jackson County Health Department and the Health Officer for Jackson County and Allegiance Health System. Thank you for allowing us to share the perspective of local health departments on the proposed 2014 budget for the Department of Community Health.

The purpose of my testimony today is to ask for your continued support of essential resources that we need to protect and promote the health of our communities, to highlight the importance of local public health departments, and the essential relationships and infrastructure that are necessary to achieve a community health integrated system 3.0.

We are very thankful for the restoration of $2 million for essential local public health services in 2013. Our local data show that the volume in these 8 essential services to the public increased between 2% and 6%. We are confident that if the legislature is able to restore funding to pre-recession levels with an additional $1.7-$2 million allocation that we can achieve a similar increase in 2014.

Jackson stakeholders have collaboratively defined goals of improving health status, the experience of care, and reducing per capita cost of care for the regional population of Jackson, Michigan. Population health improvement is key to the transformation of the local, state and federal health systems that serve us today. In Jackson County, we are dedicated to creating healthy communities. Since 2010, our collaboration and collective impact efforts have moved us from a county health ranking of 65 to 48 in health outcomes among Michigan's 82 counties. But we still have a long way to go to achieve our goal of being the healthiest community in Michigan. Too many of our residents report poor physical and mental health days, adult smoking and obesity, a lack of physical activity, and too many teen births. But we are making progress in addressing these health factors. Working side by side with our health system and other community partners, we are aligned with one community health needs assessment process, one community health action plan, one clinically integrated health network, and multiple health action teams that align with Michigan's 4x4 plan.

Through our partnerships, we are confident that we can make a long term contribution to reducing health care costs by continuing to address the number one preventable cause of death in our community and state, tobacco smoking. We know that the state is interested in smoking cessation because it is tracking the number of adults who smoke through the state's dashboard. It is a key healthy behavior in

Michigan's 4x4 plan. A steady 23 percent of Michiganders were smokers in 2011 and 2012. That's above the national average of 19.6 percent who did in 2012. In the city of Jackson, 35% of residents are smokers. Both the smoke free air law and cigarette tax are necessary tools that help reduce smoking. I also want to acknowledge Representative Shirkey's significant efforts to expand access to health care for 7,000-9,000 Jackson County residents through the Healthy Michigan Plan. This plan will cover some drugs and counseling services to help people stop smoking. But it is likely that they will not be enough to get the job done.

While we understand that there are a lot of competing needs for use of Michigan's tobacco settlement money, don't we need some of that money for smoking cessation and tobacco prevention? Exactly $0 of the $279 million in tobacco settlement dollars that came into Michigan last year went toward tobacco prevention. The state generates $1.2 billion per year in tobacco related revenue, but will only spend a total of $1.5 million for tobacco prevention and control. Michigan should spend $121 million to adequately fund tobacco prevention and cessation programs. There is good evidence to show that if the state did spend money, we could make an impact on preventing youth from smoking and helping current smokers quit. You can help local communities, health departments and the state reduce tobacco smoking by considering allocating just 10% of the tobacco settlement dollars for prevention and control. We could be saving thousands of lives in our state.

Despite our challenges, visionary leadership within the non-profit and business sectors has distinguished Jackson as hotbed of innovation and collaboration. Perhaps because of our long-standing resource challenges, Jackson's community leaders have become creative, resourceful, collaborative conveners and display an undaunted willingness to challenge the status quo. To improve population health, public health and healthcare must be inextricably linked to, and mutually support, one another. In 2013, Jackson County and Allegiance Health entered into a very innovative and progressive agreement to share Health Officer services, creating an integrated position responsible for administrative leadership of the county health department as well as systems-level improvement efforts in public health, primary care coordination and clinical-community linkages. Efforts are already underway to link public health services through the Jackson Community Medical Record, create closed loop referral processes, assess of burden of mental Illness in Jackson County, review ambulatory sensitive conditions within preventable hospitalizations, align the clinically integrated Jackson Health Network metrics to community health assessment results and action plans, and develop a community level score card.

The Jackson County Health Improvement Organization, clinically integrated accountable system of care represented by the Jackson Health Network, engagement with employers and payers in innovative reimbursement strategies, and health information technology use position Jackson County as an ideal candidate to consider as a site to test Michigan's State Healthcare Innovation Plan. We believe our model is scalable, sustainable and can be replicated elsewhere in the state.

Thank you for your kind attention and I would be happy to answer any questions you may have.

Sincerely,

Richard J. Thoune

Richard J. Thoune, RS, MS, MPH
Health Officer

DCH SC 2-24-14 Kathy Forzley

Michigan House Appropriations: Community Health Subcommittee

Oakland County Testimony - February 24, 2014

Presenter: Kathy Forzley, Health Officer/Manager Oakland County Health Division
Oversees more than 40 prevention programs serving a population of 1.2 million

Purpose: Local Public Health (LPH) is an excellent investment to prevent disease and injury through community wide programs, strategies and collaboration.

LPH is Unique: LPH has a skilled, multidisciplinary workforce (Nurses, Sanitarians, Epidemiologists, Nutritionists, Health Educators, Physicians, and others)
LPH knows their community through the daily delivery of essential services, assessment, disease surveillance and collaboration
LPH builds relationships and connects people to resources to support health

Essential Services: Essential Local Public Health Services supports healthy communities.
Oakland County, fiscal year 2012-2013:

Immunization and Infectious Disease Control

- 60,264 immunizations were administered (including flu)
- 10,996 clients received Sexually Transmitted Infection services
- 10,521 Tuberculosis skin tests were provided
- 10,625 HIV tests given
- 2,484 communicable disease reports investigated

Environmental Health

- 41,192 drinking water samples analyzed
- 15,964 food service sanitation inspections
- 833 food service complaints investigated
- 1,629 well permits issued and 804 water wells inspected
- 774 septic permits issued
- 1,276 public pool inspections

Hearing Screenings:

- 55,732 hearing screenings

Vision Screenings:

- 70,043 vision screenings

Education Based: More than numbers of inspections and visits, LPH is education focused so that people not only know what to do and how to do it, LPH works to help them understand why. LPH provides information, education, technical expertise, and training to support individuals, food establishments, well drillers, and septic installers to promote healthy people and successful businesses.

One Example: Immunization Program

- As the largest provider of immunizations in the community we can share valuable expertise
- LPH provides important support to medical providers to increase their vaccination rates
    - In Oakland County we provide support for 137 Vaccine for Children (VFC) providers
    - Over a third of the more than a half million vaccines given to children under 18 in Oakland County were given by these VFC providers
    - LPH ensures the safety of VFC vaccine storage and handling at each provider office
    - LPH provides technical assistance in the delivery of a complex immunization schedule (10 vaccines - 34 immunization doses required by kindergarten)
    - LPH brings providers together to provide tools and information and facilitate dialogue to assist them as they encourage parents to immunize their children
- LPH works alongside schools to ensure students are vaccinated to minimize risk of vaccine preventable disease in school
- LPH works to reduce waiver rates through school by school and one on one interaction with parents
- LPH sends out recall/reminder notices and implements phone tree technology to increase return visits at appropriate intervals for vaccination boosters
- Oakland County utilizes a nurse in WIC to increase access to vaccinations at the time of WIC visits
- Oakland County has also integrated a public health nurse in the PACE unit to increase access to services and vaccinations for this vulnerable population
- LPH provides consistent messaging in the Community - advertisements, articles, social media and presentations to educate and inform about vaccinations

Collaborators: Through assessment, disease surveillance, and relationships across all systems of care (healthcare, human services, education, etc.) LPH maintains a big picture (macro view) of health in the community. LPH utilizes this information, skills and experience to convene and facilitate partnerships/collaborations/coalitions to address public health issues and move from problem assessment to action.

Partnerships and collaborations support the essential public health services delivered by local health departments by extending our reach into the community. Partnerships lead to stronger local sustainability, leveraged resources and decreased duplication.

- In Oakland County we have developed and continue to maintain and facilitate 10 collaborations bringing together **almost 140** partners to employ innovative strategies to address complex health issues.

- Best Start for Babies (BSB)
- Energizing Connections for a Healthier Oakland (ECHO)
- Hospital Partnership
- Healthy Oakland Partnership (HOP)
- Healthy Pontiac We Can! (HPWC!)
- Homeless Healthcare Collaboration
- Fetal Infant Mortality
- Long-Term Care Partnership
- Oakland County Suicide Prevention Task Force
- Tobacco Free Oakland Coalition (TCOC)

Innovative: On February 12th, our County Executive, L. Brooks Patterson delivered his 20th State of the County Address, during which, he identified programs of excellence that contribute to quality of for those who live, work, play or worship in Oakland County. During his address, Mr. Patterson highlighted the Oakland County Health Division (OCHD) for its work to develop the Homeless Healthcare Collaboration as an innovative initiative to address a complex public health issue in our community. He described the value of this effort in terms of uniting 49 community partners dedicated to improving access to healthcare for those that are experiencing homelessness and developing solutions to reduce avoidable hospital stays to reduce healthcare costs.

Strategic: Oakland County Health Division has launched Energizing Connections for Healthier Oakland (ECHO), a county-wide health improvement initiative focused on achieving a community where every person that lives, works, attends school, worships, or plays in Oakland County is a healthy person.

- ECHO teams will conduct 4 unique community health assessments
- ECHO will develop a Community Health Improvement Plan
- ECHO will develop strategies to improve health in the community
- ECHO is overseen by a cross-sector Steering Committee with representatives from healthcare, human service agencies, non-profit and community-based organizations, mental health providers, academia, and other Oakland County agencies.
    - Steering committee – **32** individuals from **29** organizations representing **22** sectors in the community

Leveraged Funding: Healthy Pontiac, We Can! collaboration began in 2011 in response to a $15,000 Building Healthy Communities planning grant. Since then, we received additional funding through MDCH 4 X 4 Health and Wellness grants to initiate numerous successful and sustainable efforts that have encouraged 39 plus partners to get involved and stay engaged in this important initiative. (See separate insert for more initiative details).

- 4 X 4 has provided seed funding for sustainable initiatives
- OCHD has leveraged 4 X 4 funded initiatives to maximize results and ROI

Making a Difference: LPH utilizes a comprehensive approach to leverage the skills, resources and benefits of a multidisciplinary workforce, essential services and community collaborative strategies. As a result LPH is able to get results and move the needle on complex public health issues. One example is infant mortality. Without LPH, community wide efforts to reduce infant mortality would not occur or would be unfocused, fragmented and not data-driven.

Role of LPH in addressing infant mortality

- OCHD has initiated community partnerships to address the various issues contributing to infant mortality (monthly meetings).
- Initiated Fetal Infant Mortality Review (FIMR) process in 2000 to gather data on contributing factors for infant mortality in Oakland County. This data has informed and focused all of our IM reduction efforts in the community ("data-driven initiatives").
    - Contributing factors identified: prematurity (driven by infection, obesity, and substance use), positional asphyxia, and congenital anomalies.
- Initiated Best Start for Babies – community action team responding to the recommendations made by the FIMR case review team to prevent infant death through education and community partnership. This results in improvement of service systems and implementing policies that will define and maintain quality maternal/child health programs.
    - Facilitates networking, best practices and focused direction
    - Currently community initiatives focused on promoting breastfeeding & safe sleep
    - Past efforts also included emphasis on inter-conception care
    - Active partners include representatives from
        - Medicaid managed health plans
        - OB-GYN and Family Practice providers
        - Many human service agencies OFS, OLHSA, Care House, Centro Multicultural, Birthing hospitals, DHS, FQHCs, Zeta Phi Beta Sorority, etc.
- PHN home visits to at-risk pregnant women to facilitate healthy pregnancy and delivery
- Initiated Nurse-Family Partnership program: evidenced based strategy for first-time, at-risk, low income mothers.
- Initiated the Nurturing Parenting Program: evidenced based parenting curriculum for at risk clients
- Integrated services for at-risk clients
    - WIC/Imms
    - WIC/PH Nurse home visits/PH Nutritionist
    - General Clinic/pregnancy testing and teaching re results

- General Clinic/Medicaid enrollment for prenatal care
- PH Nursing/Nutrition services
- PACE PHN resources and follow-up for pregnant women

Data: Refer to attached trend line
Comprehensive community wide, focused efforts have had a significant impact on African American infant mortality disparities in Oakland County. If the African American infant mortality trend line had stayed steady instead of trending down, an additional 156 African American infants would have died.

Attachments:
Detroit News Editorial
Homeless Healthcare Collaboration Partnerships
4 X 4 Health and Wellness Funding Drives Healthy Pontiac, We Can!
Oakland County Infant Mortality Rate

K. Forzley

The Detroit News

Opinions + Editorial

February 21, 2014 at 1:00 am

OUR EDITORIAL

Editorial: Oakland shows right way to weave safety net

An Oakland County initiative to provide health care for homeless offers model of government action

Purchase Image

Oakland County Executive L. Brooks Patterson (John M. Galloway / Special to The Detroit News)

L. Brooks Patterson leads one of the nation's most affluent communities, but that doesn't mean Oakland County is immune to homelessness. So the Oakland County executive is making indigent health care a priority — without expanding the bureaucracy.

Instead, the county is working to organize existing programs in a targeted approach.

"Bring resources together," Patterson said of the initiative.

In his State of the County speech last week, Patterson introduced the Oakland County Homeless Healthcare Collaboration, an initiative that began in 2012. The county's Department of Health and Human Services coordinated more than 40 health care and service agencies, and they're working to close gaps that exist when it comes to caring for the homeless.

Patterson describes the program as both humane and fiscally responsible. Its primary goal is twofold: Reducing health care costs by diminishing the number of hospital admissions and repeat emergency rooms visits, while at the same time making sure the homeless have access to reliable medical attention.

Health officials decided to act after a county "nurse on call" hotline reported an increase of individuals in financial distress who needed care. Also, Oakland Schools had noticed a rise in homeless students. Officials realized there was ineffective communication among county service providers.

The group Michigan's Campaign to End Homelessness reports that, in 2011, Oakland County had more than 3,000 homeless individuals. In Metro Detroit, that number jumps to around 27,000.

The Oakland County collaboration pulls together hospitals, shelters, clinics and food providers. It offers one place that health care agencies can go to discuss both homelessness and the health care needs of these individuals. And it has created a portal where these partners can share useful information. "There are many different and varied partners," says Kathy Forzley, Oakland County's Health Division manager.

Forzley and her team are working on raising funds for places where the homeless can go to fully recover after being released from the hospital. Too often, the homeless end up back in the ER because they don't get the follow-up care they need.

Patterson upheld the Hope Hospitality and Warming Center in Pontiac for the way it provides this type of assistance, known as "step-down care" in the medical community.

This model of care has the potential of saving hospitals a significant sum in uncompensated care. And Forzley notes homeless individuals at the center are also connected to other community services. So it benefits them, too.

"It offers a more stable place while they are getting back on their feet," Forzley says.

This approach is government at its best. Through coordinating existing services, many of them delivered by non-governmental agencies, the county is improving the quality of life for some of its most vulnerable citizens

From The Detroit News:
http://www.detroitnews.com/article/20140221/OPINION01/302210001#ixzz2tz4LRpUB

K. Forzley

OAKLAND COUNTY

Homeless Healthcare Collaboration

Community Resources Working Together

Improving the Health and Well-Being of Persons Experiencing Homelessness in Oakland County by Coordinating Resources of Community and Health Care Organizations

OAKLAND COUNTY MICHIGAN Department of Health & Human Services HEALTH DIVISION oakgov.com/health

gary burnstein

Oakland Integrated Healthcare Network

OLHSA A Community Action Agency

MPRI

DOCTORS HOSPITAL

Arab American and Chaldean Council ACCESS

HOPE

OAKLAND COUNTY MEDICAL CONTROL AUTHORITY

CONTINUOUS INDEPENDENCE PROGRAM Substance Abuse Rehabilitation Facility

ST. JOSEPH MERCY OAKLAND

OaklandSchools

Common Ground

Lighthouse of Oakland County

TPN

Henry Ford HEALTH SYSTEM

OAKLAND COUNTY MICHIGAN Department of Health & Human Services CHILDREN'S VILLAGE oakgov.com/childvil

ST. JOSEPH MERCY OAKLAND Mercy Place

COVENANT COMMUNITY CARE

SOS

John D. Dingell VA Medical Center

HAVEN

OPHS

MERCY MEMORIAL HOSPITAL SYSTEM

DEPARTMENT OF HUMAN SERVICES

OAKLAND HEALTH PLAN

OTMC

Beaumont HEALTH SYSTEM

BALDWIN CENTER

Michigan Primary Care Association

FAMILY FOCUS Health Services Where family health comes first

COMMUNITY MENTAL HEALTH CMH AUTHORITY

Catholic Community Response Team

BOTSFORD HOSPITAL

ALLIANCE for HOUSING

Welcome Inn Day Center for the Homeless

Pontiac Housing Commission

OAKLAND COUNTY MICHIGAN Veterans' Services

TRAINING AND TREATMENT INNOVATIONS

Community HOUSING NETWORK Opening Doors • Transforming Lives

JAIL MINISTRY Jail & Outreach Ministry

St JOHN PROVIDENCE HEALTH SYSTEM

Easter Seals

Personalized Nursing LIGHT

ERNCARE

Oakland County Health Division North Oakland Health Center 1200 N Telegraph 34E Pontiac Michigan 48341 | Nurse-On-Call Public Health Information Hotline 800.848.5533

The Oakland County Health Division will not deny participation in its programs based on race, sex, religion, national origin, age or disability. State and Federal eligibility requirements apply for certain programs. condiff/HomelessHealthcareCollaboration/09-05-2013

Michigan's 4 x 4 Health and Wellness Funding Drives Healthy Pontiac, We Can! Success

Oakland County Health Division (OCHD) is the convener and facilitator of the Healthy Pontiac, We Can! Coalition. OCHD provides technical support to assess need, prioritize issues and create and implement action plans. Strategies implemented are best practice, research based or research informed, increasing the feasibility of effective impact on community knowledge, healthy choices and overall health.

Partnership Background for HPWC

- **HPWC consists of about 39 member agencies** representing diverse community sectors and community members.
    - We are working with local small business, the downtown business association, the Regional Chamber, local government, and planning and economic development, in addition to more traditional partners like hospitals, schools, universities, and clinics.
- The broad membership participation increases the sustainability of group efforts by multiple agencies sharing the time and resource commitments needed to implement community based projects successfully. Through these collaborations, we can:
    - maximize our reach
    - decrease duplication
    - address gaps

Funding

- Since 2011, HPWC has received Healthy Michigan Funds to support coalition efforts to increase healthy eating, physical activity, and tobacco free living in the city of Pontiac.
- These funds are essential to developing partnerships that facilitated completion of a city-wide needs assessment, developing a 3 year strategic plan, and implementing selected priority projects to begin moving the needle on wellness in this community.
- The foundation provided by Healthy Michigan funds has been essential in the coalition securing additional local and federal resources to implement community-based public health interventions. Resulting in an additional $1.36 of federal and local funds for every $1 of state funding awarded.

Fiscal Year	Grant	Funding amount
2011	MDCH: Building Healthy Communities Planning Grant	15,000
2011-2012	MDCH: Building Health Communities Implementation Grant	9,000
2012-2013	MDCH 4 x 4 Health and Wellness Grant	94,563
2013-2014	MDCH 4 x 4 Health and Wellness Grant	100,000

HPWC 2011-2014	
Grant Funds through MDCH's 4x4 Health and Wellness Grant	$218,563
Other State, Local, and Federal Resources Leveraged	$298,143
2012-2014 4 x 4 Funded Reach	87,354
ROI	$2.50/person For every dollar of state funding awarded to OCHD, $1.36 of federal and local funds were leveraged.

- OCHD drives these initiatives by providing technical assistance and seed funding for community based projects. These projects then stay in the community's hands, allowing for ownership of local resources.

With the support of the **Michigan Department of Community Health's Michigan Health and Wellness 4 x 4 Implementation Grant** HP, WC! partners are **developing new local initiatives that assist Pontiac residents in making healthier choices including:**

- **Improved Healthy Food access**
  - Increased access to fresh produce by supporting three neighborhood produce markets that accept SNAP/Bridge Cards. Locations at:
    - All Saints' Church @ 171 West Pike Street
    - OLHSA @ 196 Cesar E. Chavez Avenue - New in 2013
    - St. John's Church – New in 2012
  - Provided healthy recipe demonstrations at produce markets and local soup kitchen
  - Produced bi-lingual signage for All Saints' Produce Market

- **Increased Physical Activity**
  - Encouraged residents to join local walking clubs and new fitness classes by promoting the "Catch Ya Physical Activity Challenge"
  - Added a Clinton River Trail sign at Beaudette Park to ensure trails are easier to find
  - Installed adult fitness stations in the Oakland Park playground so parents can get active

- **Created Healthier Before and After-School Programs**
  - Worked with the Baldwin Center and Pontiac School District to get kids more active and eating healthier while in their care.
    - Trained staff to use the Coordinated Approach To Child Health (CATCH) evidence-based program to create a fun physical activity time and encourage healthy eating
  - Set youth physical activity and nutrition standards at the Baldwin Center
  - Restructured two community gardens to supply fresh produce to Baldwin Center's Community Summer Feeding Program: "Meet Up & Eat Up"

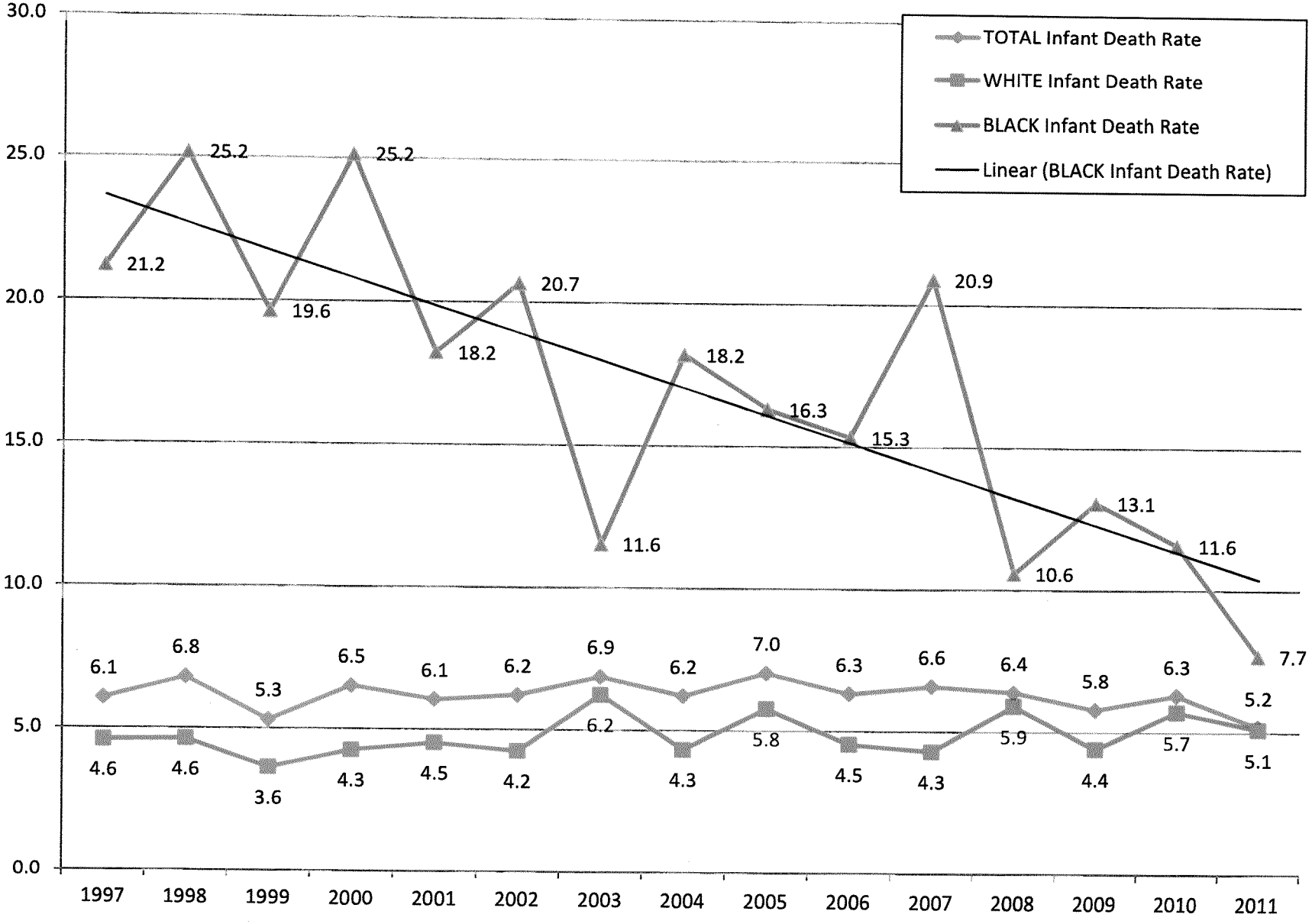
- Purchased soccer equipment for Centro Multicultural La Familia's Soccer League

In 2014 HPWC 4x4 Projects include:

- Add a new walking trail with promotional signs in city parks to make trails more accessible for all residents
- Continue the "Catch Ya Physical Activity Challenge" so residents can remain physically active for free or low-cost
- Sponsor a Healthy Food Retailer Program, called Healthy Bites, to make buying healthy foods for grocery stores or restaurants easier
    - Demo healthy recipes at participating Healthy Bites retailers to show community members how eating healthy can taste great on a budget

Oakland County Infant Mortality Rate

1997-2011



Source: MDCH 10-30-13
2010 IMR Michigan: All Races: 7.12; White: 5.5; Black: 14.2

DCH SC 2-24-14
Melissa Seiter/Al Pope

AARP
Real Possibilities

AARP Michigan
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Suite 110
Lansing, MI 48933

T 1-866-227-7448
F 517-482-2794
www.aarp.org/mi

February 24, 2014

The Honorable Matt Lori, Chair, and
Members of the House Appropriations Subcommittee on Community Health
P.O. Box 30014
Lansing, MI 48909-7514

Re: ***FY 2015 Department of Community Health Budget***

Dear Chairman Lori and Members of the Committee,

We are writing on behalf of AARP Michigan to highlight our support for several items in the proposed FY 2015 Department of Community Health budget.

