

HEALTHY AGING

MICHIGAN HEALTH ENDOWMENT FUND 2016 AND 2017 COHORT REPORT

NOVEMBER 2020

PSC PUBLIC SECTOR CONSULTANTS

MICHIGAN HEALTH ENDOWMENT FUND

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In November 2016, the Michigan Health Endowment Fund (Health Fund) awarded funds to 12 grantees through its proactive grantmaking initiative in Healthy Aging as well as six special projects. In November 2017, the Health Fund awarded funds to 12 additional grantees focused on healthy aging as well as one special project. The Health Fund engaged Public Sector Consultants (PSC) to conduct cohort evaluations of the 2016 and 2017 grantees to determine their projects' impact on healthy aging in Michigan. The Health Fund's proactive grantmaking is guided by two overarching goals:

1. **INTEGRATION**
   To develop and expand innovative and cost-effective integration models that coordinate care, services, and community resources in ways that promote the health of children and older adults in Michigan.
2. **WORKFORCE**
   To build, extend, and strengthen workforce capacity.

Total investment and grantee timelines: Together, the 2016 and 2017 grantees represent an investment of more than $14.2 million in projects aimed at improving integration and workforce capacity in healthy aging. Project timelines are approximately two to three years, with 2016 grantee start dates ranging from November 2016 to March 2017 and ending between November 2017 to December 2019. For 2017 grantees, start dates ranged from December 2017 to March 2018, with end dates between October 2019 to October 2020. Many grantees from both cohorts were granted no-cost extensions to carry out project activities beyond initial end dates.

This final report covers the time period of November 2016 through August 2020 and includes an overview of the 18 projects in the 2016 cohort (including six special projects) and 13 projects in the 2017 cohort (including one special project), an assessment of grantee projects' impact on the Health Fund's goals and aims, grantee successes and challenges, sustainability and scalability of the projects, and grant administration. PSC used information provided through grantee reports to the Health Fund as well as interviews conducted with project staff and Health Fund staff for this evaluation report.

PROGRESS ON HEALTH FUND AIMS

- **Increase access to care:**
  Grantees increased access to care primarily through long-term workforce training of formal and informal caregivers, geriatric training for health professions students (physical therapy, occupational therapy, social work, etc.) and medical residents, and enhanced use of telehealth in multiple projects.

- **Improve health outcomes:**
  Grantees sought to improve health outcomes in a variety of ways, such as fostering healthy lifestyles, reducing the effects of social isolation, and preventing unnecessary emergency department (ED) visits.
- **Decrease healthcare costs:**
  Many grantees anticipated cost savings due to reductions in costly services, such as inpatient hospitalizations, but only a few were able to demonstrate such savings during their grant funding periods.
- **Improve patient experience:**
  Grantees sought to improve patient experience in a number of ways, such as improving workforce training for residential facilities; establishing reliable, shared metrics to evaluate change in patient experience; increasing attention to the social determinants of health; providing home- and community-based care, including telehealth care; and providing compassionate end-of-life care and nonclinical enrichments.
- **Inform public policy:**
  Few grantees focused explicitly on informing or changing public policy and those that did faced significant barriers. However, some grantees focused on internal agency policy with success. Several others identified policy barriers, including healthcare reimbursement practices, which may be addressed through future changes to public policy.

CHALLENGES

All grantees experienced challenges during project implementation. Many of these were similar across cohorts, emphasizing the consistency of these issues over time. Common challenges included unanticipated delays in project implementation, participant engagement and demand for services, data collection and sharing, staff attraction and retention, and program structure.

The Health Fund has worked to make future grantees aware of common challenges to prepare them for potential difficulties that can delay or derail project activities. It also provides technical assistance to grantees to support program implementation and avoid some of these common challenges.

SUCCESSES

Many grantees demonstrated successful project implementation by achieving established targets for project activities and showing a positive impact on participants served. Common factors contributing to project success included supportive infrastructure, use of existing models, and strong partnerships. Health Fund staff also identified the following success factors:

- Formalized partnerships

- Sustained funding streams, such as demonstrating return on investment to payers or leveraging appropriate billing codes
- Programs involving those in a formative stage of their careers (e.g., university students instead of well-established clinical clinicians)

Common success factors were generally the same among the 2016 and 2017 cohorts, and they connect strongly with project sustainability.

SUSTAINABILITY AND SCALABILITY

Grantees used one or more of the following five major sustainability approaches:

- Maintain or expand partnerships
- Increase staff capacity and/or enhance workforce skills
- Obtain third-party reimbursement
- Establish a best practice or model for replication
- Seek other sources of funding

Around three-quarters of grantees' plans to sustain their projects were based on two or more of these approaches, which may strengthen their likelihood of success. Nearly half have begun to scale their projects by expanding them into additional areas of the state, and more than half are either already or have a high likelihood of sustaining their projects beyond their grant funding period.

GRANT ADMINISTRATION

The Health Fund's 2016 and 2017 grantmaking provided an opportunity to refine its technical assistance efforts and grantmaking strategies to support grantee success.

