State of Illinois
Rod R. Blagojevich, Governor

Illinois Department on Aging
Charles D. Johnson, Director

Older Adult Services Advisory Committee

Point of Entry Work Group

Date: October 14, 2005

Location: Baby Bulls, Pontiac

Attending: Jonathan Lavin (Co-Chair), Paul Bennett (Co-Chair), Ross Grove (Illinois Department on Aging), Alan Factor, Karen Freda, Chloe Frooninckx, Becky Gillen, Carolyn Guthman, Martha Holstein, Marsha Johnson, Jay Lewkowitz, Laura Prohov, Susan Real, Amy K. Riesser, Karen Schainker, Barbara Schmal, and Cathy Weightman-Moore

Jon began the meeting stating that several members had different perceptions of our last meeting, and it was his impression that we needed to talk about neutrality, comprehensive case management, AIRS and who is responsible for the completion of a comprehensive case management. Jon reported that the comprehensive assessment was given to the CPE sub-committee by the Services sub-committee for resolution.

Members inquired re. the OASAC committee's response to our list of top priorities. In general, the larger OASAC committee supported the concept of a Coordinated Point of Entry and its Access Points, but many questions arose re. definitions of our components. It appeared that in large measure because of the needed clarification re. defining the components, the OASAC committee requested that the number of demonstration sites be deleted from the recommendation.

The following items were subsequently put forward as agenda items re. the Coordinated Point of Entry and its Access Points:

Discussion of what is meant by consultation? In response, there was an explanation that the presenting problem given by the consumer may not necessarily be the real problem. The role of consultation serves as a means to assist the person seeking to clarify their need and direct them appropriately.

A question was raised about whether benefits counseling at this point was appropriate in the process and that the person seeking assistance again may not be ready for a comprehensive assessment.

In regards to how this differed, consultation from comprehensive assessment, it was stated that the comprehensive assessment provides a wholistic approach where not only the area for where a person might be seeking assistance is discussed, but 10 to 12 various domains, including physical and mental health, environment, social supports, transportation, finances, nutrition, among others are examined in order that a system's approach be applied in the assessment of the older person's needs.

The question of why and purpose of a mini-assessment was brought-up and again, the thought was that some consumers may not need a full comprehensive assessment.

The point of verification and screening was clarified as only the point where it is determined if the consumer is at the right place for help. Should they be contacting a different organization? E.g. Are you over 60 years of age? Verification and screening was not an assessment.

The group felt that we needed to not only define the mini-assessment, but verification and screening vis-à-vis the mini-assessment? We needed to identify the triggers in a mini-assessment that leads to a full comprehensive assessment.

An attempt was made to categorize the issues as to where they fit in the process and flow-chart.

Issue #1
(Verification) This process must contain information from a state-wide standard on all available federal, state, private and local programs that the local CPE has access, and the responsibility to up-date all local resources.
(Verification) Should contain a standardized profile provide for each organization
(Verification) Offer information via telephone, face-to-face and through a web-based system.
(CPE) A trained professional
(CPE) A call received at an access point must link to the local CPE.

In regards to the whole concept put forth re. the CPE, the general discussion stated that:

- We should build upon existing systems, and we have an opportunity to defined attributes;
- New system should not fragmented and recognizable.
- We are not re-creating another layer or a totally new system, but we should build on existing system of providers.
- It was again stated that there should be a single recognizable phone number which as possible, directly connect to the local CPE.
- Resources that are standardized with a core set of information and as much of it as possible be web-based or web accessible.
- Information be up-to-dated, with someone responsible for it,must be related to older adults and families, and must include information on LTC options for older people of all economic backgrounds.

A question was raised whether a resource center had to be a place and if resource centers were actually used by consumers.

Discussion moved to Goal #5 with the addition that it should state in the CPE definition that it have trained personnel that are AIRS & SHIP certified and knowledgeable of rules re. the state's CCP program.

Attendees were okay with Goal #6.

The CPE should provide a smooth linkage with comprehensive assessment and care planning. This statewide comprehensive management system should have standardized practices that include the documentation of gaps in services with reports produced that identify patterns.

A couple of attendees raised concerns re. the role of private case management vis-à-vis the comprehensive assessment. The decision was that we should defer this discussion at this time. It was however stated by a couple of attendees that the present CCU system sees all clients regardless of their

socio-economic background. Current CCUs are not simply assessing for the Community Care Program, but it is hoped that with the adoption of a state-wide comprehensive assessment and funding for comprehensive assessment, enhanced standards in practice would be realized.

One attendee suggested that perhaps we should consider only not-for-profits be allowed to administer the comprehensive assessment. Another member stated that the not-for-profits were not too different from the for-profit re. concern for the bottom-line, but the issues again related to standards of practice and expectations.

There was also discussion re. whether providers of case management could provide additional services. There was a desire for them to be independent, non-biased brokers of service. There was also a statement that if we went as providers that only provided the case management service, it might knock out many of the current CCUs and not be financially viable for the entity to exist.

The thought was that we needed to do more homework in this area and particularly look at current CCP rules and Older Americans Act regulations. It was decided that:

- Susan Real would bring information re. private case management.
- We needed to look at the ADRC
- Ross would bring-in CCP rules
- Karen F. would bring her Interagency agreements
- Martha H. would search the ethics literature
- Jon – How OOA has changed

Future discussions needed to continue re.

- Neutrality issues
- Role of care management/case management, public and private

Meeting was adjoined with the date set for November 11, 2005 at 10:00 a.m. in Pontiac. Exact location to be determined.

Respectfully submitted.
Paul H. Bennett