MI Choice Home and Community-Based Services (Medicaid). AARP supports the proposal in the Governor's FY 2015 Budget Recommendation to increase funding by $9 million general fund ($26.2 million gross) for the MI Choice Medicaid waiver program.

AARP supports the expanded availability of Home & Community Based Services (HCBS) for people who need long term care, and we support continued efforts toward "rebalancing" Michigan's long term care system – that is, providing a greater proportion of long term care services through HCBS, rather than in institutional settings. We know that the overwhelming majority of Michigan voters want to avoid ever living in a nursing home. If or when they need long term care services, they prefer to stay at home, or in a home-like, community setting.

In addition to the human benefits, **rebalancing Michigan's long term care system would save taxpayer dollars**. As discussed further in AARP Michigan's March 2012 white paper for the Michigan Legislature (*Consumer-Focused, Cost Effective Long Term Care for an Age-Friendly Michigan),* a national analysis published in 2011 found that the use of HCBS produced an average annual public expenditure savings of $57,338 per participant. On average, Medicaid dollars can support nearly three older people and adults with physical disabilities in HCBS for every one person in a nursing home.

With the passage of the FY 2013 and FY 2014 Department of Community Health budgets, the State of Michigan took some important positive steps toward increasing the availability of HCBS in Michigan, but there is still tremendous room for improvement. The inclusion of increased funding for MI Choice in the FY 2015 budget will continue Michigan's progress in this regard.

In-Home Services for Older Adults (Non-Medicaid). Together with the Silver Key Coalition, AARP supports the proposal in the Governor's FY 2015 Budget Recommendation to

increase funding by $5 million for Meals on Wheels and other in-home services provided through the Michigan Office of Services to the Aging network.

According to the Office of Services to the Aging (OSA), at the beginning of FY 2014 there were 952 individuals on waiting lists for home delivered meals in Michigan, and 3,568 on waiting lists for other in-home services. With this proposed funding increase, OSA projects that the current waitlists would be eliminated.

These services are extremely important to older adults, their families, and their local communities. Often, simply providing assistance with a person's "activities of daily living" – help with things like shopping, doing laundry, and cooking meals – can be the difference that allows the person to remain in their own home, rather than go to a nursing home. It can be the difference that allows a person's family caregiver to remain in the workforce, avoiding lost productivity for Michigan businesses. And it also supports private sector jobs in two of Michigan's fastest growing occupations according to labor market information from the Michigan Department of Technology Management and Budget: *home health aides* and *personal care aides*.

Elder Abuse Prevention and Detection. AARP additionally supports and urges the Legislature's approval of the Governor's recommendation to provide an investment of $1 million to improve detection and prevention of elder abuse in Michigan. We appreciate the work of the Office of Services to the Aging to transform Michigan's currently fragmented, underfunded efforts to address elder abuse into what we believe will be a coordinated and more effective multidisciplinary and multi-agency partnership.

We appreciate the opportunity to share this information with the subcommittee, and thank you for your work on these important issues. If you have any questions or if there is further information we can provide, please feel free to contact Melissa Seifert at 517-267-8934 or mseifert@aarp.org.

Sincerely,

Jacqueline Morrison
State Director

Tom Kimble
Volunteer State President

AARP is a nonprofit, nonpartisan 501(c)(4) social welfare organization that advocates on issues that matter to people aged 50 and over, and their families. More than 1.4 million Michigan citizens are AARP members.

DCH SC 2-24-14
Stephanie Winslow and Rod Auton

LeadingAge™ Michigan

CentraCare
COMPREHENSIVE COMMUNITY-BASED OLDER ADULT SERVICES

February 24, 2014

Testimony to the House Appropriations Subcommittee on the Department of Community Health

Chairman Lori and members of the subcommittee, thank you for the opportunity to testify on the Governor's FY'15 Budget Recommendation. My name is Dave Herbel and I'm the President and CEO of *LeadingAge Michigan*. With me today is Rod Auton, President/ CEO of CentraCare, a PACE provider serving seniors in Calhoun and Kalamazoo Counties.

LeadingAge Michigan members applaud the Governor for investing in Michigan's seniors. We support his recommendation to invest in home delivered meals and in-home services, MI Choice and his investment of $5.7M GF for PACE in the FY'15 budget.

About *LeadingAge Michigan*

LeadingAge Michigan represents more than 350 not-for-profit long term care organizations statewide affected by the DCH budget. From Adult Home Help to Skilled Nursing Care, *LeadingAge Michigan* is the only Association in Michigan to represent the entire array of programs and services to seniors.

LeadingAge Michigan has long supported funding for the entire array of long term services and supports. We strongly support the development of Michigan's Integrated Care Program for Persons with Medicare and Medicaid that will improve access to a wider range of programs. Other capitated and fee for service programs still exist however, and funding for these programs needs to be closely evaluated.

- Michigan Programs of All Inclusive Care for the Elderly (PACE) have slowly expanded since the beginning of the first demonstration project in Detroit in the mid-1990s. This program has the strongest record for delaying or avoiding nursing home placement.

- The Affordable Assisted Living demonstration project effectively paired assisted living with MI Choice Program services to provide an effective alternative to persons transitioning from nursing homes.

- Michigan Medicaid Home Health, Home Help, and MI Choice programs provide services at per person rates significantly below the national average.

- The Nursing Home reimbursement system does not incentivize performance, and wide variation in cost and quality exist within the state.

LeadingAge Michigan continues to advocate for state policies that foster the worthy ideals and principles of our mission-based members: providing prudent stewardship of taxpayer monies, focusing public dollars on care at the bedside, providing the number and level of trained staff that our seniors need and deserve, and delivering the outcomes that seniors want.

About *PACE (Program of All-inclusive Care for the Elderly)*

The PACE model centers around the belief that it is better for frail elderly individuals to be served while continuing to live independently in the community whenever safely possible.

There are currently 100 PACE organizations across the country in 32 states. The 6 independent organizations in Michigan serve approximately 1000 seniors and provide 450 jobs in the community.

6 Existing Programs	**Programs Under Development**
Wayne County	Genessee County
Kent County	Saginaw County
Muskegon County	Ingham County
Berrien County	Traverse City Region
Washtenaw County	Jackson County
Calhoun/ Kalamazoo Counties	

Eligibility

You can join PACE if you meet the following criteria:

- You are 55 years old or older.
- You live in the service area of a PACE organization.
- You are certified by the state in which you live as meeting the need for the nursing home level of care.
- You are able to live safely in the community when you join with the help of PACE services.

Services

PACE services include but aren't limited to the following:

- Primary Care
- Hospital Care
- Medical Specialty Services
- Prescription Drugs
- Nursing Home Care
- Emergency Services
- Adult Day Care
- Recreational therapy
- Meals
- Dentistry
- Nutritional Counseling
- Social Services
- Home Care
- Physical therapy
- Occupational therapy
- Laboratory / X-ray Services
- Social Work Counseling
- Transportation

PACE also includes all other services determined necessary by your team of health care professionals to improve and maintain your overall health.

PACE *Savings*

The program offers a proven cost savings to the state over nursing facility care. Each participant's capitated Medicaid payment, which varies by service area, is combined with Medicare reimbursement. Payment is made to the PACE organization monthly, effectively managed by the organization, and all services are paid for each participant without co-pays as long as they stay within the PACE medical family.

- Reimbursement from Medicaid for PACE participants averages about $100 per day compared to nursing facility average reimbursement of $168 per day.
- For the 825 participants in PACE in 2013 vs. nursing facility care, there is a savings of $20,476,000 for the state. Five year savings projections assuming expansion are estimated to be $100 million.
- The program is funded through a capitated rate with PACE providers assuming full risk that includes costs for hospitalizations.

Thank you for taking the time to discuss our priorities. Please do not hesitate to contact us with any questions or concerns you may have regarding long-term care in Michigan.

Sincerely,

David Herbel
President & CEO
LeadingAge Michigan

Rod Auton
President/ CEO
CentraCare

DCH SC 2/24/14

Tina Reynolds

Michigan Alliance for Lead Safe Housing

February 24, 2014

House Members
Department of Community Health
Appropriation Subcommittee

On behalf of the Safe Homes/Safe Kids: Michigan Alliance for Lead Safe Housing (MIALSH) coalition we thank you for your time and attention. Our coalition has members throughout the state and includes health departments, lead-abatement contractors, small business owners, homeowners, landlords, and other service providers. MIALSH works to end lead poisoning in the state and is before you today to thank you for your funding support in the FY 2013-14budget. This is the first general fund support for this line item in close to two decades.

MIALSH appreciates your past support. The Legislature put $1.25 million in the Department of Community Health (DCH) budget last year to make homes lead safe for children. These are homes that poisoned at least one child and where the family needs help with the cost of repairs and lead removal. The year-end goal is to reach 82 homes statewide with the dollars you added to the DCH budget. Thank you!

The need is still great. Michigan ranks 5th in the nation for lead poisoned children. Studies link lead poisoning to I.Q. loss, poor test scores, violent crime, incarceration, infant mortality and new research is looking at lead as a contributor to the development of Alzheimer's disease as victims age. Adding to the crisis, scientists at Centers for Disease Control have concluded that there is no safe level of lead in a child's blood. States are now scrambling to align their baseline blood-lead levels with the federal standard and develop new action plans to protect children. With a lower bar set for what constitutes lead poisoning, more Michigan children will require assistance.

You have helped to help turn this tide in Michigan's battle against lead poisoning, and we thank you. We are asking that the $1.25 million to make homes lead safe remain in the DCH budget as the Governor recommend for Fiscal Year 2015. As our MIALSH partners work with families to abate lead hazards, we are seeing additional issues and constraints. We will continue to keep you informed and work with you to remove these barriers. The attached graphs show lead facts, the funding history for lead abatement, and how current lead abatement dollars are being spent.

Thank you for your consideration and please do not hesitate to contact me with any questions you may have.

Sincerely,

Tina Reynolds

Tina Reynolds
Health Policy Director
Michigan Environmental Council

Lead Champions Update

Goal: No Future Lead Poisoned Children in Michigan

Number of Children Under 6 Years Poisoned (5ud/dL and over) in 2012: 6,772

Action Process

Step 1: Screen Family
Step 2: Test Child's Blood
Step 3: Follow-up with Parent/Guardian

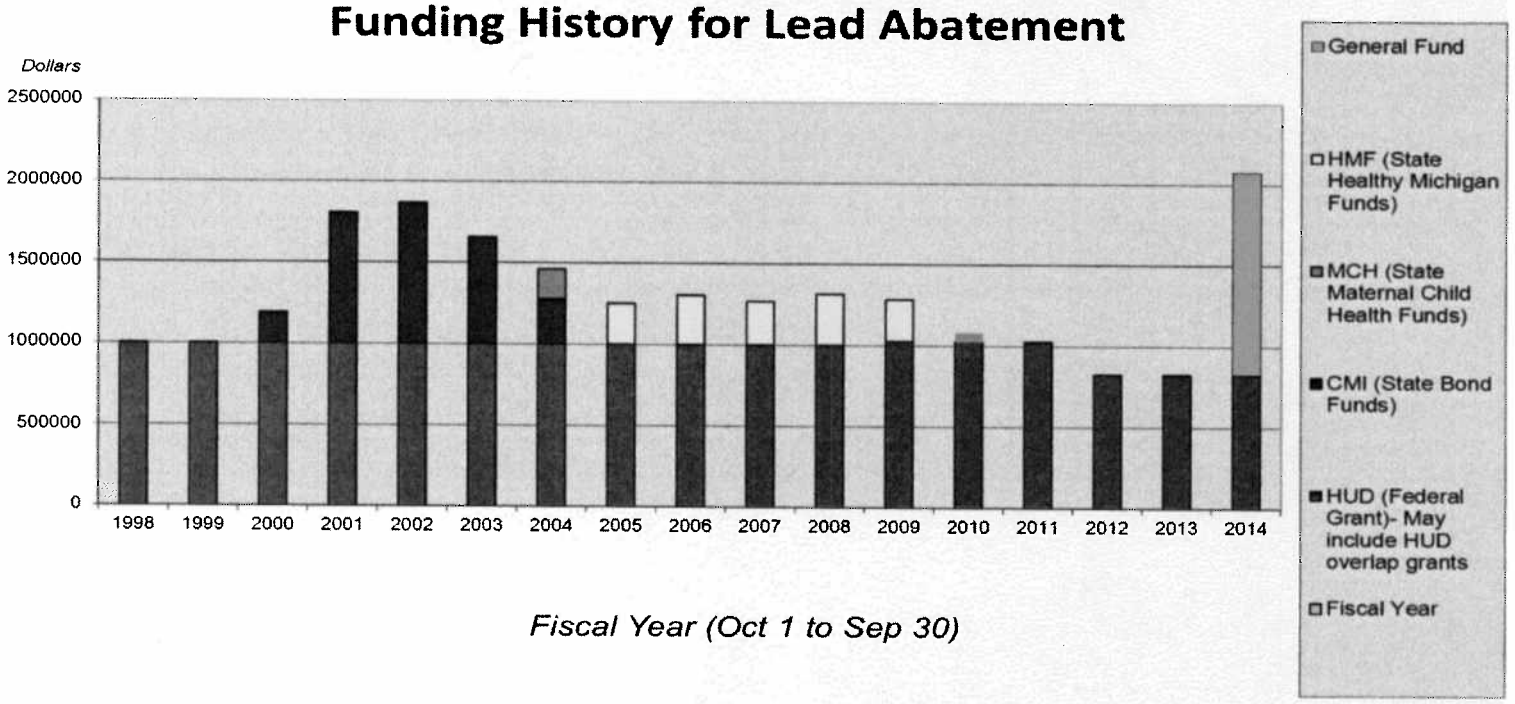
Responsible Entity: MDCH CLPPP, Medical Providers, Local Health Departments, WIC

Step 4: Test Home, With Certified Lead Professional
Step 5: Remove Lead Hazard, With Certified Lead Abatement Firm

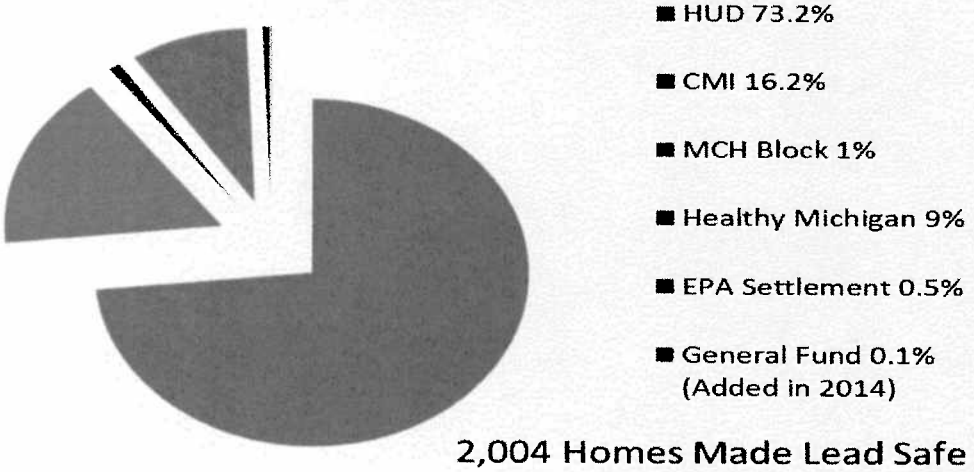
Responsible Entity: MDCH HHS, Lead Professionals, HUD Grantees

Note: MDCH certifies all lead professionals in the State of Michigan.

Michigan Department of Community Health Funding History for Lead Abatement



Michigan Department of Community Health Lead Safe Home Program Units Made Lead Safe



2,004 Homes Made Lead Safe

General Funds FY 2014
Are currently being used to:

Detroit EBL Investigator

Administrative

FY 2014

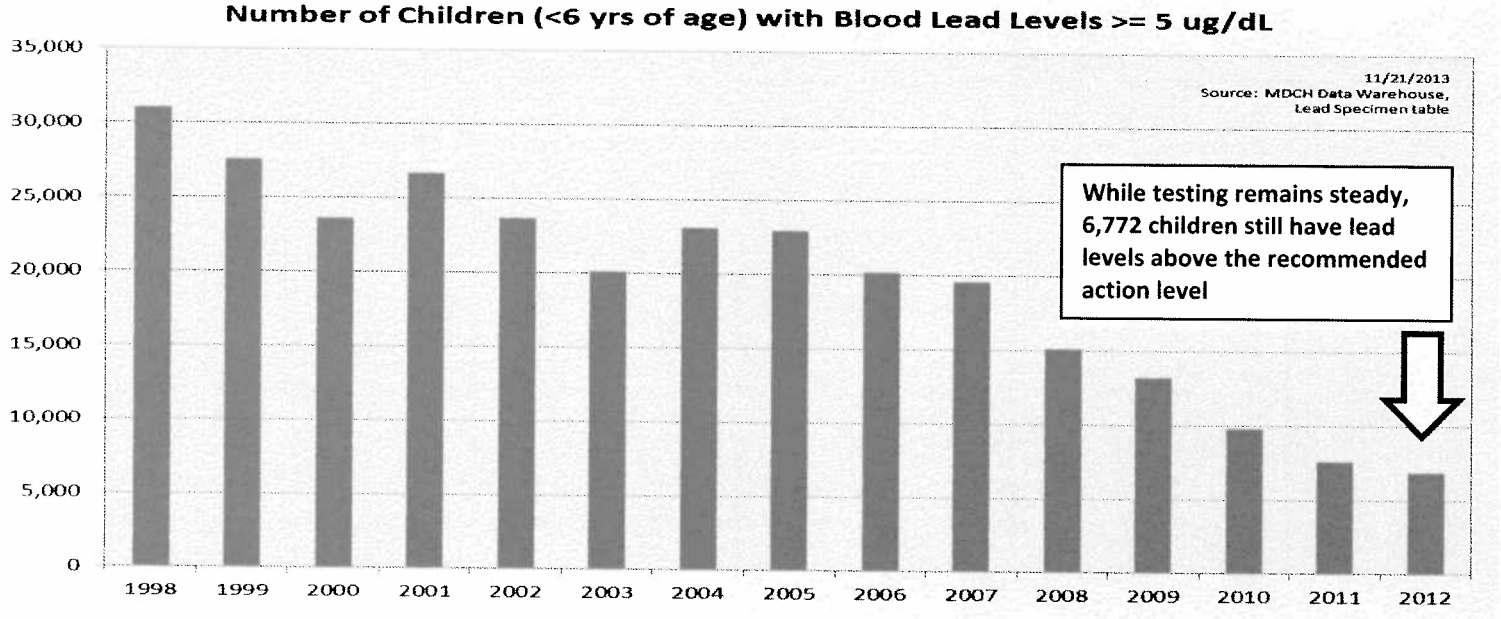
The Hard Facts on Childhood Lead Poisoning

Nearly 20,000 Michigan children have been diagnosed with lead poisoning over the last ten years and the effects o lead poisoning last a lifetime. In 2012, over 6,772 Michigan children were identified with elevated lead levels greate than 5ug/dL. Yet only about 21% of children under age 6 in Michigan are tested for lead each year.[1] A recent stud indicates that over 50% of children in the Detroit Public School system have a history of lead poisoning.[2]

Lead Paint produces brain damage, learning disabilities[3], hearing loss, speech delays[3], violent behavior[3] and, in rar cases, seizures and even death. University of Cincinnati researchers have determined that elevated blood lead level are associated with higher rates of criminal arrest in adulthood.[4]

Prevention efforts in the past have resulted in tremendous strides for Michigan; the rate of lead poisoning amon young children is now substantially lower than ten years ago. Yet Michigan continues to rank 5th worst in the natio for the number of lead-poisoned children.[5]

Funding cuts including the Clean Michigan Initiative and Healthy Michigan Funds have severely reduced cost-effectiv state programs for testing children, providing case management and supporting homeowners and landlords in makin homes lead-safe. Worse yet, these cuts have limited Michigan's ability to leverage federal lead poisoning preventio dollars. United States Department of Housing and Urban Development (HUD) grants for lead hazard control require a minimum 10% match from state and local applicants for federal funding consideration. In Fiscal Year, 2014 Lea Champions were able to secure $1.25 million in General Fund for Lead-based Paint Abatement.



Studies Link Childhood Lead Poisoning to...

- Lowered IQs
- Lowered academic achievement
- Increased attention deficit-hyperactivity disorder (ADHD)
- Increased violent crime
- Other cardiovascular, immunological, endocrine, and behavior

New GF Dollars

... and it costs Michigan $4.85 billion per year.

What Michigan needs:

- **Sustainable funding** to find and remove sources of lead ***before*** children are exposed
- **Screening** to identify and help children who have already been lead-poisoned
- **Partnerships** to promote and

Lead in Household Dust is #1 Cause of Lead Poisoning

- In homes built before 1978, lead paint on walls, doors, windows and sills may be dangerous. Three granules of lead dust are enough to poison a child.[6]
- Approximately 70% of the housing stock in Michigan was built before 1978, the year which lead paint was banned.[7]

DCH SC 2-24-14
Lindsay Bacon

Michigan House of Representatives
Appropriations Subcommittee on Community Health Committee Meeting
Monday, February 24th, 2014

Text of Public Testimony Provided by Lindsay Bacon, Alzheimer's Association – Michigan Chapters & Sandra Enness, Alzheimer's Association Constituent and Volunteer

Representative Lori and members of the Committee,

My name is Lindsay Bacon. I am the Director of Public Policy for the Alzheimer's Association – Michigan Chapters. Thank you for hearing my testimony today.

- Alzheimer's disease is the most common type of dementia. It is a progressive, degenerative neurological disorder with no known cure, effective treatment or even a way to slow its progression.
- Nearly 200,000 Michiganian's are living with Alzheimer's or another dementia.
- It is the 6th leading cause of death in our country and 1 in 3 persons over age 85 will die of some form of dementia or Alzheimer's disease.
- It is the most expensive disease in the United States. More expensive than diabetes, heart disease or cancer according to the New England Journal of Medicine.
- Lastly, Alzheimer's disease prevalence has increased by 68% since 2000 and it is expected to continue to skyrocket with the aging of the baby boomers.

These striking statistics demonstrate a need for our state to assist families faced with Alzheimer's and plan for the growth of the aging population in Michigan.

In order to prepare Michigan for the aging of the baby boomers, we must invest in programs and services that help seniors to plan for the emotional and financial toll of this disease. We must also provide resources for seniors with dementia to remain at home and out of Medicaid long term care facilities for as long as possible.

The Alzheimer's Association is Michigan's leading voluntary health organization providing this type of care and support. Our programs include:

- A 24/7 helpline for anyone affected by Alzheimer's or dementia.
- Care consultation and planning with trained and experienced social workers.
- Support groups in local communities across the state.
- Community education programs to raise awareness about this disease and train professionals and family caregivers.

With our state poised for a great increase in the aging population, and subsequently in Alzheimer's and dementia, I'd like to urge the committee members to support a pilot program called the Michigan Alzheimer's Care and Support Pilot. This pilot is modeled after a statewide project in North Dakota that demonstrated that the programs provided by the Alzheimer's

Association can and do provide a return on investment to the state government by helping seniors to remain in their homes longer.