- **Technical assistance:**
  The Health Fund provided more individualized and targeted technical assistance through one-on-one conversations, specialized consultants, and topical webinars and conferences to support grantees.
- **Grantmaking changes:**
  The Health Fund has strengthened its request for proposals (RFP) and sharpened its focus on promising areas for targeted grantmaking, including projects that address caregiving, dementia care, frailty and fall risk, home visiting and hospital diversion, care coordination models, and technology use to expand workforce capacity and effectiveness. The Healthy Aging team is also engaged in strategic planning, with a concerted focus on raising the profile of aging issues, streamlined access to healthy aging services, integration, and systems change.

OVERVIEW OF GRANTEE GOALS AND AIMS

The grantees in the 2016 and 2017 cohorts worked to improve healthy aging and initiate positive change in Michigan using a variety of strategies and approaches with diverse target populations, in different areas of the state, and within various types of organizations.

Most 2016 grantees implemented a project that addresses both of the Health Fund's overarching goals. While two 2017 grantees implemented projects that addressed both of the Health Fund's overarching goals, most addressed just one in particular. By focusing on either goal, the grantees are working to achieve the Health Fund's aims.

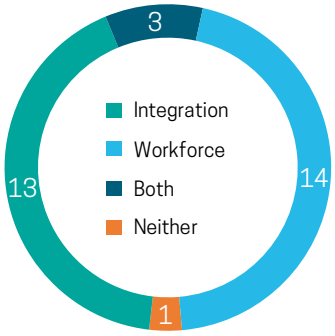
A summary of the number of grantees working toward each of the Health Fund's goals and aims is provided in Exhibit 1.

EXHIBIT 1. Goals and Aims Summary Table, by Number of Grantees

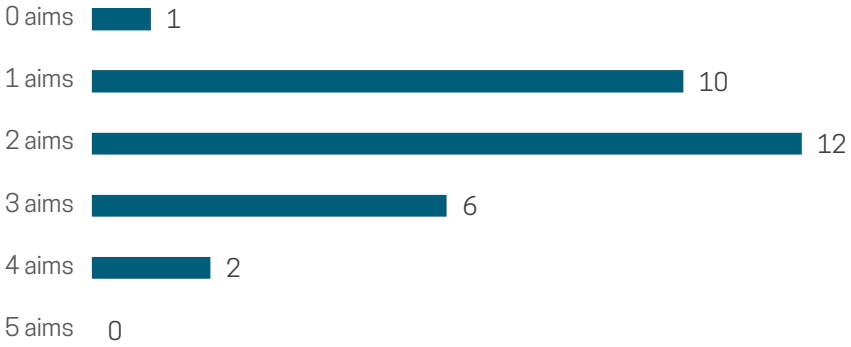
HEALTH FUND GOALS		
	Integrate physical and behavioral health	Enhance and expand workforce capacity
2016	9	10
2017	7	7
Total	**16**	**17**

HEALTH FUND AIMS					
	Increase access to care	Improve health outcomes	Decrease healthcare costs	Improve patient experience	Inform public policy
2016	10	11	3	1	5
2017	9	7	4	5	5
Total	**19**	**18**	**7**	**6**	**10**

Health Fund Goals Targeted, by Number of Grantees



Number of Health Fund Aims Targeted, by Number of Grantees



GRANTEE PROGRESS TOWARD GOALS AND AIMS

As of August 2020, all 2016 grantees and five 2017 grantees completed their projects. Eight 2017 grantees received no-cost extensions to complete their work later in 2020, with one receiving an extension until February 2021. Several of the 2017 grantees who sought no-cost extensions were delayed due to the novel coronavirus (COVID-19).

Grantees in the 2016 and 2017 cohorts increased access to healthy aging services, improved health outcomes, decreased healthcare costs, improved patient experience, and informed public policy. Select grantee examples are provided below to highlight the Health Fund's impact on healthy aging in Michigan.

Increase Access to Healthy Aging Services and Supports

Grantees seeking to increase access to care frequently worked to enhance workforce skills and/or increase integration of healthy aging services and supports in clinical as well as home- and community-based settings.

ENHANCED WORKFORCE SKILLS

Central Michigan University (CMU) created a replicable experiential learning program to train health professions students to conduct in-home visits with older adults and intervene based upon individual assessments. CMU enrolled 150 older adults for home-based interventions, approximately 40% of whom were at a moderate to high risk of falling. Many participants reported the program was valuable.

The **American Civil Liberties Union Fund of Michigan (ACLU FM)** worked with Area Agencies on Aging (AAAs) in three targeted regions to train staff on policies that are inclusive of the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) community. In addition to training more than 80 AAA staff through daylong trainings in each region, project staff created nine eLearning modules and facilitated the development of referral guides to help residents find service providers that are inclusive of LGBTQ+ individuals in the three regions.

Lake Superior Life Care & Hospice (LSLC&H) trained medical students in hospice services, including every resident in the Marquette Family Medicine Residency Program, and educated broad audiences during conferences on services for individuals with serious illnesses. LSLC&H enrolled 41 patients in its program and held anticipatory grief sessions with 400 patients and families, with positive participant feedback following the sessions.

