State of Illinois
Pat Quinn, Governor

Illinois Department on Aging
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Clarification of Roles and Responsibilities of Existing Aging Network Providers Participating in the Nursing Home Transition Process

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August 2006

Funded through the Illinois Department on Aging
by a Real Choice Systems Change Grant
from the Centers for Medicare and Medicaid

Illinois Department on Aging

Executive Summary

Study and Purpose

This report is in partial fulfillment of the agreement between the University of Illinois at Chicago (UIC) Disability and Human Development and the Illinois Department on Aging (IDOA) and IDOA's Centers for Medicare and Medicaid Real Choice Systems Change grant.

The goals of the Real Choice Systems Change grant are to help Illinois build the infrastructure that will result in effective and enduring improvements to reform Illinois' long-term care system including a shift in the balance from nursing home to home and community-based care. This is being initiated in order for older adults, including persons with disabilities, to live in the most integrated community setting suited to their needs, to have meaningful choices about their living arrangements, and to exercise more control over the services they receive.

Methodology

During the Spring 2006, a total of thirteen sessions that included key informant interviews and focus groups ranging in size between eight to twelve participants were conducted. Participants included representatives of Illinois' CCU case managers; acute care hospital social workers and discharge planners; representatives from nursing homes; a disability service and advocacy organization; a rural health department; a project leader for one of the state's *Home Again,* enhanced transition demonstration sites, and a staff member of the Illinois Department on Aging's Home and Community Services. These meetings were held to obtain their understanding and execution of the processes associated with nursing home transition.

Stated below are several key areas of concern that emerged from the discussions in relationship to Illinois' *Choices for Care* program of offering older adults alternatives to nursing home placement. Potential solutions to these identified areas may be found at the end of this report.

(1) The role of the CCU (Case Coordination Unit) case manager of providing alternatives to nursing home placement, per the intent of the law, needs to be re-established.
(2) Case manager, hospital and nursing home discharge planners' practice standards need to be improved.

All stakeholders interviewed were able to cite the law and the intent of the screen. However, it appears that over time, hospital discharge planners now refer primarily nursing home candidates and potential Community Care Program (CCP) recipients. Case managers do not appear to question the need for placement and simply validate the discharge plan. It appears that if and when an older adult refuses placement, alternatives are suggested and advocacy is initiated. It should be noted that hospital stays have even shortened since the implementation of *Choices for Care*. Older adults require further medical care that is provided at a step-down setting such as a nursing home. This is the preferred treatment setting due in large measure for the ease of the physician and family, and Medicare home health, community options and CCP are limited. Also, nursing homes appear to lack trained and neutral personnel responsible for discharge planning.

(3) A legislative and procedural mandate for nursing home follow-up and offering of community alternatives is necessary.

IDOA, *Choices for Care* assessment forms, including the Determination of Need (DON) instrument, have sections for the older adult to request follow-up at the nursing home, although this follow-up is not mandated. Case Coordination Units (CCU) appear to vary in the implementation of follow-up. Some have systematic procedures to contact and visit the older adult in the nursing home while others have no procedures. The ability to perform follow-up is exacerbated by CCU boundaries. Older adults may be seen by one CCU and transferred to a nursing home in the jurisdiction of another CCU. The result is that older adults may be staying longer or indefinitely at nursing homes.

All stakeholders in the process reported little or no time to make decisions. Consequently, nursing home placement appears to make the most sense at that particular point in time.

Case managers and discharge planners reported little to no incentive for the nursing home to discharge the older adult. Nursing home representatives report that they know little about the older adult's prior community home and support system, and the older adult is assisted by a whole new set of health professionals at the nursing home. Consequently, older adults may stay longer or indefinitely at the nursing home.

(4) Continuity of care and care planning needs to be improved; the assessment information should travel with the older adult.

Discharge planners and nursing home representatives report receiving little information concerning the older adult's history including supports in the community. Consequently, older adults are asked similar questions over and over. Hospital-based case managers, particularly if the older adult is not a client of that CCU, state they know little about the current plan of care, home situation and past assessments.

Plans for temporary nursing home stays developed at the hospital are forgotten, due in large measure, to a new set of professionals treating the older adult and a lack of incentive for the nursing home to discharge. There is possibly no advocate for the older adult if they are not able to advocate for themselves.

Again, older adults may be seen by one CCU and transferred to nursing homes in the jurisdiction of another CCU. **This is a critical issue in the metropolitan Chicago area and surrounding counties.** CCUs are not notified of the new nursing home resident and again may have no procedure to follow-up for this older adult or even the older adult they saw in the hospital.

5) Older adult and family's access to information and the delivery of information needs to be improved.

Case managers and discharge planners do not appear consistent in the information shared with older adults and their families concerning the implementation of the *Choices for Care* program. Consequently, there is not statewide uniformity of practice. This appears to be exacerbated when the older adult reaches the nursing home. Often there is a less qualified individual in the role of a social work designee discussing community-based options.

Additionally, there is a problem with nursing homes receiving required paperwork on a timely basis. When this occurs, the causes for this problem appear to be:

- CCUs do not receive a referral to assess the older adult from the hospital discharge planners.
- CCUs do not know the outcome of the older adult's hospital stay.
- Nursing homes are not informed by the hospital discharge planner and/or the CCU regarding completion of a screen.
- Discharge planners are not informed by the CCU if a screen was completed.
- Discharge planners are less than truthful to the nursing home regarding the screen.

The case manager's neutrality is a keystone to the Illinois *Choices for Care* Program. Absent quality information and consistent follow-up by the case manager, the older adult's ability to successfully use community-based alternatives to nursing homes is constrained.

Background

The University of Illinois at Chicago (UIC) researchers agreed the first deliverable under the Real Choice Systems Change grant was to clarify and document the roles and responsibilities of the existing aging network providers participating in the reintegration process. This activity was completed in order to gain a thorough understanding of the current process of assessing older adults prior to the nursing home placement and the process of offering community-based alternatives to institutional care. This process included:

- An analysis of policies and procedures of existing government agencies in relationship to the current system.
- Interviews with key stakeholders at the state level and selected local officials involved in the processes.
- Development of a flow-chart mapping the process including strengths and barriers to be used for further discussion and research.

It is also hoped that this report will kindle discussion concerning current policies and procedures relating to nursing home transition and whether changes in Illinois' processes could lead to improved choices, living arrangements and control concerning home and community-based options. It offers:

- A set of recommendations to be considered by all state agencies, case coordination units, and discharge planning departments of hospitals and nursing homes.
- A resource for members of the Older Adults Services Advisory Committee, including its workgroups.
- A resource for members of the Illinois General Assembly who have the authority to mandate that the Illinois system, which is fundamentally on-target, achieve better outcomes pertaining to the prevention and/or premature permanent nursing home placement of older adults.