This Michigan pilot project would require an investment of $150,000 for providing care and support programs in three Michigan Counties – Monroe, Macomb and St. Joseph. In these counties, master level social workers would provide comprehensive care and support for approximately 250 people living with Alzheimer's disease and their caregivers. Along with providing services to those in the community, the Alzheimer's Association would partner with a university to study how such a program can provide a return on investment to Michigan tax payers.

Until 2009, the Alzheimer's Association received some state funding to support programs that are helping to fill gaps in services provided through Area Agencies on Aging and senior service providers. However, this funding was completely eliminated in 2009 and since then the need has only continued to grow. Investing in this pilot program will support state agencies charged with caring for the elderly and will begin to prepare Michigan for the aging of the baby boomers. I kindly ask that you will consider our request to fund the Michigan Alzheimer's Care and Support Pilot at $150,000.

Before concluding, I have brought with me today a constituent and volunteer, Sandra Enness to share about her experience with Alzheimer's and reiterate the great need for support. Thank you again for your time and consideration. I will be happy to take any questions after Sandra's testimony.

Sincerely,

Lindsay Bacon
Director of Public Policy
Alzheimer's Association – Michigan Chapters
lbacon@alz.org
734-320-8898

[Sandy Enness Testimony to follow]

DCH SC 2-24-14
Sandra Enness

How the Alzheimer's Association has Helped Our Family Face this Disease

By Sandra Enness

In the summer of 2008, my father in law was experiencing health issues, eventually being diagnosed with prostate cancer and a subsequent surgery was scheduled.

As his surgery date approached, his cognition and behaviors were changing rapidly. It was immediately after his surgery that we knew something was quite wrong with him.

Bringing our concerns to his physicians brought responses like "he must be an alcoholic, these are classic withdrawal symptoms." The reality was he didn't drink. Doctors insisted, though, that he must be a closet alcoholic, ignoring our requests to figure out why he was so confused to the point where he didn't recognize his own daughter or grandchildren.

After his surgery, he was discharged to a local post-op rehab facility to help him with his medical needs associated with the cancer surgery. Still no one would listen to our concerns about his cognition. Eventually, a young social worker at this facility witnessed what we were saying about his behaviors and cognition. Though she brought it to the attention of the facility physician, he rebuffed her and our concerns. Privately, she suggested to us that she thought he was showing signs of dementia, perhaps Alzheimer's disease. From there, I turned to the Internet and the Alzheimer's Association website.

I located plenty of helpful information on the website, but I needed to talk to a person because I had questions. I called the 1-800 number listed on the site and was connected with a wonderful member of the Alzheimer's Association staff. She spent well over an hour on the phone with me as she listened to our observations of his behaviors and cognition. She provided me with a list of questions to ask his physicians when talking with them more about additional testing.

It took us an additional three weeks, but eventually a nurse practitioner heard our concerns and helped us get my father in law assessed by one of the area's most well-respected providers. He was indeed suffering from Alzheimer's disease, and in fact, was quite compromised. Like many seniors who suffer with the disease, he had developed enough coping mechanisms to try hide many of his symptoms.

Our family gives full credit to the Alzheimer's Association in helping us get our parent the assessment and eventual care he needed. Looking back, I shudder to think how long we would have gone on trying to get this man the medical help he desperately needed had someone not been there to pick up that 24 hour help line at the Alzheimer's Association.

Since my father in law's diagnosis, my husband I and assumed responsibility for the management of his all of his care and affairs – a very overwhelming responsibility, to say the least. Through my initial contact with the Alzheimer's Association, I learned that support groups were another resource to get more information and talk with other families experiencing the disease.

We have been attending a monthly support group meeting since mid-2009 and I can't begin to list the ways this experience has helped us. Unless you are actually dealing with this disease, firsthand, as a caregiver or a care manager, you really have no clue what we endure. In the support group environment, we can talk freely with others who "get it" and understand our fears, anxiety, anger, and all the other emotions that come out in people dealing with the disease.

We share our acquired consumer knowledge with each other in Alzheimer's support groups – we share who we've had the best experiences with in terms of finding a really good neurologist, or a really good neuropsychologist for testing our loved one. We share who the "best" attorneys in the area are in terms of elder law and Medicaid law. We talk about what types of medications our loved one might be on, or what to look for and questions to ask when considering an assisted living or skilled nursing facility placement. This is information that most physicians just cannot give a family.

In our experience, too many physicians still have no clue how to react to or treat the disease. In fact, we had one doctor tell us that Alzheimer's was a made up disease to satisfy the public when Ronald Regan's cognitively decline was made public. More often than not, the family is handed a few brochures about dementia and Alzheimer's disease as the physician's last effort to "help" when you walk out of the appointment.

Thankfully, for most families, usually one of those brochures suggests the family get in touch with the Alzheimer's Association.

Thank you.

Sandra Enness

Michigan must invest in caring for people with alzheimer's in their own homes

January 2014

- **Alzheimer's is the most expensive malady in the U.S.**

  Associated Press 4/4/13

- **Exceeding that for heart disease and cancer . . .**

  Bloomberg 4/4/13

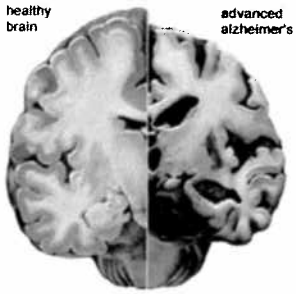
- Alzheimer's is the **6th leading cause of death overall,** and the **5th leading cause of death for those aged 65 and older.**

- Alzheimer's is a degenerative disease that currently has **no cure, no treatment, and not even a way to slow its progression.**

- In 2010, **180,000 people in Michigan had Alzheimer's, the 8th highest prevalence in the country.**

- In Michigan in 2012, there were over **507,000 unpaid caregivers** providing **577,000 hours of unpaid care** for someone with Alzheimer's disease or dementia. The cost of this caregiving exceeds **$7 million**.

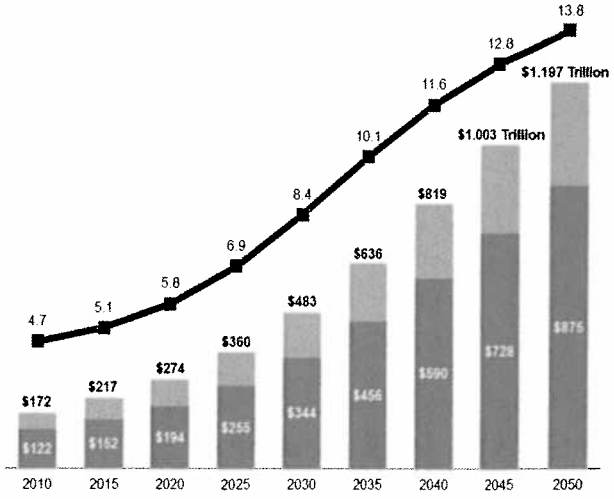
- In 2011, the costs for hospitals, medical providers, skilled nursing facilities, nursing homes, hospice care, home health care and medications is over **$43,000 per year for just ONE individual.**



- **And the cost to Michigan is growing** as the disease is projected to increase by nearly 10,000 people diagnosed by 2025, **a 12% increase**.

2013 Nationwide Alzheimer's Prevalence & Costs

In millions of people and billions of 2013 dollars



Legend: Purple - Alzheimer's disease prevalence
Light Green - Additional caregiving costs to families
Dark Green - Costs to Medicare and Medicaid

Source: 2013 Alzheimer's Disease Facts and Figures (prevalence) and Changing the Trajectory of Alzheimer's Disease: A National Imperative (costs, adjusted to 2013 dollars)

Alzheimer's Association
Greater Michigan Chapter
25200 Telegraph Road, Suite 100
Southfield, MI 48033
248.351.0280 | alz.org/gmc

Alzheimer's Association
Michigan Great Lakes Chapter
310 N. Main Street, Suite 100
Chelsea, MI 48118
734.475.7043 | alz.org/mglc

alzheimer's association®

24/7 Helpline: 800.272.3900 www.alz.org

Programs Providing Care and Support

The **Alzheimer's Association** provides care and support for thousands of Michigan residents living with or caring for someone with Alzheimer's disease. The Association is the world's leading voluntary health organization in Alzheimer's care, support and research. Our mission is to eliminate Alzheimer's disease through the advancement of research, to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. Our vision is a world without Alzheimer's®.

The two chapters in Michigan - **Greater Michigan Chapter and Michigan Great Lakes Chapter** - provide care and support services in all 83 counties of our state. The following programs are available to all Michigan residents when they are faced with Alzheimer's disease.

24/7 Helpline - Serves 7,500 people annually

The 24/7 Helpline - 800.272.3900 - provides support, education, and referral services to individuals seeking information about Alzheimer's disease and related dementias. Additional 24/7 support is available at alz.org.

Care Consultations - Serves 3,500 families annually

Care Consultation is a service provided to help families understand Alzheimer's disease and to develop an individualized care plan that maximizes symptom management and communication.

Education Programs - Annually reaches over 15,000 people through over 900 programs

Education programs inform the community, professionals and families about Alzheimer's disease and research trends.

Family Caregiver and Early Stage Support Groups - Helps over 2,000 people annually

Support groups allow participants a safe, confidential place in which to share experiences, resources and support.

Early Stage Programs such as Social Clubs, Support Groups and Lectures - Reaches about 200 people every year

Participants in the early stages of memory loss meet to engage in activities that promote cognitive, physical and social stimulation. The Early Stage Lecture Series is a six week series that allows individuals in the early stages and their caregivers to learn about and discuss Alzheimer's disease.

Safety Services

MedicAlert® + Alzheimer's Association Safe Return® and Comfort Zone® work to help find individuals with memory loss who wander or have a medical emergency. **One in six seniors with Alzheimer's disease will wander.**

Creating Confident Caregivers - Over 200 served by the Alzheimer's Association Michigan chapters annually

In partnership with the Michigan Office of Services to the Aging, this program provides an in-depth education experience for caregivers. This programs is designed for family caregivers living with the person with dementia. The Creating Confident Caregivers (CCC) training program has been proven to reduce caregiver stress by empowering caregivers with useful tools and information.

A Small Investment for a BIG Return

The programs of the Alzheimer's Association demonstrate return on investment by helping seniors with dementia to remain in their homes longer and relying on the supports and services of the Association, saving our state money in Medicaid long term care, 911 calls and emergency room visits. In North Dakota, the Alzheimer's Association showed a 26:1 return on investment in a state-funded program called the Dementia Care Services Program.

Michigan has the potential to demonstrate these types of savings by investing in a pilot program called the Michigan Alzheimer's Care and Support Pilot Program.

By **investing $150,000 in the Alzheimer's Association** - Michigan Chapters, social workers in three counties - Monroe, Macomb and St. Joseph - will be able to provide comprehensive care and support for approximately 250 people living with Alzheimer's disease and their caregivers. Services include a 24/7 Helpline, regular care consultations and follow-up with trained professionals, community support groups and caregiver training.

Along with excellent services, a strong public-private partnership will be established with the Alzheimer's Association to refer Michiganders to existing state services as well as services provided by local government and other non-profit organizations. Lastly, the **Michigan Alzheimer's Care and Support Pilot Program** will place a strong emphasis on data to demonstrate cost savings in Medicaid long term care (nursing home care), 911 calls, ambulance services, emergency room visits and hospitalizations. This investment by the State of Michigan has the potential to save millions of dollars and further prepare our state for the aging of the baby boomers (individuals born between 1946 and 1964).

Regional Programming Across Michigan

LIVEWISE - An education and exercise group for people with Early Stage Alzheimer's and their caregivers based at the YMCA in Marquette and in collaboration with the Brain and Spine Center from MGH and palliative medicine program Community Care.

LifeTracker - A radio controlled device that a person with Alzheimer's wears in case they wander from caregivers.

Gather at the Gallery - Provides an opportunity for social engagement, creative expression and intellectual stimulation through museum -led art gallery discussions and art studio time.

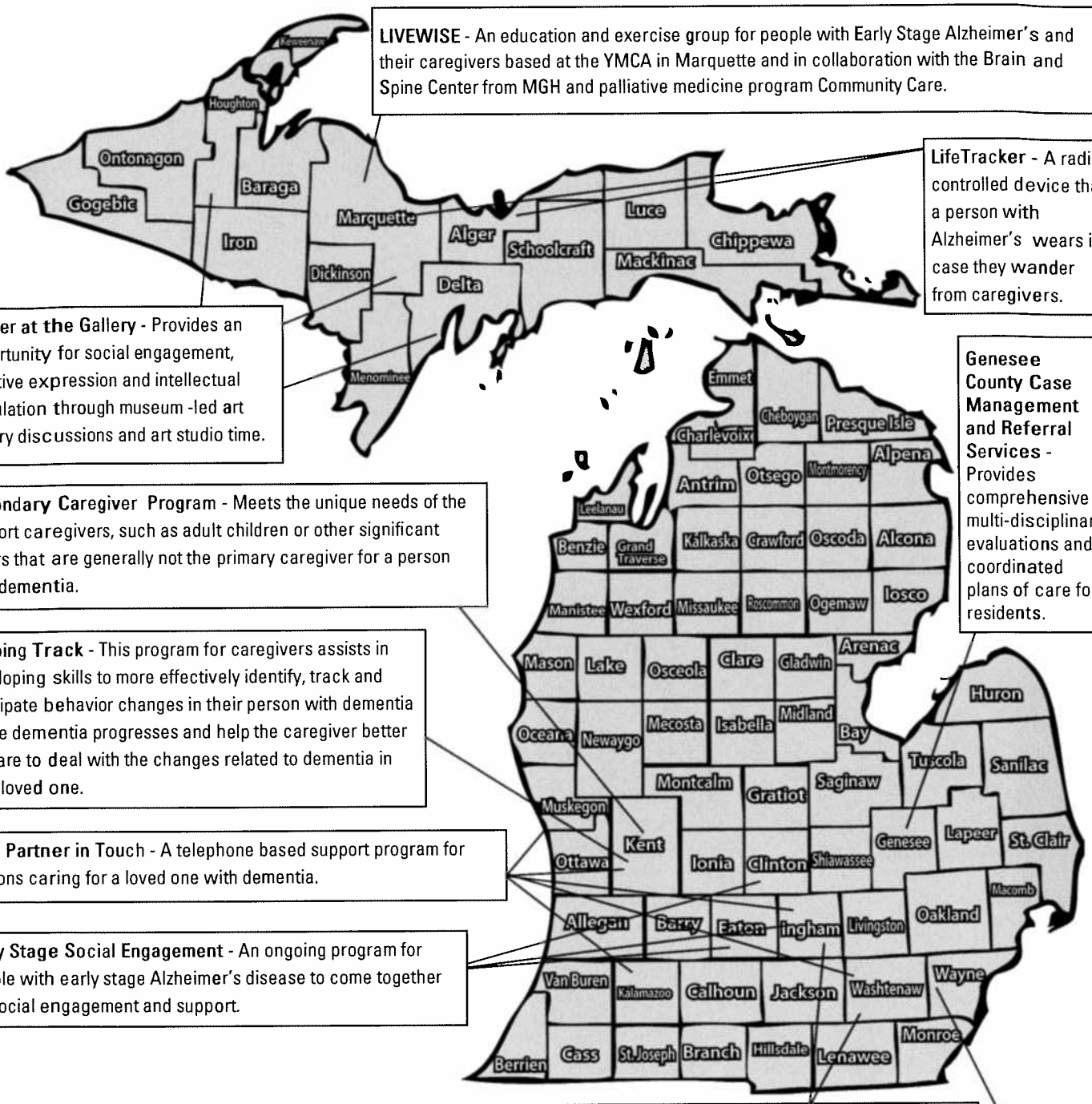
Genesee County Case Management and Referral Services - Provides comprehensive multi-disciplinary evaluations and coordinated plans of care for residents.

Secondary Caregiver Program - Meets the unique needs of the support caregivers, such as adult children or other significant others that are generally not the primary caregiver for a person with dementia.

Keeping Track - This program for caregivers assists in developing skills to more effectively identify, track and anticipate behavior changes in their person with dementia as the dementia progresses and help the caregiver better prepare to deal with the changes related to dementia in their loved one.

Care Partner in Touch - A telephone based support program for persons caring for a loved one with dementia.

Early Stage Social Engagement - An ongoing program for people with early stage Alzheimer's disease to come together for social engagement and support.



Approaching Alzheimer's - A training program designed for first responders to provide an overview of dementia and Alzheimer's disease, communication and approach tips, and how to optimize successful outcomes when dealing with persons in dementia on calls related to pedestrian/vehicular wandering, abuse/neglect. domestic violence, shoplifting, firearms and natural disasters.

Metro-Detroit Programs

Minds on Art - A collaborative program with the Detroit Institute of Arts and the Birmingham Bloomfield Arts Center that provides social engagement, creative expression and intellectual stimulation through led art gallery discussions and art studio time.

Wraparound Program - An intensive care consultation program involving in home assessments and family meetings to assist caregivers and families with difficult issues.

Adult Day Programs - Offers individualized recreational programming designed to help older adults with Alzheimer's or a related dementia, maintain their optimum level of functioning.

Integrated Care Counseling Program - A health care partnership between the Alzheimer's Association, Greater Michigan Chapter and Henry Ford Health System for comprehensive diagnosis and care management.

This document was created in part by Social Work Interns, Mary-Margaret Morris, Alex Farber, and Lisa Harteau. December 2013

DCH SC 2/24/14
Brewster Hamm

February 24, 2014

Testimony to Appropriations Committee at State Capital / Gov. Snyder's proposed $ 5 M Budget Increase for Food & Senior Services

Delivered by - Brewster C. Hamm, President & CEO Senior Meals on Wheels, 2900 Wilson Avenue S.W., Grandville, Michigan 49418

Good Morning.....I'm Brewster Hamm, President & CEO of Senior Meals on Wheels located in Grandville, Michigan.....

I'm excited to be here to share my enthusiastic support for Gov. Snyder's proposed addition of $ 5 million dollars to the budget to go for Food, Senior services and to make Michigan a no-wait state.

My comments today will be specifically directed to the critical issue of Food and will share some shocking statistics from our experience in Kent County.

Proposed increase in funding of Food and Senior services is badly needed. As many of you may know, the level of state funding for Home Delivered Meals to Seniors is the same today as it was in back in 1997 ! .... (16 years ago).

Today.....we have significant un-met needs.
At Senior Meals on Wheels, our primary mission is to provide nutritious meals to home bound Seniors (60+), to help them remain healthy and independent in their own homes.

Why is this issue so significant?

First....Seniors, (those 60 years of age and above), are the fastest growing segment of all age groups.

- **In Kent County, since year 2000, Seniors have grown 30% to slightly over 100,000 people in only 13 years. It is projected that this growth rate of "Baby Boomers" in Kent County will be approximately 200,000 Seniors by about 2034!.. (only 20 years) Seniors are the fastest growing age group.**

Second……there is a hunger and nutrition issue in North America and in Kent County.

- **1 in 6 Seniors face hunger and nutrition issues based on research from the National Meals on Wheels Association. This is primarily due to the dramatic increase in the numbers of Seniors over 60 and the general economic issues of the last decade. We find the MOWA numbers consistent in Kent County too.**

Third…..there is a growing un-met need for food for Seniors.

- **By early last summer, we at Senior Meals, experienced a rapidly increasing need for meals that was running 15% ahead of the previous year. The need for meals was growing faster than our ability to fund raise for the extra meals.**

- **So……to be good stewards of our financial resources, we had to carefully cut second & weekend meals that were unfunded. The cuts amounted to approximately 7,000 meals per month. This is approximately 84,000 meals per year, affecting about 250 people.**

- **To put those numbers in perspective…….. last year we made and delivered over 400,000 meals to home bound Seniors. These are folks that cannot stand at their stoves and prepare a nutritious meal or they are unable to go to the grocery store to shop for their food.**

My parting message is .....the need for meals is growing faster than we can fund raise, to pay for the extra meals.

If additional resources flow to Senior Meals as a result of Governor Snyder's budget increase, this would help restore at least some of those on the waiting list for meals that had to be cut.

I urge you to support Governor Snyder's proposed increase!
Support Governor Snyders's increase.

Thank you for your attention.

Any questions?

SENIOR MEALS ON WHEELS

2900 Wilson Ave SW, Ste 500 Grandville, Michigan 49418
Phone: (616) 459-3111 Fax: (616) 224-0220
www.seniormealsonwheels.org

B. Hamm

Providing nutrition services to enable seniors to remain healthy and independent in their homes.

Service Information:

- Senior Meals prepares more than 500,000 meals annually for older adults in Kent County. Of these meals, over 400,000 are Meals on Wheels which are delivered to homebound older adults.

- Meals provided meet strict requirements and include an entrée, bread, two vegetables, fruit and milk.

- More than 5,500 unduplicated individuals in Kent County annually are served through our nutrition programs.

- 82% of our meals on wheels clients are low income and 54% live alone.

- Over 100,000 congregate meals are served at 14 different community locations in Kent County including low-income senior housing complexes and Senior Centers. In addition to a much needed meal, seniors are able to stay socially engaged and have many programs available including exercise.

- Our client choice pantries serve over 1,000 older adults each month. Clients may shop up to twice per month and receive about seven days' worth of food at each visit. The pantries provide a wide variety of nutritious foods from all food groups including dairy and fresh produce. Food provided at our pantries allows seniors to use their limited cash to purchase their medications, pay their utilities or rent.

- The number of seniors coming to us for help is outpacing our ability to raise the dollars needed to help everyone who needs us.

B. Hamm

Senior Pantry - Senior Meals on Wheels

The Senior Pantry program was started in 1998 with funding from the Kent County Senior Millage. There are currently three locations to receive our pantry services. The pantries are open to Kent County residents who are 60 years of age and older who meet income requirements. Clients may shop at the senior pantries up to twice per month (not twice in one week), choosing from a variety of different food items equaling $80-$100 in groceries per month. We request a $2 donation for each visit.

Grand Rapids NE
1954 Fuller NE Suite B (just south of the Knapp and fuller intersection)
Grand rapids, MI 49505
616-364-1104
Mondays and Wednesdays 9am-2:45pm and Thursdays 10am-3:45pm.

Grand Rapids
Located in the Head Start Building next to the Messiah Baptist Church
513 Henry Ave SE
Grand rapids, MI 49503
616-364-1104
Hours: Eligible clients may shop up to two days per month, call for more details.

Rockford
Located at North Kent Service Center
10075 Northland Drive
Rockford, MI 49341
616-866-3478
Hours: Eligible Clients may shop one day per month, call for more details.

Senior Dining Centers- Senior Meals on Wheels

A hot noon meal is served at 11 senior centers throughout Kent County. Any Senior citizen aged 60 and over may attend. Spouses under 60 are welcome.

Some dining locations also offer special services and activities, such as exercise classes and games. Please contact your local center for more details.

Meal menus are prepared for the whole month at a time, and are designed to serve each community according to its needs and preferences.

All sites have a requested meal donation for seniors 60 and over and a required low price for guests under 60.

Latin American Services
Monday-Friday
121 Franklin St SE
Grand Rapids, MI 49503

Café on the Mount- Mt. Mercy Apartments
Monday-Friday
1425 Bridge NW
Grand Rapids, MI 49504

Delaware Manor
Monday-Friday
10 Delaware SW
Grand Rapids, MI 49503

Grandville Senior Neighbors
Monday-Friday
3380 Division
Grandville, MI 49418

Grand Rapids Senior Neighbors
Monday-Friday
333 S Division
Grand Rapids, MI 49503

Grattan Township Hall
Monday & Wednesday
12050 Belding Rd
Grattan, MI 48809

Lowell Senior Neighbors
Monday-Friday
314 South Hudson
Lowell, MI 49331

Sparta Senior Neighbors
Monday-Friday
100 Ida Red
Sparta, MI 49345

United Methodist Community House
Monday-Friday
904 Sheldon SE
Grand Rapids, MI 49507

Walker Firehouse Café
Monday, Wednesday, & Friday
4101 Lake Michigan Drive NW
Grand Rapids, MI 49504

Wyoming Senior Center
Tuesday & Thursday
2380 DeHoop SW
Wyoming, MI 49509

Nourishment for the Body and Soul

SENIOR MEALS ON WHEELS

Volume 1, Issue 1
January 2014

INSIDE THIS ISSUE:

SENIOR MEALS ON WHEELS

2900 Wilson Ave.
Suite 500
Grandville, MI 49418
P :(616) 459-3111
F: (616) 224-0220

Find us online at:
seniormealsonwheels.org

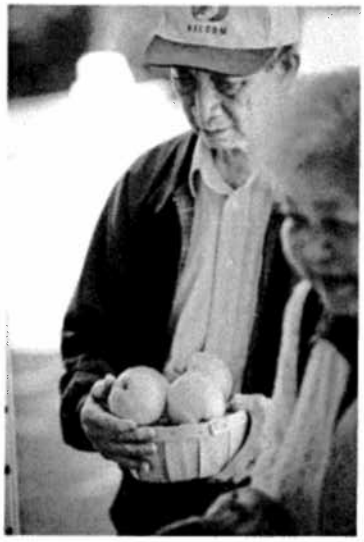
Facebook.com/
Seniormealsprogram

Mission Statement:
The purpose of Senior Meals on Wheels is to provide nutrition services to enable seniors to remain healthy and independent in their own homes.