The **Michigan State University (MSU) Integrated Model for Personal Assistant Research and Training (IMPART)** improved access to and quality of home care for older adults by implementing a train-the-trainer model for personal care assistants (PCAs). Using an evidence-based curriculum, the

initiative enhanced PCA workforce skills by providing training to nearly 200 PCAs from 14 Michigan counties.

The **University of Michigan (U-M)** created a program to train formal and informal caregivers for people with dementia using the **Describe, Investigate, Create, Evaluate (DICE)** approach. More than 180 caregivers participated in the program, with most indicating improved knowledge and skills on a variety of measures. In addition to developing in-person training, U-M also created an online component as a continuous and accessible training resource for all caregivers throughout Michigan.

INCREASED INTEGRATION

Genesee Health System (GHS) implemented a home-visiting care coordination model with health navigators. During the grant period, 585 clients were referred for services, due in large part to community partner outreach. Additionally, GHS increased project referrals when individuals do not qualify for other internal services, filling a gap for behavioral health services for older adults.

The Jewish Hospice and Chaplaincy Network (JHCN) expanded the LifeLinks program—a home-based palliative care program for older adults who do not qualify for hospice—to improve the quality of life for people with life-threatening illnesses and their families. JHCN conducted more than 1,700 visits, serving more than 550 terminally ill patients, and aims to serve every patient through the program in the future.

The **Michigan Oral Health Coalition (MOHC)** developed a cost-effective integration model that aligns federally qualified health center (FQHC) and older adult housing community services to improve the oral health of older adults with low incomes in six affordable senior housing communities. MOHC screened 65 older adults for existing illnesses and oral health problems and provided travel vouchers to clinic sites for treatment. It also trained dental and housing community staff to implement an evidence-based oral health curriculum with older adults.

Otsego County Commission on Aging (OCCOA) deployed a new CommunO_2 SuperApp to reduce social isolation in a difficult-to-serve region of the state by bringing community services into older adults' homes. Through partnerships with local resource providers, OCCOA used the app to provide home-bound seniors one-stop access to community and faith events, social service providers, virtual doctor visits, and health biometrics. The pilot's successes are now being scaled and replicated in other parts of the state.

Region 3B AAA implemented a collaborative community health initiative for older adults called the Southwest Michigan Aging Mastery Program (AMP®). AMP® combines education with goal setting, daily practices, and peer support to help participants make meaningful changes in health, finance, life enrichment, and advance planning. Region 3B embedded the program into nine community-based settings, such as libraries and community centers, and engaged more than 1,000 older adults.

Saint Joseph Mercy Ann Arbor (SJMAA) created a geriatric behavioral health (GBH) model to integrate behavioral health services within primary care settings and assisted living communities. SJMAA embedded its GBH program in five sites, serving more than 460 older adults in need of behavioral health services, particularly those outside of the Medicaid population.

Improve Health Outcomes

Some grantees sought to improve healthcare outcomes for older adults by increasing healthy lifestyles, reducing anxiety, and preventing unnecessary ED visits.

Calvin University (CU) developed an interprofessional model for fall prevention and education among older adults who fear falling and those with significant physical/mobility issues. CU delivered education to more than 300 older adults who experienced fewer falls and reported zero ED visits due to falls in the six months following program participation.

LSLC&H implemented Transitions, a program designed to coordinate care for patients who exit hospice care. Though there was limited enrollment, initial data show a 38% reduction in ED visits and hospital admissions for Transitions program patients.

MSU Partners in Aging Strategies and Training (PAST) trained community-dwelling older adults and their caregivers on how to adopt a healthy lifestyle, self-manage chronic conditions, and have effective partnerships with their healthcare providers. MSU PAST trained almost 500 older adult participants who reported improved confidence after each workshop.

The **United Methodist Retirement Communities (UMRC) Foundation** used the Positive Approach to Care® (PAC) model to train more than 1,300 memory care center staff, community members, and families of people living with dementia. The PAC model helps care partners recognize residents' underlying unmet needs that can lead to behavioral distress. Following implementation of the training, transfers to EDs due to distressed behaviors decreased by 75% and UMRC Foundation staff indicated fewer falls among residents.

U-M, in partnership with the **United States Department of Veterans Affairs Ann Arbor Healthcare System (VA)**, helped older veterans who experienced a decline in physical function following discharge from the VA hospital transition to an optimized physically active lifestyle. More than 70% of participating veterans and their caregivers utilized telehealth and wearable sensor technology to improve mobility, increasing mean total steps by 1,892 and decreasing mean sedentary time by two hours after six months.

Wayne State University (WSU) developed the first evidence-based program in Michigan to assist older adult victims of scams and identity theft, known as the Successful Aging through Financial Empowerment (SAFE) program. Given that financial scams and identify theft may produce declines in

cognitive abilities and emotional functioning, the project focused on measuring the health impacts of exploitation. WSU created a tool to prevent financial exploitation, conducted presentations on scam protection, and provided financial coaching services, reaching more than 5,000 service providers. WSU found that the SAFE intervention was related to greater improvements in health, anxiety, and cognition among participants, compared to those who did not receive the intervention.