Choices for Care

Since July 1996, the Illinois Department on Aging (IDOA) has had a program and process of screening all nursing home applicants prior to admission labeled *Choices for Care*. This includes those seeking Medicaid to cover the nursing home costs, persons using Medicare coverage for skilled nursing or rehabilitation or those with private insurance or self pay. There are policies and procedures associated with the *Choices for Care* program, and they include offering Community Care Program's (CCP) home and community-based services as an alternative to nursing home placement for persons who do not elect nursing home placement. The agencies under contract to perform the case management service are responsible for the hospital and community-based screen. The Case Coordination Unit (case management) may designate the discharge planners at the hospital to perform this task if training and certification by IDOA has occurred. In actuality, the Case Coordination Unit (CCU) has retained this responsibility and the hospital discharge planner's role is to refer the older adult to the CCU.

The *Choices for Care* program was implemented several years before the United States Supreme Court's 1999 Olmstead v. L.C. decision. However, the Olmstead decision has implications for Illinois' efforts at reintegration of potential nursing home candidates and IDOA's *Choices for*

Care program. Under Olmstead, "the Supreme Court ruled . . . that it is a violation of the Americans with Disabilities Act for states to discriminate against people with disabilities by providing services in institutions when the individual could be served more appropriately in a community-based setting" (Fox-Grange, Folkemer, Horahan, 2001, p. 1). Illinois' *Choices for Care* program is one means to exercise the intent of the Olmstead decision, not only for advising persons of home and community-based alternatives, but as a means to access the CCP program on a temporary basis.

In addition to Illinois' *Choices for Care* and CCP procedures, an enhanced transition project, labeled *Home Again* is targeting potential nursing home residents in six communities including Chicago and its northern suburbs, Quincy, Carterville, Rock Island and Rockford. It focuses on CCP eligible candidates (Adler, 2006). "Under this demonstration, seniors receive financial assistance for expenses such as housing and security deposits, utility services, furniture and household items for up to six months and then receive more typical community care services (Johnson, 2006). This project was implemented by the Illinois General Assembly's amendments to Public Act 93-0902. Specifically:

> "(a) The Department on Aging shall assist eligible nursing home residents and their families to select long-term care options that meet their needs and reflect their preferences. At any time during the process, the resident or his or her representative may decline further assistance. (b) To provide assistance, the Department shall develop a program of transition services with follow-up in selected areas of the State, to be expanded statewide as funding becomes available. The program shall be developed in consultation with nursing homes, case managers, Area Agencies on Aging, and others interested in the well-being of frail elderly Illinois residents. The Department shall establish administrative rules pursuant to the Illinois Administrative Procedure Act with respect to resident eligibility, assessment of the resident's health, cognitive, social, and financial needs, development of comprehensive service transition plans, and the level of services that must be available prior to transition of a resident into the community."

Best Practices

A number of states have conducted similar research on nursing home transition. Their findings indicate areas where Illinois' current efforts regarding transition are on the right track. However, their findings also mirror opportunities for Illinois to improve its processes.

In the final report entitled, *Diversion and Transition Services in the United States: Promising Practices and Options for the Future*, completed by the University of Massachusetts Medical School, Center for Health Policy and Research, five barriers to diversion and transition were identified. These are:

1. Lack of knowledge about available community-based supports;
2. Restrictive Medicaid eligibility rules coupled with a lengthy eligibility process for community supports;
3. Complex medical, psychiatric and substance abuse issues related to individuals;
4. Lack of affordable, accessible housing;
5. Insufficient diversion/transition activities.

These barriers were identified by examining nursing facility screens, access to community resources, education, care coordination, funding including rebalancing mechanisms and supportive housing options. While the states studied included Washington, Massachusetts, New Hampshire, Colorado, Maryland, Kansas, Michigan, Oregon, Maine, Wisconsin, Pennsylvania and Vermont, not all of the states were examined for each of these diversion and transition activities. (O'Connor, Long, Quach, Burgess, Shea-Delaney, 2006).

Reinhard and Farnham (2006) for Rutgers Center for State Health Policy Meeting Summary entitled S*ustaining Nursing Home Transition* identified critical elements for success. These elements included:

- Statutory framework (preadmission screening law);
- Staffing with a mix of skills, adequate funding, realistic caseload size and training;
- Collaboration with single entry points to aging services;
- Consumer and stakeholder input and advocacy;
- Methods for identifying nursing home residents for transfer;
- Assessment tools;
- Identification of characteristics of nursing home residents seeking transfer;
- Articulation with nursing home staff regarding transfers;
- Transition funding;
- Accessible, affordable housing options including assisted living;
- Data tracking and evaluation;
- Ability to learn and overcome barriers to transition;
- Ensure sustainability of transition efforts.

States have operationalized their efforts at transitional services in different ways. For example, Washington State allows for the home and community-based waiver services, similar to Illinois, to begin on a presumptive eligibility basis and utilizes a post nursing home admission screen within seven days of nursing home placement. Additionally, several states offer counselors or case managers to assist in the development of transitional plans of care and with transitional costs. The inclusion of transitional costs is one strategy of the "Money Follows the Person" concept where Medicaid dollars allocated to nursing home care follow the older adult to the community setting for care. Some of these same states offer funds to be used for a wide range of home and community-based service options including an array of housing options (O'Connor, Long, et al., 2006).

Current Illinois Policies and Procedures

Screening Assessment and the Determination of Need (DON)

The screening for nursing home placement and for home and community-based services utilizes Illinois' DON assessment instrument. A score is obtained by administering the DON instrument. Mollica and Reinhard (2005) describe the Illinois DON score as:

> "The score is derived from the Mini-Mental State Examination (MMSE), six activities of daily living (ADLs), nine instrumental activities of daily living (IADLs) (including the

> ability to perform routine health and special health tasks and the ability to recognize and respond to danger when left alone). Each ADL, IADL and special factor is rated by level of impairment (0-3) and unmet need for care (0-3). Scores for each area are totaled and applicants with a DON score of 29 or more are eligible. The MMSE component is weighted toward people with moderate or severe dementia. The process is designed to target services to people with high levels of impairment who may have informal supports, and to people with lower levels of impairment without informal supports" (p. 2-3).