Rose & Harvey's Story

Nine months ago, Harvey called Senior Meals on Wheels to see if he could get home-delivered meals for himself and his wife, Rose. The phone screening deemed them eligible because neither of them were able to drive or prepare meals. When their assessor visited them for their initial assessment she documented that Harvey was 87 years old, totally blind, had difficulty hearing, had hypertension, diabetes, was overweight, a history of heart problems, and skin cancer. Rose was 86 years old and her dementia had progressed to the point where she was quite confused and beginning to lose weight. She suffered from hypertension and had a history of heart problems. The nutrition risk assessment showed both were eligible for weekend meals and possibly a second meal, if needed. Their goal was to stay home together as they relied on each other.

At their bi-annual assessment visit, the assessor learned that their son, Peter was in the hospital having his leg amputated due to diabetes. She suggested they sign the son up for home -delivered meals as soon as he returned home. Peter was also eligible for the meals as a disabled child of an eligible client. Additional meals were approved. The assessor's third visit showed that Harvey had reduced his weight, which he attributed to eating more nutritious meals from Senior Meals on Wheels, to the point where he no longer had to take medication for his diabetes. His wife's weight had stabilized, and they had begun donating towards the cost of their meals. The entire household was doing well with a total of 5 meals each per week. Harvey, Rose, and Peter are so grateful for Senior Meals on Wheels. The program is able to provide their family with nutritious services to keep them healthy and in their own home as opposed to going to a nursing home. This story is a great example of how Senior Meals delivers more than just a meal to our seniors!



More than a Meal

Senior Meals on Wheels held our first table hosted event on November 7, 2013. The *More than a Meal* luncheon included a program on the impact of Senior Meals on Wheels in our community and client testimonies which supported our mission. This event helped us to connect with people and organizations who share a heart for our mission.

We would like to thank Advance Packaging Corporation, Advantage Label, Buist Electric Foundation, Doyle and Ogden Insurance Advisors, F & AM Inc., Land & Company, Oliver Products, Parrish Consulting, Prairie Farms, Speed Wrench Inc., Star Truck Rentals, Inc., and the Law Offices of David Carrier, P.C., for making this event possible. Because of their generous sponsorships, every dollar donated that afternoon went back to our mission - a total of $17,762! Thank you for your support and the overall success of the event!

Please contact Mallory Buth at (616) 459-3111 ext. 12 or mbuth@seniormealsonwheels.org if you have any questions or would like to attend or even volunteer at our 2014 luncheon!

County Wide Food Drive

"I was down to my last few cans of food. This place is a blessing!"

- Senior Pantry Client

This past October, Senior Meals on Wheels teamed up with Access of West Michigan in a county wide food drive. The food we collected provided food for our three Senior Pantries in Kent County. The residents of Grandville and surrounding areas in Kent County were given brown bags to fill with non-perishable food items. With this effort, we collected 12,000 pounds of food that helped keep the pantry shelves stocked for 7 weeks!

Food donations are always accepted! We look forward your involvement this fall in your neighborhood. Thanks for your donations!

county wide food drive
because hunger hasn't gone away

"More than a Meal" Sponsors

DOYLE & OGDEN INSURANCE ADVISORS

THE LAW OFFICES OF DAVID L. CARRIER, P.C.
ESTATE PLANNING & ELDER LAW

parrish consulting

MERCHANDISE EQUIPMENT & SUPPLY

Feed the Hungry with our Adopt-a-Senior Program

Senior Meals on Wheels is excited to offer another opportunity for you to get involved by supporting our clients. Here's how **you** can Adopt-a-Senior!

- A $25 donation provides a senior with two pantry visits per month. (The equivalent of $100 worth of groceries!)
- A $100 donation will feed a senior for an entire month.
- You will receive a card with your seniors' first name, their city, and the number of meals they receive per week.
- Just choose how you are willing and able to help and donate online today or utilize the enclosed envelope.

We appreciate your support!

Wish List

- Microwaves for clients to heat up their meals
- Non-perishable food items
- Volunteers for kitchen, pantry, and office help
- 2014 Table Hosts

Please contact Mallory Buth at mbuth@seniormealsonwheels.org if you wish to get involved or donate items.

"Thank you so much for providing meals for my mom, Dorothy, for the past few months. It was a wonderful service that gave us some peace of mind that she was getting regular meals when we weren't able to be there."

-Mary, daughter of home-delivered meal client, Grand Rapids

"More than a Meal" Sponsors (continued)

Who We Are

Home-Delivered Meals can be provided to any homebound senior in need who is at least 60 years age and is living in Kent County. Up to 7 well-balanced, nutritious meals are delivered each week. In the past year, we have provided 413,294 meals to 2,156 different individuals.

Senior Project Fresh provides $20 coupon booklets redeemable at local farmer's markets on Michigan grown products. In the past year 940 seniors were provided with a coupon booklet; which allowed them to get needed fresh produce.

"Thank you for recognizing the importance of socializing, laughing, and exercising for seniors. It has been such an uplifting experience."

- Senior Dining Center Client

Senior Dining Centers are intended to provide nutritious meals and socialization activities to the more mobile seniors. In partnership with Senior Neighbors and United Methodist Community House, Senior Dining Centers provide nutritious meals and socialization activities to the more mobile seniors. In the past year 103,407 meals were served to 1,730 people at 14 locations around Kent County. Participants not only receive a healthy noon meal, but also much needed activities to keep them engaged in life.

Senior Food Pantry services are provided for those who meet low income requirements and whose primary need is access to food. Meeting this need allows seniors to spend income on much needed things like medication. In the past year 1,854 people visited our pantries. A wide variety of foods from all food groups are provided for seniors who may shop up to twice per month at the Senior Food Pantry. Seniors can save from $80-$100 on groceries. A suggested donation is $2 per visit.

Thank you to our Supporting Agencies!

Kent County Senior Millage

United Way Heart of West Michigan United Way

Wyoming Michigan City of Vision and Progress

County of Kent Michigan

Area Agency on Aging of Western Michigan The Source for Seniors

SENIOR MEALS ON WHEELS
2900 WILSON AVE SW.
SUITE 500
GRANDVILLE, MI 49418

RECIPIENT NAME
STREET ADDRESS
ADDRESS 2
CITY, ST ZIP CODE

Senior Meals on Wheels

Volunteer Opportunities

Whether you have a few hours on one day per week, can volunteer sporadically, or can only work a few hours on a one-time project, your assistance is needed.

FOR INDIVIDUALS:

Delivery Driver: to follow a specified route to deliver meals to needy, homebound seniors. (Requires at least a one- time per week, 3 hour a day, commitment.) Volunteer uses own vehicle with some mileage reimbursement, if desired.

Birthday Fairy: to make or obtain birthday cards for the delivery drivers to give to the seniors in our program.

Dining Room Greeter/Assistant: to greet and sign-in seniors for lunch and/or assist with serving, clean-up or other activities, at one of our congregate dining sites. (county-wide)

Kitchen Food Packager: to help spoon/place food in individual meal containers to be delivered to homebound seniors.

Pantry Assistant: to help needy seniors shop at one of our senior pantries by repacking/sorting food, or bagging groceries.

Program Assistant: to provide general office/operational support to program staff. Responsibilities may include filing, copying, and answering phones, making calls, mailings and basic data entry. Some computer experience is necessary. (Schedule is very flexible)

Safety Checker: Make afternoon calls to seniors and/or emergency contacts for those who did not come to the door for their meals, to make sure they are safe.

For CORPORATE/GROUPS:

Talk about team work! Have your company or group join together to feed the elderly:

Special Events/Projects: we have events and fundraisers that require extra help periodically and we can often schedule a group who is willing to help with anything from spring cleaning a facility, to special *meal prep, and any of the following:*

Each October there is an ***Annual FOOD Drive*** where on one Saturday volunteers are needed to pick up bags of food in a mapped out neighborhood and deliver them to a designated site. Packers are then needed to box the items to go to one of our Senior Meals pantries.

Each December we participate in the ***Be A SANTA to a Senior*** program and with Home Instead to deliver Christmas presents to isolated seniors who otherwise would not be getting a Christmas gift.

Every fall we package hundreds of shelf-stable, ***EMERGENCY meals*** to deliver to each senior in our program to have available in case of bad weather and we are unable to make our usual delivery.

Every winter we set up people/organizations with ***WINTER-hardy vehicles*** to make essential food deliveries, if our usual drivers are unable to travel.

Any time of year food is needed. A group could do their own ***FOOD Drive*** to deliver to one of our pantries.

If you know of ***FARMERS OR GARDENERS*** who have extra produce of any amount, we are happy to share it with the seniors who are no longer able to garden.

To volunteer to meet any of these needs, please fill out the enclosed application and mail to: Senior Meals on Wheels, 2900 Wilson Ave SW, Suite 500, Grandville, MI, 49418. Or send by fax to Senior Meals at 616-224-0220.

Senior Meals on Wheels Volunteer Application

Please return to: (Mail or Fax) Fax: 616-224-0220
Senior Meals on Wheels Program
2900 Wilson Ave SW, Suite 500, Grandville, MI, 49418

Date:_____

Name(please print):_____Date of birth:_____

Address:_____City_____ Zip_____

Phone:_____Email:_____

Best way to contact you: ☐ Phone ☐ Email Foreign Languages spoken:_____

Emer Contact:_____Phone:_____ Relationship:_____

How did you hear about Senior Meals Program?_____

Do you have any special skills or training that would be helpful?_____

_____

Physical limitations? ☐N ☐Y if yes, please describe:_____

Availability (check all applicable) ☐Mon ☐Tues ☐Wed ☐Thurs ☐Fri ☐Sat

days/week _____or # days/month:_____ or Special event only_____

What times are you available? From_____am/pm to _____am/pm

Location Preference:

☐Pantry (1954 Fuller,NE Grand Rapids) ☐Central Kitchen (2900 Wilson Ave SW, Grandville)

☐Administrative office (2900 Wilson Ave SW, Grandville) ☐Dining Site (14 locations throughout the county)

Areas of Interest:

☐Food Prep/packaging

☐Deliver Meals (requires criminal background check)

☐Pantry stocking shelves, carrying out groceries, repacking food

☐Dining site: greeting clients, assisting with registration, meal prep, serving food, cleanup.

☐Clerical: answering phones, data entry, wellness check calls, filing

☐Special Events

Please describe any prior volunteer experience:_____

Why do you want to volunteer for Senior Meals?_____

References: Please list two personal references not related to you.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Demographic reporting purposes only: Some of our funders want to know the demographic characteristics of our volunteer base.

Gender ☐ M ☐ F

Race ☐White ☐Black ☐ Hispanic ☐Asian ☐Hawaiian/Pacific Islander ☐Native American

As a volunteer for Senior Meals Program Inc. (SMP), I (name) _____ acknowledge and agree to the following:

I will not receive any monetary compensation for my services and I will not accept any compensation or other form of remuneration from any SMP clients.

Client information is strictly confidential and I will not discuss client or agency information with any other person or entity.

I will accept the supervision of the staff I am assigned to and I will discontinue my service if I am requested to do so by the organization.

I agree to hold harmless and hereby indemnify Senior Meals Program, Inc. if through the course of my volunteer work I am injured, become ill and/or require medical treatment. I hereby waive any claim, known or unknown, against Senior Meals Program, Inc., its officers, directors and/or employees resulting from such circumstances.

Applicant Signature:_____ Date:_____

Senior Meals Program Staff Use:

Location Assigned to:_____ Supervisor:_____

Drivers Only if Approved- Attach copies of the following:

☐Driver's License ☐Proof of Insurance ☐Criminal Background Check Authorization

☐Criminal Background Check Results

DCH SC 2-24-14
Lois DeMott

THE ASSOCIATION FOR CHILDREN'S MENTAL HEALTH

TESTIMONY FEBRUARY 24TH, 2014

My name is Lois DeMott. I am speaking on behalf of the statewide non-profit family organization, the Association for Children's Mental Health. I am also the parent of a young adult who has experienced a serious mental illness.

The Association would like to commend the legislature and the Department of Community Health for recent initiatives focused on public education around children's mental health, expanded provision of home based therapy and statewide coordination of care.

I would like to share with you the Association's 2014 priorities, which you will find attached.

1. **We want assure that all children have access to the full array of community and home based services.**

   These services include home based support and treatment, behavior management training for parents, respite care, wraparound, community living supports and transition services. These services have proven most effective for the majority of minors, are most cost effective and are most likely to involve family members in the treatment process.

   Our concerns focus on the cuts to General Fund dollars to CMHSP/PIHPs. These funds have provided community based services to some minors who are ineligible for Medicaid. A misperception seems to exist that these children who are not receiving Medicaid will now be able to obtain community based services through the new insurance policies being offered on the Michigan Health Insurance Exchange. After considerable research, there is no insurance policy on the exchange that provides more than traditional outpatient services and inpatient hospitalization. Thus, thousands of minors will not receive the intensive home and community based services that are huge deterrents to the need for very costly psychiatric hospitalization.

   ACMH strongly urges the legislature to assure that all children in Michigan who could benefit from community based services have access to them. Increasing the non-Medicaid GF funding will increase the number of minors who can receive needed services and become productive, independent citizens of Michigan.

2. **Promote mental health/juvenile justice collaboration on behalf of children and youth with emotional, mental and behavioral challenges.**

   Thousands of minors each year enter the Juvenile Justice system who have significant emotional, mental and behavioral challenges. The mental health services to these children and youth are inadequate or nonexistent. Important mental health medication is often not administered while the minor is in the justice system.

   Education and training by the mental health system about the nature and needs of children and youth with emotional, mental and behavioral challenges and ongoing collaboration between the mental health and juvenile justice systems are critically important. Funding for youth diversion, comprehensive mental health services in the JJ system and restorative justice programs is needed to prevent these minors from deteriorating in the justice system.

3. **Support prevention/early intervention mental health services for young children.**

   ACMH is encouraged by the increased funding for prevention/early intervention services for young children. We urge the legislature to continue this trend. As we all well know, the sooner children receive mental health services, the better their chances of becoming mentally healthy adults who can truly contribute to communities in Michigan.

Association for Children's Mental Health

2014 ACMH Priorities

- **Promote adequate home and community based services for children and youth with emotional, behavioral, or mental health challenges.**

Why:

- Service most effective for majority of children with serious emotional disturbance.
- Treatment most cost effective for children with serious emotional disturbance.
- Treatment most likely to keep child in home and community.
- Treatment most likely to involve family members.

How:

- Increase CMHA general fund dollars, scheduled to be cut in 2015 to 28.2% of previous amount.
- Ensure that non-Medicaid insurance policies in Michigan cover community based services.
- Ensure a full continuum of community based services in all areas of the state.

- **Promote mental health/juvenile justice collaboration on behalf of children and youth with emotional, behavioral, or mental health challenges.**

Why:

- Children with serious emotional disorders generally do not receive appropriate mental health service in the juvenile justice system.
- Juvenile justice agency personnel typically lack an understanding of the nature and needs of children with serious emotional disturbance.
- A lack of collaboration between public mental health and juvenile justice agencies exists.

How:

- Educate juvenile justice systems about the needs of children with serious emotional disorders.
- Increase youth diversion programs and restorative justice programs.
- Increase mental health services to youth in detention centers and jails.
- Increase collaboration between mental health and juvenile justice agencies.

- **Support prevention/early intervention mental health service for young children.**

Why:

- Decreases the number of children with serious emotional disturbance in Michigan.
- Increases opportunities for support, education/training for parents/caregivers.
- Leads to more positive, sustained outcomes for children and families.

How:

- Increase funding to public and mental health programs engaging in prevention/early intervention.
- Increase public awareness about mental health issues in young children.

DCH SC 2/24/14
Alan
Brown

Senate and House Appropriations Subcommittees on Community Health

Office of Services to the Aging Budget

2/20/14

Good afternoon. I am Alan Brown, Executive Director of the Midland County Council on Aging. I am here also representing the 55 members of the Michigan Directors of Services to the Aging Association (county level commissions and councils on aging), who provide direct services to Michigan's older adults in most of our counties. Thank you for the opportunity to testify today. We are grateful for the support of the committee for the increase in the current year OSA budget for Home Delivered Meals, and are very encouraged by the proposed $5 Million increase recommended by the Governor for the Community Services and Nutrition line items in the 2015 budget. MDSA is proud to be a partner in the Silver Key Coalition, which is supporting this funding increase and calling attention to the needs of our most frail and impoverished seniors.

The White Paper developed by the coalition clearly demonstrates the cost savings and total return on investment gained through providing in home services that keep seniors out of costly institutional placement. I would like to point out how this investment leverages and supports the vital contributions of family caregivers. Estimates are that between eighty and ninety percent of caregiving tasks and activities are provided by families or other unpaid caregivers who provide an average of just over 20 hours per week in direct caregiving activities. Fifty-three percent of these caregivers are over 65 themselves, most are women, over twenty-five percent are low-income, and many struggle with their own disabilities. Among the tasks they perform are helping the person get in and out of beds and chairs, dressing, bathing or showering, getting to and from the toilet, dealing with incontinence, and helping with meal preparation and feeding. In an AARP study of the economic value of caregiving, it was reported that the average family cargiver incurred out of pocket costs of over $5,500 a year in addition to their time and non-cash support.

And these contributions come at a high cost to the caregivers. OSA reports that almost thirty percent of caregivers in Michigan describe their own health as fair or poor. A national study found that spouses who experience mental or emotional strain due to their caregiving have a sixty-three percent greater chance of dying than non-caregivers. They also report that caregiver burden causes high levels of depression, takes time away from family and friends, and interferes with work performance for those still in the workforce.

In-Home services and Home Delivered Meals provide respite, direction, encouragement, and added hands to ease the burden on caregivers. These additional funds will provide a tremendous return on investment and gives us one of those rare opportunities where doing the right thing is also the most economical. By supporting this increase, you will enhance the quality of life for both our frail seniors and their caregivers.

As Rosalynn Carter has stated, **"There are only four kinds of people in the world --**
those who have been caregivers,
those who currently are caregivers,
those who will be caregivers,
and those who will need caregivers."

Supporting this increase will ultimately support us all.

Thank you for your time and attention.

DCH SC 2-24-14
Kaithlynn Colbert

Testimony: Department of Community Health

February 2014

Mary B. Sutton Michigan After-School Partnership mustton@uwmich.org www.miafterschool.org

Childhood Obesity Prevention and Afterschool Programs

The obesity crisis in America is ubiquitous and irrefutable, and it's hitting youth so hard that health experts warn that this generation of children will be the first to have a shorter life expectancy than their parents. Tackling and reversing this epidemic will require a comprehensive and sustained effort in every community in Michigan. Our growing network of afterschool providers can make a significant contribution to this battle. Afterschool programs can provide physical activity and nutrition education, healthy snacks and a safe place to play and socialize in the hours after school.

- **Childhood obesity is a growing epidemic.**
- **The health and economic costs are astounding.**
- **Children are not getting enough physical activity and have unhealthy eating habits.**
- **Afterschool programs can help combat the epidemic of childhood obesity.**

- A study measuring the health and social benefits of afterschool programs found that controlling for baseline obesity, poverty status, and race and ethnicity, the prevalence of obesity was significantly lower for afterschool program participants (21 percent) compared to nonparticipants (33 percent). (Mahoney, J., Lord, H., & Carryl, E., Lawrence Erlbaum Associates, Inc, 2005)
- Teens who do not participate in afterschool programs are nearly three times more likely to skip classes than teens who do participate. They are also three times more likely to use marijuana or other drugs and are more likely to drink, smoke and engage in sexual activity. (YMCA of the USA, 2001)
- Early childhood education expert James Heckman concludes that a complement of early education and participation in afterschool programs can reduce initiating drug use among youth by nearly 50 percent. (University of Chicago, 2006)

Additional before- and after- school programs will also help decrease child obesity, expand physical activity, and increase parent and community involvement in schools.

Afterschool: Key to Health and Wellness for Pre-teens and Teens

With a growing number of school hours devoted to increased instructional time and physical education programs being scaled back in many schools, the afterschool hours are becoming increasingly crucial to ensuring the healthy development of our nation's youth. Additionally, with students spending the majority of their waking hours and consuming the majority of their meals out of school, afterschool and summer learning programs present a unique opportunity to promote healthful eating and living habits. Middle schoolers in particular, who are often fueled by their desire to find a place where they belong and are at risk of making decisions that negatively affect their overall health, can benefit greatly from the lessons on nutrition and the increased opportunities for physical activity that afterschool programs can provide. Middle school programs across the country offer youth a mix of academic and physical enrichment that promotes positive physical, emotional and social development. By offering sports programs, teaching children about healthy food choices, supplying mentors to steer teens and pre-teens away from drugs, smoking and alcohol, and displaying other innovative ways to promote healthy lifestyles among adolescents, afterschool programs are leading the way toward healthier lifestyles for America's middle schoolers.

There is Work to Be Done to Promote a Healthier Generation of Teens and Pre-Teens

There are innumerable health issues facing middle school students. The childhood obesity crisis continues to worsen in the U.S., with an estimated one in six children (16 percent) from ages 10 to 17 considered to be obese.. Type 2 diabetes, once known as "adult-onset diabetes", is now becoming more common among adolescents, especially in minority communities. Additionally, overweight children are more likely to be the target of taunting and teasing in school, a serious risk to mental health, leading to lower

self-confidence and a higher risk of depression.3 Middle school is also a time of increased independence, and with it comes the risks of poor decision-making, which can be reflected in poor food choices and in drug or alcohol use. In addition, there are many recent developments that have led to the increased health dangers to pre-teens and teens:

The Future for Health and Wellness in Afterschool Looks Bright

Afterschool programs for middle schoolers that focus on positive physical, as well as academic, outcomes are an invaluable resource for alleviating the health crisis facing teens and pre-teens. The afterschool time allows schools and community organizations to reinforce nutritious food choices and encourage involvement in physical fitness activities.

Afterschool programs can be a particularly valuable resource to middle schoolers' health because they:

- Serve children most at risk for being overweight, including minorities and those from lower socio-economic status families.
- Occur during a time of the day that many children would otherwise be sedentary and not likely to participate in physical activity.
- Provide meals and snacks that can serve as nutritious examples.
- Provide staff who understand children's needs and can promote healthy eating and active lifestyles.12
- Provide an opportunity for young people to interact with role models displaying healthy eating habits and leading healthy lifestyles.

Research shows that programs that utilize the afterschool space as a site for enjoying physical activity and learning about healthy lifestyles can improve student health outcomes.

- A study measuring the health and social benefits of afterschool programs found that controlling for baseline obesity, poverty status, and race and ethnicity, the prevalence of obesity was significantly lower for afterschool program participants (21 percent) compared to nonparticipants. (33 percent).
- A report by the U.S. Department of Education found that 10-16 year olds who have a relationship with a mentor are 46 percent less likely to start using drugs and 27 percent less likely to start drinking alcohol.
- A study reported in the Journal of Adolescence found that youth whose summer arrangements involved regular participation in organized activities showed significantly lower risk for obesity than other youth. This was most evident during early adolescence – the middle school years. Youth whose regular summer arrangement was primarily parent care without organized activity participation showed the greatest risk for obesity

Solutions Exist to Overcome Barriers and Encourage Stronger, Healthier and Smarter Middle Schoolers after School
Afterschool programs encourage youth to monitor their nutrition and physical activity habits on a continuous basis and encourage improvement. In addition, they can integrate interactive nutrition education and physical fitness learning through activities such as taste testing, planting vegetable gardens, analyzing food commercials, preparing healthy snacks, measuring fat content in typically consumed foods or visiting a local recreation facility.

Afterschool programs can involve the entire family to ensure that the nutrition and fitness lessons learned after school are implemented in the home.

Afterschool programs increase partnerships between schools, local governments, community-based organizations, and local businesses to enhance physical activity offerings after school.

Afterschool programs promote healthy eating by offering healthy meals and snacks – particularly through participation in the federal afterschool snack and supper programs. They also combine physical development with academic and social gains that encourage overall health in participants, especially among students who would otherwise be uninterested in fitness activities.

In addition, policies that encourage shared-use or joint-use agreements, widespread adoption of guidelines and standards and funding for staff training and equipment will help afterschool programs effectively promote a healthy childhood for all middle school students. With an established track record, afterschool and summer learning programs should not be underestimated as potential 'game changers' in promoting wellness among young people.

