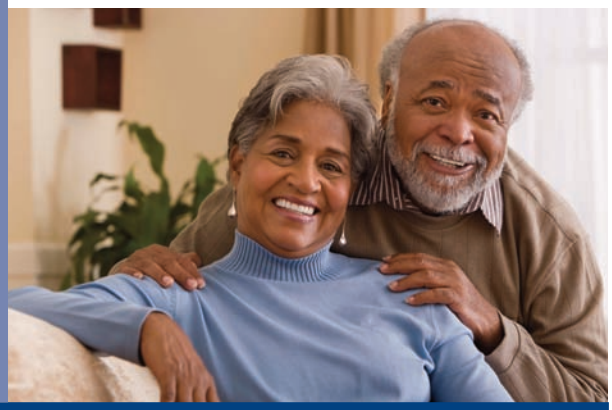
State of Illinois

Illinois Department on Aging
Charles D. Johnson

Plan to Restructure the State of Illinois Service Delivery System for Older Adults



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Older Adult Services Advisory Committee

September 2010

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Executive Summary

In 2009, the Older Adult Services Act was amended by the authorization of PA 96-0248. This public act amended the Older Adult Services Act by mandating that the Department on Aging and the Departments of Public Health and Healthcare and Family Services develop a plan and implementation schedule to restructure the State's service delivery system for older adults pursuant to this Act no later than September 30, 2010.

The OASAC Executive Committee engaged Dr. Robert Mollica to facilitate the planning process. Dr. Robert Mollica is the former Senior Program Director at the National Academy for State Health Policy. He has conducted several studies on long-term care reform and has published a number of articles, reports and case studies on the topic. Dr. Mollica also has experience with rebalancing efforts in other states (e.g., California, Oklahoma, New Mexico, Pennsylvania, Vermont, Washington and Kansas).

The planning process consisted of a series of meetings, followed by a 2-day retreat. During this time, the following activities were completed:

- Reviewed the vision and guiding principles of OASAC
- Outlined the accomplishments of OASAC for the period 2008 – 2010
- Identified outstanding issues that had not been fully addressed
- Discussed each of these issues in detail, including the prior work of OASAC on each issue, the gaps that still exist, and why the issue is still important
- Prioritized the issues by importance and by feasibility
- Engaged in a 2-day retreat to further discuss the priority issues in greater detail and to develop an implementation plan

This plan includes the following priority areas which will guide the work of OASAC and the Department for the next three years.

Priority #1:	Improve funding for home and community-based services programs
Priority #2:	Improve transition and integration between medical, hospital and long-term care systems and settings
Priority #3:	Improve access to long-term care services through comprehensive pre-admission assessment screening and options counseling
Priority #4:	Ensure service allocation equity and the service package
Priority #5:	Increase caregiver support
Priority #6:	Facilitate access to supportive housing options and affordable housing
Priority #7:	Improve the home and community-based quality management systems
Priority #8:	Convert excess nursing facility capacity
Priority #9:	Maximize the use of technology to support policy development and delivery of long-term care services

Specific objectives associated with each priority area, as well as an implementation table, are included in the report.

In addition to Dr. Mollica, the Department on Aging would like to acknowledge the support provided throughout this process by the OASAC Executive Committee, guests, and other state agencies including the Illinois Department of Healthcare and Family Services, Illinois Department of Public Health, Illinois Division of Rehabilitation Services, Illinois Housing and Development Authority, and the Governor's office.

Background

The Older Adult Services Act was enacted in 2004 through Senate Bill 2880 (Public Act 093-1031) by the Illinois General Assembly in order

> *"to promote a transformation of Illinois' comprehensive system of older adult services from funding a primarily facility-based service delivery system to primarily a home-based and community-based system, taking into account the continuing need for 24-hour skilled nursing care and congregate housing with services. Such restructuring shall encompass the provision of housing, health, financial, and supportive older adult services. It is envisioned that this restructuring will promote the development, availability, and accessibility of a comprehensive, affordable, and sustainable service delivery system that places a high priority on home-based and community-based services. Such restructuring will encompass all aspects of the delivery system regardless of the setting in which the service is provided."*
> *(PA 093-1031 Section 5)*

The Older Adult Services Act and the creation of the Older Adult Services Advisory Committee (OASAC) resulted from advocacy at many levels to reform the Illinois system of long-term care. The Illinois system of care for older adults has long favored institutional care over viable, adequate community-based alternatives. Efforts to transform this system must include a commitment from the Administration, legislative leaders, advocates, and those organizations representing various provider groups to reallocate existing resources, reduce the supply of nursing home beds, and increase flexibility and consumer direction of home and community-based services. The Older Adult Services Advisory Committee was established to lead this effort.

The Act also established the Older Adult Services Advisory Committee to advise the Directors of Aging, Public Health, and Healthcare and Family Services on all matters related to the Act. The Illinois Department on Aging (IDoA) formed the Older Adult Services Advisory Committee (OASAC) in January 2005 and created five workgroups to examine the following areas: Finance, Services Expansion, Nursing Home Conversion, Coordinated Point of Entry, and Workforce and Family Caregiving. Each year, the OASAC workgroups set priorities and work toward developing short term and long term recommendations.

In 2009, the Older Adult Services Act was amended by the authorization of PA 96-0248. This public act amended the Older Adult Services Act as follows:

"The Department on Aging and the Departments of Public Health and Healthcare and Family Services shall develop a plan to restructure the State's service delivery system for older adults pursuant to this Act no later than September 30, 2010. The plan shall include a schedule for the implementation of the initiatives outlined in this Act and all other initiatives identified by the participating agencies to fulfill the purposes of this Act and shall protect the rights of all older Illinoisans to services based on their health circumstances and functioning level, regardless of whether they receive their care in their homes, in a community setting, or in a residential facility. Financing for older adult services shall be based on the principle that "money follows the individual" taking into account individual preference, but shall not jeopardize the health, safety, or level of care of nursing home residents. The plan shall also identify potential impediments to delivery system restructuring and include any known regulatory or statutory barriers." (PA 96-0248, Section 1)

Planning Process

In order to comply with the mandates of PA 96-0248, the OASAC passed the following two motions presented by the Executive Committee:

1. To suspend the workgroup activities at the end of December 2009 until after the facilitated planning process is complete; and
2. To have the Executive Committee, in collaboration with the full committee, engage in a facilitated planning process to develop a plan to rebalance long-term care and recommend the plan to the state before 9/30/2010.

A steering committee composed of several members of the Executive Committee was established to determine the process that would be used to develop a plan and complete the report. It was recommended that an external professional facilitator would provide an objective perspective for our efforts in Illinois.

Dr. Robert Mollica was identified as an ideal candidate for this project. Dr. Mollica has recently retired as Senior Program Director at the National Academy for State Health Policy. He has conducted several studies on long-term care reform and has published a number of articles, reports and case studies on the topic. Dr. Mollica also has experience with rebalancing efforts in other states (e.g., California, Oklahoma, New Mexico, Pennsylvania, Vermont, Washington and Kansas).

On November 9, 2009, the full OASAC approved a motion for the Department to engage Dr. Mollica to conduct a series of telephone calls with the Executive Committee and to lead a 2-day retreat to complete the planning process. Members of the full OASAC were invited to participate in the process. The Executive Committee also identified several experts from the full OASAC that could contribute a unique perspective to the process. These individuals are Dr. Tom Prohaska, Professor of Community Health Sciences, Institute for Health Research and Policy at the University of Illinois at Chicago; Thomas Cornwell, MD, FAAFP, Physician, Homecare Physicians; Jan Costello, Executive Director, Illinois HomeCare & Hospice Council; and Robyn Golden, Director of Older Adult Programs at Rush University Medical Center.

Meetings were held in Chicago and Springfield on January 25, 2010, February 22, 2010, and March 22, 2010. A 2-day retreat was held on April 6 and 7, 2010, at Health Care Council of Illinois in Chicago.

Activities of the Planning Group

During the course of the planning process, the following activities were completed:

- Reviewed the vision and guiding principles of OASAC
- Outlined the accomplishments of OASAC for the period 2008 – 2010
- Identified 10 outstanding issues that had not been fully addressed
- Discussed each of these issues in detail, including the prior work of OASAC on each issue, the gaps that still exist, and why the issue is still important
- Prioritized the issues by importance and by feasibility (Importance measures the potential impact of reform in the area. Feasibility means how practical or doable reform is over the medium to long term, considering the complexity of the topic, the resources needed to implement the reform, and the likelihood of reaching agreement.)
- Engaged in a 2-day retreat to further discuss the priority issues in greater detail and to develop an implementation plan

Vision and Guiding Principles

The following vision statement and guiding principles were approved September 11, 2006, by the full Committee, and affirmed by the OASAC Executive Committee during the planning process.