Decrease Healthcare Costs

The Altarum Institute (Altarum) developed service packages and à la carte options to expand access to the Program of All-Inclusive Care of the Elderly (PACE) for older adults who are ineligible for PACE but need services. While few participants were engaged in these services, program data show they spent less per month on healthcare than they would have without PACE services and delayed their potential spend down to Medicaid. However, more enrollees are needed to identify the true efficacy of the program.

Region VII AAA implemented an integrated care model for older adults transitioning from hospital to home, known as Community Care Transitions. By improving coordination and communication between healthcare providers and home- and community-based organizations for its 500 program participants, Region VII AAA reduced hospital readmission rates from 15% to 3%. These reduced readmissions contributed to an estimated $1 million in Medicare savings (at an estimated $10,000 per readmission).

Trinity Health implemented a continuous, collaborative effort to enable rapid triage by providing older adults with the right resources, in the right setting, at the right time before they require hospitalization. Through this integrated, community-based delivery system, 73% of patients were able to stay home, saving an estimated $500,000 in ED and paramedic costs.

Inform Public Policy

Several grantees advocated for policy changes at the federal and state level, and others raised awareness of policy barriers impacting healthcare delivery to older adults. While permanent changes may require more time beyond the grant period, grantees were successful in elevating issues impacting older adults.

Altarum successfully generated support for broad system changes to make PACE more accessible to individuals in need of long-term services and supports (LTSS). While unable to expand state Medicaid eligibility for individuals with low incomes to enroll in PACE and obtain a federal waiver to provide lower-cost prescription drug coverage for Medicare-only PACE enrollees, Altarum elevated these issues at the state and national level, prompted other PACE organizations to submit similar waiver requests, and continues to advocate for these changes. They have also had positive conversations with the Centers for Medicare and Medicaid Services (CMS) about implementing this approach nationally.

The **ACLU FM** created guidance on standard language that is inclusive of LGBTQ+ individuals for state aging services and requested state tracking of services for LGBTQ+ older adults.

In addition to implementing a community-based oral health program for older adults with low incomes, the **MOHC** developed a report outlining the process to replicate the program and disseminated it across the state and nation. MOHC also advocated for added or expanded Medicaid and Medicare adult dental benefits and shared documents related to this cause with coalition partners and national organizations.

MSU IMPART educated policymakers on the critical role of PCAs, their challenges as members of the healthcare team, and strategies for growing this workforce by testifying before the Michigan Senate's Families, Seniors, and Veterans Committee about the home care worker shortage and potential solutions to the crisis. It also led 170 organizations in a coalition to promote direct care worker issues and plans to continue engaging this network.

Region VII AAA has presented its transitions from hospital-to-home model and findings to local hospitals and at national conferences. It has had discussions with the Michigan Department of Health and Human Services (MDHHS) to expand the care transitions model statewide.

Upper Peninsula Health Care Solutions (UPHCS) raised awareness of advance care planning (ACP) services throughout the Upper Peninsula, trained ACP facilitators, and created service access points beyond clinics (e.g., homes, churches, and libraries). Upon identifying the need for a central repository for ACP documentation, UPHCS advocated for an established statewide system to be used for this purpose to ensure providers can access and follow patients' care plans.

Some grantees did not engage in formal advocacy efforts but did raise awareness of policy barriers impacting care for older adults. For example, **SJMAA** raised awareness of the need to expand Medicare codes to cover case managers and other support for older adults with behavioral health needs, while

All grantees experienced challenges during project implementation. Common challenges included unanticipated delays, participant engagement and demand for services, data collection and sharing, staff recruitment and retention, and program structure. Health Fund staff observed staff recruitment and retention as a particularly common challenge. In these instances, turnover of leadership or other key project staff or challenges in hiring clinical workers with limited funding and short periods of time made it difficult for some grantees to succeed. Many challenges were similar across cohorts, emphasizing the consistency of these issues over time.

The Health Fund has worked to make future grantees aware of common challenges to prepare them for potential difficulties that can delay or derail project activities. It also provided technical assistance to grantees to support program implementation and avoid some of these common challenges.

Program Structure

Many grantees had to reevaluate or revise aspects of their project when they experienced challenges with program design. Some examples of this included more severe participant needs than anticipated, participants' hesitancy to engage in projects requiring technology or staff entering participant homes, or difficulty billing for services when reimbursement was expected. While some grantees showed flexibility and were able to modify their approaches, others faced structural challenges that limited achievement of project goals.

Unanticipated Delays

Grantees experienced unanticipated delays implementing their projects for several reasons. Some were due to having misaligned visions or lack of buy-in with project partners, forming relationships with new partners or participant populations, needing long periods of time to obtain administrative approvals, or experiencing organizational changes. Some also faced delays once the project was underway due to unexpected staff changes or the need to modify organizational infrastructure. Spending more time planning at the outset of a project may help to address some of these delays, particularly in formalizing partnerships and obtaining needed approvals.