Support Sec.4 – 654 for before and afterschool healthy exercise programs and request expansion to $3 mill to include students beyond grade 6.

Saginaw County Community Action Committee, Inc.
2824 Perkins Street
Saginaw, MI 48601
(989) 753-7741

February 20, 2014

Dear Chairman Lori,

I regret that I was unable to attend the Department of Community Health budget hearing on February 24. In my absence, please accept this letter in lieu of a support card as a show of my support for increasing the Office of Services to the Aging budget.

An increase of $5 million in FY 15 will provide much needed help to the nearly 4,500 seniors languishing on long waiting lists for services. These services help seniors to remain independent and in their own homes for as long as possible. Please help to make Michigan a No Wait State for senior in-home services.

Sincerely,

Lillie L. Williams
Executive Director
Saginaw County Community Action Committee Inc.
2824 Perkins Street
Saginaw, MI 48601
(989) 753-7741 Office

REGION VII AREA AGENCY ON AGING

YVONNE CORBAT, CHAIR

ANDREW ORVOSH, EXECUTIVE DIRECTOR

MEMBER COUNTIES: BAY ■ CLARE ■ GLADWIN ■ GRATIOT ■ HURON ■ ISABELLA ■ MIDLAND ■ SAGINAW ■ SANILAC ■ TUSCOLA

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Sincerely,

Andrew Orvosh

Andrew J. Orvosh
Executive Director
Region VII Area Agency on Aging

AO/aj

1615 S. EUCLID AVENUE
BAY CITY, MI 48706
989-893-4506 ■ FAX 989-893-3770
1-800-858-1637 ■ WAIVER FAX (989) 893-2651

www.region7aaa.org

6240 W. MAIN STREET
CASS CITY, MI 48726
1-800-276-2137 ■ 989-872-5477
FAX 989-872-5691

Silver Key Coalition

Working to Make Michigan a No Wait State for Senior In-Home Services

www.silverkeycoalition.com

Steering Committee

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Area Agency on Aging 1-B

Region IV Area Agency on Aging

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Michigan Directors of Services to the Aging Association

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Sincerely,

Liz Abbate Marzolf

lizabbatemarzolf@comcast.net
564 Grey Rd.
Auburn Hills, MI 48326

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Sincerely,

TRAVIS KELLY
411 VALLEY HOME CARE
441. S. LIVERNOIS STE 160
ROCHESTER HILLS, MI 48307

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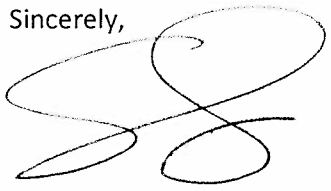

STEVEN FAINE
22446 SHADOWGLEN DR
FARMINGTON HILLS, MI 48335

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Sincerely,

Theresa Johnson, AAA 1-B Adv. C.
39114 Adams Dr.
Sterling Hts., MI 48313

Silver Key Coalition

Working to Make Michigan a No Wait State for Senior In-Home Services

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Sincerely,

Director, Aging Studies Program
Eastern Michigan University

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Sincerely,

David Eisler

Kirkwood Home Care

Silver Key Coalition

Working to Make Michigan a No Wait State for Senior In-Home Services

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I regret that I was unable to attend the Department of Community Health budget hearing on February 24. In my absence, please accept this letter in lieu of a support card as a show of my support for increasing the Office of Services to the Aging budget.

An increase of $5 million in FY 15 will provide much needed help to the nearly 4,500 seniors languishing on long waiting lists for services. These services help seniors to remain independent and in their own homes for as long as possible. Please help to make Michigan a No Wait State for senior in-home services.

Sincerely,

Anne Armstrong Sweeney

24911 Rockford

Dearborn, MI 48124

Ryan Cowmeadow

From: Fetterolf,Mark E [Mark.Fetterolf@edwardjones.com]
Sent: Wednesday, February 19, 2014 7:14 PM
To: undisclosed.for.privacy
Subject: RE: Support the Silver Key Coalition

February 19, 2014

Dear Chairman Lori,

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Sincerely,

Mark E. Fetterolf
Edward Jones
Making Sense of Investing
Financial Advisor
cell: 989-859-5376
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Silver Key Coalition

Working to Make Michigan a No Wait State for Senior In-Home Services

www.silverkeycoalition.com

Steering Committee

Area Agency on Aging Association of Michigan

Area Agency on Aging 1-B

Region IV Area Agency on Aging

Community Living Services

Disability Network of Michigan

Michigan Directors of Services to the Aging Association

Collaborative Partners

Advocates for Senior Issues

Area Agency on Aging Association of Western Michigan

Region 3-B Area Agency on Aging

Senior Regional Collaborative

Paraprofessionals Healthcare Institute (PHI)

Michigan Association for Home Care

Michigan Senior Advocates Council

National Multiple Sclerosis Society Michigan Chapter

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Sincerely,

Robert Fox

Chairman: Michigan Senior Advocates Council

Silver Key Coalition

Working to Make Michigan a No Wait State for Senior In-Home Services

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Sincerely,

Valerie Pierson

Valarie Pierson
2651 International Dr. Apt 1407
Ypsilanti MI 48197

Silver Key Coalition

Working to Make Michigan a No Wait State for Senior In-Home Services

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Sincerely,

Ryan Commerford
Ypsilanti, MI 48197

DCH SC 2/24/14
Jim McGuire

Silver Key Coalition

Working to Make Michigan a No Wait State for Senior In-Home Services

WHITE PAPER EXECUTIVE SUMMARY

State supported home and community based services provide the basic necessities that help enable seniors to stay safely in their housing of choice. The need for these services exceeds availability, forcing seniors to wait for help and bear the negative consequences of going without. As a result, thousands of Michigan seniors languish on wait lists for key in-home services made available through the Michigan Office of Services to the Aging (OSA) like personal care, homemaking and home delivered meals, with little hope for assistance. This White Paper was developed by the Silver Key Coalition to document the impact of in-home service wait lists, underserving and unmet needs, and support its goal of making Michigan a no wait state for in-home services.

Key Findings:

- In 2014 there are nearly 4,500 seniors languishing on wait lists for basic services such as home-delivered meals and help with bathing, dressing, medication, shopping and household chores. About half of the individuals on the wait lists have been waiting for more than 180 days.
- Individuals on wait lists for extended periods of time are:
  - More likely to end up living in a nursing home
  - Less likely to remain living in their own home
  - More likely to seek health care from a hospital emergency room
  - More likely to die waiting for assistance.
- An increase of $5 million for the fiscal year 2015 will be needed to allow the Michigan Office of Services to the Aging in-home services programs to begin addressing the service needs of those on wait lists, accommodate anticipated new requests for assistance, and begin addressing the needs of the underserved population of individuals who are receiving assistance, but not in the amount that they need due to service rationing.
- The effort to make Michigan a "No Wait State" for in-home services will be a key component of a larger strategy to make Michigan a retirement destination of choice that attracts and retains retirees, and captures the significant social and economic benefits of an aging population.
- A $5 million investment will yield many benefits to taxpayers, businesses and the state, including:
  - Creating approximately 200 new jobs
  - Return approximately $350,000 in state tax revenue
  - 75% of food purchased from Michigan based sources

A FY 2015 allocation increase of $5 million in state general revenue funding for in-home services provided through the Michigan Office of Services to the Aging, coupled with the leveraging of participant donations and other funding sources, will represent an important step in eliminating the state's chronic in-home service wait lists of older Michiganians.

The Silver Key Coalition is a group of individuals and organizations committed to supporting the desire of older adults and adults with a disability to remain living independently in their own home for as long as possible. The Coalition advocates for a $10 million multi-year increase in state supported in-home services through the Michigan Office of Services to the Aging. The Coalition goal is to make Michigan a "no wait state" for in-home services, beginning with a $5 million increase in state funding for FY 2015.

www.silverkeycoalition.com ** silverkeycoalition@gmail.com

DCH SC 2/24/14
Jim McGuire

Silver Key Coalition

Working to Make Michigan a No Wait State for Senior In-Home Services

THE EXTENT AND IMPACT OF UNMET IN-HOME SERVICE NEED ON MICHIGAN'S NON MEDICAID ELIGIBLE SENIORS, ADULTS WITH DISABILITIES AND THEIR CAREGIVERS

February, 2014

The Silver Key Coalition is a group of individuals and organizations committed to supporting the desire of older adults and adults with a disability to remain living independently in their own home for as long as possible. The Coalition recognizes that having a key to one's own home is one of the most important quality of life elements, and advocates for a $10 million multi-year increase in state supported in-home services through the Michigan Office of Services to the Aging. The Coalition goal is to make Michigan a "no wait state" for in-home services, beginning with a $5 million increase in state funding for FY 2015.

www.silverkeycoalition.com ** *silverkeycoalition@gmail.com*

This White Paper was developed by the following members of the

Silver Key Coalition Data Workgroup

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Ryan Cowmeadow
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EXECUTIVE SUMMARY

State supported home and community based services provide the basic necessities that help enable seniors to stay safely in their housing of choice. The need for these services exceeds availability, forcing seniors to wait for help and bear the negative consequences of going without. As a result, thousands of Michigan seniors languish on wait lists for key in-home services made available through the Michigan Office of Services to the Aging (OSA) like personal care, homemaking and home delivered meals, with little hope for assistance. This White Paper was developed by the Silver Key Coalition to document the impact of in-home service wait lists, underserving and unmet needs, and support its goal of making Michigan a no wait state for in-home services.

Key Findings:

- In 2014 there are nearly 4,500 seniors languishing on wait lists for basic services such as home-delivered meals and help with bathing, dressing, medication, shopping and household chores. About half of the individuals on the wait lists have been waiting for more than 180 days.
- Individuals on wait lists for extended periods of time are:
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- The effort to make Michigan a "No Wait State" for in-home services will be a key component of a larger strategy to make Michigan a retirement destination of choice that attracts and retains retirees, and captures the significant social and economic benefits of an aging population.
- A $5 million investment will yield many collateral benefits to taxpayers, businesses and the state, including:
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    - Return approximately $350,000 in state tax revenue
    - 75% of food purchased from Michigan based sources

A FY 2015 allocation increase of $5 million in state general revenue funding for in-home services provided through the Michigan Office of Services to the Aging, coupled with the leveraging of participant donations and other funding sources, will represent an important step in eliminating the state's chronic in-home service wait lists of older Michiganians.

PURPOSE STATEMENT/INTRODUCTION

Research consistently shows that the vast majority of older adults wish to remain in their homes as they age as opposed to more institutional settings. A 2011 AARP survey found, "nearly 90 percent of people over age 65 want to stay in their home for as long as possible, and 80 percent believe their current residence is where they will always live. However, for older adults to age in place, their physical and service environment must be accommodating[1]." State supported home and community based services provide the basic necessities that help enable seniors to stay safely in their housing of choice. The need for these services exceeds availability, forcing seniors to wait for help and bear the negative consequences of going without.

As a result, thousands of Michigan seniors languish on wait lists for key in-home services made available through the Michigan Office of Services to the Aging (OSA) like personal care, homemaking and home delivered meals, with little hope for assistance. At the beginning of FY 2014 there were 3,568 seeking help with in-home services and over 952 requesting home delivered meals due to their difficulty being able to perform necessary activities of daily living such as meal preparation, grooming, bathing, etc. A recent survey of those on in-home service wait lists found dire consequences for individuals, family caregivers, and taxpayer-supported state services when they are denied the help needed to remain living independently in a safe and supported environment. Within two years after being placed on a wait list those who received no help were:

- Five times more likely to be living in a nursing home
- 20% less likely to be still living in their own home
- Twice as likely to have received treatment from a hospital emergency room in the past 90 days
- 25% more likely to have died

The increased burden on disabled seniors' family caregivers was also significant:

- Caregiving was three times more likely to interfere with their work
- Caregivers were five times more likely to have suffered a financial loss due to their caregiving responsibilities[2]

The wait list problem has been compounded by an annual 2% increase of about 50,000 Michigan seniors and the loss of $8.1 million in state support for OSA programs since 2009.

The purpose of this white paper is to document the extent and impact of unmet in-home service needs among older Michiganians and adults with a disability, as well as the impact on family caregivers. The paper provides data that justifies an increase in state support for in-home services targeted to near-poor individuals who do not qualify for welfare or other Medicaid long term care programs.

The paper has been prepared by the Silver Key Coalition, a group of individuals and organizations committed to supporting the desire of older adults and adults with a disability to remain living independently in their own home for as long as possible. The Coalition recognizes that having a key to one's own home is one of the most important quality of life elements, and advocates for a $10 million multi-year increase in state supported in-home services through the Michigan Office of Services to the Aging. The Coalition goal is to make Michigan a "no wait state" for in-home services, beginning with a $5 million increase in state funding for FY 2015.

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[1] (2011). Aging in place: A state survey of livability policies and practices. *In Brief, 190*, Retrieved from http://www.aarp.org/home-garden/livable-communities/info-11-2011/Aging-In-Place.html

[2] Based on a study of two-year outcomes for 1,471 individuals placed on in-home service wait lists in Livingston, Macomb, Monroe, Oakland, St. Clair, and Washtenaw counties in 2008, conducted by Area Agency on Aging 1-B.

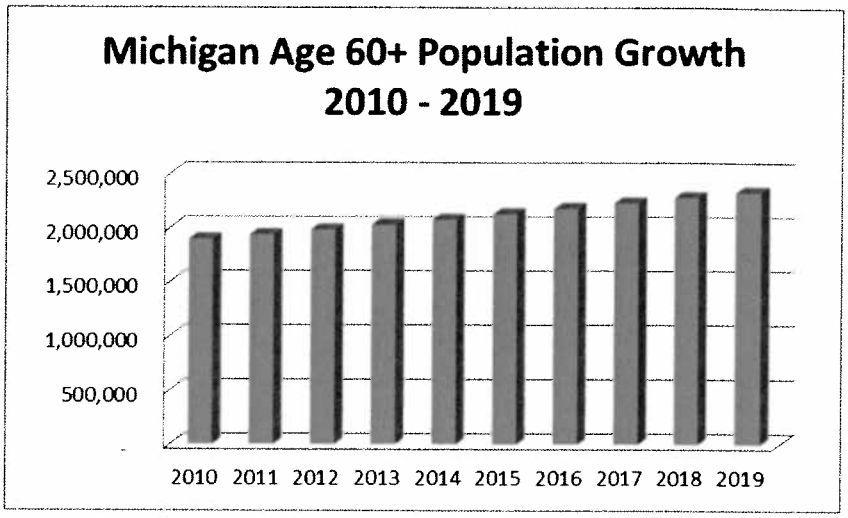
DEMOGRAPHICS

MICHIGAN'S OLDER ADULT POPULATION GROWTH

Michigan's age 60 and older population exceeds 2 million, will increase by over 50,000 in 2014, and will continue at that level of annual increases throughout the rest of the decade according to the US Census Bureau population projections.[3] This represents a growth rate of 141 more seniors each day. In contrast, every other age group is expected to decline.

Michigan has more seniors age 60 and older than school age children (ages 5 – 19).

6% of the 2014 senior population increase is for the age 85 and older population (3,147), which is increasing at a rate of 60 more seniors each week, and which represents the population that is the highest users of home and community-based services. The growth figures suggest a potential annual growth in home and community-based service demand of approximately two percent for the remainder of the decade based on population alone.



Annual Growth of Michigan 60 and Older Population

Year	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*2018*
60+	1,892,731	1,935,541	1,981,026	2,027,038	2,074,944	2,126,668	2,177,017	2,229,323	2,281,412
Increase	42,810	45,485	46,012	47,906	51,724	50,349	52,306	52,089	48,301
Percent	2.26%	2.35%	2.32%	2.36%	2.49%	2.37%	2.40%	2.34%	2.12%

PREVALENCE OF DISABILITY IN MICHIGAN

Of the 4,092,847 adults in Michigan age 18-59, almost one in six of them are living with a disability. For adults over age 60 the prevalence of disability increases to almost one in three.[4]

	Total Population	**Population with a Disability**
Total Age 18+	6,104,749	1,240,906 (20%)
Age 18-59	4,092,847	603,133 (15%)
Age 60+	2,011,902	637,773 (32%)

[3] File 2. Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July, 1 2004 to 2030. Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.

[4] U.S. Census Bureau, 2012 American Community Survey 1-Year Estimates (Tables S1810 ,B18108, and S0102)

Not only are there almost 1.25 million adults in Michigan with a disability, but 10%, or 627,158 of those individuals suffer from multiple disabilities. Multiple disabilities are especially prevalent in the population over age 65, where nearly 20% have two or more disabilities.[5]

The table below details the estimated number of adults in Michigan living with each type of disability.[6]

	Total Population	Any Disability	Two or More Disabilities	Independent Living	Self-Care	Ambulatory	Hearing	Vision	Cognitive
Adults 18+	6,104,749	1,240,906	627,158	499,061	266,503	700,648	347,592	187,921	452,347
% of Adults 18+		20%	10%	8%	4%	11%	6%	3%	7%
Adults 65+	1,404,130	505,535	354,776	220,213	119,385	316,381	210,181	82,342	127,077
% of Adults 65+		36%	25%	16%	9%	23%	15%	6%	9%

The two disability categories that are relevant in this paper are self-care difficulty, defined as "difficulty dressing or bathing" and independent living difficulty, defined as "difficulty doing errands alone, such as visiting a doctor's office or shopping, because of a physical, mental, or emotional condition." (2011 Disability Status Report Michigan) These definitions lead to the assumption that people with a self-care difficulty correspond with those who have difficulty performing at least one activity of daily living (ADL) and that people with an independent living difficulty can also be said to have difficulty with at least one instrumental activity of daily living (IADL).

Based on this assumption, it is estimated that 266,503 people in Michigan, 119,385 (45%) of whom are over the age of 65, have difficulty with an activity of daily living. Additionally, 499,061 people have difficulty with an instrumental activity of daily living, 220,213 (44%) of whom are over the age of 65. These figures are for the population living independently in the community, and exclude nursing home or assisted living facility residents.

IN-HOME SERVICE PARTICIPANT CHARACTERISTICS[7]

In-home services assist individuals with functional, physical, or mental characteristics that limit their ability to care for themselves and for whom informal supports (e.g., family or friends) are either unavailable or insufficient. Targeting for in-home services is based on social, functional, and economic characteristics. In 2013,

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[5] U.S. Census Bureau, 2012 American Community Survey 1-Year Estimates (Tables S1810 ,B18108, and S0102)

[6] U.S. Census Bureau, 2012 American Community Survey 1-Year Estimates (Tables S1810 ,B18108, and S0102)

[7] All service, participant characteristic and expenditure contain in the report is preliminary data taken from the 2013 Michigan Aging Information System NAPIS Participant and draft Service Report prepared by the Michigan Office of Services to the Aging. This data is considered preliminary until such time that it has been submitted by the Michigan Office of Services to the Aging (OSA) as part of fiscal year 2013 State Program Report (SPR) and certified by the federal Administration on Aging.

19,585 older adults were supported by 748,087 hours/units of care management, case coordination and support, chore, homemaker, home health aide, and personal care provided through OSA. There were 51,187 home delivered meal participants who received 7,886,265 meals.

IN-HOME SERVICE PARTICIPANT PROFILE

In-home service participants are more likely to be female, live alone, have low income, be of advanced age, and report ambulatory, self-care, and independent living difficulties compared to Michigan's older adult population. A higher proportion of Michigan's older racial and ethnic minority populations and older rural population is served by OSA in-home services.

Participant Characteristics

In-Home Service Participant Characteristics	Home Delivered Meal Participant Characteristics
69% were 75 or older	67% were 75 or older
35% were 85 or older	35% were 85 or older
56% lived alone	49% lived alone
31% were low income	36% were low income
71% were female	65% were female

Participant Limitations in Ability to Perform Activities of Daily Living and Independent Activities of Daily Living

In-Home Service Participant ADL and IADL Limitations		Home Delivered Meal Participant ADL AND IADL Limitations	
Shopping	**66%**	Shopping	**76%**
Cleaning	**61%**	Cleaning	**54%**
Cooking meals	**62%**	Cooking Meals	**75%**
Using transportation	**55%**	Using Private transportation	**58%**
Stair climbing	**53%**	Stair climbing	**58%**
Doing laundry	**55%**	Doing laundry	**62%**
Walking	**50%**		

AT RISK PARTICIPANTS

Approximately 6.8% of in-home service participants (4,252) were classified as at-risk individuals who have specific activity of daily living limitations that are consistent with a nursing facility level of care[8]. This nursing home-eligible population was older, had lower incomes, and was at greater nutritional risk than the general in-home services population. Interestingly, they were less likely to live alone, presumably because they required such a high level of support that OSA in-home services were filling the gaps in care that family caregivers were unable to provide. These individuals at highest risk for institutionalization were disproportionately high users of case management and personal care.

[8] "At-Risk" includes in-home and home-delivered meals participants that require assistance with daily toileting, transferring, and mobility. These ADLs were selected based on Scoring Door 1 for the Michigan Medicaid Nursing Facility Level of Care Determination in MSA 04-15.

At-Risk Participant Service Utilization[9]

	Service Units	At-Risk Participants*	All Participants*	% At-Risk
Care Management	3,708	597	3,469	17.2%
Case Coordination & Support	2,647	308	8,632	3.6%
Chore	2,138	136	2,479	5.5%
Home-Delivered Meals	547,652	3,436	51,187	6.7%
Homemaker	28,650	409	7,541	5.4%
Personal Care	37,796	414	3,799	10.9%
Totals	**622,591**	**4,252**	**62,812**	**6.8%**

** Particpant totals are unduplicated*

[9] At Risk Participant Data is for the combined in-home service and home delivered meal population.

IN-HOME SERVICE NEED

IN-HOME SERVICE WAIT LISTS[10]

Michigan has a long history of chronic waiting lists for in-home programs supported through the Michigan Office of Services to the Aging (OSA). Wait lists exist when the demand for government subsidized services by individuals who cannot afford to purchase needed in-home assistance at private market rates, which in Michigan averages $19 an hour for homemaking workers and $20 an hour for home health aides[11], exceeds the supply of subsidized services in a given community, usually county-wide or region-wide. As a general rule, the federal funds provided through the Older Americans Act to states are insufficient to support the level of services needed by the state's older adult population to support independent living of disabled seniors. Adequately meeting needs requires contributions of state and/or local dollars that exceed minimum federal matching requirements. In Michigan, the largest portion of these additional dollars are provided locally through the 63 voter-approved county senior millages. The estimated $60 million in local senior millages raised annually is more than twice the amount of state funds allocated for senior services. Older adults living in communities with a senior millage are less likely to face a wait list when seeking services.

The OSA collects home delivered meal and other in-home service waiting list data from area agencies on aging on a quarterly basis. At the beginning of FY 2014, there were 952 individuals on waiting lists for home delivered meals and 3,568 on waiting lists for other in-home services in Michigan. 63% of Michigan's 16 area agency on aging regions have waiting lists for home delivered meals, and 88% have waiting lists for the other in-home services.

The absence of a wait list does not mean that there are no unmet service needs for a program or community. Many programs ration the amount of service to older adults, offering fewer hours or meals than are needed in order to extend at least some level of service to a higher number of individuals. There are also instances where some services have been completely eliminated. For example one out-of-home respite program was closed due to the FY 2013 sequestration cuts, despite having services reserved six months in advance. The wait list for this terminated service is no longer kept. Other examples of unmet needs in Michigan that are not documented by wait lists include home delivered meal recipients who need assistance with a second evening or weekend meal, offering chore services only to individuals with income below 150% of the federal poverty level, offering the choice of a chore service of lawn mowing or snow removal but not both, offering personal care clients one bath a week when two are requested, or offering time-limited subsidized services that require private pay for the full

[10] All service, participant characteristics and expenditures contained in the report are preliminary data taken from the 2013 Michigan Aging Information System NAPIS Participant and draft Service Report prepared by the Michigan Office of Services to the Aging. This data is considered preliminary until such time that it has been submitted by the Michigan Office of Services to the Aging (OSA) as part of fiscal year 2013 State Program Report (SPR) and certified by the federal Administration on Aging.

[11] Metlife, Metlife Mature Market Institute. (2012). *Market survey of long-term care costs*. Retrieved from website: https://www.metlife.com/assets/cao/mmi/publications/studies/2012/studies/mmi-2012-market-survey-long-term-care-costs.pdf

cost of ongoing service. OSA receives information on underserving, but the information is difficult to accurately quantify, and no formal consolidated reports are available.

The study on the impact of long term presence on a wait list referenced elsewhere in this paper[12] found that going without services for one to two years significantly increases the possibility of negative consequences such as nursing home placement, forced move, lost work for family caregivers, and death. This is a troublesome issue for older Michiganians because approximately one in three seniors on a home delivered meals wait list have been waiting for meals longer than six months, and almost one half of individuals waiting for in-home services have been on a wait list longer than six months.