Vision Statement

The OASAC vision is one where older adults across Illinois live in elder-friendly communities, with accessible transportation, affordable housing appropriate for their needs and a consumer-driven array of services nearby. Through the collaborative efforts of local, regional and state service providers, it will be easy for Illinois seniors and the families who care for them to find the right service at the right time in the right place at the right price. This network is designed and implemented to provide high quality services with participation and feedback from the older adult, families and the staff. A coordinated public relations program, including web-based tools, ensures that the public knows whom to call when seeking older adult services. Older adults and their families know what is available and understand that they must take responsibility for meeting the challenges of old age. Those workers who provide services are offered adequate salaries and benefits at all levels. They are qualified, receive on-going training, and are appropriately recognized for their efforts. The effectiveness of the service programs are assured through regulations, accountability and evaluation, and supported by ongoing data collection and analysis. Overall, the system maintains a balance between the important values of freedom and safety for every older adult while a flexible, reliable funding stream ensures that a variety of services are available with consistent delivery and levels of care throughout the state.

Guiding Principles

Rights of Older Adults

All services provided to older adults, regardless of the oversight agency, should promote the right of older adults to live out their lives with dignity, retaining their autonomy, individuality, privacy, independence, and decision making ability. Acknowledgement of these principles is the first step to incorporating them into state efforts to transform long-term care and services for older adults.

Consumer Direction

All programming provided for older adults using public funds in Illinois, regardless of the agency providing oversight, should incorporate the concept of consumer direction. This should include the right of an older adult to be fully informed of all options and to choose, decline, and have input into how any and all services are provided for which they are eligible. Through consumer direction, older adults are empowered to make decisions about the services they want and how they wish to receive them, thereby better meeting older adults' needs. In addition, consumer direction is necessary because it is a major key to providing quality, satisfactory services.

Accountability and Accessibility of Information

All providers of services to older adults should be monitored by their oversight agency to assure they meet contract requirements, all applicable federal and state requirements, and program standards. Appropriate sanctions shall be levied for failure to report complaints, service delivery deficiencies, and failure to meet contract requirements and program standards. Information concerning sanctions should be available for public review and should be taken into account in contract renewal decisions. While performance-based contracting is routinely used by the state, oversight of compliance with contracts, federal and state regulations, and standards varies greatly from service to service. A more balanced approach to oversight must be developed in order to protect older adults vulnerable to substandard care, exploitation, and neglect.

Standards

State standards should be established that maximize the program participants' quality of care and assure the services shall be rendered in a timely manner to protect and promote the rights of older adults to live in the least restrictive settings. Examine minimum request for proposal standards and assess their validity, contracted agencies attainment of their requirements, and their effect on program participant's quality of care. Currently, home services have very minimal standards with provider-defined "enhancements" allowed, but not required, as part of the bidding process. This practice has led to little consistency area to area. In areas that simply strive to meet minimal standards, older adults face loss of independence due to substandard care.[1]

[1] In March 2009 the Department adopted rules for All Willing and Qualified requests for proposals and CCP standards. In doing so, the Department requires providers to adhere to a high standard of quality and insures consistency across the state. A procurement process that is open to all providers, at any time, leads to greater competition and higher quality of service.

Accomplishments

The Department on Aging, in collaboration with OASAC has made substantial progress in the past several years to expand service options and increase the quality of care for frail older adults. The following table summarizes the accomplishments in each of the areas mandated by the original legislation (PA 093-1031).

Summary of Accomplishments (2008, 2009 & 2010 OASAC Reports)

Area	Status of Initiative	IDoA Action/OASAC Recommendation & Priorities
Comprehensive care coordination	Comprehensive Care Coordination and an assessment instrument were implemented in April, 2007. The assessment assists older adults to access services regardless of funding source. Training was provided to care coordinators, AAAs, nursing home administrators and professional registered nurses and social workers.	Rules will be promulgated. Subject to funding, a time cost/cost study will be conducted to determine appropriate rates.
Coordinated point of entry	Efforts continue toward improving coordination of entry points to services through the IDoA Senior HelpLine, I&A funded through the OAA, and 3 ADRCs operating in suburban Cook County, Decatur, and Rockford. IDoA collaborated with IDHS to establish a "welcome center" one-stop service model in suburban Cook County and to establish 211-line pilot projects around the state.	IDoA will identify funding to develop the name and logo and develop a process, standards and training for the CPOEs in each PSA. IDoA will continue to collaborate with IDHS to implement the "Welcome Center," and support the Area Agency on Aging and Care Coordination Unit that serve their immigrant older adult clients.
Public website	IDoA is constructing an inventory of websites that link older adults and their caregivers to relevant information. A housing registry – www.ILHousingSearch.org – became operational in 2009. IDOA developed a web-based resource database using a common format and taxonomy (2008).	IDoA is reviewing the content and accessibility of its website and will incorporate necessary changes.

Area	Status of Initiative	IDoA Action/OASAC Recommendation & Priorities
Expansion of older adult services	IDHFS is expanding the number of SLFs. The Home Modification program received $2 million from the IHDA-administered Illinois Affordable Housing Trust Fund. PA 95-0535 established medication management services statewide as a stand-alone service available to all case coordination clients. A white paper on medication management was prepared on using pharmacists to review cases from CCUs for drug-related issues due to prescriptions written by multiple physicians. Legislation (PA 95-0565) restructured the Community Care Program to: evaluate service cost maximums, allow home care aides to perform personal care tasks, require intermittent, night and weekend hours for all subcontractors of in-home and care coordination services, and provide consumer direction and the availability of personal assistant services. (2008) Obtained $2 million to expand home delivered meals (2008).	Preserve use of IHDA trust fund to expand affordable housing options. Support SLF program.

Area	Status of Initiative	IDoA Action/OASAC Recommendation & Priorities
Consumer- directed HCBS	IDoA implemented a Cash and Counseling demonstration program in four PSAs in November 2007. IDoA is developing a tool to evaluate the Cash and Counseling demonstration.	IDoA will publish the results of the Cash and Counseling evaluation and utilize the findings to make recommendations about a personal assistant program for seniors. IDoA will update the array of CCP services and allow participants to choose among the preventative services contained in their care plan (PA 95-0565).
Comprehensive delivery system (integrated acute and chronic care)	IDHFS contracted with McKesson Health Solutions to manage chronic diseases, such as asthma, diabetes, heart disease or other chronic health problems through a disease management initiative. (2009) IDHFS is working with the CMS to implement a PACE program.	IDHFS is implementing a Primary Care Case Management program to improve the health and quality of life for Medicaid beneficiaries. IDoA will continue to explore with IDHFS opportunities to encourage CCP clients to enroll in MCOs that assure high-quality clinical care and that is closely integrated with HCBS.
Enhanced transition and follow up services	IDoA operates a Money Follows the Person demonstration program for Medicaid beneficiaries who have lived for 6 months or more in an institution.	Transitions from nursing homes will be monitored closely by HFS to assure that extremely vulnerable clients are not put at risk by transition activities.

Area	Status of Initiative	IDoA Action/OASAC Recommendation & Priorities
Family caregiver support	IDoA continued funding under the OAA for respite care and caregiver support. "A Working Caregiver Symposium" was held during the November 2009 Family Caregiver Conference and the Annual Conference on Alzheimer's Disease and Related Disorders. IDoA obtained a 3-year Lifespan Respite Services grant to expand and enhance respite services and information to persons of all ages. In 2008 $16 million in general funds was applied to flexible senior services in the FY 2008 IDoA budget which supported funding for respite care in accordance with the Family Caregiver Act (PA 93-0864) and expanded alternative respite services such as home care, vouchers, transportation assistance, emergency respite and other services.	IDoA continues to collaborate with AAAs and their Family Caregiver Resource Centers to work locally and regionally to develop and expand private partnerships in support of caregiving strategies. The Lifespan Respite Services grant will provide emergency respite services, training, and respite resources to family caregivers, as well as paid and unpaid caregivers throughout the state. Support increase in general funds for services to family caregivers.

Area	Status of Initiative	IDoA Action/OASAC Recommendation & Priorities
Quality standards and quality improvement	Adopted rules for All Willing and Qualified requests for proposals and CCP standards. IDoA initiated a standardized evaluation process for HCBS demonstration projects. The waiver renewal includes the development of a quality management plan. The consumer satisfaction survey tool was validated and tested for reliability. A participant survey was developed which will identify participant overall satisfaction with the program and provide input related to preference in service options. A new critical events tool and database was developed to collect and track service complaints, abuse/neglect issues, critical incidents, and requests for reassessments. Long-term care measures were developed to better understand how consumer satisfaction and quality of life can inform program development and systems change efforts.	IDoA HCBS demonstration projects will be studied to determine the feasibility of statewide implementation. Annual consumer satisfaction surveys will be collected. The critical events tool will be fully automated into a web-based system.
Workforce	In 2008, IDoA implemented legislatively mandated increases in home care aide hourly wages and rates ($1.70/hour), and increased rates ($1.33/hour) to cover healthcare benefits for home care aides, and increased rates for adult day service.	Continue support for improved wages and health insurance benefits for home care aides. The Workforce and Family Caregiver Workgroup will explore standards for certified/accredited training for in-home workers and create a career ladder.