The score as described above is the threshold point for admission to a nursing home or access to CCP home and community-based services. CCUs may utilize additional assessment tools as part of the screen. Again, the DON score of 29 represents the number of points required or needed to validate nursing home service.

By assessing the need through the administration of the DON and identifying 29 points, an older adult's need for nursing home services is validated. This validation is required should the individual qualify for Medicaid to pay for the nursing home stay. Nursing home compliance of this documentation is monitored by the Illinois Department of Public Health. Again, the screening assessment and the subsequent documentation are needed for the older adult's application for Medicaid coverage. Payment by Healthcare and Family Services (HFS) to the nursing home begins on the assessment date of the screen or the effective date of Medicaid eligibility. The results of the screen are documented on the Inter-Agency Certification of Screening results for Long Term Care (HFS 2536).

Statutory Authority

Several Illinois Administrative Codes of HFS and IDOA and the Illinois Act on Aging established policies, procedures and performance expectations relating to screening assessments for nursing facility and alternative residential settings.

HFS 89 Illinois Administrative Code, Chapter I, Section 140.642, Subchapter (d)

> "Beginning July 1, 1996, any individual 18 years of age or older, except those identified in subsection (c) of the Section seeking admission to a nursing facility licensed under the Nursing Home Care Act [210 ILCS 45] for nursing facility services must be screened to determine his or her need for those services pursuant to this Section."

Subsection (c) specifies a screen is not required prior to admission for older adults receiving sheltered care services, transfers from one nursing home to another that occur within 60 days or less, persons under hospice care, persons readmitted to the nursing home after a therapeutic home visit and those who were residents of the nursing home on or prior to June 30, 1996. The code also states that any person who applies to the Medical Assistance program (Medicaid) for long term care services while residing in a facility must be screened prior to receiving assistance.

HFS 89 Illinois Administrative Code, Chapter I, Section 140.642, Subchapter (d), (b) also speaks to the Level I screen which is conducted to determine if there is a reasonable basis for suspecting that an individual has development disabilities (DD) or severe mental illness (MI).

Individuals with an indication of DD are to be referred to the designated PAS (Pre-admission Screen) agent of the Department of Human Services (DHS) – office of Developmental Disabilities or the DHS – Office of Mental Health. This screening, which is a component of the *Choices for Care* assessment, is valid for 90 calendar days. "Individuals with exceptional circumstances must then receive a Level II assessment to determine the individual's needs for specialized service related to the placement in a nursing facility." There are exceptions when the individual has a terminal illness and life expectancy is less than six months, a short-term stay of no more than 120 calendar days following acute care, where severe physical health conditions are present such as coma, ventilator dependency, congestive heart failure or a diagnosis of dementia, Alzheimer's disease or a related disorder for the DD population.

20 ILCS 105 Section 4.02, Illinois Act on Aging

The Illinois Act on Aging addresses the same policy. It states:

> "The Department shall establish a program of services to prevent unnecessary institutionalization of persons age 60 years and older in need of long term care or who are established as persons who suffer from Alzheimer's disease or a related disorder under the Alzheimer's Disease Assistance Act, thereby enabling them to remain in their own homes or in other living arrangements. Such preventive services, which may be coordinated with other programs for the aged and monitored by area agencies on aging in cooperation with the Department, may include, but not limited to . ."

It lists a number of home and community-based services including community reintegration services.

Illinois Department on Aging in 20 ILCS 105, Section 4.03

There are additional references to responsibilities relating to cooperation with DHS.

> IDOA "shall, without regard to income guidelines establish a nursing home prescreening program to determine whether Alzheimer's Disease and related disorders victims, and persons who are deemed as blind or disabled as defined by the Social Security Act and who are in need of long term care, may be satisfactorily cared for in their homes through the use of home and community based services."

20 ILCS 105, Section 4.12 speaks to IDOA's responsibility of offering options to nursing home residents and their families. Additionally, IDOA is to develop a program of transition services with follow-up in selected areas of the state. This portion of the law relates to the *Home Again*, re-integration and transition project currently underway in cooperation with several Area Agencies on Aging.

Community Care Program Rules

In order to operationalize **Section 4.02, the Joint Committee on Administrative Rules: Administrative Code, Title 89: Social Services, Chapter II Department on Aging** and **HFS 89 Illinois Administrative Code, Chapter I, Section 140.642, Subchapter (d), (b). Part 240 Community Care Program, Section 240.1010** states that it is the CCUs' responsibility to assess the individual's need for nursing home placement.

IDOA's CCP Rules, **Section 240.260 – Case Management Service** defines the assessment as a two-step process. The case manager completes the Level 1 screen to determine whether or not the individual has either a developmental disability or severe mental illness. The individual is also assessed using the DON to determine need for nursing home care. This is documented on the HFS 2536 form which **validates the need for nursing facility services at least at the time of admission.**

Timing and Types of Assessments

Joint Committee on Administrative Rules, Administrative Code, Title 89 Social Services, and Chapter II: Department on Aging, Part 240 Community Care Program, Section 240.260 Case Management Service specifies that the assessments for nursing home placement are to be conducted by the local CCU where the older adult is present at the time of the screen. For example, if the older adult's home residence is located in one CCUs' jurisdiction, but the older adult is a patient in a hospital in another CCUs' jurisdiction, the screen is completed by the CCU where the hospital is located. There are a few exceptions within the City of Chicago.

Under the *Choices for Care* program, older adults that receive this assessment screen are to be advised of their right to refuse nursing facility care and home and community-based services. However, the older adult is to be advised of home and community-based options as an alternative to nursing home care. The older adult and/or family are to be advised that CCP may be available, as well as, other government and private services. Eligible older adults that elect not to choose nursing home placement may access the CCP program on a temporary or *Interim* basis prior to determining financial eligibility. Services are delivered based on need at the time of the initial assessment. The assessment of need is usually completed just prior to a hospital discharge. Services are to begin by the provider agency within two days of notification by the CCU. The CCU is to complete a follow-up in-home and generally more thorough assessment within 15 days following the start of the CCP service. The financial eligibility determination process begins at the follow-up assessment.

If the transfer to nursing home occurs while the older adult is in an emergency situation, a post screen must be conducted. The post-screen is conducted within 15 days of the request of the CCU. Emergency situations are defined as: admission from a hospital emergency room or outpatient service; the older adult is moving to Illinois from out of state; or there is a loss of a caregiver and consequently there was no time for a screen to take place prior to admission. Screens are also required if the older adult was residing in a nursing home, and has been out of the nursing facility for sixty days or more.