	Number on waiting list	Stay less than 30 days	30 to 60 days	61 to 179 days	Greater than 180 days	% Greater than 180 days
Home Delivered Meals	952	218	182	232	320	33.6%
Other In-Home Services	3,568	454	568	879	1,667	46.7%

OSA also collects data on the root causes of wait lists, and for those areas with wait lists, the limited availability of governmental or philanthropic funding to subsidize the cost of in-home services is the primary causal factor. Lack of funding is a cause for 69% of the areas with home delivered meals wait lists and it is the cause for 94% of areas with wait lists for other in-home services. Other causes relate to an inadequate infrastructure for service delivery, such as an inadequate volunteer or worker availability.

Demand Exceeds Service Availability due to:	HDM	In-Home
Limited funding for services	69%	94%
Limited service area/service delivery availability	19%	13%
Driver/worker shortage	19%	25%
Client choice	19%	38%

When individuals seeking in-home assistance are placed on a wait list, efforts are made to link them with other related community resources. The table below indicates the type of resources wait listed older adults are referred to, and the frequency at which they are referred.

AAA Assistance/Referrals are Provided to:	HDM	In-Home
Local non-AAA food assistance program (e.g., MiCAFE, Senior Project FRESH)	69%	75%
Local food bank/pantry shelf	56%	81%
Michigan Department of Human Services (DHS) office	50%	94%
HCBS/ED MI Choice Medicaid Waiver Program	50%	88%
ADRC/CLP options counseling for service options	25%	50%
Private pay program	38%	94%
Other assistance	32%	50%

[12] Based on a study of two-year outcomes for 1,471 individuals placed on in-home service wait lists in Livingston, Macomb, Monroe, Oakland, St. Clair, and Washtenaw counties in 2008, conducted by Area Agency on Aging 1-B

THE COST TO ELIMINATE IN-HOME SERVICE WAIT LISTS

The 2013 – 2014 Older Michiganians Day Platform calls for making Michigan a "No Wait List State" for in-home services. Based on inflation adjusted costs stated in the 2012 OSA NAPIS report, which is the most recent completed report available, it is a straightforward exercise to calculate the amount of dollars needed to provide a historically expected amount of in-home services to every individual on a wait list. The calculated cost to provide services for a year to all wait listed individuals carried into FY 2015 would be $3,325,823. This calculation assumes that the cost per unit of service would increase consistent with the projected rate of inflation[13] and that the distribution of service needs and length of service for wait listed individuals among the various in-home services would remain consistent with the FY 2012 distribution.

	In-Home Service Category	# Served in 2012	% of Total In-Home Services in 2012[14]	# on In-Home Wait List 4th Quarter 2013 (3,568)[15]	Cost per Unit[16]	Average # of Units per Participant[17]	Cost
1	Care Management	3,159	12.27%	438	$326.53	7.49	$1,070,707
2	Case Coordination and Support	8,752	34.01%	1,213	$23.73	7.79	$224,318
3	Chore	3,026	11.76%	420	$23.01	11.95	$115,374
4	Homemaker	6,689	25.99%	927	$13.39	46.52	$577,630
5	Personal Care	4,105	15.95%	569	$16.61	58.17	$549,856
6	Home Delivered Meals	NA	NA	952[18]	$4.34	157.35	$650,119
	Totals	25,731	99.98%	4,519			**$3,188,006**
	Inflation Adjustment of 4.323% (includes 2014 - 2.17%; 2015 - 2.151%) = **$137,817**						**$3,325,823**

[13] Source: www.tradingeconomics.com

[14] 2012 Funding Source Distribution (2012 OSA NAPIS Report pg. 7)

Local Program Income	5.4%
Local Matching Funds	20.7%
State Funds	54.2%
Federal Funds	19.6%
Total	100%

[15] Estimated number on wait list for each service was extrapolated by using the total number of individuals receiving service in 2012 divided by the overall number of individuals utilizing all above listed services. The total waiting for service per FY 13 4th quarter wait list data is 3,568 x each service percentage = estimated number waiting per service.

[16] Cost per unit was calculated by dividing the overall service expenditure by the total number of units provided in FY 2012

[17] Average number of units was calculated by taking the total number of units provided per service divided by the total number of participants for each service.

[18] Actual wait list data based upon FY 13 fourth quarter preliminary data from Michigan Aging Information System NAPIS Participant and draft Service Report prepared by Michigan Office of Services to the Aging

It must be noted that wait lists for service is a meaningful indicator of the extent of unmet needs for in-home services, but should not be interpreted to be the sole indicator of unmet need. Wait lists can underestimate unmet need for a variety of reasons:

- Many areas with chronic or excessive wait lists have what is known as wait list fatigue – a situation where applicants and referral sources no longer contact service providers because they know that they will be placed on a long waiting list if they reach out for help, with little hope for receiving services.
- There is significant rationing of services, where participants receive some help, but not as much as is needed, such as only receiving assistance with one bath per week, or one day of adult day care respite per week. On October 1, 2013 63% of Area Agencies on Aging regions reported they had home delivered meal recipients who are underserved in this way, and receive services at levels that are less than the participant's identified need. 69% of the regions reported the same for other in-home services.

PROJECTED UNMET NEEDS RESEARCH

Adults who need help with activities of daily living (ADLs) require assistance with things like bathing, continence, dressing and undressing, eating, toileting, transferring, and walking. Research shows that about 20.7% of older adults who need help with one or more ADL's have an unmet need for assistance. [19] Unmet need is more prevalent among older adults who have difficulty with two or more ADL's. Up to 29% of this group may have an unmet need.[20] Based on this information, there are almost 25,000 older adults in Michigan who have trouble with one or more ADL's and need more assistance than they currently receive[21].

It is estimated that half of all individuals with unmet needs for such assistance are experiencing negative consequences as a result of not receiving the help that they need.[22] Examples of a negative consequence include:

- Discomfort at not bathing often enough
- A burn or scald caused by bathing with water that is too hot
- Discomfort at not changing dirty clothing often enough
- Inability to eat when hungry
- Inability to walk to the bathroom when necessary
- Discomfort or soiled clothing because of inability to get to the bathroom

The study found that because an adequate level of in-home services are not provided to these adults with an unmet need, more than 12,000 of them likely experience one or more of these negative consequences, to the detriment of their health, safety, and well-being.

The most common reasons for having an unmet need for in-home services, according to another study, are lack of awareness of an available service, no services available, discomfort with accepting help from strangers, and a

[19] Desai, M.M., Lentzner, H.R., Dawson Weeks, J. (2001). Unmet need for personal assistance with activities of daily living among older adults. *The Gerontologist 41(1).* 82-88.

[20] LaPlante, M.P., Kaye, S., Kang, T., Harrington, C. (2004). Unmet need for personal assistance services: Estimating the shortfall in hours of help and adverse consequences. *Journal of Gerontology 59B(2).* S98-S108.

[21] 119,385 adults age 65+ have a self-care difficulty, 119,385*.207 = 24,713

[22] Desai, M.M., Lentzner, H.R., Dawson Weeks, J. (2001). Unmet need for personal assistance with activities of daily living among older adults. *The Gerontologist 41(1).* 82-88.

prohibitive financial cost.[23] In fact, the likelihood of having an unmet need for services increases with multiple ADL difficulties, living alone, increased age, and lower income.[9] Another study found that 25% of all older adults with annual income less than $20,000 reported an unmet need, compared with 15% of older adults with annual income of $20,000 or more.[24] This difference was statistically significant and shows that the lower income population has a greater unmet need for services.

AAA/PROVIDER SURVEY RESULTS

Results of a 2013 survey[25] designed to assess the current state of unmet needs for Office of Services to the Aging in-home services indicate that several years of flat and reduced funding have had significant negative impacts on the ability of Area Agencies on Aging and their network of direct service providers to provide adequate levels of basic services. For the purpose of this survey in-home services include personal care, homemaking, respite, home-delivered meals, chore/minor home repair, care management, personal emergency response systems and medication management. The survey yielded 131 responses from Michigan Area Agencies on Aging, commissions and councils on aging, and other direct service providers.

Key findings regarding unmet need:

- More than 3 out of 4 respondents feel there are not adequate resources to meet the need for personal care (76.1%) and homemaking services (77.1%).
- More than 7 out of 10 respondents feel there are not adequate resources to meet the need for minor home repair (72.3%) and respite services (72.8%)
- The majority of respondents feel there are inadequate resources to meet the need for home-delivered meals (63.8%), medication management (66.3%), care management (59.8%) and personal emergency response systems (50.6%).

Deciding Between Competing Needs: Rationing and Funding Reductions Force Seniors to Make Dangerous Choices

"With reductions in services and increased cost of care we now have to pay 3 times as much privately and are only allowed 10 hours a week of service... This small amount of service does not begin to meet the daily needs I have. If we cannot continue to pay the majority of my care privately I fear my remaining living independently will be greatly compromised." – Ronna, 66

"[Services] keep me independent otherwise I would be in a nursing home. They take me out to shop, take a shower, meal preparation [and] pick up my prescriptions. Since my services were reduced...I have to decide what I need most and things don't always get done." –Darlene 64, Rochester

"[Service level reductions] are really affecting me a lot. My family is not able to help as much as I need. I have to try to find other ways to get help. I spend a lot of time on the phone trying to find out where I can get help." – Lottie 64, Farmington Hills

According to Marie Verheyen, Associate Director for Older Adult Services at Oakland Livingston Human Service Agency seniors can receive either lawn mowing service or snow removal service as there is not adequate funds for both. Seniors who choose lawn mowing service risk being snowed-in. "Unplowed driveways can prevent meals on wheels deliveries, making it to doctors' appointments and seniors who receive their prescriptions by mail risk falls and injuries trying to reach their mailboxes."

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[23] Casado, B.L., van Vulpen, K.S., Davis, S.L. (2011) Unmet needs for home and community-based services among frail older Americans and their caregivers. *Journal of Aging and Health 23(3).* 529-553.

[24] Desai, M.M., Lentzner, H.R., Dawson Weeks, J. (2001). Unmet need for personal assistance with activities of daily living among older adults. *The Gerontologist 41(1).* 82-88.

[25] Silver Key Coalition State of Senior Unmet Needs: OSA Funded In-Home Services Survey

Several consequences for older adults have been observed as a result of inadequate service levels. Key findings include:

- 88.4% of respondents have observed less hours of care being provided than is needed with 82.6% reporting observing this in moderate (6-10 instances) to frequent occurrences (11+ instances).
- Over 9 out of 10 respondents have observed at least one instance of social isolation or depression with 83.7% reporting a frequency of moderate (6-10 instances) to frequent occurrences (11+ instances).
- 89.7% of respondents have observed caregiver burnout with 80.5% reporting moderate (6-10 instances) or frequent occurrences (11+ instances).
- 83.7% of respondents have observed a greater likelihood of falls.
- 80.2% of respondents have observed a greater likelihood of inadequate nutrition.
- 81.3% of respondents have observed a greater likelihood of emergency room visits.
- 84.8% of respondents have observed a greater likelihood of costly nursing home placements as a consequence of inadequate levels of in-home services funding or rationing of in-home services.

In addition to the potentially life-altering negative consequences felt by older Michiganians, agencies and service providers are also feeling the pain of budget cuts.

Key impacts on the aging network:

- Nearly 70% of survey respondents reported reductions in staff work hours
- 45.3% reduced the benefit package offered to staff
- 41.5% reduced staff pay
- One out of 3 respondents reported laying off staff members

Results of this survey are validated through similar findings of a 2013 survey conducted by the National Association of Area Agencies on Aging[26] which queried Michigan Area Agencies on Aging regarding the impacts of federal budget cuts. Similarities of note include:

Silver Key Coalition Survey	National Association of Area Agencies on Aging Survey
81.4% of aging network and direct service provider respondents also report significant impacts of reduced funding on their agencies	85.7% of Michigan Area Agencies on Aging report that budget cuts affect their ability to meet the demand for services
76.1% of aging network and direct service provider respondents believe there is inadequate funding levels for personal care services	71.4% of Michigan Area Agencies on Aging report reductions in personal care services as a result of federal funding cuts
68.7% of aging network and direct service provider respondents have reduced staffing hours	50% of Michigan Area Agencies on Aging report reducing staffing levels

[26] Markwood, S., Gotwals, A., & Karkhanis, N. (2013). Squeezing seniors: Aging community fears national crisis as a result of federal budget cuts. National Association of Area Agencies on Aging, Retrieved from http://n4a.org/pdf/n4a_SequesterSurveyReport_FINAL.pdf

Results of these surveys indicate a high level of agreement between both AAAs and direct service providers regarding the inadequacy of the levels OSA in-home services funding and the ability to meet unmet needs of seniors. Resulting from inadequate funding, essential programs that help seniors to live independently have been compromised or even closed.

Serious consequences with potentially life altering effects due to unmet needs are real and have been observed statewide with frequency by survey respondents. These consequences have direct impacts on quality of life and the ability of seniors to remain independent and out of costly alternative living settings.

OSA NEED ASSESSMENTS

In 2012, the Michigan Office of Services the Aging conducted a state-wide needs assessment survey to determine current and emerging needs and service gaps in the state's service delivery system. The survey was made available online and through telephone interviews of residents 50 years and over throughout the state.

Of the age 60+ Michigan residents surveyed, 45% reported having a disability that results in serious difficulty walking or climbing stairs (32.8%), difficulty concentrating, remembering or making decisions (14%) or difficulty doing errands alone such as visiting a doctor's office or shopping (13.6%). Nine percent (9%) had difficulty dressing or bathing as a basic activity of daily living and 13% reported providing care to one or more persons themselves due to injury, disability or long term illness.

Of those age 60+ providing care, 39% are caring for a spouse, 23% are caring for a parent, 16% are caring for a child, 10% are caring for a friend, 8% are caring for an acquaintance and 5% are providing care for a sibling. Seventy-eight percent (78%) of these caregivers are caring for one individual and 13% are caring for two individuals. About 9% are caring for 3 or more persons at one time.

When asked about the type of care being provided, 20% report providing personal care, 20% nursing care and 51% report providing housekeeping assistance. Key difficulties experienced by caregivers are:

- 42% report emotional worries and stress;
- 38% report having to make personal adjustments
- 34% report stress and illness
- 29% report developmental burden experienced through inconvenience and labor intensive support
- 22% report financial strain
- 20% report physical strains from lifting, etc.
- 13% report taking time off work to provide caregiving

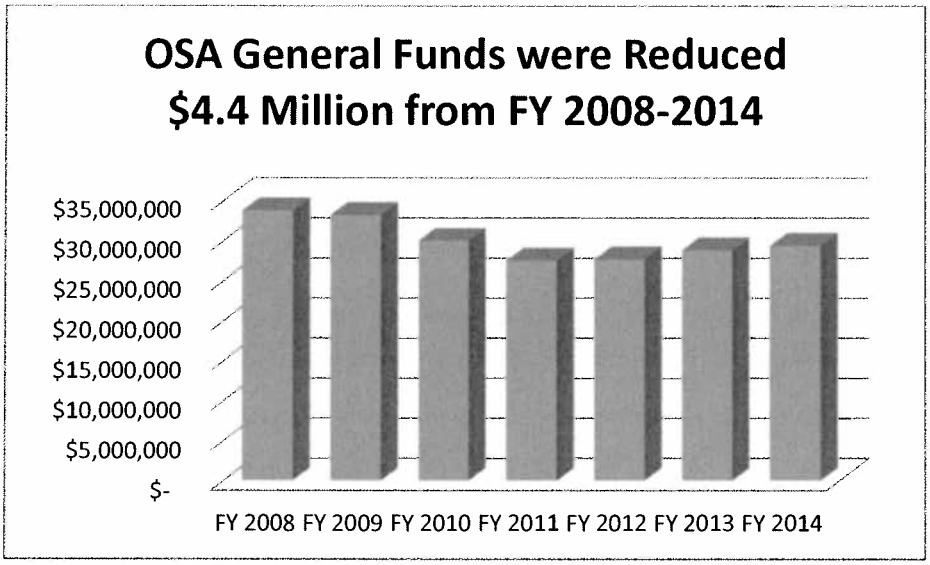
Michigan age 60+ residents report needing help with caregiving and financial strains from trying to pay for it over time.

- 20% need help with activities of daily living such as preparing meals, bathing and housekeeping
- 31% can't find good people
- 50% can't afford to pay for home care for a loved one
- 8% report being on a wait list for home care services

HISTORY OF STATE FUNDING FOR MICHIGAN OFFICE OF SERVICES TO THE AGING

The Michigan Office of Services to the Aging's approved FY 2014 budget totals $94,081,600, with about 63% federal funds, primarily from the Older Americans Act, and 37% from state General and Restricted funds. State General Funds ($29,380,800) constitute 31.2% of the OSA budget and Restricted Funds constitute the remaining 5.8%.

OSA funding for in-home and other services has been under severe pressure from the state and national recessions, the effort to eliminate Michigan's chronic structural budget deficit, and the ongoing effort to reduce federal deficit spending. The chart below shows that OSA has lost $4,398,100 in General Funds since 2008, which represents a 13% reduction. This is despite a $500,000 increase for the senior nutrition program for FY 2014.[27] During this seven year period, Michigan's senior population has increased approximately 13% or over 260,000 individuals.



Restricted Funds

Approximately 18% of OSA's state funding comes from restricted sources, including Merit Trust Funds collected from the tobacco settlement and Abandoned Property Funds from un-cashed health care reimbursement checks that escheat to the state. These funds vary significantly from year to year based on actual revenues collected and policy changes that affect collection and accounting procedures. The table below shows a reduction of $420,800 (6%) in Restricted Funds appropriated between 2008 and 2014. In addition, there was a dramatic 35% loss from FY 2013 to FY 2014 ($3.8 million). This Restricted Fund reduction for respite services, coupled with the federal sequestration-related cuts in FY 2013 and 2014, are expected to increase the number of individuals on waiting lists for in-home services in Michigan.

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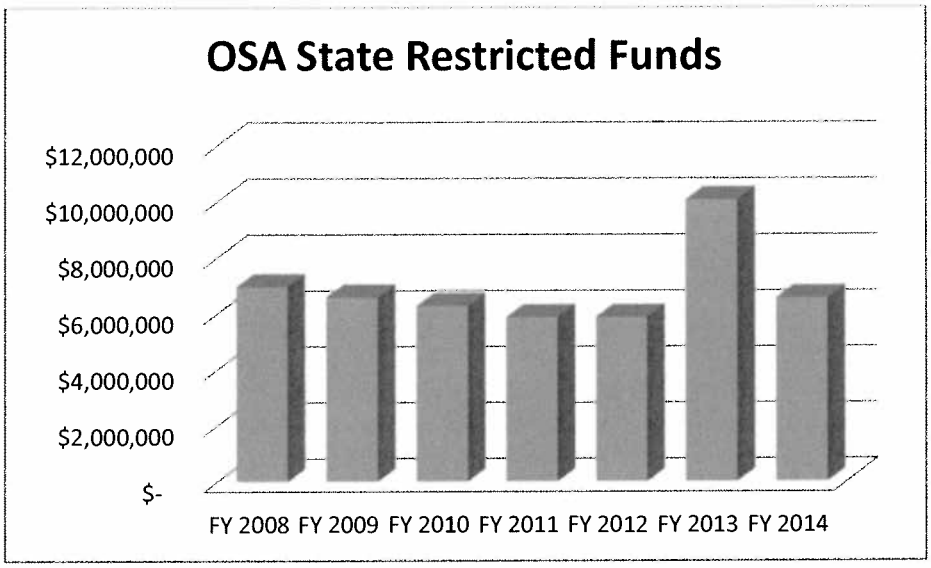
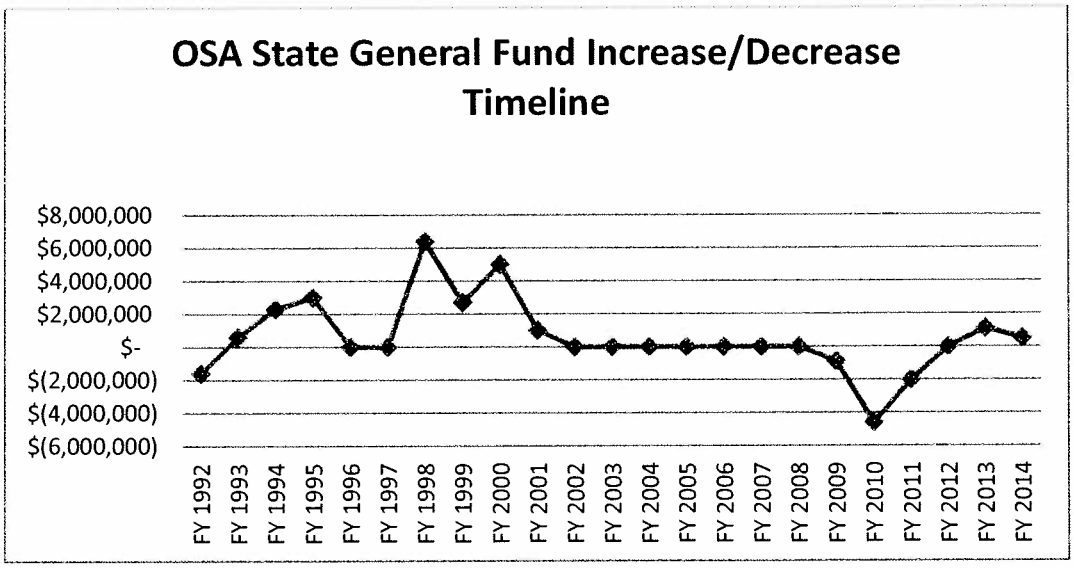
[27] *Note that this analysis is based on approved fiscal year OSA appropriation bills. Actual allocations may vary based on mid-year adjustments, variations in restricted revenue collections, and past or pending sequestration cuts.*



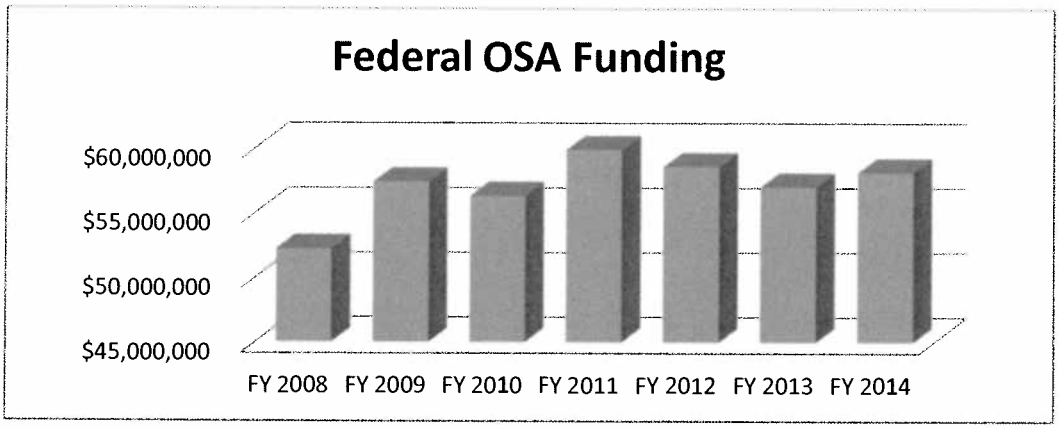
Historical Perspective

The $29.4 million OSA General Fund appropriation is about the same amount of state funding appropriated for OSA in FY 2001. The OSA funding timeline below shows that prior to the 2009 – 2011 period, General Fund allocations either increased or remained the same since FY 1993. Most increases since 1993 have targeted incremental development of Michigan's Care Management program during the 1990s and/or expansion of home delivered meals. The $500,000 increase for FY 2014 is exclusively for home delivered meals.



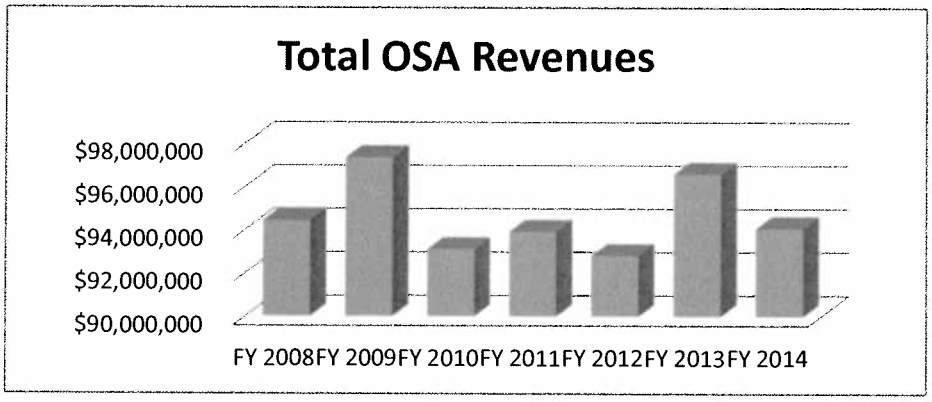
Concurrent Federal Support

Recent federal funding appropriations through the Older Americans Act or Department of Labor (older worker program) have been artificially skewed upward by the onetime increase in economic stimulus funding provided through the American Recovery and Reinvestment Act, which was stretched to last for several fiscal years. The scheduled FY 2014 sequestration cut for Older Americans Act programs has been averted due to approved continuing resolutions and budget agreements, but remain pending for future fiscal years.