Area	Status of Initiative	IDoA Action/OASAC Recommendation & Priorities
Coordination of services	IDHFS held joint training sessions for its staff and SLF providers in Chicago and Springfield on topics of mutual concern. The OASAC subcommittee designed a pilot program that would certify home care aides, health care aides and CNAs to work with high risk clients; create a regional system of experts to provide direct services to high risk clients and training for staff; provide technical assistance to the pilots; study how CCUs may monitor home care and health care workers employed by other entities.	IDHFS will continue to hold the semi-annual training sessions.
Barriers to services	Housing was identified as a barrier to allowing older adults to live at home. IL-HousingSearch.org was implemented with funding from IHDA, IDHS, IDHFS and IDoA, to assist service providers and consumers to find available, accessible rental housing.	IHDA will continue to market www.ILHousingSearch.org and train service providers to use the web site.
Reimbursement and funding	The Finance Workgroup completed research on funding of long-term care — exploring models from other states and summarizing the findings in a PowerPoint presentation.	IDOA is continuing efforts to strengthen its cost accountability for federal, Medicaid and general revenue funds provided to support older adults in Illinois.

Area	Status of Initiative	IDoA Action/OASAC Recommendation & Priorities
Medicaid nursing home cost containment	The Nursing Home Conversion Workgroup reviewed Nebraska, Michigan, Wisconsin and Minnesota bed reduction plans; Minnesota's plan will provide a model for Illinois' bed reduction. In 2008, OASAC developed measures to monitor nursing home census trends and increases in the number of HCBS participants.	A conversion plan will be developed by IDHFS and IDPH with advice from OASAC.
Bed reduction	IDPH continues to work with the Nursing Home Conversion Workgroup to develop a conversion program. The Nursing Home Conversion Workgroup made progress in addressing the issues of a capital rate conversion that will meet the criteria of budget neutrality while not adversely impacting the facility's Medicaid capital rate component.	Initiate a pilot for single occupancy rooms in three areas of the state using the capital rate adjustment as an incentive to participate. Subject to appropriation.

Area	Status of Initiative	IDoA Action/OASAC Recommendation & Priorities
Financing	The Finance Workgroup prepared a PowerPoint summarizing best practices for long-term care financing from various states in the nation. In 2008, IDoA required older adults who received services under CCP to enroll in Medicaid if eligible. The State FY 2009 Budget Implementation Act established a mechanism for IDoA to receive funds from IDHFS to cover the increased expenses of home and community-based services caused by the transfer of long-stay nursing home residents to the community via an interagency agreement for MFP. The Finance Workgroup completed research on best practices including policy analysis and recommendations on estate and asset recovery under Medicaid and its effect on long-term care.	The Finance Workgroup will examine the impact of mandatory enrollment in Medicaid for eligible CCP participants.
Older Adults Services Demo grants	IDoA worked with the Governor's Office, IDHFS and IDHS to begin the Money Follows the Person program, a federal long-term care rebalancing initiative.	IDoA will continue the implementation of MFP demonstration and apply the experience to other State efforts to restructure long-term care.
Bed need methodology update	A sub-committee of the Nursing Home Conversion workgroup has developed strategies for determining bed need methodology. The recommendations went to the Nursing Home Conversion Workgroup for review and then to the OASAC Executive Committee.	Subject to appropriation.

Area	Status of Initiative	IDoA Action/OASAC Recommendation & Priorities
Nursing Facility	The Nursing Home Conversion Workgroup recommended developing a pilot conversion program based on Minnesota's bed buyback program and other models to convert to single occupancy. The goal is cost neutrality.	
Housing	See barriers and service expansion	

Priority Issues

During the planning process, the Executive Committee of the Older Adult Services Advisory Council identified the following top five priority areas:

1. Finance and funding
2. Transitions & integration between medical and long-term care systems and settings
3. Access to the long-term care system through comprehensive pre-admission screening/options counseling
4. Service allocation equity and the service package
5. Caregiver support

The Executive Committee identified four additional areas that are important:

6. Supportive housing options/affordable housing
7. Quality assurance
8. Conversion of excess nursing home capacity
9. Use of technology, electronic access, data sharing

The remainder of this report summarizes the discussion on each of these topics that occurred during the retreat, objectives for each of the priority areas, followed by an implementation schedule for the next three year period. The Department on Aging acknowledges Dr. Robert Mollica for his role in summarizing the discussion, goals, tasks and timelines contained in this report.

Discussion of Priority Areas (Goals) and Objectives

1. Improve funding for home and community-based services (HCBS) programs

Increase revenues

The OASAC Executive Committee identified a need to expand funding for HCBS programs. Two provider tax options were discussed – implementing a Medicaid provider tax for HCBS service providers and a tax on homemaker services.

Federal regulations allow states to assess fees to Medicaid providers. The fees are eligible for federal reimbursement. Provider fees must be broad based. They are usually charged to hospitals and nursing facilities however, federal law does not preclude charging fees on HCBS providers. A recent report on financing LTC services for the state of California[2] noted that Alabama charges fees to pharmacy providers. Indiana imposes fees on community-based mental retardation programs. Kentucky charges fees for home health care providers and health maintenance organizations. Louisiana charges fees for pharmacies, physicians and medical transportation providers. Minnesota charges fees for physicians, hospitals and HMOs.

[2]Mollica, Robert and Hendrickson, Leslie. "Home and Community-based Long-term care: Recommendations to improve access for Californians." California Health and Human Services Agency. November 2009. Available at: http://www.communitychoices.info/docs/ltc_study/REPORT%20Final%20PDF.pdf.

The report cited the criteria for setting the fees. Fees must be imposed uniformly. A health care-related fee is considered to be imposed uniformly if any one of the following criteria is met:

- If the fee is a licensing fee or similar fee imposed on a class of health care services or providers, the fee is the same amount for every provider furnishing those items or services within the class.
- If the fee is a licensing fee or similar fee imposed on a class of health care services or providers, the amount of the fee is the same for each bed of each provider of those items or services in the class.
- If the fee is imposed on provider revenue or receipts with respect to a class of items or services, the fee rate is imposed at a uniform rate for all services in the class, or on all the gross revenue or net operating revenues relating to the provision of all items or services.

The plan includes the following objectives:

- ▶ Evaluation of options to establish a Medicaid HCBS provider fee
- ▶ Evaluation of options to establish fees for Community Care Program (CCP) homecare providers

Federal long-term care initiatives

Two new HCBS initiatives were recently enacted by Congress as part of the Patient Protection and Affordable Care Act (PPACA). The State Balancing Incentives Payments Program increases federal reimbursements to states that increase the percentage of Medicaid spending for HCBS. States that spend less than 50% of Medicaid LTC expenditures on HCBS may apply to CMS for an increase in the state's Medicaid reimbursement rate. The reimbursement rate will be increased by five percentage points for states whose HCBS spending is below 25% of total long-term care (LTC) spending and two percentage points for states between 25-50% for HCBS. The application must include a proposed budget that achieves target spending percentages. States that are under 25% HCBS must achieve 25% by October 2015 and states that are above 25% but less than 50% must achieve 50% HCBS by October 2015. The application must also describe structural changes that will be implemented within six months. States must describe plans to implement the following:

- No wrong door/single entry point
  - Develop a statewide system to enable consumers to access all LTC services through an agency or organization, a coordinated network or a portal
  - System will provide information about services and how to apply, referral services, determinations of, or assistance with, financial and functional eligibility

- Conflict-free case management services to develop a service plan, arrange for services and supports, support with self-direction and monitoring
- Core standardized assessment instrument to determine beneficiary needs for training, support services, medical care, transportation and other services and to develop an individual service plan

The Patient Protection and Affordable Care Act also offered the states a new option to provide home and community-based care to older adults and people with disabilities without using a traditional Medicaid waiver. The Community First Choice Option, a new Medicaid state plan option to provide attendant services and supports, under Section 1915 (k) of the Social Security Act, allows states to serve individuals who are otherwise eligible for Medicaid and have income that does not exceed 150% of federal poverty level (FPL), or have income that does not exceed the income level for individuals who would require an institutional level of care in the absence of these services. States may be reluctant to adopt this new option due to the potential cost because they will be required to cover the entire eligible population and may not cap enrollment or target by population. However, the option provides an enhanced federal match for certain services such as transitional housing costs now only available through a waiver or Money Follows the Person Grant. Thus, states may be able to utilize this new option to continue the strides they have made in transitioning populations from nursing facilities to the community in MFP projects.