There are other situations in which a screen is exempt at the time of admission to a nursing facility, if that facility operates under the **Hospital Licensing Act [210 ILCS 85].** These are usually nursing facilities that are in or near the hospital, operated by the hospital and the older adult experiences a short-term stay not to exceed 21 days.

Concerning persons in a nursing facility, a conversion screen is to be conducted by the CCU for persons who have applied for and been found eligible for Medicaid and would benefit from home and community-based services. These conversion screens, per **Section (i) (3) of the Section 240.1010 Nursing Facility Screening**, "shall include the option of CCP transitional services for those individuals who are appropriate for in-home and community-based services."

The following table summarizes the processes.

State Agency/Act	Policy/Procedure	Summary
Healthcare and Family Services	89 Illinois Administrative Code, Chapter I, Section 140.642 Subchapter d	Effective July 1, 1996, any individual 18+ years of age or older, with a few exceptions must be screened to determine need for nursing home services.
Illinois Act on Aging	20 ILCS 105 Section 4.02	IDOA shall establish a program to prevent unnecessary institutionalization of 60+ in need of LTC.
	20 ILCS 105 Section 4.03	IDOA shall establish a nursing home prescreening program to offer options of home and community based services without regard to income guidelines.
	20 ILCS 105 Section 4.12	IDOA is responsible for offering options and to develop a program of transitional services to nursing home residents in selected areas.
IL Department on Aging	Joint Committee on Administrative Rules: Administrative Code, Title 89: Social Services, Chapter II Department on Aging, Section 240.1010	CCUs are responsible for nursing facility screen and forms completion.
	Joint Committee on Administrative Rules: Administrative Code, Title 89: Social Services, Chapter II Department on Aging, Section 240.260	Restates the responsibility of CCUs regarding nursing facility prescreening and completion of the Level 1 Screen.

Illinois Department on Aging *Choices for Care* Process

The referral process from the hospital to the CCU varies. Hospital discharge planners call, fax, leave a referral in a designated place in the hospital or physically hand a referral to the local CCU representative responsible for the pre-admission screen. Per the policies stated above, the

CCU is to complete the assessment within two calendar days of the referral. Some CCUs may have promised shortened time frames under the terms of their contract.

The CCUs, in general, notifies the nursing home that a screening has occurred. Nursing homes receive a faxed and/or mailed copy of the Level I Screen and the HFS 2536.

Under the policies and procedures for the CCP program, the CCU is to complete follow-up at the nursing facility for those individuals that request it. Additionally, per previously stated policy, the CCU is to complete a conversion screen if so requested by the older adult nursing home resident, family or the facility. **Based on examination of the policies, procedures and rules, the CCU has no mandate or expectation for the follow-up of an older adult placed in a nursing home. This is true even for persons who may have indicated a desire for a follow-up contact and/or assessment by the CCU at the time of the initial screen.**

Roles and Responsibilities

Several entities appear to have major roles whether these roles are mandatory or voluntary. This information was obtained through the review of policies and procedures and from the interviews conducted with the focus group participants and key informants.

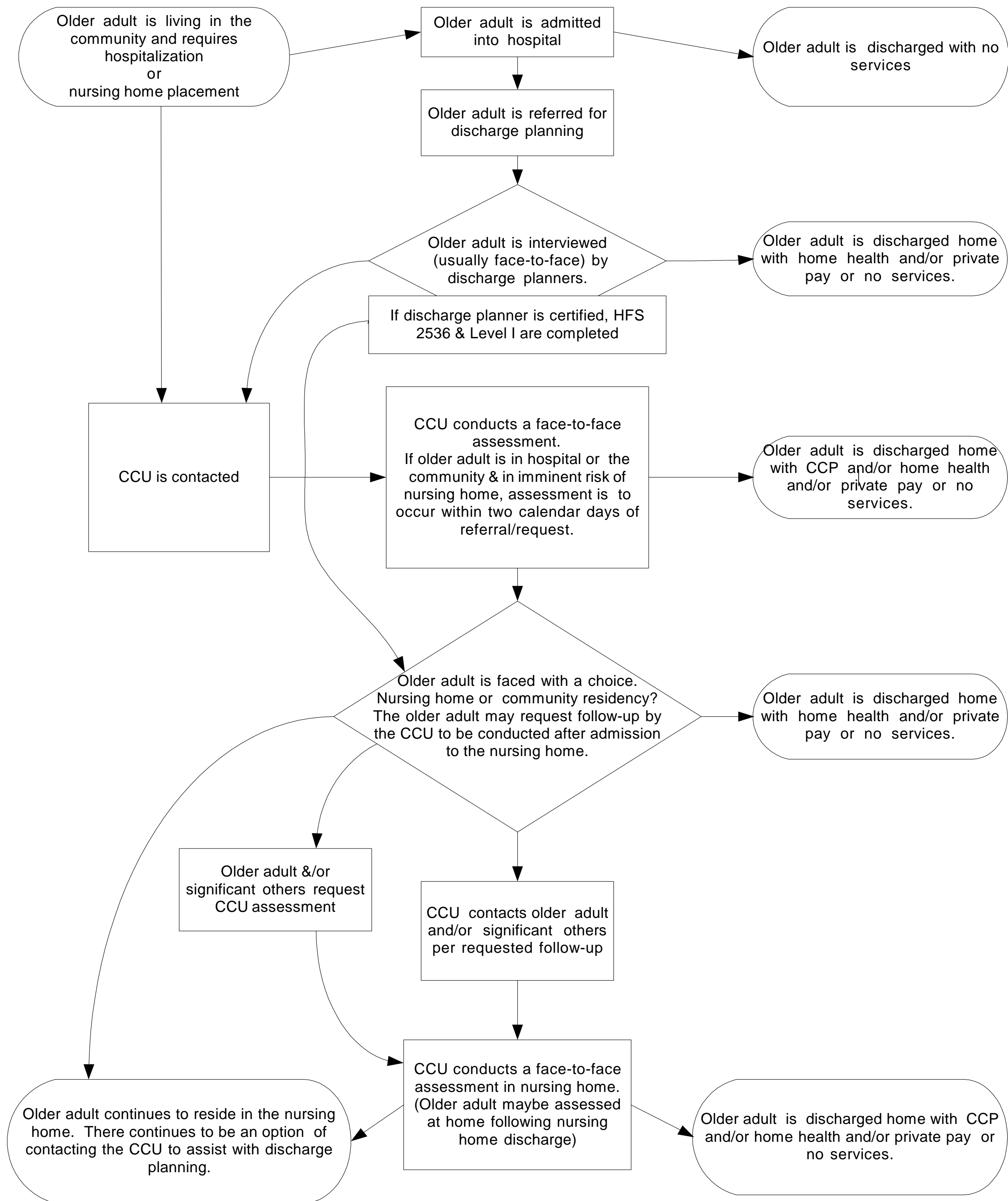
Entity	Pre-admission Role
Older Adult and/or family	Older adult and family have a role to choose between nursing home placement or receipt of home and community-based options. Older adult and family have the option to request follow-up at the nursing home to assist with transitioning back to community residency.
Hospital	Discharge planning staff role is to assure a safe and appropriate transition and refer older adults to the local CCU for screening assessment for nursing home placement or home and community-based options.
CCU	Case managers' role is to assess the older adult through a screen, which minimally includes the administration of the DON instrument to validate need for nursing home and Level I concerning MI or DD status within two calendar days of the referral.
Nursing Home	Must receive Level I and HFS 2536 screens to document that nursing home placement is appropriate.
Ombudsman	No role in pre-admission process.
Entity	**Transition Role to Community Residency**
Older Adult and/or family	Older adult and family may utilize nursing home internal resources for discharge planning assistance and/or seek assistance from the CCU to assist with home and community-based options including the CCP program.
Hospital	No official role.
CCU	CCU should, but is not required to have, a procedure in place to complete follow-up screens and/or assessments of older adults and families that have requested follow-up at the time of the initial screen or have reached-out for assistance. Again, there is no IDOA mandate regarding a policy, procedure and/or timeframe.
Nursing Home	Nursing home has a role in regards to securing payment and having on file documentation of the Level I and HFS 2536 screens.
Ombudsman	Role as an advocate for those residents who want to be discharged into the community using a proactive approach after receiving the resident's consent. Ombudsman hand-out *Choices for Care* brochure as well as refer residents to the CCU for an assessment.

