DATA ANALYSIS:
NEXT STEPS

Deliverable 6 (Ref: Contract Scope/Plan)

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Commissioned by:
Detroit Area Agency on Aging
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Purpose of this report:

This report was prepared by the Gardin Consulting Group, LLC (GCG) in response to a request by the Detroit Area Agency on Aging that it ***succinctly*** take key findings of an earlier, comprehensive report and offer next practical steps to be taken by the Dying Before Their Time Task Force.

Introduction:

In a report submitted to the DAAA titled, Dying Before Their Time: Another Look – An Independent and Critical Analysis (Dated: April 16, 2004) key findings were summarized as:

"Key findings:

- Older adult population in DAAA region is declining at a greater rate than the total population
- Components of formula funding will have to change to mitigate DAAA funding losses
- Use of proportionate share funding methods vs. absolute numbers assessment puts DAAA at a funding disadvantage
- In some instances (e.g., cost of health care) DAAA's older adults reflect "problematic national trends"
- Some of DAAA's older adults use physician services at greater rates than indicated by national trends
- DAAA's older adults are generally happy with their quality of life
- Some debatable observations exist in the current body of presented information"

What follows are some recommended "practical next steps" for each key finding that the DBTT task force may find useful in its planning activities.

Practical next steps:

- Older adult population in DAAA region is declining at a greater rate than the total population

It is precisely this observation by earlier researchers that ultimately led to the formation of the Dying Before Their Time Task Force.

It is important to recognize that this key finding specifically uses the term “declining” rather than “dying” as the reduction in the older population in the Detroit area is due to more than premature death. The “out-migration” of these citizens is also significant (although also undoubtedly accounted for in part by premature death rates).

Reasons cited in various reports and data analyses provided to DAAA include:

1. Limited availability in the quantity and quality of medical services;
2. Limited availability in the quantity and quality of nursing home and community based care;
3. Limited awareness of those support services that are available (e.g., transportation), explained in part by inadequate marketing of those services rather than lack of capacity (See also Best Practices report);
4. Limited help with activities of daily living;
5. Limited access to and use of exercise activities and nutritional counseling (i.e., healthy aging);
6. Need for safe and attractive neighborhoods; and,
7. General retention of younger populations as they age

Much has already been written on each of these deficiencies and the DBTT Task force members are to receive the documentation supporting and describing these observations in detail.

Using all the talent and experience available and assembled on the task force, a first practical step would be to engage in solution focused brainstorming once task force members are familiar with all the background material collected to date. Brainstorming sessions could be engaged in by the committee of the whole or via task force subgroups formed to focus on specific issues. The goal of these brainstorming sessions would be the production of viable solutions. This would be followed by the development of action plans to institute those solutions via new pilot programs and/or replication of known best practices already used successfully by others agencies.

- Components of formula funding will have to change to mitigate DAAA funding losses

- Use of proportionate share funding methods vs. absolute numbers assessment puts DAAA at a funding disadvantage

These two key findings are related and therefore addressed together.

As has been reported in earlier documents, change in population composition (i.e., increasing diversity) throughout the state of Michigan has resulted in a shifting of funds away from the DAAA and its service area. This has a negative impact on the level of services available to the older adults in the charge of the DAAA.

Again, the task force membership should first become familiar with the details of the funding formula (perhaps through an orientation session provided by DAAA financial executives).

Then, using the considerable political "clout" of Mayor Kilpatrick's office and the task force, pressure leveraged by objective data collected by the DAAA should be brought to bear on Lansing regarding provision of **additional funding**. In the original report cited, a case is made for funding based on "absolute numbers" of older adults in need rather than on proportionate share.

Another strategic yet practical approach would be to avoid recommendations that are "zero sum" in nature. To argue for changes in the formula that would take dollars from others and redirect them back to DAAA would simply stimulate counter claims and aggressive responses from those that would lose funding. However, should a budget neutral discussion be unavoidable, than the task force should make the case of introducing a Medically Underserved Area (MUA) factor into the funding formula. (Again, details on this approach are offered in the original report.)