Under 1915(k), eligible individuals must need assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs) or health-related tasks through hands on assistance, supervision or cueing. Health related tasks are defined as tasks related to the needs of an individual that can be delegated or assigned by licensed professionals to an attendant. Services that must be covered include assistance with ADLs, IADLs, and health-related tasks (delegated); the acquisition, maintenance and enhancement of skills necessary to accomplish ADLs, IADLs and health-related tasks and back-up systems or mechanisms to ensure continuity of services and supports, and voluntary training on how to select, manage and dismiss attendants. Optional services that may be covered are transition costs (rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies and other necessities) and services that increase independence or substitute for human assistance.

The reimbursement rate for states that elect this optional service is an additional six percentage points above the standard matching rate.

The plan includes the following objectives:

- Evaluation of the impact of the state balancing incentive program and an application which will be submitted to CMS
- Evaluation of the impact of adopting the Medicaid state plan attendant services option authorized by Section 1915 (k)

Budget and appropriation process

The OASAC finance workgroup spent a year mapping the financing of long-term care services in Illinois. The workgroup concluded that Illinois' budgeting process is segmented. Funds for long-term care services are appropriated to the Department of Health and Family Services' Medicaid budget (nursing facility services and the supported living facility waiver) and the Department on Aging (CCP).

The finance workgroup reviewed budgeting practices in 11 states and found that several states have mechanisms to balance long-term care or allow more flexibility to transfer funds from one type of service or program to another. These practices are often referred to as global budgeting, unified budgeting and money follows the person.

While reviewing budgeting options, the OASAC Executive Committee recognized that budgets follow the organizational structure and discussed creating a Department of Long-term care. Oregon, Vermont and Washington combined programs for older adults, individuals with physical disabilities and individuals with developmental disabilities in one Department.

Designing an appropriation process that maintains the current Departments but combines funding for multiple programs is preferred. The state of Ohio designed a unified budget while maintaining separate Aging and Medicaid long-term care Departments. Under the plan, an interagency council will meet to determine the funding needs of each program covered by the unified budget and allocate funds based on enrollment, utilization and provider rates. More research is needed to understand how Ohio's process might be implemented in Illinois.

The unified budget encourages agencies to consider the impact of spending reductions or increases on total long-term care spending rather than individual program or agency spending. Under the current budget process, each agency focuses on their own budget and may not recognize that a decrease in one budget might result in increases in another area. The budget process should assess how programs work in tandem with each other. The Office of Management and Budget (OMB) and the Governor's Office should be responsible for designing a cross-agency budget planning process based on caseload and spending forecasts.

Illinois has attempted to maximize federal Medicaid reimbursements but the increased revenue is returned to the General Revenue Fund and does not directly support long-term care programs. Illinois could consider allowing programs that earn added reimbursement to retain the increased revenue, or a portion of it, to expand HCBS programs. At one point Vermont established a "trust fund" to hold unspent HCBS funds at the end of the fiscal year for spending in a subsequent fiscal year.

The plan includes the following objectives:

- Development of a cross program/agency budget process
- Review and preparation of options for a unified budget
- Consideration of which programs and agencies would be included in the unified budget
- Evaluation of different options to phase in a unified budget
- Advocate that the House and Senate Appropriation Committees hear the long-term care budget as a whole from the relevant State agencies (e.g., Aging, Healthcare and Family Services, Department of Human Services, etc…)
- Development of a caseload and utilization forecasting methodology to establish the level of appropriations for long-term care services

Private long-term care insurance

Private long-term care insurance was identified as a potential funding source for consumers who are not eligible for publicly funded long-term care services. The Deficit Reduction Act of 2005 expanded the scope of LTC Insurance Partnership programs. HFS is filing regulations to implement changes.

OASAC Executive Committee members expressed concerns that private long-term care insurers may be denying coverage for applicants with pre-existing conditions. LTC insurance is regulated by the Department of Insurance and the OASAC Executive Committee recommended that the Department seek to prohibit such denials if they are allowed under current regulations.

PPACA includes a voluntary, self-funded public long-term care insurance program, the Community Living Assistance Services and Support Act (CLASS). The program will allow workers who contribute to the plan to be vested after five years of contributions and receive a cash benefit of at least $50 a day if they meet functional eligibility criteria. The Department on Aging has an opportunity to make recommendations to the Department of Insurance with regard to wrapping existing LTC insurance around the CLASS Act.

The plan includes the following objectives:

- A review of the results of the long term insurance partnership program
- Development of strategies to increase participation in the partnership program and other long-term care insurance programs, and an implementation plan
- Analysis of the CLASS Act and a strategy to promote participation

2. *Improve transition/integration between medical/hospital and long-term care systems and settings*

Supported care transitions are critical for older adults with multiple chronic illnesses. Poor communication between silos of care, delays in service referrals from the hospital and lengthy response times by community-based service providers can negatively impact the transition for many older adults and their families. Inadequate transition planning can result in unnecessary nursing home placement, medication errors, and increased burden on caregivers and families. It can also lead to re-admission to the hospital and increased health care costs.[3,4] Studies have found that 40-50% of hospital re-admissions are linked to social problems and a lack of community resources. Social work-based transition planning models have not been extensively studied.[5]

Hospital re-admission can result from poor discharge planning or poor medical care. On the other hand, effective quality discharge planning and follow up care reduces re-admission rates. Professionals recognize the need to improve coordination between medical care, chronic care and long term services and supports. With the recent passage of the Affordable Care Act, Medicare will be paying a reduced rate for 10 targeted conditions for patients who are re-admitted to the hospital within 30 days of discharge. The OASAC Executive Committee recommended exploring the impact of the development of long-term care hospitals and other settings and how they will be incorporated into and/or impact the continuum of care.

Social work is well suited to support care transitions. Social workers have extensive knowledge of community resources, expertise in complex social systems, and training in interdisciplinary collaboration and care coordination.

Hospital discharge planners often have little advance notice of a discharge and lack sufficient time to develop a service plan and make arrangements with home and community-based providers to assure that the beneficiary's health and support needs will be met. Initiating discharge planning and coordinating with community programs can avoid unnecessary admission to a nursing facility or ensure that the person will return home after they receive post-hospital rehabilitation care. Involving Care Coordination Units (CCUs) early in the admission helps to ensure the appropriate use of long-term care nursing facilities while supporting family members who can be overwhelmed by the care needs and the process for applying for HCBS. There are incentives in PPACA to insure that home and community-based service, and aging and disability networks are coordinated.

In 1996, Illinois enacted the Choices for Care (CFC) process (Public Act 89-21) that requires that all persons age 60 and older seeking admission to a nursing facility receive information about community service options. Care Coordination Units typically conduct the screenings primarily in hospitals immediately prior to discharge. The screening process gives older adults and their families the opportunity to ask questions about service options, discuss their needs and to understand the array of options available to them. Committee members noted that the CFC sometimes begins too close to discharge and families and participants do not have enough time to implement a plan to provide care in the person's home.

[3]Naylor, M.D., Brooten, D., Campbell, R., Jacobsen, B.S., Mezey, M.D., Pauly, M.V., & Schwartz, J.S. (1999). Comprehensive Discharge Planning and Follow Up of Hospitalized Elders: A Randomized Clinical Trial. JAMA, 281(7) 613-620.
[4]Coleman, E.A. & Chambers, S. (2006). The Care Transitions Intervention. Arch Intern Med. 166, 1822-1828.
[5]Proctor, E.K., Morrow-Howell, M., Li, H. & Dire, P. (2000). Adequacy of Home Care and Hospital Readmission for Elderly Congestive Health Failure Patients. Health and Social Work. 25 (2) 87-96.

CFC began when hospital lengths of stay were much longer and older adults were more likely to return home rather than enter a nursing facility for a short-term rehab stay. The OASAC Executive Committee members noted that the program should be revised to reflect the changing environment in which it operates.

Several pilot programs were described that improve the discharge planning and community transition process. The average length of stay in a hospital is 5.6 days, which creates pressure on the discharge process. Staff need to develop a discharge plan in a short period of time. In Suburban Cook County, Aging Care Connections, the Care Coordination Unit, established an Aging Resource Center (ARC) in the hospital (Adventist Hospital, La Grange).

The ARC Care Coordinator in the Adventist LaGrange hospital, employed by the community-based Care Coordination Unit, starts working with at-risk older adults and their families upon admission. The Care Coordinators are located in the hospital and benefit from the relationships that form with the hospital staff. The family is engaged and learns how to access the system. The Care Coordinator has extensive knowledge of community-based systems, conducts comprehensive assessment, determines eligibility for multiple services, and develops the community care plan. The model also includes contact within 48 hours of discharge and in-home follow up as demonstrated effective by the Rush University Medical Center Older Adult Programs.