The ombudsman assists in the monitoring of nursing home quality and is responsible for the investigation and resolution of resident and family complaints (Krassner, 2001).

Map of Illinois Department on Aging Choices for Care Process

As mentioned previously, in order to develop a map or flowchart of the processes and particularly to appreciate the strengths and barriers associated with transitioning from the home/ hospital to a nursing home and from the nursing home to community residency, representatives from CCUs, hospital discharge planning departments, nursing homes, an advocacy group and a member of the IDOA staff were interviewed. The map of this process is on the following page.

Map of Illinois Department on Aging Choices for Care Process



Introduction to Results

During the Spring 2006, a total of thirteen sessions that included key informant interviews and focus groups ranging in size between eight to twelve participants were conducted. Participants included representatives of Illinois' CCU case managers; acute care hospital social workers and discharge planners; representatives from nursing homes; a disability service and advocacy organization and a rural health department; a project leader for one of the state's *Home Again,* enhanced transition demonstration sites, and a staff member of the Illinois Department on Aging's Home and Community Services. These meetings were conducted by the Systems Change Project Director, Paul H. Bennett of the University of Illinois at Chicago, Disability and Human Development, College of Applied Health Sciences. The selection of these focus group meetings were not conducted using scientific methods, however a concerted effort was made to reach-out and hear from urban, suburban and rural CCUs, hospitals and nursing homes.

The meetings were held to obtain perspectives from these various stakeholders regarding:

- Understanding of the nursing home transition processes;
- Practice wisdom on why nursing home placements occur in Illinois;
- Thoughts on the strengths and barriers associated with the nursing home transition processes including community residency.

The discussions at these meetings focused only on older adults (persons 60 years of age and older) who sought nursing home placement for health reasons and their return to community residency. A few comments made by the participants related to experiences of older adults that may require an additional screen performed by developmental disabilities and mental health PAS (Pre-admission Screen) agencies.

Analysis of Focus Group Discussions

The discussions with the representatives of various stakeholders and key informants in the *Choices for Care* process were asked a series of questions.

Reasons for Placement

1. What common reasons do your patients/clients go from the hospital or home to a nursing home? Why can't they go home?

Transition Process

2. Explain the transition to nursing home process?
3. What are the perceived strengths of this process? What are the perceived weaknesses of this process?
4. What is your understanding of purpose of the screening process or *Choices for Care* program?

Recommendations for Improvement

5. What might make these processes have better outcomes at enabling older adults to move from the hospital to a nursing home and from a nursing home back to community residency?

<u>Responses from Focus Group Participants</u>

Reasons for Placement

Regardless of the source, all the stakeholders interviewed expressed similar reasons for older adults to be placed in a nursing home. The primary reason for placement was a continued need for medical and rehabilitation services. The more experienced discharge planners noted that much of this type of care was provided at the hospital prior to the 1983 implementation of the Diagnostic Related Groups (DRG) payment structure to hospitals. Nursing home placement was seen as an extension of treatment modalities that were initiated in the hospital which needed to be continued or monitored.

The discharge planners and case managers stated that Medicare home health benefits were limited; I.V. therapies, catheter care, and colostomy care that could be done in the home were not covered. There was also a common theme that families needed to be trained, and this could not be provided adequately prior to discharge. Additionally, discharge planners noted that many families expressed feelings of being overwhelmed by this type of care and did not want to accept this responsibility. Families also expressed concern about their ability to balance home and family responsibilities with the care of the older adult. The discharge planners reported that many older adults and/or their families could not afford to pay privately or did not think it logical to pay for treatments that were covered by Medicare in a skilled nursing unit.

The discharge planners and the case managers reported that the placement for medical and rehabilitation services was temporary. The older adult was told that once the continued medical care was no longer needed or he/she had realized the benefit of the rehabilitation, then the older adult would return home. In general, the discharge planners and case managers believed this to be happening. However, most of the discharge planners reported little to no follow-up with the older adult and/or his/her family after transfer to the nursing home. Those that did report follow-up stated it was often initiated by the older adult and/or his family requesting assistance with discharge planning from the nursing home. The hospital discharge planners' responses ranged from, "we refer the older adult to the nursing home staff" to "we help set-up the home and community-based services."

The nursing homes representatives reported that in general, they are aware of those older adults that will be returning home. Returning home was either part of the plan from the very beginning and indicated in goals set on the MDS assessment, or "those that are going home, tell us all the time." Nursing home staff also reported that they receive very little information concerning the older adult's history, home environment or prior home and community-based services from the professionals involved in the placement. They reported that their information comes mainly from the older adult and/or family.