Participant Engagement and Demand for Services

Some grantees faced challenges with participant engagement and demand for services. In some cases, targeted populations were difficult to reach, such as older adults in rural areas or LGBTQ+ older adults. Other grantees found limited demand for their services; for example, when participants did not want to engage with unfamiliar staff, already received the services offered, or did not have time to engage in the program. Some grantees increased enrollment by identifying new or expanded populations, modifying approaches to make grantees comfortable with the services, partnering with organizations able to reach targeted populations, or obtaining media coverage to increase awareness.

Data Collection and Sharing

While some grantees successfully used data to inform their projects and demonstrate outcomes, many faced difficulties in collecting data or evaluating programs. Challenges included absence of, or unfamiliarity with, evaluation processes or data collection measures, participants' unwillingness to submit data, and difficulty integrating programs into electronic health record systems. Limited data collection led to challenges in demonstrating impact or intended outcomes. This affected program sustainability efforts.

Staff Recruitment and Retention

Some grantees experienced challenges in hiring qualified candidates to deliver services within a limited grant period or with limited funding for clinical staff. Others had trouble retaining staff due to the challenging nature of the work. For example, one grantee project required staff to fulfill multiple roles, while others required working with patients who had behavioral and chronic conditions or were near the end of life. Other grantees experienced challenges where key staff left during project implementation, leaving gaps that were difficult to fill with new staff who did not have the same expertise and/or passion for the project. Some were able to address these challenges by expanding their recruitment searches, adjusting responsibilities, or finding an alternative staffing approach.

COMMON SUCCESS FACTORS

Many grantees demonstrated successful project implementation by achieving established targets for project activities and showing a positive impact on participants served. Common factors contributing to project success included supportive infrastructure, strong partnerships, high demand for services, and use of existing models. Common success factors were generally the same among the 2016 and 2017 cohorts and strongly connect with project sustainability.

Health Fund staff also observed the following success factors:

- Formalized partnerships
- Sustained funding streams, such as demonstrating return on investment to payers or leveraging appropriate billing codes
- Programs for individuals in a formative stage of their careers, as opposed to busy clinical staff already in well-established roles (e.g., university curricula or graduation requirements that include program goals)

Supportive Infrastructure

Some grantees, including universities and health systems, leaned on existing infrastructure to support their projects. Universities leveraged staff and students, used cross-departmental knowledge, and/or integrated programs as part of course requirements to ensure appropriate staffing and participant engagement. Health systems have access to electronic health records, billing systems, and clinical staff. Many of these organizations were also able to depend on partners for additional resources and support.

Strong Partnerships

Strong partnerships contributed to grantee success. This was particularly true for those able to formalize partnerships before or during the first quarter of the grant, ensuring partners were engaged and had a clear understanding of their commitments. Strong partners contributed to projects in several ways, including offering subject-matter expertise, referring participants to programs, or expanding access to their networks and resources.

High Demand for Services

Several grantees implemented projects that fulfilled an unmet need for certain populations or aligned with outside organizations' goals and strategies, leading to high demand for services. Grantees that experienced high demand for their services frequently exceeded their participation targets or had high attendance rates at their events or trainings. Other grantees had substantial interest from partner organizations, leading to expanded site locations or contributions to support the programs. Some

received state or national attention for their services, which may increase interest and help sustain and expand their programs.

Use of Existing Models

Some grantees implemented existing models already proven successful. This frequently involved grantees expanding a model to a new location or population or, in some cases, combining two models into a single project. Implementing an existing model contributed to project success by providing a foundation and tools for grantees to work with, rather than developing an entirely new model, and allowing some to plan for and modify their projects based on what worked well and what did not in the initial pilots.

SUSTAINABILITY AND SCALABILITY

Grantees employed five primary approaches to sustaining their projects:

- Maintain or expand partnerships
- Increase staff capacity and/or enhance workforce skills
- Obtain third-party reimbursement
- Establish a best practice or model for replication
- Seek other sources of funding

Around three-quarters of grantees' sustainability plans were based on two or more of these approaches, which may strengthen their likelihood of success. Nearly half have begun to scale their projects by expanding them into additional areas of the state. More than half are either already or have a high likelihood of sustaining their projects beyond the grant funding period. The examples below are not exhaustive; instead, they highlight the ways in which the varying approaches have contributed to the longer-term impact of the Health Fund's Healthy Aging grantmaking.

Maintain or Expand Partnerships

Grantees' primary strategies to maintain or expand partnerships included continuing and building on existing partnerships within health systems; creating multiagency teams and/or systems to enhance community capacity to meet residents' needs; relying on partners to refer, enroll, and retain program participants; and involving partners in service delivery.

The Michigan Health Council (MHC) leveraged partnerships with organizations with similar missions and values, including AARP of Michigan, the Michigan Dementia Coalition, and the IMPART Alliance. These partnerships enabled MHC to generate content for the Center for Caring website, a resource for older adults and their caregivers. MHC is leveraging its relationship with AARP of Michigan to maintain and update the website.