The model (Bridge Model) is being developed by the Illinois Transitional Care Consortium (ITCC) with partial funding from the Weinberg Foundation. The ITCC members, in addition to Aging Care Connections and Older Adult Programs at Rush University Medical Center include Solutions for Care (Berwyn-Cicero CCU), Shawnee Alliance for Seniors (rural southern Illinois CCU), Health and Medicine Policy Research Group, and the Clinical Assistance Professor of Community Health Services at University of Illinois at Chicago, School of Public Health. The Bridge Model utilizes social work Care Coordinators, who support the transition of older adults at risk for post-discharge complications from hospital to home. The Bridge Model aims to reduce caregiver stress, increase consumer safety, reduce emergency department visits and re-hospitalizations, improve adherence to the medical plan of care, and increase older adult and caregiver satisfaction. On-site assessment and access to community-based services through the ARC offices will also reduce the time between discharge and start of community services and will divert consumers from unnecessary nursing home admission. The ITCC will translate data findings into transitional care practice and policy recommendations appropriate for urban, suburban, and rural care settings. A program manual will be developed for replication and implementation of the Bridge Model.

Executive Committee members cited the need to formalize collaboration among hospital staff, community program staff and family members.

CCU care coordinator caseloads were cited as a barrier to timely discharge planning and options counseling. Caseloads of 200-300 clients per care coordinator are common in urban areas but caseloads are lower in rural areas. Expanding the CCUs' capacity will lower the burden on hospital staff and potentially reduce Medicaid nursing home spending by diverting more people to HCBS programs.

To improve transitions and discharge planning, members recommended that a memorandum of agreement be negotiated between CCUs and hospitals. Funding sources will need to be developed. Hospitals with higher re-admission rates may be willing to pay CCUs for discharge planning to reduce unreimbursed Medicare costs.

Transition planning is also needed for older adults with chronic conditions who move between the acute medical, chronic care and long-term care systems. The chronic care model focuses on conditions (such as hypertension, congestive heart failure, and diabetes) rather than settings. CCU staff needs resources and training to recognize and respond to health conditions that require medical attention and/or consultation with experts. The Executive Committee identified the need to develop triggers for, and linkages to health and mental health consultations.

The plan includes the following objectives:

- Develop strategies to prepare individualized transition plans for older adults leaving a hospital or nursing facility
- Develop interventions based on health and social characteristics or chronic conditions
- Provide training to CCU staff on relevant medical conditions and terms
- Examine and improve the Choices for Care screening process to improve discharges and successful placement in appropriate settings
- Review results from the nursing home transition and Money Follows the Person programs and formalize processes that improve transition efforts (e.g., implementation of MDS 3.0, Section Q)
- Identify assessment data that will trigger referrals for a health assessment
- Review CCU care coordinator caseloads and set standards
- Explore methods to ensure that home and community-based services, and aging and disability networks are coordinated as PPACA is implemented

3. *Improve access to long-term care services through comprehensive pre-admission assessment screening; options counseling*

The aging network over the past 36 years has emphasized the importance of timely, accurate and local information. The Older Americans Act created information and assistance services throughout the country. Illinois, through the area agencies on aging, is required to assure access to quality information by older adults and their families with many community agencies included in the aging network performing this function. Over time, the Department on Aging has provided leadership and support for information services, even before they established the statewide Senior HelpLine. This foundation led

to the establishment of Care Coordination Units in the mid 1980s by the Department and area agencies on aging, the development of the web-based Enhanced Services Program (ESP) resource database, the Benefits CheckUp.org, the creation of OASAC Coordinated Point of Entry standards and the building of bridges with the disability community through Aging and Disability Resource Centers. All of this came from a commitment to quality information to those making important decisions on their long-term care and supports, their independence and quality of life.

The Department acknowledges that consumers and family members use many paths to access long-term care services, all of which meet the requirements of established standards for Coordinated Points of Entry (CPoE) and which are coordinated by a statewide Aging and Disability Resource Centers (ADRC) network that can assist persons of any age with LTC planning including LTC insurance, financial planning, and health issues. The Department will continue to expand and coordinate the ADRC network to benefit the aging and disability community.

Long term support options counseling is an interactive decision-support process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate long-term care choices in the context of the consumer's needs, preferences, values, and individual circumstances.

Pre-screening through the Choices for Care program occurs when a person is seeking admission to a nursing facility. Options counseling might be provided to an individual who wants to remain at home but needs supports to do so, after someone has been admitted to a long-term care facility following a hospital stay, or when a family caregiver needs help to continue providing care in the community.

Participants who apply for HCBS programs receive an assessment and care coordination services when they enroll. Comprehensive care coordination encompasses the assessment of the participant's situation and circumstances related to all factors contributing to quality of life and ability to live independently in the community. It includes review of the participant's living environment, and their physical, cognitive, psychological, and social well being. It also includes identification of existing support systems and the need for further evaluation(s) by other disciplines. Care coordinators must be aware of the multi-faceted components of human functions when evaluating the participant. Comprehensive care coordination includes the identification of services and supports that would assist the client in maintaining maximum possible independent living.

The plan of care identifies all services, need for additional evaluation(s), participant expressed needs/wants, service arrangements, and service needs/wants for which there are no resources available. It also includes identification of service needs being met by existing support systems including public, private, family, and community.

All stages in the process – intake, assessment, care plan development – are completed using an automated assessment tool. Information from the assessment and care plan will be integrated with a web-based system operated by the Department on Aging. The use of a web-based system improves the opportunity to monitor participants' service plans and utilization, expedite coordination of services and integrate information with the DHS information technology project.

Branding access points

Committee members discussed the need to refine the process for receiving information about the array of long-term care services and programs and branding the primary access point to increase awareness and expedite access to information and services. The Department on Aging expects to finalize a "brand" by July 2010. Legal research will be needed to identify potential trademark or other infringements. A national branding with state and local tag lines would save money but it is unlikely because of the difficulty reaching consensus on a name and logo. Once a brand is selected, IDoA should work with provider organizations to see if they will send information about services for older adults to their members.

Executive Committee members noted that funding for comprehensive assessments is decreasing as numbers seeking assessments increases. The process for accessing a comprehensive assessment varies across CCUs and the options counseling aspect is not as well developed in some areas. Standards for Coordinated Points of Entry have been developed and approved by OASAC and adopted by the Department.

Technology enhancements

Members of the committee described the complexity of the application process and variations in the steps from region to region. The existing 1-800 Senior HelpLine number might be used to initiate an application. An automated on-line application would expedite the process. However, an accurate comprehensive assessment requires a face-to-face visit to observe the home environment and to confirm the applicant's capacity to perform activities of daily living and instrumental activities of daily living and other tasks. Once completed on a laptop computer, the assessment data will be uploaded to a main server. Over time, the system could allow access to relevant information by service providers, physicians and others who would be able to update information through case notes.

The plan includes the following objectives:

- Evaluate and select a preadmission screening/options counseling model
- Develop a branding campaign for the Coordinated Point of Entry
- Implement Coordinated Point of Entry standards
- Determine standards and regulations for common intake systems

4. Ensure service allocation equity and improve the service package

Members of the Executive Committee discussed the importance of designing programs and services that do not impoverish older adults. The poverty level, which is sometimes used to determine financial eligibility, understates the income needed to live in Illinois. The Services Workgroup reported that, according to the Elder Economic Security Standard™ Index, the true cost of community living for older adults in Illinois is between 179% and 248% of the Federal poverty level, depending on the person's housing situation.

The OASAC Executive Committee discussed the legislative mandate to develop and maintain an inventory of the service coverage, capacity and unmet need in each area of the state. The comprehensive care plan includes information about a person's need for a service and whether the service is available. The assessment identifies services which may not be covered under CCP – home delivered meals, transportation, medication management – or the absence of providers of a covered service. The Executive Committee recommended that the Department on Aging complete the inventory of service providers and develop instruments to measure unmet need. Strategies should be developed to reduce service gaps and identify unmet needs due to the limited capacity of service providers and limitations in the array of covered services.