The second most common reason for placement identified by the focus group participants was cognitive impairment. Safety in the community was viewed as a concern for older adults that were reported to be confused. The discharge planners especially voiced concern that the older adult required more supervision and stated that the case managers would only offer two or three days a week of the CCP program. While the discussions were not focused on service gaps, discharge planners and case managers voiced the need for intermittent service throughout the day or assistance over longer periods of time, in the evening and weekends. They reported that if there were more home and community-based options and especially alternative housing arrangements, that perhaps an alternative to the nursing home could be pursued.

Concerning cognitive impairment, again it was reported by discharge planners and case managers that families were feeling unable to provide or supplement in-home care and supervision. Discharge planners reported families were burned-out with care and supervision and juggling home and family responsibilities. Some of the discharge planners, case managers and nursing home representatives stated it was their belief that those families that say they wish to continue providing the care and supervision were often in need of the older adult's social security check. Consequently, placements did not occur when in their opinions, they should have taken place.

The third most common concern was environmental issues associated with the older adults' community residency situation. This response was heard more strongly in the Chicago area, and was echoed in the suburban and rural areas. A common expression of the discharge planners and case managers was that, "Oh, they just couldn't go home." The environment was either perceived to be unsafe, presented a health risk, and/or gas, electric or water utilities were not working.

The discharge planners and case managers reported that often a combination of these circumstances were present. Older adults, particularly ones with little or no social support from family and friends, decompensate in the community. This deterioration may be the result of untreated mental health issues and/or the inability to financially support themselves in the community. Dementia, malnutrition, and declines in the older adults' physical condition were also reported to contribute to difficulties in maintaining independence.

Several of the Chicago hospital discharge planners and nursing home representatives spoke of a subset of the older adult population that uses short-term nursing homes stays as respite from the struggles of daily life. This population of older adults appears to be borderline in their medical need for nursing home placement. They use the placement for rehabilitation and temporary housing offering room and board. They subsequently leave the nursing home prior to completion of the Medicaid payment process to the nursing home.

A common theme expressed by the hospital discharge planners and many case managers was that nursing home placement was a safer option. Chicago hospitals reported that they never know if an older adult receives the CCP services. The suburban and rural hospitals felt better about the communication with the CCUs. Additionally, the health department representatives felt that setting-up home and community based services, particularly medical services was not easy and may require several physician orders, particularly if home care did not go well initially.

In addition to the perception that nursing home placement was safer, it appeared that placement was easier than arranging home and community-based services. This was expressed most by the case managers and the health department nurses.

Transition Process

The discharge planners, case managers and nursing home representatives were fairly consistent and accurate in their articulation of the law, policy and procedures associated with screening. Many of the case managers expressed taking seriously the screening process and the offering of home and community-based service options. However, there also appeared to be general decline of the quality in the discharge planners and case managers' practice associated with the *Choices for Care* program's purpose and intent.

Many of the case managers, while stating they were offering choices, appeared to be restricting their efforts to only Community Care eligible older adults. This appeared to be true too for the discharge planners. In general, the discharge planners stated they refer to the CCU only Community Care eligible persons that they know are going home. Overwhelmingly, the discharge planners felt they had an excellent handle on home and community-based services. A case manager that made that statement subsequently cited the eligibility requirements for the CCP program inaccurately.

The discharge planners and the nursing home representatives also expressed that they felt the purpose of the screening process was completion of paperwork, rather than offering choices and options. A number of discharge planners reported that it was positive to have an outside entity, the CCU, validate the placement decision. A few stated that they use the process to invalidate the need when the physician requests nursing home placement and the discharge planner does not agree. These same discharge planners felt that they could then say to the physician, "the patient did not qualify for nursing home placement."

The nursing home representatives and discharge planners often saw the transition process as burdensome. The nursing homes representatives state they spend time searching for forms and documentation of the screening. We're told that a screening has been completed, only to find out later on that no screening occurred. When we call the discharge planner, his/her response is "I referred." Subsequently a call is made to the CCU and they report that no referral was ever made to them, and "we're (nursing home) out the money." This concern was expressed less in the rural areas.

A common concern from the nursing homes in Chicago including Cook and surrounding counties was that they did not know what CCU performed the assessment. Similarly, the discharge planners did not know what CCU to contact to arrange home and community-based services.

The discharge planners, case managers and nursing home representatives reported that communication was a significant problem. Many of the discharge planners reported that they did not know if the assessment actually took place, or what was the outcome of the assessment. Others expressed a high level of satisfaction with the communication between discharge planner

and case manager. The case managers state that they encourage early referrals and the discharge planners report that they will often refer early. The concern expressed by the case managers was they are not told of the actual placement or disposition. Nursing homes validated this comment by saying that they are often told by the CCU that they completed the screening, but did not know where to send the forms. However, all of the entities reported needing to know outcomes in an extremely brief period of time.

Discharge planners, case managers and nursing home representatives all reported that the current hospital and Medicare environment to discharge quickly put an unfair pressure on the transition process. The discharge planners and case managers stated that there was little time to offer alternatives to placement for those that had needs beyond home health care. Case managers reported being notified either so early that the older adult was in intensive care or minutes before the ambulance was transferring the older adult to the nursing home. Case managers also reported that they were often discussing nursing home placement with the older adult, before the topic was approached by hospital personnel. Based on some of the comments of the case managers, it appeared that alternatives to nursing home placement were raised when the older adult and/or family raised the concept of alternative options. Several of the case managers became quite passionate in expressing their advocacy role, if an older adult was refusing placement.

Focus Group Participants' Recommendations for Improvement

The case managers, discharge planners and nursing home representatives offered limited recommendations. However, there appeared to be a pattern in all of their responses that timing was a concern for older adults, families, significant others and professionals. The discharge planners were the most vocal group in suggesting that the screen be moved. They felt most strongly on this timing issue concerning the older adult transitioning to the nursing home for skilled care. It was their recommendation that the screen be moved to a date after the transfer from the hospital to the nursing home. The discharge planners also thought little discharge planning occurs at the nursing home, because staff has a lack of incentive to discharge. The discharge planners felt that having the CCU conduct assessments in the nursing home, might help in counter-balancing their perception of the nursing homes' lack of incentive to discharge. Nursing home representatives recommended that screenings be eliminated for the population coming to their facilities under the Medicare skilled nursing facility benefit.

Concerning the concept of moving the screen to the nursing home setting, several of the hospital discharge planners spoke of not having time in their schedule to assist older adults and significant others with discharge planning from the nursing home. In several of the meetings, discharge planners spoke of referring the older adult and significant others to the nursing home for assistance. One discharge planner put it succinctly, "I tell the families to go bug the nursing home; I can't help them."

