State of Illinois
Illinois Department on Aging

Older Adult Services Advisory Committee
Meeting Minutes

Date: February 22, 2016 1:00 - 3:00 p.m. (Minutes approved May 16, 2016)

Locations:

Illinois Department on Aging, 160 N. LaSalle St., 7th floor, Chicago
Illinois Department on Aging (at the DNR bldg.), One Natural Resources Way, Springfield

IN ATTENDANCE: Committee Members
Carol Aronson- Shawnee Alliance for Seniors
June Benedick – Parish Nurse St. Paul Lebanon & St. Mark Lutheran
Cindy Cunningham – Illinois Adult Day Service Association
Kelly Fischer – Journey Care Hospice
Jan Grimes – Illinois HomeCare and Hospice Council
Sherry Barter Hamlin – River-to-River Residential Corporation
Robyn Golden – Rush University Medical Center
Lori Hendren – AARP
Susan Hughes – UIC Community Health Sciences School of Public Health
Michael Koronkowski – UIC College of Pharmacy
Jonathan Lavin – AgeOptions
Dave Lowitzki – SEIU Healthcare Illinois and Indiana
Phyllis Mitzen – Health and Medicine Policy Research Group
Susan Real – Caregiver – East Central Illinois Area Agency on Aging
Cathy Weightman-Moore – Catholic Charities LTC Ombudsman Program
Ancy Zacharia – Home Care Physicians

Ex-officio Committee Members:
Jean Bohnhoff, Director – Department on Aging
Jamie Freschi – State Long Term Care Ombudsman
Kelly Cunningham– Department of Healthcare and Family Services
Megan Spitz – Illinois Housing Development Authority

Guests:
Renae Alvarez - Health and Medicine Policy Research Group
Katie Cunningham – Adult Day Services
Teresa Collins- Senior Services Plus
Sharon Post – Health and Medicine Policy Research Group
Amy Brown- CRIS Healthy Aging
David Vinkler - Molina Health

Department on Aging staff:
Jodi Becker, Alex Burke, Betsy Creamer, Elizabeth Delheimer, John Eckert, Mary Gilman, Sophia Gonzalez, Jose Jimenez, Lora McCurdy, Jennifer Reif

NOT IN ATTENDANCE: Committee Members
Jennifer Belkov- Alzheimer's Association, Greater Illinois Chapter
Andy Chusid – Health Care Council of Illinois
Dr. Thomas Cornwell – HomeCare Physicians
Terri Harkin – SEIU Health Care – Illinois and Indiana
Michael Koronkowski – UIC College of Pharmacy
Samantha Olds Frey – Illinois Association of Medicaid Health Plans
Patricia O'Dea-Evans – A Silver Connection
Jason Speaks – Leading Age Illinois

Ex-officio – Committee Members not in attendance:
Debra Bryars – Department of Public Health
Linda Gonulsen – Department of Human Services
Representative – Department of Veterans Affairs
Representative – Governor's office

Introductions:
Director Jean Bohnhoff called the meeting to order, welcomed everyone to the meeting and introductions were made.

Approve minutes of Full OASAC Meeting:
John Eckert asked everyone to review the minutes from November 16, 2015 and asked for a motion to approve the minutes. Phyllis Mitzen noted that the minutes were good descriptions but that there were several follow ups that have not been addressed. OASAC had requested additional details under the Nursing Home diversion project and the MCO's. Jamie Freschi noted that her last name had an incorrect spelling. John agreed to make sure that any follow ups from meetings are addressed in the future and to correct and review the names. Carol Aronson made a motion to approve the November 16, 2015 meeting minutes with the correction, Susan Real seconded. The minutes were approved unanimously. John asked everyone to review the meeting minutes for December 11, 2015, again it was noted that there were follow-up areas that had not been addressed and some of the members' names appear as being present and absent. Phyllis Mitzen made a motion to approve the meeting minutes for December 11, 2015 with the name corrections, Carol Aronson seconded. The minutes were approved unanimously.

The Bridge Model Presentation:
Robyn Golden thanked everyone for the opportunity to present on the Bridge Model. Robyn noted that she was very excited that this model has been adopted by other States. The Bridge Model is not a one size fits all approach; it must meet the specific needs of an individual, even the most vulnerable and is built on connections between the community and the hospitals. The Bridge Model is a community-based transition model that was created under the Affordable Care Act (ACA). The provisions from the ACA have helped people access preventive services that include the acknowledgement of well being and there has been a shift from fee-for-service to outcome-based services. Robyn noted the importance at looking into social factors that influence health outcomes and the need to develop better payment structures. Other examples of transitional care models include the Eric Coleman Transitional Interventions. Transitional Care looks at re-admissions to hospitals and unnecessary costs by working with individuals during the time when they are more fragile, during post hospital discharges. It was also noted that a section under the ACA penalizes hospitals if patients are readmitted, even if the re-admission is to a different hospital. Robyn noted the importance of providing care beyond the hospital discharge and how families may become inundated with discharge plan information and medications: and are expected to care for the person being discharged not taking into consideration that psychosocial issues may be involved.