The OASAC Services Expansion workgroup prepared a Medication Management ISSUE White Paper which was approved by the full OASAC on June 15, 2009. The recommendations of this workgroup are to establish funding for medication audit services and medication management services statewide as stand-alone services available to all clients identified as high risk. Medication audit and medication management, as distinct services, need to become available statewide to truly effect change in a way that makes home and community-based care possible for more people who have complex medication regimens. The OASAC Services Expansion workgroup further recommended that the Illinois program contain core elements as defined by the American Pharmacists Association:

- A comprehensive review of a patients medication therapy
- Creation and updating a personal medication record (medication list)
- A medication-related action plan – instructions for the patient to manage their medication
- Intervention and/or referral for any medication problems to the patient's physician or other health care provider
- Documentation and follow-up

The Department on Aging should also develop a method to forecast future demand for services based on a profile of older adults who receive Department on Aging services. The results would be disseminated to policymakers, legislators and stakeholders to design policies that respond to changing demographic trends and demand for service to maintain independence.

Assessment tool module for caregivers

The OASAC Executive Committee members discussed changes needed to the Determination of Need (DON) scoring, and the comprehensive assessment tool to account for the care provided by family members and friends, and to insure that the care recipient is not penalized for having this support. Currently, if a family member assists a participant with activities, the participant's DON score is reduced on Part B (unmet needs). If a family member assists a participant with activities, his/her ADL/IADL score (Part A) is also reduced. Both of these practices reduce the total DON score, and the service cost maximum allocated to the participant. Similarly, the comprehensive assessment tool does not assess for the caregiver's needs. It is recommended that the DON and that the comprehensive assessment should incorporate the needs of caregivers, and that the availability of caregivers should not penalize the participant's Service Cost Maximum.

Homecare tasks

The Executive Committee described the differences between the CCP and Division of Rehabilitation Services (DRS) waiver programs. Personal care attendants sometimes perform a wider range of tasks under the DRS waiver than homecare aides under CCP. Members of the Executive Committee requested clarification of the regulations pertaining to personal care tasks that can be performed by homecare aides. The regulations state that:

> *Performing/assisting with personal care tasks that are not medical in nature, such as the examples set forth at 77 Ill. Adm. Code 245.40(c) (e.g., shaving, hair shampooing, drying and combing, bathing and sponge bath, shower bath or tub bath, toileting, dressing, nail care, respiratory services (as authorized by 20 ILCS 105/4.02(5)(F)), brushing and cleaning teeth or dentures and preparation of appropriate supplies, positioning/ transferring client, and assisting client with exercise/range of motion), and as defined by the Plan of Care.*[6]

The Committee recommended improving the training program to prepare workers to perform the tasks and to assess the participant when changes occur in his/her health or social conditions.

As consumer direction expands, CCP participants will benefit from a worker registry for home care workers. Worker registries help consumers identify and hire independent providers and help independent providers find customers. Registries include background information, the language spoken, the hours the worker is available, the worker's qualifications and training and other information needed by consumers to identify potential workers. A personal attendant registry is being developed for DRS waiver clients and could be expanded to include homecare aides who serve CCP participants.

DON study

In June 2008, PA95-565 required the Department to ensure that the Determination of Need (DON) tool accurately determines the participants' level of need. The Department, in conjunction with the Older Adult Service Advisory Committee, conducted a study of the relationship between the DON scores, level of need, Service Cost Maximums (SCM) and the development and utilization of services plans. Advocates were concerned that the program for younger people with disabilities in the Home Services Program (HSP) fared better than people with similar characteristics who received services through CCP.

The Health and Medicine Policy Research Group – Center for Long-term Care Reform and the Center for Research on Health and Aging – University of Illinois at Chicago conducted a study to respond to three key questions about the current service cost maximum (SCM) methodology and its impact on CCP services to older adults:

- Why is the DON-based SCM schedule different for older adults and adults with physical disabilities? To what extent can these differences be explained by differences in the characteristics of the population served?

[6] 89 IAC 240.210(a)(6)

- How will the legislatively mandated changes in the CCP's service package affect service utilization and cost? What are the implications of these changes for the current DON-based system of service dollar allocation?
- How does Illinois' approach to determining eligibility and need and allocating service dollars for older adults compare to best practices in other states?

The study found that:

- CCP serves large numbers of older adults at risk for nursing home placement at a cost considerably less than the nursing component in nursing home care (the current allowable CCP SCM is less than 60% of the nursing component of the state's nursing home reimbursement and CCP participants use only 32.8% of the nursing home component).
- The services provided by CCP are geared more for participants with IADL impairments as opposed to basic ADL's.
- Each of the best practice states offered a broad array of services to address both ADL and IADL needs and they target their services to those most likely to be institutionalized.
- There is considerable unmet need for assistance among high-end DON score participants.
- CCP participants have numerous chronic conditions.
- Many family caregivers of CCP participants need short-term respite.
- All best practice states had completed independent evaluations to improve the program.
- When compared to the HSP, CCP offers far fewer services and hours of service to people with similar characteristics.

Recommendations based on the DON/Service Cost Maximum study included:

- Expand the resources available to participants, target people who could benefit from consumer directed services.
- Add medication management to the mix of services as a new cost outside the existing SCM schedule.
- Provide short term respite for family caregivers.
- Link CCP SCM's with the Medicaid nursing component of the nursing home rates.

Members of the OASAC Executive Committee noted that nursing facility transition programs, including Money Follows the Person, will serve older adults with higher needs. The Service Cost Maximums should be reviewed in relation to expected needs of the people who transition. The DON scale can be an effective tool to target services to people with the greatest needs.

The goal of HCBS is to avoid unnecessary, or premature nursing facility admission and promoting the appropriate use of long-term care nursing facilities. Incontinence and lack of compliance with prescription medication orders were noted as factors that predict admission to a nursing facility. Other triggers may predict admission as well. The Department on Aging should study the assessment and service authorization patterns of participants who move from Supported Living Facilities and the CCP program to identify these triggers and develop strategies that will avoid or delay these admissions.

The plan includes the following objectives:

- Update and maintain an inventory of services and providers
- Create a profile of IDoA participants and their needs
- Disseminate information about changing demographic trends and demand for services
- Develop an assessment module that identifies caregiver needs for supports and respite services
- Clarify the tasks that may be performed under homecare aide services which include hands-on assistance with activities of daily living, and provide training to enable workers to meet the needs of the participants they serve as well as identify health triggers that require reassessment
- Determine the characteristics that predict admission to a nursing facility for older Illinoisans in general, and in the CCP population in particular
- Implement a medication management services program
- Evaluate the existing Cash & Counseling demonstration project and explore the feasibility of expanding this program model throughout the state
- Develop triggers and linkages for care coordinators and service staff to obtain health and medical care consultation, and mental health consultation. Develop training to recognize the need for such consultation
- Develop plans to maintain the level of service for high DON score participants

5. *Increase caregiver support*

The needs of family caregivers continue to grow. The 2009 MetLife Foundation "Report on Caregiving in the US" found that seven in 10 caregivers care for someone over the age of 50. Family members and friends provide 85% of all home care. The economic value of un paid family caregiving is approximately $375 billion. Just over half of the caregivers are employed. Caregivers provide support for an average of 4.6 years. The study also found that caregivers have more stress-related illnesses than non-caregivers.

The OASAC Executive Committee identified a range of strategies that will support family caregiving. The committee recommended that the first step to support family caregivers is to expand funding for respite services and other supports. Two national organizations – the Family Caregiver Alliance and the National Alliance for Caregiving – study developments in caregiver programs and their reports should be reviewed to identify evidence based programs for caregivers.

Caregivers often lack information about the chronic conditions of the person for whom they are caring. Health practitioners can prepare caregivers by educating them about the symptoms of their chronic conditions, how to respond to the symptoms and when to seek medical care. Care coordinators who do not have a health background need access to medical expertise either through interdisciplinary teams or nursing consultants to work more effectively with caregivers.

Resources from the U.S. Administration on Aging to fund the caregiver support program are allocated by the 13 AAAs through area plans. The Executive Committee recommended that the Department on Aging establish consistent priorities to the AAAs with regard to respite care while maintaining control at the local level.

The plan supports expanding coverage of respite services for caregivers. The committee identified five respite service models: companion/sitter; homecare aide; home health; adult day services; and institutional respite. An option to covering a specific menu of services is the "cash and counseling" or budget model which sets a cap on the amount of money that is available for each caregiver and allows the caregiver to purchase the type and amount of service that best meets their needs and the needs of the care receiver.