The discharge planners spoke most strongly that in addition to a lack of incentive to discharge individuals from the nursing home, it was their opinion that most nursing home discharge planners lacked adequate training and credentials to perform the task. Several participants mentioned the term, "social work designee" at the nursing home, as being inadequately educated and poorly trained.

The case managers supported the present system of the pre-admission screening; however there were comments that suggested a mandated follow-up might lead to a better outcome concerning a return to community residency. One CCU representative stated that "we haven't figured-out a way to perform the follow-up." This statement was made referring to persons going to nursing homes out of their CCU's jurisdiction.

The case managers and the discharge planners felt that if older adults, families and/or significant others had more information prior to the decision making process, again there might be better outcomes. This issue appeared, in large measure, to the stress associated with making critical decisions in a very limited space of time.

All three groups felt that better outcomes would be realized if they had better communication and collaboration. The nursing home representatives reiterated that the two forms they receive from the CCUs offer little helpful information concerning home and community-based resources prior to admission to the nursing home. In two focus groups, nursing home representatives commented that they receive much better information pertaining to an older adult that has required a Level II PAS screen. The nursing home representatives and the rural Board of Health staff suggested use of technology as a means of communication. Both groups felt that if they could access data on-line concerning the older adult, this might again lead to better outcomes.

The nursing home representatives felt strongly that an improvement in the process would be to get the needed paperwork immediately upon admission to the nursing home. They again attributed a significant portion of this problem on timing, but also on not being able to validate that a screen actually occurred and by whom. A few suggested that the case manager could leave the form in the chart, and it would come with the transfer papers, or they could receive it electronically.

While the nursing home representatives were a bit less vocal on the need for more home and community-based options, all three groups felt that older adults and significant others had few options. The discharge planners felt most strongly that the CCP program was quite limited in what it offers and expressed concern about the quality of its service. A significant number of the discharge planners stated that when they approach CCP with their older adult patients, a common response is that "I tried it." There was an expressed concern about the quality of homemaker services and the limited number of hours for the older adult that is truly in need of nursing home placement.

Case managers also spoke of limited options for the older adult that is truly a nursing home candidate. It was a predominant feeling that three or four hours a day was inadequate. Older adults may need intermittent care throughout the day, and older adults, families and/or significant others lacked the financial resources to supplement the care. Additionally, the case managers and discharge planners spoke of insufficient community-based housing options, including various levels of care. Both groups suggested more affordable assisted living facilities and small group homes as options that would at the least offer medication management assistance.

Critical Issues Emerged

Based on the focus group discussions, a number of issues emerged concerning the nursing home screening process. These issues are highlighted on the subsequent Map of Illinois Department on Aging Choices for Care Process with Issue Points. It is believed that if these issues were more closely examined, Illinois' processes could produce better outcomes concerning transition and the intent of the Olmstead decision. Following the Map of Illinois Department on Aging Choices for Care Process with Issue Points, further analysis of our current policies and procedures and recommendations is provided by this researcher.

Map of Illinois Department on Aging Choices for Care Process

Older adult is living in the community and requires hospitalization or nursing home placement

Older adult is admitted into hospital

Older adult is discharged with no services

Older adult is referred for discharge planning

Critical Issue: Who is Referred? Discharge planners vary in referring older adults especially those believed not to be eligible for CCP.

Older adult is interviewed (usually face-to-face) by discharge planners

Older adult is discharged home with home health and/or private pay or no services.

If discharge planner is certified, HFS 2536 & Level I are completed

Critical Issue: Purpose Discharge planners question process esp. re. necessity for short term placements under Medicare.

CCU is contacted

CCU conducts a face-to-face assessment. If older adult is in hospital or the community & in imminent risk of nursing home, assessment is to occur within two calendar days of referral/request.

Older adult is discharged home with CCP and/or home health and/ or private pay or no services.

Critical Issue: Limited time CCUs report older adult is sometimes unaware of referral or never seen by discharge planner.

Critical Issue: Purpose Are HCBS options offered?; CCUs offer options or simply validate already made decision?

Older adult is faced with a choice. Nursing home or community residency? The older adult may request follow-up by the CCU to be conducted after admission to the nursing home.

Older adult is discharged home with home health and/or private pay or no services.

Critical Issue: Information Nursing homes report limited knowledge of resident's prior HCBS.

Critical Issue: Limited Options CCUs & discharge planners report that older adults &/or families must decide on options very quickly; All stakeholders report limited housing options.

Older adult &/or significant others request CCU assessment

CCU contacts older adult and/or significant others per requested follow-up

Critical Issue: Paperwork Timing of paperwork completion & who gets it?

Critical Issue: Timing & Frequency Older adult's health may improve & no CCU follow-up planned.

Critical Issue: Follow-up CCUs appear to vary in their response. Some have procedures from limited to aggressive follow-up; others have no procedures.

CCU conducts a face-to-face assessment in nursing home. (Older adult maybe assessed at home following nursing home discharge)

Older adult continues to reside in the nursing home. There continues to be an option of contacting the CCU to assist with discharge planning.

Older adult is discharged home with CCP and/or home health and/or private pay or no services.

Analysis of Current Policies and Procedures and Recommendations

(1) The role of the CCU case manager of providing alternatives to nursing home placement, per the intent of the law, needs to be re-established.

(2) Case manager, hospital and nursing home discharge planners' practice standards need to be improved.

***Critical Issue:* Who is Referred?**
Discharge planners vary in referring older adults especially those believed not to be eligible for CCP.

Illinois' *Choices for Care* processes appear to support in principle the intent of the Olmstead decision and the current direction of the Centers for Medicare and Medicaid. It appears based on what the CCU case managers, hospital discharge planners and nursing home representatives said, the intent of the Illinois statues and the Illinois Department on Aging's policies and procedures are not carried out in actual practice.

***Critical Issue:* Purpose**
Discharge planners question process esp. re. necessity for short term placements under Medicare.

Medicare changes have impacted where the older adult is to receive care, financial pressures have incentivized quick discharge and the CCU case manager does not have the time to offer real choices in care. Discharge planners maintain that it is their role to facilitate the discharge plan. They view the CCU case manager as either the professional to validate their action or help fast track CCP services. It is unclear why the role of CCU case manager is not more fully utilized for offering home and community-based options. The reality is that it varies throughout the state. Referrals to the *Choices for Care* program for non-nursing home candidates appear to be used primarily for only the older adult perceived to be eligible for CCP.