Total OSA Funding

When all of OSA's state and federal revenue sources are included, the balance shows an overall decrease in OSA funding from FY 2008 – 2014 of $354,300. While this reduction may not seem dramatic, when increased demand from population growth and inflationary costs are considered over that 7 year period, it has imposed severe hardship. The current reduction from FY 2013 to FY 2014 of $2.5 million has had a significant immediate impact. The January 2014 federal budget deal will provide some yet to be determined relief for the senior nutrition program (includes congregate and home delivered meals), but it maintains the 2013 sequestration cut into 2014, meaning no additional support for other essential OSA programs like personal care, homemaking and caregiver respite.



Michigan's Commitment in Comparison to Other Great Lakes States

A 2011 study conducted by the AARP Public Policy Institute[28] measured the level of state funding supporting state unit on aging programs for all states. Data from that report shows that when measured on a per capita basis for state residents age 60 and older, Michigan is far less generous with state support for senior services than other Great Lakes states. The average allocation of state General Funds by Great Lakes legislatures was $46.69 per state resident age 60 and older. Michigan's per capita allocation was only $14.34, with only Ohio ($3.35) spending less state money on senior services according to this measure. Illinois was the most generous at $123.85.

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[28] **Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports**

by: Jenna Walls, Kathleen Gifford, Wendy Fox-Grage, Rex O'Rourke, Martha Roherty, Lindsey Copeland, Catherine Rudd, from: Public Policy Institute, January 2011

State Unit on Aging Non-Medicaid Home and Community-Based Service Expenditures

State	FY 2009	FY 2010	2011	2011 State Expenditure per Senior	Age 60+
Michigan			$ 27,000,000	$ 14.34	1,882,954
Ohio	$ 11,557,000	$ 8,060,400	$ 7,477,400	$ 3.35	2,228,884
Indiana	$ 31,900,000	$ 34,800,000	$ 34,800,000	$ 30.04	1,158,470
Illinois	$228,420,800	$ 295,914,750	$275,662,600	$ 123.85	2,225,761
Pennsylvania	$219,673,375	$ 223,649,100	$223,649,100	$ 84.58	2,644,174
Minnesota	$ 30,400,000	$ 31,258,000	$ 33,650,000	$ 35.99	935,109
State Average				$ 46.69	

Source: AARP Public Policy Institute

LOCAL DOCUMENTATION OF UNMET NEED

Detroit

In 2012, the Detroit Area Agency on Aging conducted a series of five Aging Summits throughout its region to examine the needs of older adults, caregivers and service providing agencies through the use of clicker technology. Six hundred and six (606) individuals participated in the community forums and shared their views on keypads. Key findings:

- Sixty-five percent (65%) of participants believe that home care assistance is the most important in-home service to fund followed by in-home respite (19%), friendly visiting (9%) and telephone reassurance. About 4% had other responses.
- 44% of participants support the funding of medical transportation; followed by 19% for both chore services and medication management. Eleven percent (11%) supports the funding of in-home meals.

Calhoun County

In 2013, Calhoun County surveyed approximately 200 individuals from a variety of organizations and agencies throughout the county to identify needs and gaps in the current structure of supports and services available to the older population. The participants told what requests for services they receive from older adults, but did not offer.

- The most common responses were requests for chore services (n=24) and hearing assistance (n=19).
- Respondents ranked transportation and chore services as the greatest unmet needs.
- Respondents overwhelmingly responded that insufficient funding was the number one barrier to providing services, but also that lack of public awareness and transportation were also significant barriers.

St. Clair County

A February 2010 St. Clair County study developed a methodology for projecting the increase in senior service demands for the decade. The model accounted for population changes in seniors living alone, minorities, disability levels, gender, and inflation. The mid-range annual projected increase in demand for senior services was 3.5%. An additional $2 million more than what was available in 2010 for state, federal, and county senior millage funds will be needed to maintain senior services at 2010 levels in 2015.

Case Example: In-Home Services Provide Independence and Save Michigan Money

Office of Services to the Aging (OSA) services are cost-effective preventing seniors from going on Medicaid and costing the state more money.

Eugene* is a 74 year-old, diabetic, double amputee who also suffers from MS-induced dementia. Eugene has been a Care Management service recipient since June of 2007. Care Manager Jillian works with other local community service providers and Medicare skilled care to stitch together the care Eugene needs to be able to stay in the community. OSA funds provide 13 hours per week of respite care to Marilyn*, Eugene's wife and caregiver which enable her to continue in her caregiving role.

It is estimated that family caregivers provide 80% of elderly care at no cost to the state. The same is true in Eugene's case. Marilyn provides the bulk of Eugene's care but states that without the supportive service provided by OSA, she could not continue to keep Eugene in their home.

Eugene's level of care needs and their income qualify Eugene for Medicaid funded long-term care service, but their assets are slightly above Medicaid limits. Without OSA services, Eugene would impoverish himself and spend down into Medicaid in a matter of just a few months. This would force Eugene to use Medicaid funded long-term care.

Eugene's care plan costs the state of Michigan $29.11 per day as compared to $172/day for Medicaid funded nursing home care. This is a cost savings of $52,155 per year, every year or a total of $339,007 over the past 6 ½ years since Eugene's services began.

Marilyn and Eugene are very proud individuals. They do not want to rely on Medicaid to pay for Eugene's care. OSA services allow them the dignity of contributing to the cost of Eugene's care, extending AAAs capacity to serve additional seniors.

*Client stories are shared with their permission.

RETURN ON INVESTMENT/VALUE FOR MONEY

LITERATURE REVIEW OF IN-HOME SERVICES OUTCOMES

A review of national literature supported the claim that providing state supported in-home services improves the physical and mental health of frail older adults and prevents costly nursing home admissions.

Services have been shown to impact the following outcomes:

- Depression: Where no informal support was available from non-spouse family or friends, states that provided more support for home and community based services were associated with lower depression rates than states with comparatively less support for services.[29] Also, older adults who were provided services to help them stay in their homes showed lower rates of depression than older adults who were placed in a nursing home.[30]
- ADL (Activity of Daily Living) Functioning: Older adults with services to help them stay in their homes also demonstrated higher levels of ADL functioning, or were better able to independently complete their daily tasks, than those who were in a nursing home.[31]
- Cognition: Staying at home, as compared to placement in a nursing home, was associated with greater alertness, short-term memory, ability to make decisions, ability to make one's self understood, and ability to feed one's self.[32]
- Incontinence: Those older adults who were helped to stay at home had a statistically lower incidence of incontinence than those who were placed in a nursing home.[33]

Additionally, several studies have found a lower risk for nursing home admission among older adults in the community who suffer from cognitive and/or functional impairments and are receiving in-home services than those who are not receiving services.[34] This effect extends to the state as a whole, as one study found that

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[29] Muramatsu, M.; Yin, H.; and Hedeker, D. 2010. *Functional declines, social support, and mental health in the elderly: Does living in a state supportive of home and community-based services make a difference?* Social Science & Medicine 70. 1050-1058.

[30] Dorman Marek, K.; Popejoy, L.; Petroski, G.; Mehr, D.; Rantz, M.; and Lin W. 2005. *Clinical outcomes of aging in place.* Nursing Research 54(3). 202-211.

[31] Dorman Marek, K.; Popejoy, L.; Petroski, G.; Mehr, D.; Rantz, M.; and Lin W. 2005. *Clinical outcomes of aging in place.* Nursing Research 54(3). 202-211.

[32] Dorman Marek, K.; Popejoy, L.; Petroski, G.; Mehr, D.; Rantz, M.; and Lin W. 2005. *Clinical outcomes of aging in place.* Nursing Research 54(3). 202-211.

[33] Dorman Marek, K.; Popejoy, L.; Petroski, G.; Mehr, D.; Rantz, M.; and Lin W. 2005. *Clinical outcomes of aging in place.* Nursing Research 54(3). 202-211.

[34] Luppa, M.; Luck, T.; Weyerer, S.; Konig, H.; Brahler, E.; Riedel-Heller, S. 2010. *Prediction of institutionalization in the elderly. A systematic review.* Age and Ageing 39. 31-38.

"living in a state supportive of [home and community based services] lowers the risk for nursing home admission among seniors."[35]

Other key in-home service outcomes studies are summarized below:

Michigan's expansion of home and community-based services resulted in the state's first ever decline in nursing facility expenditures[36]

Michigan is one of 10 states that received a CMS grant under the Real Choice Systems Change program to develop a profile of the state's publicly funded LTSS. The profile presented in this report includes an overview of demographics and projected LTSS demand; service utilization; a description of the infrastructure and capacity needs; and initiatives and progress toward reforming the system to increase HCBS options. The report notes that expenditures and LTSS days in nursing facilities declined for the first time in FY 2008 because of balancing efforts. The state legislature increased HCBS funding beginning in FY 2006.

Older Americans Act/State Unit on Aging services delay nursing home entry and results in state cost avoidance [37]

The report summarizes four studies completed under the Administration on Aging's (AoA's) Advanced Performance Outcomes Measure Project (POMP) grant to assess the impact of AoA programs in a manner that can be associated with cost. The analysis addresses the demographics, client program and service data, and client functional and clinical assessment data to determine the impact on older adults. In addition, a qualitative analysis helps to clarify findings in the quantitative studies. The report concludes that individuals residing in a nursing home who received State Unit on Aging (SUA) services prior to their entry are older on average than individuals residing in a nursing home that did not receive SUA services; and the services delay entry into a nursing home on average by 17 months for all clients, and by 23 months for clients at high risk. In addition, the highest risk factors for SUA service recipients include caregiver proximity, client age, and client mental status. Although the report notes that costs were avoided by comparing the average cost per month for nursing home clients with an average cost of SUA services for basic, intermediate, and high-intensity services, more analysis is needed to determine the specific (non-average) annual cost avoidance savings.

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[35] Muramatsu, M.; Yin, H.; and Hedeker, D. 2010. *Functional declines, social support, and mental health in the elderly: Does living in a state supportive of home and community-based services make a difference?* Social Science & Medicine 70. 1050-1058.

[36] Michigan Department of Community Health, Office of Long-Term Care Supports and Services; "Michigan Profile of Publicly-Funded Long-Term Care Services"; June 2009. Accessed December 2012 at: http://www.michigan.gov/documents/ltc/SPT_Final_ Report_7-01-09_300163_7.pdf.

[37] Rhode Island Department of Elderly Affairs (DEA); "Preliminary Findings: Summary of DEA Services Impact on the Entry of Clients to Rhode Island Nursing Homes"; December 31, 2009.

Longitudinal study finds home and community-based services for those at risk of entering nursing homes resulted in a 23.8% reduction in overall Medicaid expenditures and returned on investment of $2.92 for every dollar invested.[38]

Researchers studied the effectiveness of the Arkansas Community Connector Program (CCP), a Medicaid demonstration program in three counties that targets individuals at risk for entering nursing homes and links them with appropriate community-based services and supports. They tested the hypothesis that the CCP participants experienced larger growth in the use of and spending for Medicaid HCBS, and smaller growth in overall Medicaid spending, compared with the comparison group. Expenditure measures included inpatient and outpatient medical services, nursing home services, HCBS, and other services. The longitudinal study spanned 3 years of intervention, plus 1 year before and after the intervention, for both the intervention group and a statistically matched non-intervention group. Researchers determined the result of the intervention was a 23.8 percent average reduction in annual Medicaid spending per participant during the 3-year period. Net savings equaled $2.619 million for the 919 individuals included in the study's intervention group, or a return on investment of $2.92 per dollar invested in the program.

Seven year look back analysis long term care service costs for nursing home residents finds overall spending for those who received home and community-based services to range between $1,000 and $1,500 per month less than for those who were on wait lists and never received in-home services before entering a nursing home[39]

This analysis built on prior work of the authors to determine whether HCBS is cost effective. The researchers obtained cost and assessment data for individuals residing in nursing homes who were placed in three study groups: 1) individuals who had applied for and received HCBS; 2) individuals who had applied for but did not receive HCBS (waitlist); and 3) individuals who did not apply for or receive HCBS. The longitudinal study spanned service years from 2002 through 2008. The authors presented evidence that HCBS utilization produces cost savings compared with costs of individuals that do not use these services, most notably in a reduction of nursing home expenses. Nursing home cost savings associated with HCBS use ranged from $1,000 to $1,500 per member per month compared with non-HCBS applicant utilization, depending on HCBS use intensity. The authors incorporated both Medicaid and non-Medicaid LTSS in assessing overall cost effectiveness.

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[38] Holly C. Felix, Glen P. Mays, M. Dathryn Steward, Naomi Cottoms, and Mary Olson; "Medicaid Savings Resulted When Community Health Workers Matched Those with Needs to Home and Community Care"; Health Affairs 30, no. 7 (2011): 1366–1374. Accessed December 2012 at: http://content.healthaffairs.org/content/30/7/1366.full?ijkey=zrqbtjW.Gr7NQ&keytype=ref&siteid=healthaff.

[39] Adam Shapiro, PhD; Chung-Ping Loh, PhD; "Advanced Performance Outcome Measures Project (POMP): Estimates of Medicaid and General Revenue Cost-Avoidance from HCBS Utilization"; University of North Florida; August 2010. Accessed April 2012 at: http://www.gpra.net/ppt/POMP2010_UNF_Final_Report.pdf.6

Individuals receiving Care Management found to have improved access to physician services, lower emergency room use, resulting in cost savings.[40]

The purpose of this evaluation was to determine the impact of Rhode Island's Global Waiver on Medicaid expenditures. Three areas of interest were evaluated:

1. The impact of LTSS delivery changes on enrollment, utilization, and cost of services and supports for older adults and adults with disabilities in HCBS settings and in institutions;
2. The effect of care management initiatives on Medicaid cost and health outcomes; and
3. Progress toward state efforts to ensure "the right services, at the right time, in the right setting."

The evaluation concluded that the Global Waiver was successful in balancing the LTSS system to greater reliance on HCBS with estimated savings of $35.7 million over the 3-year period. In addition, an analysis of medical services utilization found improved access to physician services and lower emergency room use by individuals receiving care management, for estimated savings of about $5 million in FY 2010, including individuals with disabilities and those with mental health disorders or chronic conditions. Findings were based on analysis of data pre- and post-implementation of the waiver, and through comparing costs to those in traditional fee-for-service delivery.

Brown University study finds home delivered meals to be the only statistically significant factor among Older Americans Act programs that affected state-to-state differences in low-care nursing home population. [41]

Brown University documented the positive impact of increased spending on home-delivered meals programs for older adults. The study compared state-level expenditures on Older Americans Act (OAA) programs with the population of "low-care" seniors in nursing homes (i.e., residents of nursing homes that might not need the suite of services that a nursing home provides). According to the analysis from a decade of spending and nursing home resident data, states that invest more on home-delivered meals to seniors have lower rates of "low-care" seniors in nursing homes.

Major findings from the Brown study include:

- Home-delivered meals emerged as the most significant factor among OAA services that affected state-to-state differences in low-care nursing home population.
- For every $25 per year per older adult above the national average that states spend on home-delivered meals, they could reduce their percentage of low-care nursing home residents compared to the national average by one percentage point.

The Brown study included state spending on OAA programs and information from each state between 2000 and 2009 as well as a variety of public health and nursing home data sources compiled by Brown University's Shaping Long-Term Care in America Project. In all, 16,030 nursing homes were included in the research.

[40] The Lewin Group; "An Independent Evaluation of Rhode Island's Global Waiver"; December 6, 2011. Accessed December 2012 at: http://www.ohhs.ri.gov/documents/ documents11/Lewin_report_12_6_11.pdf

[41] Kari Thomas and Vincent Mor, Health Services Research, November 2012

Time-To-Event study finds significant reduction in nursing home placement risk for those who receive higher level of Older Americans Act services supported through the State Unit on Aging[42]

The evaluation used time-to-event analysis (e.g., time to nursing home placement) to determine whether the use of Older Americans Act (OAA) services serve to delay nursing home placement. Two sets of data from the Department of Elderly Affairs spanning different periods (December 1998 through December 2005; and January 2005 through September 2007) were used to conduct the analysis. The authors conclude that a statistically significant reduction in risk for nursing home placement is associated with increased number of OAA services received, controlling for demographics and functional status. No single type of service contributed directly to the decreased risk, but the total program of services was important to reducing risk.

IN-HOME SERVICE WAITING LIST OUTCOMES STUDY

In 2011 the Area Agency on Aging 1-B, in collaboration with Dr. Louanne Bakk, University at Buffalo, conducted a longitudinal analysis of the outcomes for individuals who were placed on the AAA 1-B wait list for in-home services in 2008, and what happened to them after two years. Outcomes measured included mortality, nursing home admission, relocation, hospital admission, emergency room visits, and caregiver well-being, with outcome predictions for each category.

The longitudinal research[43] on the impact of in-home service wait lists produced evidence that individuals on wait lists who do not receive services have poorer outcomes than those who were on the wait list but eventually received services. The comparison of these two groups found that while there is a cost to providing services to those on a wait list, these costs are mostly offset by a savings in reduced health care utilization that is predictable. For example, those receiving service have a 20% greater chance of living in their own home two years after going on a wait list, than those who did not receive service. A cost savings ratio was constructed that factors in health care utilization and the impact on communities is assessed and quantified.

Methodology

1,471 individuals were placed on the AAA 1-B MI Choice and Care Management wait list in 2008. Approximately two years later, efforts were made to determine their status. Of the 1,471 individuals, 769 (52.28%) were contacted and interviewed (mostly caregivers). Intake records were reviewed to assess health and demographic information for all 1,471. It was determined that 441 had died and 273 were alive and living locally.

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[42] Dwight B. Brock, PhD; Beth Rabinovich, PhD; Jacqueline Severynse, BS; Robert Ficke, MA; "Risk Factors for Nursing Home Placement Among OAA Service Recipients: Analysis of Two Data Sets From the Rhode Island Department of Human Services"; Westat; U.S. Administration on Aging Contract No. 233-02-0087.

[43] In addition to the measures contained in the survey, variables providing health and demographic information for each respondent were obtained from the AAA 1-B Universal Intake report and merged with the survey dataset. All univariate, bivariate, and multivariate statistics were conducted in Stata version 12.0. Significance in bivariate and multivariate analyses were tested at the $p<.05$ level.

Key Findings

- When contacted, about 70% were still waiting to receive MI Choice or Care Management and 30% were receiving services.
- Of those receiving services, 76% were still living in their own home, while only 57% of those still waiting for service remained in their own home.
- Those not receiving service were more than five times more likely to be living in a nursing home (4% vs. 22%).
- 84% of those who did not receive service and moved to a nursing home did so because the care receiver's needs exceeded the capacity of their caregivers, while only 33% of those who received services moved to a nursing home for the same reason.
- Of the 33 individuals whose caregiving needs exceeded their caregivers' capacity, 97% were not receiving AAA 1-B services.
- For caregivers who were still working, 76% of those not receiving services said the caregiving responsibility interfered with the caregiver's employment, while only 24% of employed caregivers receiving services stated caregiving interfered with their work.
- Of employed caregivers whose employment was negatively impacted by their caregiving responsibilities, those not receiving AAA 1-B services were five times more likely to suffer a financial loss (i.e. quit work, reduce hours, etc.).
- The state can save $964,000 annually by providing OSA/OAA services for every 100 individuals on in-home service waiting lists. This is because:
    - The typical annual average long term care cost to taxpayers for publicly supported services for 100 wait listed individuals who need in-home services is $1.38 million (Medicaid cost for 22 individuals expected to move to nursing home ($172/day, $0 for the 78 others).
    - The typical annual average cost to taxpayers for publicly supported services for 100 wait listed individuals who receive OSA in-home services ($4.74/day) is $416,000 (OSA cost for 96 individuals of $165,000, plus nursing home cost for 4 individuals of $251,000)
    - The public savings represents the difference between the expense for the 100 individuals not served ($1.38 million) minus the cost of serving all 100 individuals ($416,000) - $964,000

The study concluded that Michigan taxpayers would benefit from a net savings of $964,000 in state taxes to support every 100 individuals on the in-home service waiting lists by providing access to in-home services. The survey sample included those on MI Choice and non-Medicaid OSA in-home service wait lists.

RETURN ON INVESTMENT FOR IN-HOME SERVICE FUNDING

The economic impact of state funds allocated for Michigan Office of Services to the Aging (OSA) in-home services are significant and magnified by the ability of these funds to:

1. Generate local matching contributions by participants and local governments and charities;
2. Create an economic return to taxpayers through job creation, and tax revenue generation; and
3. Provide services at below market rates due to volume and value purchasing.

The return on investment for every $1 million in state funds allocated generates:

- Between $354,300 (in-home care) and $488,100 (meals) more in local matching contributions
- Between $68,000 (in-home care) and $75,000 (meals) in state tax revenue
- 40 – 44 new jobs created
- Saves taxpayers and homebound older adults between $230,000 (homemaking) and $352,000 (personal care) for in-home care and at least $491,000 for home delivered meals over private market rates

A 2010 study by Dr. Yong Li, Assistant Professor, Department of Public Health, Indiana University[44] quantified the economic "multiplier effect" of MI Choice funding as those dollars ripple through the state's economy by using the Regional Input-Output Modeling System (RIMS II) developed by the US Bureau of Economic Analysis. MI Choice is a Medicaid home and community-based services program that assists older adults and adults with disabilities who have nursing facility level of care needs to remain living independently in a community setting. The vast majority of MI Choice service expenditures are the same as OSA in-home services, such as personal care, homemaking, home delivered meals, caregiver respite, etc. The study utilized RIMS II to calculate the impact of home and community-based services on job creation and tax dollars returned to the state.

Leveraging Additional Contributions

The table below utilizes 2012 NAPIS data to demonstrate the leveraging impact that state in-home services funding has on generating additional local contributions toward service expenditures. Home delivered meals funding leveraged an additional 48.81 cents to purchase services for every dollar allocated, and the other in-home services leverage an additional 35.43 cents per dollar. This means that for every $1 million funding increase, an additional $354,300 will be raised for in-home services (excluding meals) and an additional $488,100 will be raised to purchase additional home delivered meals.

	AMOUNT LEVERAGED BY $1 MILLION IN STATE FUNDS					
	Total Expenditure	**Local Expenditure**	**Local Expenditure Rate**	**State Expenditure**	**Local Percent Leveraged**	**$1 Million Leveraged Total**
In-Home Services	$ 18,383,829	$ 4,809,433	26.10%	$ 13,574,396	35.43%	$ 1,354,300
Home Delivered Meals	$ 33,681,037	$ 11,047,380	32.80%	$ 22,633,657	48.81%	$ 1,488,100

[44] Dr. Yong Li, Assistant Professor, Department of Public Health, Indiana University, Economic Impact of the MI Choice Medicaid Waiver Program, July 2010

Tax Revenue Creation

The table below demonstrates how leveraged in-home services funding creates a direct dollar return to state government by applying the "multiplier effect" calculated by Dr. Li (5.08%) to three levels of in-home service allocations. Every $1 million allocated by the Michigan Legislature for home delivered meals has a net cost of only $924,405, and the net cost for other in-home services is only $931,212. This is because the Dr. Li study found that each dollar allocated returns 5.08% in tax dollars to state government through various taxes and fees.

	AMOUNT RETURNED IN STATE TAXES AND FEES				
	$1 Million State Leveraged Total	**State Tax Return Rate per $1 Million**	**State Tax Return per $1 Million Allocated**	**State Tax Return per $5 Million Allocated**	**State Tax Return per $10 Million allocated**
In-Home Services	$ 1,354,300	0.0508	$ 68,798	$ 343,992	$ 687,984
Home Delivered Meals	$ 1,488,100	0.0508	$ 75,595	$ 377,977	$ 755,955

Job Creation

Dr. Li's study found that for every $34,030 in state funding allocated for in-home services, one new job is created. Based on this finding and the capacity of state funds to leverage additional resources, every $1 million in state funding creates 40 – 44 new full time jobs.