The plan includes the following objectives:

- Seek increased funding for respite services for family caregivers
- Increase outreach and education to family caregivers to increase their awareness of and access to services
- Explore evidence based caregiver programs and best practices
- Document the gaps in the availability of respite services
- Utilize ADRCs and CPoEs to increase access to family caregiver services
- Explore improvements to the assessment tool to identify caregiver needs
- Incorporate a nurse consultation model into the delivery of services for caregivers and clients
- Explore strategies to integrate the social and medical model
- Compile and provide information to legislators on the social and economic value of family caregiving
- Establish guidelines to improve the consistency in respite services programs statewide
- Study options to expand the availability of home health services
- Clarify Federal regulatory requirements for completing the minimum data set (MDS) tool in nursing facilities for respite clients
- Explore the role of nursing facilities as respite providers
- Explore the role of hospitals as respite providers in rural areas
- Assess the impact of adult day services as a respite option
- Study the benefits and challenges of developing a caregiver assessment module
- Explore how the state is using the National Family Caregiver Support Program funds

6. Facilitate access to supportive housing options/affordable housing

The OASAC Executive Committee recognized the need to support the addition of affordable, accessible housing for older adults and individuals with physical disabilities. During the retreat, the committee learned about a new program that encourages developers to target 10% of the units funded by Low Income Housing Tax Credits (LIHTC) to individuals with income below 30% of the area medium income who have a disability, or are homeless or are at risk of becoming homeless. About four developments have opened and more were proposed in response to an RFP issued by the Illinois Housing Development Authority. Proposals that lease units to individuals with disabilities receive additional points in the LIHTC selection process. Medicaid beneficiaries who participate in the Money Follows the Person program are eligible for the units. However, leasing units to Medicaid beneficiaries is hindered by delays documenting the applicant's eligibility for low income housing. Care coordinators from DHS offices used to provide the documentation required by the project but staff cutbacks and closure of many DHS offices limit their ability to provide timely documentation.

The plan includes the following objectives:

- Advocate for the development of web-based system to expedite the application process for subsidized housing
- Design strategies to improve collaboration between IHDA, ADRCs, CCUs, AAAs and local public housing authorities
- Advocate for the addition of rental assistance funding for special needs populations

7. Improve the HCBS quality management system

The OASAC Executive Committee stated its commitment to improving HCBS quality management systems. The effort should begin with an inventory of evidence-based practices in the design, management and delivery of HCBS. Once completed, the components developed for CCP participants may include quality controls adopted by Money Follow the Person. These include a critical incident reporting system, a 24-hour backup system to assure services are provided when workers do not show up when scheduled, and a risk mitigation plan to identify potential risks that may occur for older Illinoisans in general, and among CCP participants in particular and to design steps that prevent unwanted outcomes associated with the risks. There is also the need to integrate evidence-based interventions (e.g., strict adherence to recommended measurement of performance procedures) in the delivery of home and community-based services and supports which have been proven effective in improving and maintaining functional abilities and managing multiple chronic conditions (e.g., Take Charge of Your Health: Live Well, Be Well; Strong for Life, Healthy Moves, and Healthy IDEAS).

The plan includes the following objectives:

- Incorporate evidence based practices and models into our service delivery system (e.g., strict adherence to recommended measurement of performance procedures)
- Implement a critical incident reporting system
- Implement a 24-hour backup system for CCP participants
- Design and implement a risk mitigation process for CCP participants

8. Convert excess nursing facility capacity

The average nursing facility occupancy rate is under 80% statewide. The Committee discussed the recommendations of the Nursing Home Bed Conversion workgroup to convert unused capacity to other uses. The Executive Committee supported two initiatives that were developed through collaboration with the Department on Health and Family Services and the Department of Public Health:

- Establish a pilot project to convert multi-occupancy rooms to single occupancy rooms in three areas of the state (northern, central, and southern)
- Allow nursing facilities to provide short-term respite care for Medicaid beneficiaries and other low-income seniors living in the community

Single rooms increase privacy and create an environment that is more home-like. It also increases the consumer's ability to establish their schedule. The conversion pilot requires an adjustment to the capital component of the nursing facility rate. Legislation to permit the adjustment has been introduced in the state legislature.

The Nursing Home Bed Conversion workgroup also examined the need for respite care for Medicaid and low-income seniors in order to develop an accessible and affordable in-facility respite service model that will support individuals who provide care to older adults living in the community.

The Health Care Council of Illinois surveyed its members to determine what facilities were providing in-facility respite services, how these services were funded, the referring organizations, the financial status of clients receiving these services, length of stay, and other items. The workgroup identified possible regulatory and other barriers that prevent access to respite services provided by nursing facilities. These barriers include, but are not limited to:

- Lack of knowledge/education about the availability of these services
- Lack of knowledge/education about in-facility respite and referral process for referring agencies (CCUs and AAAs)
- Lack of knowledge about how to access the funds for in-facility respite care
- Lack of adequate funding
- The assessment and care planning process for in-facility respite care clients

The survey found that access to facility-based respite care is limited to private pay clients. Steps to expand coverage for this service are included in the caregiver section.

The plan includes the following objectives:

- Obtain funding to implement the bed conversion pilot project
- Explore the role of nursing facilities as respite providers

9. Maximize the use of technology to support policy and program development and delivery of long-term care services

The OASAC Executive Committee stated its commitment to using technology to support access to services, as well incorporating the use of assistive technology in program development. The Department on Aging should monitor technological advances to avoid designing a system that will be obsolete before it is implemented. A strong information technology plan is needed to create an effective “no wrong door” approach to access information about long-term care service options, an assessment of the individual’s need, and access to the services identified in the assessment. Several opportunities exist at the state level for collaboration on this issue.

The State of Illinois Framework project works collaboratively across various state agencies to develop a common vision for an integrated and efficient healthcare and human services delivery system that provides "No Wrong Door" access to high-quality services. The Frame work project envisions convenient locations and channels of entry for Illinois residents who seek services that the state provides or funds.

The Illinois Assistive Technology Program (IATP) promotes the availability of assistive technology services and programs for people with disabilities. IATP serves all people with disabilities in the state of Illinois, their families, service providers, state agencies, private industry, educators, and other interested individuals, regardless of age or income.

The state of Illinois is also expanding the use of health information technology to improve the delivery of healthcare in Illinois. HIE is the use of electronic medical records and e-prescribing to assist medical providers in understanding a patient's full medical history.

The committee recommended that aging issues be represented on the Illinois Framework project, and Health Information Exchange (HIE) advisory committee being established in each area of the state.

The plan includes the following objectives:

- Explore technological innovations to streamline the application and assessment process including a universal instrument or process that populates applications with existing information
- Implement the information technology framework
- Design and implement information technology initiatives that support access to services
- Ensure representation from aging interests on the Illinois Framework project, and in each HIE advisory committee

Tasks and Timelines

The following tables list the goals, taks, lead agency and timeline for each task.

Goal 1: Improve funding for home and community-based services programs

Tasks	Lead responsibility	Year 1				Year 2				Year 3			
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
1. Develop a plan to increase revenues for HCBS	OMB, Governor's office	x	x										
Evaluate HCBS Medicaid provider tax	OMB, Governor's office	x	x										
Evaluate homecare provider tax	OMB, Governor's office	x	x										
2. Expand funding for LTC services	IDoA, HFS							x	x	x	x		
Examine state balancing incentive program option	HFS			x	x								
Prepare application to CMS to participate	HFS, IDoA												
Explore 1915 (k) state plan amendment	HFS					x	x						
3. Develop revised budget process	OMB, Governor's office			x	x	x	x	x					
Develop cross program/agency budget process	OMB, Governor's office			x	x								
Review Unified Budget option	OMB, Governor's office				x								
Develop Unified Budget process	OMB, Governor's office					x							
Determine programs/agencies to include	OMB, Governor's office					x							
Develop phase-in plan	OMB, Governor's office						x	x					
Develop budget forecasting process	OMB, Governor's office					x	x						
4. Expand long-term care insurance coverage	HFS, Department of Insurance									x	x	x	x
Review Partnership results	HFS, Department of Insurance									x			
Develop strategies to increase participation	HFS, Department of Insurance										x		
Prepare implementation plan	HFS, IDoA, DOI											x	
Analyze impact of CLASS Act	IDoA, HFS, DOI									x			
Promote participation in the CLASS Act program	IDoA, DOI										x		

Goal 2: Improve transitions/integration between medical and long-term care systems and settings													
Tasks	**Lead responsibility**	**Year 1**				**Year 2**				**Year 3**			
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**
1. Explore strategies that improve transitions	IDoA					x	x						
Develop formal arrangements between hospital discharge planning staff and CCUs	IDoA						X	x					
Provide training to CCU staff on relevant medical conditions and terms	IDOA					x	x						
Develop access to nurse consultation services for CCU staff	IDoA							x	x				
2. Develop interventions based on patient characteristics and/or chronic conditions	IDoA									x	x		
3. Examine Choices for Care screening process	IDoA			x	x	x	x						
Identify areas for strengthening CFC such as integration with the comprehensive care assessment	IDoA			x									
Develop a plan to improve CFC	IDoA				x								
Implement improvements in CFC	IDoA					x	x						
4. Review nursing home transition & Money Follows the Person program results	IDoA				x	x	x	x					
Identify barriers to working with institutional staff	IDoA					x	x						
Develop a plan to improve transition efforts	IDoA						x						
5. Identify assessment data to trigger referrals for home health service/health assessment	IDoA							x	x				
Implement training plan for all relevant organizations	IDoA								x	x			
6. Review CCU care coordinator caseloads	IDoA							x	x	x	x	x	x
Set caseload standards	IDoA									x			
Determine funding needs	IDoA										x		
Obtain funding and implement standards	IDoA									x			x