Region 3B engaged health plans and employers to obtain support for, build awareness of, and increase referrals to AMP® by healthcare providers. Additionally, Region 3B (CareWell Services Southwest) embedded AMP® into numerous organizations, including one social service agency, one county library system, three older adult centers, and four AAAs. All but one of Region 3B's partners and subgrantees purchased their own AMP® licenses and continue to offer AMP®.

The **AAANM**'s partnership with the Northern Physicians Organization (NPO)—a physician-led group that manages two accountable care organizations and maintains an electronic medical record system—enabled successful electronic integration of care systems, engagement of physician practices, and evaluation of health outcomes. Through its relationship with the NPO, the AAANM reframed the project to focus on overall systems change and collaboration among healthcare providers, community

agencies, and informal caregivers. The AAANM developed a community pathway where conversations, resources, and referrals are shared among various providers, community organizations, and caregivers, which will be rolled out to NPO physicians. The AAANM will continue to offer the caregiver support initiated under the grant and anticipates participating organizations will sustain this system for the immediate value they derive from it.

The **JHCN** has focused efforts on building strong relationships with community health leaders and clinical partners, and community organizations are approaching the JHCN to develop deeper relationships. Hospice of Michigan is training all LifeLinks staff to recognize the need for palliative care interventions and has a data system to measure progress. The Michigan Community Visiting Nurse Association assisted with delivering palliative care. Additionally, the JHCN can access nurse practitioners who conduct assessments and in-home visits through Hospice of Michigan and Seasons Hospice and Palliative Care of Michigan. Another partner has extended access to a variety of clinical staff, including physical, occupational, and speech therapists, as well as home health aides, who make home visits to patients. Finally, LifeLinks has developed referral relationships with major hospital systems, including Henry Ford Health System, Beaumont Health, Trinity Health, and Ascension.

MSU Extension's (MSUE's) Tailoring Healthy Resources Through In-person Instruction and Virtual Education (THRIVE) Network has several key partners with extensive expertise in train-the-trainer and other caregiver-related programs. These organizations include the Michigan Alzheimer's Disease Center, the MSU College of Human Medicine, and WSU's Institute of Gerontology (IOG). The THRIVE Network has built-in sustainability among partners who operate and collaborate within existing education and support networks in their regions.

Increase Staff Capacity and Enhance Workforce Skills

Grantees' primary strategies to increase staff capacity and/or enhance workforce skills include developing a train-the-trainer model, offering free online training modules, serving as teaching programs for healthcare professional students and medical residents, growing the skills of providers in the workforce, and increasing internal program staff.

MSU IMPART sought to increase the number and availability of competent PCAs to promote the health of Michigan older adults. It worked with key partners to establish the train-the-trainer program and plans to engage schools in its next phase of work. MSU IMPART intends to offer its train-the-trainer program on a wider scale for a fee and has already developed a cost structure and payment model to continue the work. It has also added full- and part-time staff.

CMU created a replicable experiential learning program to train health professions students to conduct in-home visits with older adults and intervene based upon individual assessments. While initial funding was needed to start the program, curricular resources are available to continue it. The program allows

CMU health professions students to fulfill their requirement to participate in interprofessional learning activities that mirror actual practice, a model that other medical schools or universities could replicate.

WSU seeks to continue its integrated frailty prevention model among prefrail older African Americans living in Metro Detroit by continuing frailty screenings through the Detroit Medical Center. It has applied for a postdoctoral fellowship to bring on another researcher to accelerate data analysis. WSU also seeks to integrate frailty prevention service delivery into its occupational therapy students' Aging and Clinical Practice course. This would allow WSU to continue serving up to 60 older adults annually without outside resources.

Obtain Third-Party Reimbursement

Grantees' primary strategies to obtain third-party reimbursement include integrating the delivery of services already reimbursable by Medicaid, developing service delivery models likely eligible for Medicaid reimbursement, advocating for Medicaid income eligibility expansion, and developing relationships with health plans.

Trinity Health implemented a pilot program to decrease the need for ED visits and reduce the number of preventable hospital admissions and readmissions. It found many organizations had an interest in and were willing to contribute to the program for little or no cost during the grant period. Moving forward, Blue Cross Blue Shield of Michigan agreed to fund patients not covered by Medicare or Medicaid. In addition, a CMS program called Emergency Triage, Treat, and Transport embraced components of the program and will become the primary source of sustainable funding nationwide for at least the next five years.

AAANM is working on requirements to bill its integrated and coordinated system of care services under behavioral health codes; Altarum engaged the Michigan Caring Majority coalition to continue work for expanding Medicaid income eligibility; the Luella Hannan Memorial Foundation is exploring the possibility of obtaining funding for caregiver respite and support under a recent expansion of Medicare Advantage supplemental benefits for social determinants of health; and WSU plans to sustain its frailty prevention program through third-party reimbursement for treatments delivered in a clinical setting.

Establish a Best Practice or Model for Replication

Grantees' primary approaches to establishing best practices or models for replication include developing a training package or model replication guide, toolkit, or service package based on project implementation.