***Critical Issue*: Purpose**
Are HCBS options offered?; CCUs offer options or simply validate already made decision?

Nursing homes' purpose needs to be more clearly defined. Are they end-of-life, long-term residential care facilities or short-term facilities? If they identify themselves as short-term facilities, concerns were expressed that more knowledgeable and skilled individuals are needed to assist and advocate for home and community-based service options. Additionally, **CCU case managers and hospital discharge planners need to think of home and community-based services as the plan, and nursing home as the alternative.**

(3) A legislative and procedural mandate for nursing home follow-up and offering of community alternatives is necessary.

***Critical Issue:* Purpose**
Discharge planners question process esp. re. necessity for short term placements under Medicare.

Where is the discharge planning? In large measure because of the changed role of the acute care hospital in relationship to the nursing home, hospital stays are very short. There is pressure to send the older adult to a step-down facility for rehabilitation and continued treatment. Discharge planners stated that suggesting nursing home, as a short-term option is frequently used. The need to facilitate the discharge plan, in many cases, has shifted from the hospital to the nursing home.

***Critical Issue:* Limited time**
CCUs report older adult is sometimes unaware of referral or never seen by discharge planner.

Hospital discharge planners admitted not usually knowing what happens to the older adult once transferred to the nursing home and the current documentation allows the older adult to remain in the nursing home for the remainder of his/her life.

***Critical Issue:* Timing & Frequency**
Older adult's health may improve & no CCU follow-up planned.

One group of nursing home representatives stated that you know who the short-term stays are. They tell you all the time. However, what happens to the older adult that is not a self-advocate or does not have someone to advocate for them? The disability advocates stressed this point. Again, continuity of care, communication and care planning needs to be improved. The responses from nursing homes appear to be varied. Older adults that are admitted to nursing homes for short-term rehabilitation stays may receive excellent assistance with discharge planning and linkages to home and community-based services. However, short-term stays may become long-term stays because no one, but the older adult and significant others viewed the stay as short-term.

(4) Continuity of care and care planning needs to be improved; the assessment information should travel with the older adult.

***Critical Issue:* Limited Options**
CCUs & discharge planners report that older adults &/or families must decide on options very quickly; All stakeholders report limited housing options.

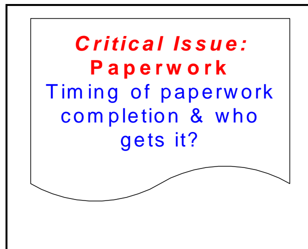
As stated previously, short-term stays become long-term stays. This development may be due to a complete change in the professionals attending to the health and welfare of the older adult. New physicians, nurses and social work designees are unaware of previous plans and/or community resources.

***Critical Issue:* Follow-up**
CCUs appear to vary in their response. Some have procedures from limited to aggressive follow-up; others have no procedures.

CCU jurisdictional boundaries appear to be problematic in Chicago, suburbs and surrounding counties. While CCU nursing home follow-up appears to be excellent in some areas, particularly when it involves all the same CCU, in other areas it goes from being limited to non-existent. The older adult that leaves their home CCU area for either hospitalization and/or nursing home placement appears to have the opportunity to get lost in the system.

(5) Older adult and family's access to information and the delivery of information needs to be improved.

All the groups spoke about not having enough information concerning the older adult, and the older adult and significant others not having enough information pertaining to options prior to making critical decisions. These issues extend to who is the conveyor of the information. It also relates to issue #4, the need for continuity of care and care planning.



Related to this issue, nursing homes need to receive their required paperwork. It is unfair to expect nursing homes to assume financial responsibility for an older adult based on what is said and not documented.

Potential Solutions

(1) The role of the CCU case manager of providing alternatives to nursing home placement, per the intent of the law, needs to be re-established.

(2) Case manager, hospital and nursing home discharge planners' practice standards need to be improved.

- The Illinois Department on Aging needs to provide adequate financial incentives and training support concerning the various policies, procedures and statutes related to the screen. The intent of Olmstead and the concept that an older adult will be going home and nursing home care is the alternative choice needs to be institutionalized.
- The Illinois Department on Aging needs to monitor CCU compliance in relationship to the screen.
- Case managers must receive training in aging issues, including ethics' training beyond CCP eligibility standards. This training should lead to a certificate in aging and be tied to the case manager's DON certification. IDOA should provide the financial support for this training and monitor compliance

(3) A legislative and procedural mandate for nursing home follow-up and offering of community alternatives is necessary.

- Continue to screen all potential nursing home candidates prior to hospital discharge with the exception of Medicare skilled nursing recipients. However, change the law that makes the HFS 2536 and Level I to **be time limited and expire**. Placements should be viewed as temporary and require validation assessment(s) to become permanent.
- Require a mandated screen of the Medicare skilled nursing recipients between the 7th and 14th day to validate the need for nursing home placement and assist in the discharge planning process.

- Require that all nursing home admissions be seen within 30 days of admission to assess the potential for discharge and validate the need for placement. Documentation would be affirmed at this assessment by either validating the placement as permanent or continuing its temporary status. Older adults that express a desire and/or appropriateness for community residency would continue on a temporary status.
- Continue to follow-up all older adults by community-based CCU case managers that either express a desire and/or appear appropriate for community residency. These older adults would remain active CCU clients regardless of his/her financial status.

(4) Continuity of care and care planning needs to be improved; the assessment information should travel with the older adult.

- Develop and implement a process that uses technology where CCUs can observe the older adult's assessment history and plan of care. This is critical to address the boundary issues identified in Chicago, its suburbs and surrounding counties.
- Consider the concept of one case manager following the older adult across all settings along the continuum of care – community, hospital, nursing home and community. By considering this change, the CCU boundary issue will be addressed and continuity of care improved.
- Develop and implement a process and/or form that would share information concerning an older adult's in-home supports prior to hospitalization and/or nursing home placement that can be reviewed by nursing home and CCU staff to be used for MDS nursing home documentation, nursing home discharge planning and CCU follow-up.
- Link IDOA and CCU assessment tools to the MDS Nursing Home Assessment Tool where information can be shared and mutual goals defined.

(5) Older adult and family's access to information and the delivery of information needs to be improved.

- Support efforts where case managers, hospital discharge planners, nursing home representatives, older adults and significant others, including caregivers have access to information concerning home and community-based resources.
- At the time of hospital admission, all older adults, and families and/or significant others should be given a brochure and information pertaining to the screen process. In addition, hospital admission personnel should be required to share the brochure and information.
- The same brochure and information must be presented by the CCU at the time of the screen and nursing home follow-up assessment(s).

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Clarification of Roles and Responsibilities of Existing Aging Network Providers Participating in the Nursing Home Transition Process

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August 2006

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Printed by Authority State of Illinois (8/06)