Goal 3: Improve access to long-term care services through preadmission screening and options counseling													
Tasks	Lead responsibility	Year 1				Year 2				Year 3			
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
1. Evaluate and select PAS/Options Counseling model	IDoA			x	x	x	x						
Define options counseling	IDoA			x									
Differentiate options counseling/comprehensive assessment and I&R	IDoA				x								
Move from pre-admission screening to a comprehensive assessment earlier in the process	IDoA						x						
Establish a no wrong door system to access assessment, services and general information	IDoA						x						
2. Develop branding for CPoE	IDoA					x	x	x	x	x			
Analyze legal considerations	IDoA					x							
Determine cost	IDoA						x						
Develop materials for distribution	IDoA							x					
Develop linkage to CCP	IDoA								x				
Develop implementation plan to coordinate with ADRC branding	IDoA									x			
Explore availability of OAA funds to pay for outreach	IDoA									x			
Define target market	IDoA										x		
Develop information platform so that various agencies can access certain information (e.g., CarePath Workflow)	IDoA										x		
Explore applicability of a Health Information Exchange network to CPoEs	IDoA											x	
3. Implement CPoE standards	IDoA					x							
Survey agencies to determine compliance with CPoE standards	IDoA								x				
Develop common web based intake form	IDoA					x	x	x	x				
Develop method to coordinate with information collected at physician offices	IDoA									x	x		
Explore decision tree options to direct consumers to appropriate services (e.g., Benefits Check up, Elder Locator)	IDoA									x			
4. Determine standards and regulations for common intake systems	IDoA										x		

Goal 4: Ensure service allocation equity between older adults and adults with physical disabilities, and improve the service package														
Tasks	**Lead responsibility**	**Year 1**				**Year 2**				**Year 3**				
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
1. Update & maintain service inventory	IDoA					x	x	x	x					
Complete inventory of validated, computerized instruments that measure unmet needs	IDoA					x								
Identify funding sources to conduct research to assess the adequacy of current comprehensive case management tools to track service adequacy & identify unmet needs	IDoA				x	x	x							
Select a sample of CCU comprehensive case management assessments to identify unmet needs	IDoA						x							
CCUs collect data on service gaps and unmet needs	IDoA						x	x						
CCUs report information on gaps and unmet needs to AAAs and IDoA	IDoA								x					
Develop strategies to reduce service gaps and unmet needs	IDoA									x				
2. Create a profile of IDoA customers and their needs	IDoA					x	x							
Describe existing methods to forecast need for services	IDoA					x	x							
Evaluate the accuracy of forecasting methods	IDoA									x	x			
Recommend methods to improve forecasting	IDoA					x	x					x		
Implement forecasting improvements	IDoA							x	x	x	x			
3. Disseminate information about changing demographic trends and demand for services	IDoA					x	x							
Disseminate DON/SCM study findings comparing CCP and DRS participants (post results on web site, prepare findings summary)	IDoA	x	x											
4. Develop assessment module that identifies caregiver's need for respite services	IDoA							x	x					
Examine impact of adding respite services to the HCBS waiver	IDoA					x	x							
5. Clarify the tasks performed under homemaker services which include hands-on assistance with personal care (e.g., bathing, toileting).	IDoA			x	x									
Develop personal assistance training for homecare aides	IDoA			x	x									
Expand worker registry to include CCP workers	IDoA									x	x			
6. Determine characteristics that predict admission to a nursing facility for older adults and the CCP population	IDoA											x	x	
Develop strategies to avoid or delay unnecessary nursing facility admissions	IDoA												x	
7. Implement medication management service	IDoA					x	x	x	x					
Evaluate Cash & Counseling project for possible statewide expansion	IDoA													
Provide training for CCP care coordinators	IDoA				x	x	x							

Goal 4: Ensure service allocation equity between older adults and adults with physical disabilities, and improve the service package													
Tasks	**Lead responsibility**	**Year 1**				**Year 2**				**Year 3**			
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**
8. Develop linkages for care coordinators and service agency staff to obtain health & medical care, and mental health consultation	IDoA					x	x						
9. Develop plans to maintain the level of service for high DON score participants	IDoA					x	x						

Goal 5: Increase caregiver support													
Tasks	**Lead responsibility**	**Year 1**				**Year 2**				**Year 3**			
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**
1. Seek increased funding for respite services to family caregivers	IDoA					x	x	x	x	x	x	x	x
2. Increase outreach and education to family caregivers to increase their awareness of and access to services	IDoA									x	x	x	x
3. Explore evidence based caregiver programs and best practices	IDoA					x	x						
4. Document the gaps in availability of respite services	IDoA							x	x	x	x		
5. Utilize ADRCs, CPoE's to increase access to family caregiver services	IDoA							x	x				
6. Explore improvements to the DON to identify caregiver needs	IDoA									x			
Develop a caregiver module to the DON assessment tool	IDoA			x	x								
Amend the DON to allow needs met by caregivers	IDoA							x	x				
7. Provide education to family caregivers	IDoA									x	x	x	x
8. Incorporate nurse consultation model into the delivery of services for caregivers and clients	IDoA									x	x		
9. Explore strategies to integrate social and medical model	IDoA					x	x	x	x				
10. Compile & provide information to legislators on the social and economic value of family caregiving	IDoA			x	x	x	x						
11. Study options to expand the availability of home health services	IDoA									x	x		
12. Establish guidelines to improve consistency in respite services statewide	IDoA									x	x	x	x
13. Explore role of nursing facilities as respite providers	IDPH	x											
Clarify Federal regulations for completing MDS in nursing facilities for respite clients	IDoA		x	x	x								
14. Explore role of hospitals in providing respite in rural communities	IDoA			x	x								
15. Assess the impact of adult day services as a respite option	IDoA			x	x								
Assess impact of hours of operation	IDoA			x									
Determine cost impact of expanding hours of operation	IDoA				x								
16. Explore how the State is using the National Family Caregiver Support Program funds	IDoA							x	x				

Goal 6: Facilitate access to affordable supportive housing													
Tasks	Lead responsibility	Year 1				Year 2				Year 3			
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
1. Advocate for the development of a web based system to document eligibility for low income housing	IHDA					x	x	x	x	x			
2. Develop collaboration between IHDA, CCUs, AAAs and public housing authorities to increase referrals to affordable housing	IDoA, IHDA						x	x	x	x			
3. In partnership with IHDA seek out opportunities to advocate with legislators, developers and others for increased rental assistance for persons with special needs.	IDoA, OASAC												

Goal 7: Improve the HCBS quality management system													
Tasks	Lead responsibility	Year 1				Year 2				Year 3			
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
1. Develop an inventory of existing evidence based Initiatives	IDoA			x	x								
2. Implement a critical incident reporting system	IDoA			x	x								
3. Implement a 24 hour back up system for CCP participants	IDoA			x	x								
4. Design and implement a risk mitigation process for CCP participants	IDoA			x	x								

Goal 8: Convert excess nursing facility capacity													
Tasks	Lead responsibility	Year 1				Year 2				Year 3			
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
1. Obtain funding for the bed conversion pilot project	HFS					x	x						
Implement pilot project to convert to single bed rooms	HFS							x	x	x	x		
Evaluate results from pilot project	HFS										x	x	
Implement statewide conversion program	HFS												x

Goal 9: Maximize the use of technology to support policy and delivery of long-term care services													
Tasks	**Lead responsibility**	**Year 1**				**Year 2**				**Year 3**			
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**
1. Submit advance plan document for IT Framework Project to US DHHS	Governor's office	x											
Publish RFP	Governor's office		x										
Award framework planning effort	Governor's office			x									
Begin planning	Governor's office				x								
2. Design & implement IT initiatives that support access to services and program development	IDoA, Governor's office					x	x	x	x	x	x	x	x
Establish a no wrong door IT system to access assessment, services and general information	IDoA, Governor's office									x	x		
Develop information platform so that various agencies can access certain information (e.g., CarePath Workflow)	IDoA, Governor's office										x	x	
Explore applicability of Health Information Exchange network to ADRC/CPoEs	IDoA, Governor's office											x	x
3. Ensure representation from aging interests in each HIE advisory committee	IDoA	x	x										
4. Explore technological innovation to streamline the application, assessment process, and use of technology in program development	IDoA											x	x

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- Stephanie Altman - Programs and Policy Director, Health and Disability Advocates
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State of Illinois
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