ACLU FM's online training modules are free for AAA staff statewide and may be offered for a fee to private agencies nationally. ACLU FM also shared an LGBTQ+ inclusion toolkit that contained policies, training, and marketing advice with all AAAs in Michigan and online. Both the referral guide and the

training have been recognized by Services & Advocacy for Gay, Lesbian, Bisexual, & Transgender Elders (SAGE), a national organization working to create a national quality index to rate organizations on their inclusivity, and the MDHHS.

MSU PAST provided continuing education to multidisciplinary healthcare professionals and primary care providers as well as presentations and workshops to older adult patients and their caregivers. MSU did not intend to continue PAST in-house; instead, it aimed to provide program materials and scales to the MDHHS Aging and Adult Services Agency for statewide use.

The UMRC Foundation had the infrastructure and knowledge to successfully embed PAC training into the memory care center's everyday operations. This initial site could serve as a model for other dementia care service providers and will serve as a training site for students and instructors in geriatric care. The UMRC Foundation plans to expand PAC to an additional assisted living facility and has spoken with other housing communities about replicating it.

U-M plans to sustain the **DICE** approach to assess and manage the behavioral and psychological symptoms of dementia through online training across the state and, possibly, nationwide. It created a fee structure for the online training, a DICE approach manual, and one-year online subscription to support the cost of maintaining the online platform. U-M is also drafting a paper to report project outcomes. The DICE approach continues to receive national attention, which has unexpectedly led to interest in the DICE manual and website. Long-term care facilities have also expressed an interest in using the website as part of their training.

SJMAA is part of two larger health systems—Saint Joseph Mercy Health System (SJMHS) and Trinity Health—that have provided support, funding, and staffing for the GBH program. Through these systems, SJMAA intends to create a replicable model of GBH care delivery, which includes reimbursement for some consulting services but not case management work. SJMHS is willing to support the program if cost savings can be demonstrated. Additionally, SJMAA plans to seek additional grant opportunities through Trinity Health's internal grant programs as well as other community-based grant funders.

Seek Other Sources of Funding

Some grantees are seeking other income from grants, donors, and community partners, developing cost and fee structures as well as payment models for private pay, and relying on existing institutional resources.

The Senior Regional Collaborative—tasked with overseeing the **Oakland Livingston Human Service Agency (OLHSA)** Quality Aging Matrix (QAM) measurement tool expansion project—recommended creating a three-tiered fee structure for member agencies, nonprofit organizations, and for-profit entities to sustain future use of QAM. As of September 2019, OLHSA was in the process of developing

a business plan and contracts for each tier, with hopes that for-profit entities' fees would subsidize nonprofit users' access at a lower cost.

WSU obtained support from the State of Michigan's Prevent Elder and Vulnerable Adult Abuse, Exploitation, Neglect Today grant to help continue the SAFE program and is seeking ways to embed the program into other grant opportunities. It also merged the SAFE program with the launch of the WSU IOG endowment fund, which has raised $1.25 million of its $1.5 million goal.

Curricular resources are available to continue the **CMU** program to train health professions students to conduct in-home visits with older adults and intervene based upon individual assessments. CMU has also identified potential funding from state and federal grants, charitable fundraising, and community partnerships.

HEALTH FUND GRANT ADMINISTRATION

The first two years of the Health Fund's proactive grantmaking initiative in Healthy Aging were 2016 and 2017. The grants made in those two years provided an opportunity for the Health Fund to learn from grantee successes and challenges and to refine its technical assistance efforts and grantmaking strategies to support grantee success.

Technical Assistance

When the initial grantee cohorts were funded in 2016 and 2017, the Health Fund engaged in many one-on-one conversations with prospective applicants about their proposals and hosted kickoff calls with each cohort to answer questions. The Health Fund also held annual convenings for all Healthy Aging grantees, providing them an opportunity to learn about each other's projects and about key topics in healthy aging policy. The 2016 grantees were initially asked to participate in occasional calls, which provided an opportunity to connect with others, discuss common challenges, and support each other in overcoming issues. While grantees provided positive feedback on each of these approaches, the Health Fund saw a need to provide more individualized, targeted topic-based support.

STREAMLINED PROCESSES

The Health Fund acknowledged the need for greater consistency and efficiency to serve a growing applicant pool. It also acknowledged the value of staff feedback to these applicants—especially unsuccessful applicants—during the application process. The Health Fund developed and hosted webinars to clarify what healthy aging means for applicants, provide common context on the state of healthy aging in Michigan, and acclimate prospective applicants to the Health Fund's role, proposal process, and grant administration practices. In 2016, the Health Fund solicited brief concept papers from prospective Healthy Aging grant applicants, providing each with individualized, written feedback. Since then, the Health Fund has established a more structured process that involves constructive feedback along with an opportunity to discuss specific concepts in more detail. Such meaningful engagement with potential grantees prior to the submission of full proposals has reduced the burden on individual grantees, increased the amount of one-on-one strategic counsel provided by Health Fund staff, and improved the quality and alignment of eventual applications with Health Fund goals and aims.