- In some instances (e.g., cost of health care) DAAA's older adults reflect "problematic national trends"

When it comes to national problems such as the escalating cost of health care, it would appear that there is little one local task force can do. However, as has already been stated, increasing the level of services available and increasing awareness about healthy living can reduce the local demand for expensive medical and other ancillary health services in the long run.

It is this author's understanding from discussions with senior DAAA officials that "awareness" of available services has been a topic of discussion in the past. Apparently, there is concern that if marketing of DAAA services is too aggressive, capacity to serve could be overwhelmed. On the other hand, research into best practices indicates that the most successful programs of service to older adults are precisely those that are well known to the public and entice greater use (rather than offering something brand new in the way of actual services rendered.)

Although concern about overwhelming capacity is legitimate, it is not clear whether or not capacity limits have actually been tested. Moreover, actual quantification of current capacity has not been reported. Currently, the DAAA is engaged in a comprehensive inventory of available services. Once this is completed, the task force should evaluate to what extent services are fully used. This evaluation would then drive discussion on whether or not more aggressive marketing of DAAA services would be productive. (The

goal of more aggressive marketing would be to assist in the reduction of morbidity and thereby produce a reduction in demand on an increasingly more expensive health care system.)

- Some of DAAA's older adults use physician services at greater rates than indicated by national trends

Although this can appear to be indicative of greater availability of such services in the DAAA service area, more likely it is indicative of higher morbidity rates (i.e., poorer health). The task force's practical response should be as already described above. In addition to taking steps to insure that these services remain available, if not indeed increased upon (via seeking of additional funding), the ultimate goal should be an improvement in the life styles and healthy living by older adults, thereby reducing the ultimate demand for such medical services. (See also, above discussion on increasing awareness of programs already available.)

- DAAA's older adults are generally happy with their quality of life

Simply and succinctly, the Task Force should take no steps in fixing what is not broken. In fact, caution is warranted not to create an environment of fear by stressing the current significantly higher rates of morbidity and mortality. The task force must consider ways in which to be able to improve older adults' living conditions without negatively impacting on their shared "collective optimism".

On the other hand, there could be benefit in learning more about why older adults in the area are generally happy with their quality of life – to insure that such factors remain strong and vibrant in the service area.

- Some debatable observations exist in the current body of presented information

Because some observations and recommendations presented in the DAAA body of research literature are debatable, the task force should avoid responding to these. To do otherwise risks engaging in discussion and debate that would bleed off energy necessary to respond to those issues with a better defined need for intervention/practical steps by the task force.

Topics of discussion the task force should avoid for the stated reason above (and fully described in the original report) include but are not limited to:

1. Suggesting to the State that only certain area agencies should receive funding from allocated budgets
2. Demonstrating higher than average morbidity rates based on hospital discharges as currently reported in earlier DAAA research
3. Looking for solutions to people dying "because" they live in PSA 1-A
4. Others

Finally, there are some other findings that did not make the “key findings” list but may be of some practical concern to the task force. These are summarized next:

1. Nearly a third of Project Choice Care Management clients had their cases closed due to “refused service”. Determining why this is so might lead to additional recommendations by the task force.

2. Medicaid waiver clients appear to first seek DAAA assistance when they are sicker than other clients first seeking assistance. Because delays in seeking help are predictive of higher mortality and long-term, more expensive morbidity, attempts should be made to get these clients in for services at earlier stages of any disease process.

3. Although older adults appear to have little trouble obtaining needed prescriptions, they report difficulty with the cost of filling them. What more can be done to assist them in getting vital prescriptions filled (in light of recent Medicare changes and some pharmaceutical companies making discount programs available)? Does proximity to Windsor offer solutions?

4. Should the task force attend to the problems of family caregivers and seek additional support for them (e.g., via respite care)?

5. The eastern portion of the empowerment zone was better able to maintain its older adult population in spite of losing the highest percentage of total residents. Because there are no remarkable differences in racial/ethnic composition, living arrangements and poverty levels between older adults here and elsewhere in the empowerment zone, this area may prove fertile ground for the task force in seeking solutions to the problems listed above.