	State Expenditure	**Local Percent Leveraged**	**$1 Million Leveraged Total**	**Job Creation per $1 Million after Leverage**	**Job Creation per $5 Million**	**Job Creation per $10 Million**
In-Home Services	$ 13,574,396	35.43%	$ 1,354,300	40	199	398
Home Delivered Meals	$ 22,633,657	48.81%	$ 1,488,100	44	219	438

Value for the Money

A 2013 survey conducted by the Area Agency on Aging 1-B (AAA 1-B) in southeast Michigan found that state subsidized personal care and homemaking services are purchased on behalf of older adults and adults with a disability through the "Aging Network" at a cost to taxpayers that is 17% to 26% below private market rates. The power of leveraging and value purchasing means the total savings ranged from the report[45] concluded that if all regions of the state purchase personal care and homemaking at the discount level that the AAA 1-B receives, the annual savings to the state and taxpayers is approximately $2.3 million for Michigan Office of Services to the Aging in-home service programs and $35 million for the MI Choice program.

A 2011 market survey of home delivered meal options available for purchase by private market sources found that meals delivered through the Michigan Office of Services to the Aging program cost 33% to 42% less to

[45] Personal Care and Homemaking Services for Older Adults and Adults with a Disability: The Value and Outcomes for Consumers, Caregivers, and Public Funders, April 1023, Area Agency on Aging 1-B. Findings based on 2011 negotiated rates and a secret shopper rate survey.

prepare and deliver.[46] This efficiency means that with leveraging, taxpayers save at between 48 cents and 62 cents on every dollar allocated for home delivered meals over what the homebound elderly would pay if they were to purchase home delivered meals from private companies such as Jenny Craig at Home, Seattle Suttons, or Mom's Meals.

	DOLLARS SAVED PER $1 MILLION OF STATE FUNDING		
	$1 Million Leveraged Amount	**Negotiated Discount Below Private Market Rates**	**Dollars Saved per $1 Million Allocation**
In-Home Services			
• Personal Care		26%	$352,000
• Homemaking	$ 1,354,300	17%	$230,000
Home Delivered Meals	$ 1,488,100	33% - 42%	$491,000 - $625,000

ECONOMIC AND COMMUNITY DEVELOPMENT IMPACT OF IN-HOME SERVICES

The demand and impact of in-home services is dramatically represented in its creation of both jobs and small businesses associated with the Michigan industry. Increasing state funding of in-home services will create and strengthen small businesses and jobs.

For local communities struggling to create meaningful employment opportunities and grow their private-sector economies, in-home services jobs are a critical foundation on which to build. The sector provides an array of jobs with modest to more intense educational requirements, creating career ladders that allow people to increase their income and advance skills and opportunities in health services, business, and management.

A survey conducted by the Office of Services to the Aging (OSA) of the 500+ small businesses across the state that deliver in-home services to the state's elders found these employers are a stable and growing part of Michigan's economy. With as many as 300 employees, these in-home services businesses have an average staff size of about 50 employees--largely aides but also nurses and office staff in almost every county. The majority of these businesses are generally locally owned as a standalone "mom and pop" business or a locally owned franchise of a national private duty company.[47] A substantial number of these employers are parts of county government, particularly in rural parts of the state. According to the U.S. Bureau of Labor Statistics[48], the number of Michigan in-home services businesses grew over 40% between 2006 (1102) and 2010 (1556) demonstrating the economic avenues for business ownership created by the industry.

In addition to being a way to stimulate business growth locally and statewide, the in-home services industry is also a job creator. Michigan's Labor Market Information (MLMI) reports that the state's two fastest growing occupations are home health aides (58%) and personal services aides (42%).[49] Both occupations are essential in the delivery of in-home services.

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[46] The Value and Outcomes for Michigan's Home Delivered Meals for the Elderly Program, May 2011, Area Agency on Aging 1-B

[47] "Findings from a Survey of MI Choice Provider Organizations: Understanding Michigan's Long-Term Supports and Services Workforce," March 2013, located at www.phinational.org/michigan/workforcesurveys.

[48] U. S. Bureau of Labor Statistics, www.bls.gov Analysis found at www.phinational.org.

[49] Michigan's Labor Market Information. www.milmi.org

MLMI projects that almost 25,000 new jobs in these occupations will be created by 2020 across the entire state. Jobs in this sector have grown and are growing at four times the rate for the overall economy even during in the depths of the Great Recession.

And, these jobs will remain parts of our states' economy. It is highly unlikely that these "high touch" jobs can be replaced by technology or outsourced to other states or countries. These jobs will continue to be performed by caregiving hands and trained minds of the people who live in this state.

And, finally, in Michigan and other states, in-home services jobs are growing at a rate faster than hospital or nursing home jobs.[50] This transition follows the private sector payer and state and federal governmental incentives to decrease admissions, the length of stays, and re-admissions to hospitals, the most expensive setting for health services. Economically, health care services are moving away from all health facilities and into the homes of people needing health care services.

IMPACT OF IN-HOME SERVICES ON FAMILY AND INFORMAL CAREGIVERS

It is commonly reported that between 80% and 90% of caregiving in the U.S. is performed by family or other unpaid caregivers. AARP investigated this issue and found that 1,280,000 Michigan caregivers perform 1,380,000,000 hours of caregiving each year. This means that about 13% of the total state population are caregivers for a friend or family member (all ages) for an average of 1,078 hours per year or 20.7 hours per week.[51],[52]

Who are the caregivers?

In 2012, Michigan's Office of Services to the Aging reported the following characteristics of caregivers who benefit from state-supported in-home services for seniors with activity of daily living and independent activity of daily living limitations in Michigan[53]:

- 70% are female
- 53% are over the age of 65
- 45% reside in rural areas
- 28% are low-income
- 24% are minority by race and/or ethnicity
- 35% are employed full or part-time.

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[50] For national data: Bureau of Labor Statistics, Employment Projections Program, 2012-2022 Employment Matrix. www.bls.gov. For Michigan: Michigan Department of Technology and Management and Budget, Labor Market Information, 2008-2018 Long-Term Employment Projections. www.milmi.org.

[51] *Valuing the Invaluable: A New Look at State Estimates of the Economic Value of Caregiving (Data Update).* AARP Public Policy Institute, 2007.

[52] 2012 Needs Assessment Survey. Michigan Office of Services to the Aging.

[53] 2012 Needs Assessment Survey. Michigan Office of Services to the Aging.

Of all caregivers in the U.S.,

- More than one third of caregivers have a child or grandchild living with them[54]
- 43% have completed college
- 42% report household income less than $50,000

Who do caregivers take care of?
Of caregivers over the age of 60 in Michigan,

- 39% are caring for a spouse
- 23% care for a parent
- 16% care for a child
- 13% are caring for two individuals and 9% are caring for three or more individuals at one time

What kind of care do caregivers provide?
Caregivers across the U.S. spend the majority of their caregiving time (an average of 20.7 hours per week in Michigan) providing assistance with at least one Activity of Daily Living (ADL). This usually takes the form of helping the person get in and out of beds and chairs, get dressed, bathe or shower, get to and from the toilet, deal with incontinence, and/or helping to feed the person. [55]

Caregivers in Michigan report the following about their caregiving situations:

- 67% provide daily, hands-on care
- 51% provide housekeeping assistance, 20% provide personal care, and 20% provide nursing care
- 55% live with the person that they cared for, and 38% travel up to an hour to provide care
- 42% indicate that there were "no other family members willing or able" to help provide care
- 72% have been caregiving for more than one year, and 49% for three or more years
- Caregivers over the age of 65 are more likely than their younger counterparts to be the sole unpaid caregiver for the care recipient[56]
- 8% report being on a wait list for home care services.

How are caregivers affected by their caregiving role?
The nature and extent of the caregiving work, while rewarding, can cause significant strain and stress to the caregiver and negatively impacts their health and daily lives in many ways.[57]

- Almost one third of caregivers in Michigan (29%) described their health as "fair" or "poor."[58]
- Nationally, worsening health is particularly present in caregivers who are high burden, co-resident caregivers, women, and those providing more than 21 hours of care per week. [11]

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[54] *Caregiving in the U.S.* National Alliance for Caregiving in collaboration with AARP, 2009.

[55] *Caregiving in the U.S.* National Alliance for Caregiving in collaboration with AARP, 2009.

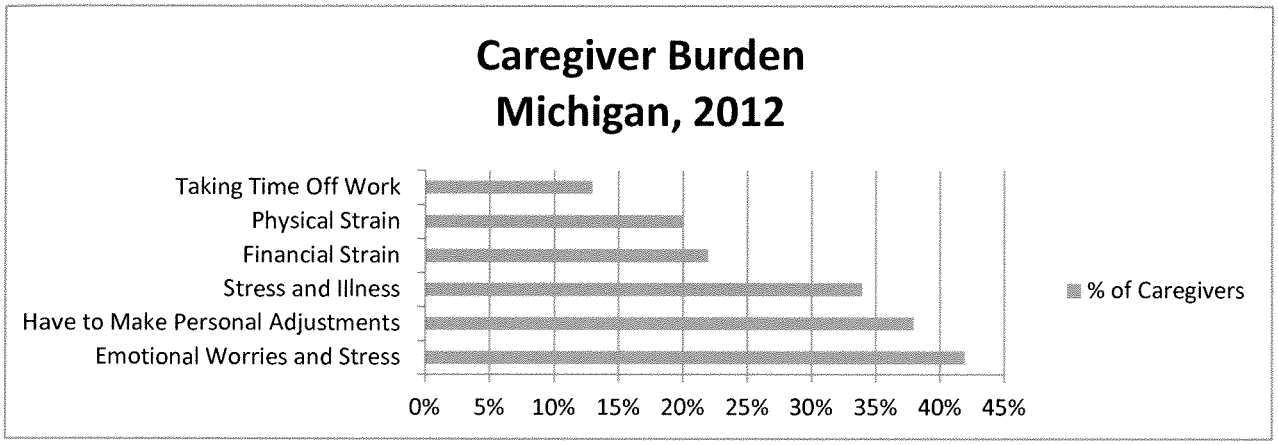
[56] *Caregiving in the U.S.* National Alliance for Caregiving in collaboration with AARP, 2009.

[57] *Caregiving in the U.S.* National Alliance for Caregiving in collaboration with AARP, 2009.

[58] 2012 Caregiver Information. Michigan Office of Services to the Aging.

- 31% of U.S. caregivers consider their caregiving to be emotionally stressful. 42% of Michigan caregivers report emotional worries and 34% report stress and illness.[59] National research supports the assertion that caregiver stress can result in increased risk of illnesses such as colds and flu, and chronic diseases such as heart disease, diabetes, and cancer.[60]
- Stress also causes increased morbidity and mortality.[61] Spouses who experience mental or emotional strain due to their caregiving responsibilities have a 63% higher risk of dying than non-caregivers, according to a national study.[13]
- Half of U.S. caregivers say their caregiving takes time away from friends and other family members.[11]
- 22% of Michigan caregivers report a financial strain due to their caregiving responsibilities.[62]
- The average family caregiver for someone 50 years or older spends $5,531 per year on out of pocket caregiving expenses, more than 10% of the median income for a family caregiver.[63]
- Six out of ten caregivers who reported an increase in their spending on care also reported having difficulty paying for their own basic necessities.[64]
- More than 70% of U.S. caregivers were employed at some point when they were caregiving, and two thirds of them have gone in late, left early, or taken time off of work because of caregiving issues.[65]

Table[66]



[59] 2012 Needs Assessment Survey. Michigan Office of Services to the Aging.

[60] *Family Caregiver Fact Sheet.* Caregiver Resource Network. <www.caregiverresource.net.>

[61] *Caregiver Health.* American Medical Association. <www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/geriatric-health/caregiver-health.page.>

[62] 2012 Needs Assessment Survey. Michigan Office of Services to the Aging.

[63] *Valuing the Invaluable: The Economic Value of Family Caregiving,* 2008 Update. AARP.

[64] *Evercare Survey of the Economic Downturn and its Impact on Family Caregiving,* March 2009.

[65] *Valuing the Invaluable: A New Look at State Estimates of the Economic Value of Caregiving (Data Update).* AARP Public Policy Institute, 2007.

[66] 2012 Caregiver Information. Michigan Office of Services to the Aging.

ECONOMIC IMPACT OF CAREGIVING

The national economic value of caregivers' contributions exceeds Medicaid spending for long-term care, which includes both nursing home care and home and community-based services. Compared to the value of existing home and community-based services alone, the economic value of family caregiving could be up to 30 times as great. AARP states that, "family members and friends are the backbone of long-term care in all states,[67]" and Michigan is no exception.

Michigan businesses also have an economic stake in supporting caregivers. According to MetLife, American businesses can lose as much as $34 billion each year due to employees' need to care for loved ones 50 years of age or older.[68]

HOW DO IN-HOME SERVICES HELP CAREGIVERS?

Research shows that supportive services can help to reduce caregiver stress and delay or even prevent the institutionalization of the care recipient[69], providing a real value to family and other unpaid caregivers. AARP recommends the following policies and programs to support caregivers and ease their burden:

1. Information and referral to services
2. Assessment of caregivers' own needs, including their health status
3. Respite services
4. Tax incentives to help offset direct expenses.

As other sections of this paper demonstrate, providing adequate in-home services for persons with disabilities and more help for family caregivers can be achieved at a small fraction of the value that caregivers already provide in Michigan. As AARP states, "supporting family caregivers is sound fiscal policy.[70]"

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[67] *Valuing the Invaluable: A New Look at State Estimates of the Economic Value of Caregiving (Data Update).* AARP Public Policy Institute, 2007.

[68] *MetLife Caregiving Cost Study: Productivity Losses to U.S.* MetLife Mature Market Institute and National Alliance for Caregiving Business. July 2006.

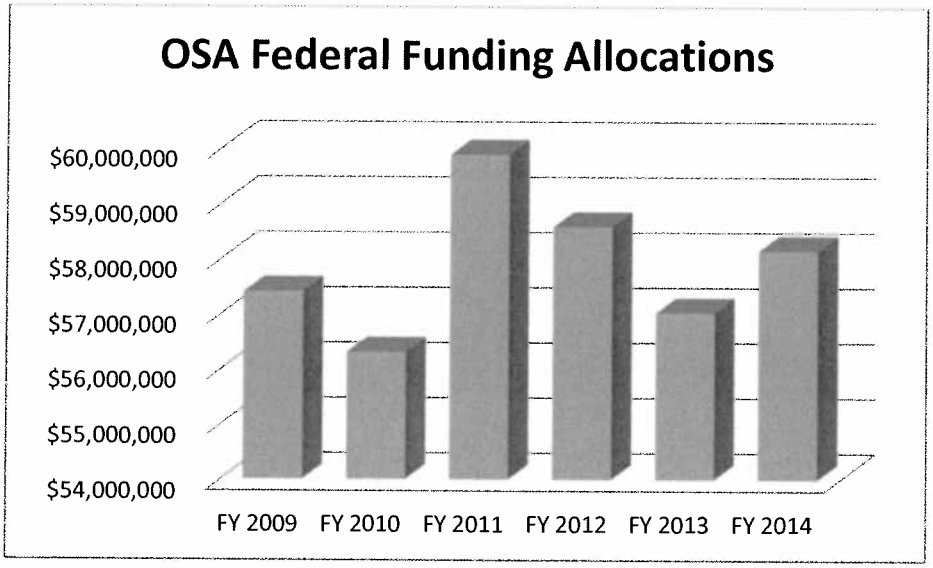
[69] *Valuing the Invaluable: A New Look at State Estimates of the Economic Value of Caregiving (Data Update).* AARP Public Policy Institute, 2007.

[70] *Valuing the Invaluable: A New Look at State Estimates of the Economic Value of Caregiving (Data Update).* AARP Public Policy Institute, 2007.

OTHER FACTORS IMPACTING MAKING MICHIGAN A NO WAIT STATE FOR IN-HOME SERVICES

OUTLOOK FOR FUTURE FEDERAL FUNDING

Federal appropriations for the Michigan Office of Services to the Aging through the Older Americans Act has been essentially level funded since 2009, and is at significant risk of cuts due to Congressional intent to reduce deficit spending. The table below demonstrates minor variations in funding, with the FY 2014 allocation an estimate that will likely not be finalized until late spring due to congressional Continuing Resolutions and a delay in approving a federal budget until January 2014.



The main factor looming over the prospects of future federal funding is how Congress manages the mandated deficit reduction measures and sequestration that were imposed by the Budget Control Act of 2011 (BCA). The BCA mandates that a ten year savings of $1.2 trillion is achieved by cutting $109 billion each year. If Congress does not agree on how this deficit reduction is achieved, an automatic cut, called sequestration, will be implemented. The first such cut was implemented in FY 2013 through mandatory cuts split equally between defense and non-defense discretionary programs. (Mandatory spending such as for programs like Medicare, Medicaid and Social Security are excluded.) The Michigan Office of Services to the Aging was cut by $2,270,540[71] due to sequestration in FY 2013. For FY 2014 the cut for senior nutrition programs was mostly restored, but the cuts to other older adult programs were sustained. Absent further Congressional action the Michigan Office of Services to the Aging faces the prospect of future Older Americans Act reductions as its share of the $109 billion in annual cuts for FY 2015 through 2022.

[71] This comes from the Estimated Federal Sequestration Reductions on FY 2013 AoA Formulary Grants to OSA table. Personal communication with MI Office of Services to the Aging.

FUTURE FUNDING OUTLOOK FOR SENIOR MILLAGES

At least sixty-five Michigan counties have voter approved county-wide senior property tax millages that raise over $60 million in local dollars to support a variety of senior services. These senior millages have been hit hard with losses due to property value declines in recent years and are just now starting to recover part of their lost funding. However, the recovery is at risk due the potential loss of another $1.2 million to $2 million that could result from the planned reduction in Michigan's Personal Property Tax (PPT).

Background[72]

On December 27, 2012, the Governor signed a series of new laws that reduce property taxes levied on personal property, and provide mechanisms to potentially replace a portion of the lost tax revenue. The exemption of PPT for commercial and industrial property is widely seen as necessary to keep Michigan competitive in attracting and retaining business, and the PPT is acknowledged to be both outdated and burdensome to administer for both the taxing units and the business entities.

Recognizing the financial impact upon Michigan's cities, counties, schools, and myriad other local entities which have received this relatively stable source of funding for many years, the Governor, and legislature sought methods to replace a substantial portion of the revenue loss. Initially proposed to come from annual general fund appropriations with income from expiring tax credits, local communities balked at that method's vulnerability to the uncertainty of the annual appropriation process, preferring a more stable and reliable mechanism.

The proposed solution in the new legislation was the creation of a Metropolitan Areas Metropolitan Authority (MAMA) under PA 407 of 2012. While the MAMA will handle other duties, the primary function of the new Authority will be to levy a local use tax authorized under PA 408 and to distribute the revenue to local units. Reimbursements to local units will be determined by formulas within the Act.

As required by PA 408, there will be an August 2014 statewide ballot which will include the question of whether to approve a local use (sales) tax levy by the MAMA. If approved, the State's 6.0% use tax rate will be lowered by the amount of the use tax levied by the MAMA. The rate of the use tax levied by the MAMA will be determined by the amount of revenue that the tax may generate. Revenue from the local use tax is required to be solely, and completely, spent on reimbursements to local units eligible for distributions under PA 407. The revenue from the local use tax will reduce the State's share of use tax revenue that is directed to the General Fund. Expiring tax credits will then backfill the state's use tax loss.[73]

There is considerable concern among the local governmental units and legislators that the ballot initiative may not be well understood and because it deals with taxation, could fail. In that case the PPT exemptions will be repealed. The worry is that the legislature could then pass new legislation authorizing the PPT exemptions with either no replacement revenue or go back to the annual appropriation methodology.

[72] This background and analysis is drawn mostly from the preliminary estimates of the Michigan Directors of Services to the Aging Advocacy Committee 2013 report.

SENIOR MILLAGE

The initial PPT proposal called for 100% replacement for "voter approved millages," while other entities were to be reimbursed at 80%. As the legislation wended through the process, only schools and intermediate school districts were provided 100% protection from PPT losses. That comes in the form of 100% replacement as the first funds out of the MAMA revenue. Although the intent was to reimburse other entities (Including senior millages) at 80%, there is no guarantee that adequate funds will be available to that level. In addition, the law is silent on the replacement distribution mechanism on the local level, leaving a concern about who would have the authority to decide on local distribution amounts among the taxing units.

Potential Impact on Local Senior Programs

Because counties vary widely in the extent of their industrial and commercial business base, there will be some communities which will be minimally impacted by the PPT exemptions, while others will experience significant revenue loss. It is estimated that when the PPT exemptions become fully effective, senior programs will lose between $1.5 and $2 million annually. The variance will depend on future property values and the actual percentage of reimbursement. Anything less than the proposed 80% will increase the losses. Senior programs in Kent, Calhoun, and Midland counties will each lose over $100,000 per year, while Lenawee, Bay, St. Clair, St. Joseph, Saginaw, and Genesee counties will see losses of around $50,000 per year. Senior programs in Grand Traverse, Hillsdale, Berrien, Monroe, and Otsego counties will lose between $25,000 to $35,000 per year. Another fourteen counties with senior millages will lose $10-$20,000 per year, and the remainder smaller amounts. Not counted, but also due to have substantial impacts are city- based senior millages in the larger counties of Oakland and Macomb. Local communities use these dollars to both match and stretch state and federal senior funding, and local dollars also allow for innovation, infrastructure investment, and meeting unique community needs.

CONCLUSIONS

Michigan has demonstrated a considerable commitment to supporting the health and independence of its residents through expansion of its MI Choice Medicaid Waiver program, expansion of Medicaid health insurance, and continued commitment to the Department of Human Services' Medicaid Home Help program. However, support for disabled adults with limitations in their ability to perform necessary activity of daily living who are not eligible for Medicaid has been limited. Michigan has been plagued by chronic wait lists for many of the in-home services supported by state and federal Older Americans Act funding, such as home delivered meals, personal care, homemaking, respite, and chore services such as lawn care and snow removal. The network of area agencies on aging, county commissions and council on aging, disability network agencies, and other local direct service providers have invested considerable effort into addressing the wait list problem, including strategies such as:

- establishing or increasing senior millages;
- prioritizing and protecting in-home services when managing funding cuts;
- shifting funding from the congregate to the home delivered meals programs;
- increasing fundraising efforts; and
- increasing efficiency through a variety of programmatic and technological enhancements.

Despite these efforts, the Michigan Office of Services to the Aging's Aging Network has been unable to overcome the barriers of flat federal funding, recent reductions in state funding, and the growing demand associated with the aging of Michigan's population to resolve the wait list problem with existing resources. This creates a crisis for many of the thousands of near poor and middle class older adults whose independence is threatened by ADL limitations, and who do not qualify for Medicaid programs, but still cannot afford to purchase needed home care services at private market rates. These individuals and families are often forced to seek subsidized in-home services from Aging Network organizations, where they are placed to languish on wait lists for months or years.

This White Paper has documented the extent of unmet needs for in-home services supported through the Michigan Office of Services to the Aging, provided evidence of the hardship this situation imposes, assessed the costs and benefits of supporting the level of services needed by this population, and concluded that the Silver Key Coalition's goal of increasing funding for in-home services by $10 million over a three year period is a viable and needed strategy to address the present needs of those on wait lists for in-home services and eliminate wait lists as a persistent and structural problem in the future.

The key findings of this investigation that policy makers, legislators, advocates, and other stakeholders should know are:

- In 2014 there are nearly 4,500 seniors languishing on wait lists for basic services such as home-delivered meals and help with bathing, dressing, medication, shopping and household chores. About half of the individuals on the wait lists have been waiting for more than 180 days.

- Individuals on wait lists for extended periods of time are:
    - More likely to end up living in a nursing home
    - Less likely to remain living in their own home
    - More likely to seek health care from a hospital emergency room
    - More likely to die waiting for assistance.

- An increase of $5 million for the fiscal year 2015 will be needed to allow the Michigan Office of Services to the Aging in-home services programs to begin addressing the service needs of those on wait lists, accommodate anticipated new requests for assistance, and begin addressing the needs of the underserved population of individuals who are receiving assistance, but not in the amount that they need due to service rationing.

- The effort to make Michigan a "No Wait State" for in-home services will be a key component of a larger strategy to make Michigan a retirement destination of choice that attracts and retains retirees, and captures the significant social and economic benefits of an aging population.

- A $5 million investment will yield many collateral benefits to taxpayers, businesses and the state, including:
    - Creating approximately 200 new jobs
    - Leverage matching federal, local, and private contributions of an additional $1.7 million
    - Return approximately $350,000 in state tax revenue
    - 75% of food purchased from Michigan based sources.

A FY 2015 allocation of $5 million in state general revenue funding for in-home services provided through the Michigan Office of Services to the Aging, coupled with the leveraging of participant donations and other funding sources, will represent a significant first step in eliminating the state's chronic in-home service wait lists of older Michiganians.