Once applicants were awarded grants, the Health Fund held introductory conference calls to kick off grant implementation for each cohort and increased the number of one-on-one technical support calls with grantees. The Health Fund also began requiring quarterly and final reports using Fluxx—a grant management platform for standardized reporting—and more routine accountability and technical assistance.

TARGETED TOPIC-BASED SUPPORT

The Health Fund replaced its annual cohort-based grantee convenings with topical webinars and conferences on relevant subjects and strategies, such as telehealth and evaluation. It brought relevant grantees together to meet with state Medicaid staff to talk about telehealth payment and billable services. The Health Fund also launched a new caregiving initiative in partnership with the Ralph C. Wilson, Jr. Foundation.

Grantmaking Role

Between 2016 and 2017—and since then—the Health Fund refined its approach to funding Healthy Aging projects, revising its RFP to clarify the types of initiatives it seeks to support. The Health Fund has also continually considered its role in informing healthy aging services, workforce, funding, and public policy.

SYSTEMIC CHANGE

Between 2016 and 2017, the Health Fund more strongly emphasized its crosscutting goals and aims in the RFP and application process. It also placed more emphasis on partnerships between organizations and across sectors in 2017, resulting in projects less focused on program implementation within an organization and more focused on systemic change. Lastly, the Health Fund added one-year planning grants to its portfolio in direct response to feedback from the 2016 and 2017 Healthy Aging grantees.

INTEGRATION

As the Health Fund seeks to improve integration of physical, behavioral, and social determinants of health, including the provision of LTSS in nonclinical home and community-based settings, it has strengthened its RFP to more explicitly define integration and outline the types of projects it will support.

TARGETED ISSUES

In addition, the Health Fund has found these early funding years helped identify promising areas for targeted grantmaking. For example, Healthy Aging program staff have proactively sought to fund projects that address caregiving, dementia care, frailty and fall risk, home visiting and hospital diversion, care coordination models, and technology use to expand workforce capacity and effectiveness.

STRATEGIC PLANNING

The Healthy Aging team has recently been engaged in a five-year visioning and strategic planning process. Moving forward, it foresees several critical ways to leverage the Health Fund's position as a funder in the changing healthy aging landscape. These include a concerted focus on awareness building, streamlined access to healthy aging services, and integration and systems change.

Awareness: First—and most consistently—the team seeks to raise awareness of the growing aging population, of the increasing demand for services, and of the need for statewide preparedness. The unfortunate and disparate impact of COVID-19 on older adults nationwide has drawn much-needed awareness to aging issues state- and nationwide.

Coordination: Michigan's COVID-19 response has also exposed a lack of cohesion between local public health, aging service organizations, and healthcare systems. Thus, the Health Fund will focus more strongly on the preparedness of older adult-serving organizations and the entire aging network to collaboratively address emergent issues moving forward.

Access: The Health Fund is focused on increasing access to healthy aging services and supports. It is determining its role in supporting state-level, statewide systems change, whether through funding, convening, or policy advocacy. The Health Fund will focus more on interrelated issues in rural health, telehealth, social isolation, and medication management moving forward.

Integrated policy and systems change: Lastly, the Health Fund also seeks to implement a policy and systems-change strategy for 2020 and 2021 based on learnings from 2016, 2017, and subsequent grantees. It has contracted with the Michigan Health and Hospital Association to implement aging-friendly health systems and is looking for opportunities to support a growing age-friendly movement in Michigan. This focus will include more concerted engagement with planners, community development corporations, and similar organizations.

Grantmaking Impact

The Health Fund's proactive grantmaking in Healthy Aging has impacted its overarching goals and aims to increase integration and enhance workforce capacity.

Integration has been improved through geriatric mental health first aid in clinical and nonclinical settings, hospital-implemented home- and community-based care, shared measurement (e.g., the QAM and a shared set of program evaluation tools across grantees), and concerted Medicaid policy efforts to improve access to PACE.

The Health Fund remains focused on caregiving and caregivers but has struggled to increase the direct care workforce because—like other state and national funders—it receives few applications for fundable projects that address the systemic root causes of an inadequate workforce, including low wages for demanding jobs. Instead, the Health Fund has focused on bolstering its family caregiver support work, through training and respite, to lessen the need for paid professionals. It will focus more on respite strategies moving forward as well as adding a geriatric lens to existing healthcare workforce training. As such, the Health Fund's ability to impact the workforce is, in fact, growing. The workforce has also been strengthened through training and certification for formal and informal caregivers, curricular and experiential learning in geriatrics for undergraduate students in a variety of fields,

support for clinical residents in practice, and the dissemination of evidence-based trainings, such as CCC and PAC.

The Health Fund also continues to face challenges with improving access to healthy aging services; however, as efforts to address access issues are implemented in new areas of the state and new program models and curricula are disseminated, the issue is gaining renewed attention. The Health Fund's grantmaking will continue contributing to improved health outcomes and reduced healthcare costs as it increases access statewide. Beyond these benefits, the Health Fund can also continue to inform healthy aging policy across the state.