Robyn noted the Bridge Model began as Rush University's Enhanced Discharge Planning Program (EDPP) in 2005. Aging Care Connections in La Grange liked this model and created their replicated model, in which they brought the community into the hospital to maintain a client-centered care transition. In 2014, the Bridge Model became National and a collaborative was launched. The Bridge Model core components include the community providers and the hospital, with the Bridge Care Coordinator (BCC) facilitating the collaboration. The Bridge Model transition can be delivered in-person but is mostly telephonic, with the first contact occurring within 1 to 2 days post discharge, and continued for 30 days (in which 20-25 contacts are made). The importance of building a relationship with Primary Health Physicians was noted. Robyn also noted that the Bridge Model has been replicated in 65 sites that have been trained and it is the 2nd most replicated transitional care program. Renae Alvarez noted that she works on BMC monthly webinars and calls, along with Sharon Post. Robyn mentioned that she has been collaborating with two other OASAC members (Phyllis Mitzen and Carol Aronson) on the Bridge Model for the past 8 years. Robyn asked everyone to refer to the presentation handout for additional information.

Carol Aronson from Shawnee Alliance Care Coordination Unit presented on how Shawnee became involved with the Bridge Model program by looking at what they were already doing; preventing premature Nursing Facility admissions/placements. Shawnee thought the face-to-face visits in the hospital settings would be a good fit for the service area they work with. For individuals to have an opportunity to speak to a Care Coordinator in the hospital setting after being discharged worked along with the development of ADRCs. Carol reported that Shawnee worked in Memorial Hospital in 2008 and 2009. She mentioned that the Carbondale University Mall opened a space where hospital staff and Shawnee Alliance staff provided access to healthcare resources. This location within University Mall also served as an ADRC for Shawnee. Carol reported that their Bridge Model Coordinators bring experience into the hospitals, participate in "huddles" which are discussions with patients and develop client-centered plans. They are part of an inter-disciplinary team that works intensively with the hospital staff. She explained that in Southern Illinois, half of the counties do not have a hospital or doctor within 100 miles. Respiratory Disease was noted to be common in Southern Illinois. Shawnee Alliance Bridge Care Coordinators are required to have a Master's degree and specific hours of experience.

Amy Brown from CRIS Healthy Aging shared about a cross analysis study that her agency completed with regards to transitional care in their service area. Amy stated that they reviewed readmission reoccurrences for 90 clients in hospital and found that lack of transportation to be an issue. Amy shared that the study looked at 30 day re-admission reoccurrences; where contact was made at days 2 and 10. It had had been noted that day 7 was right when readmissions tend to reoccur; the CCU rapid response during this time is crucial. Amy stated that she would send a Power Point on this information to the Department to be distributed to the Chicago participants. One member began a discussion on being able to identify risk areas that would prevent the readmissions. Some risk areas may be transportation, pain within a community, mental health, family caregiver and home delivered meals in rural areas. Amy noted that visiting someone within 2 days after a hospital discharge and just bringing something to them is a gateway to build a rapport with the person. June Benedick mentioned being a Parish nurse, she is able to go to the patient's home and check on them and she would like to be able to go into the hospital and introduce herself and provide resources versus only attending emergencies. Amy also shared that there are only a few mental health professionals that specialize in Geriatrics. One of the OASAC members noted that the Bridge Model is a fantastic model and asked if there has to be a specific number of patients in the hospital for this to be cost effective? Robyn responded that it would depend on where you are but a BCC can cover more than one hospital and look at high risk categories. Carol shared that being a rural area, Southern Illinois has only two hospitals and BCC's are scheduled with both hospitals. Amy stated that a program with 140 cases a month, with 2 full time staff (Bridge Coaches) would be $143 per case and would generate enough revenue for it to be cost effective. Director Bohnhoff thanked all three presenters.

Community Reinvestment Program:

Deputy Director Jennifer Reif led the discussion on the new program that the Department was developing that was introduced as part of the Governor's FY 2017 proposed budget: the Community Reinvestment Program (CRP). This program is being rolled out by the Department as a pro-active approach to maintain quality services in the community in anticipation of the growth within the aging population in the State. Some of the questions that the Department has been trying to answer are the following: How are we going to service older adults in the future with this growth? How are we going to sustain older adults in their home? CRP will provide the necessary supports and flexibility in service provision to enable older adults to remain independent, enjoy a quality life, and avoid premature institutionalization. CRP is targeted to individuals who are not eligible for Medicaid and have a DON Score of 29 or higher. These individuals will be eligible for a package of home and community-based services that include core services as well as locally driven services that are unique to each of the Area Agency on Aging's 13 Planning and Service Areas (PSAs). CRP is a network driven program in which the role of the Aging network (led by the AAAs and CCUs) will be to serve older adults, make referrals, complete assessments, and work with the individual to develop person-centered plans to establish the needs of the older adult.

A member commented that the growth of CCP has decreased Nursing Home placements. Jennifer stated that that was one of the primary reasons for CRP to meet the increased demand to keep people in their homes. Lori Hendren raised a question regarding Service Cost Maximums and JCAR rules. Jennifer responded that that information is not currently available because the Department is still working on those numbers as well as finalizing the draft rule in collaboration with the Governor's office. It was clarified that comments are being solicited from the network at this time and that JCAR rules will not require legislation. Jennifer stated that a notice of publication is required and the plan is to roll out CRP effective July 1, 2016 (FY17). No specific dates are known at this time for the first notice of rules. Lora McCurdy added that the Department will need feedback on what type of evaluation process needs to be put in place for CRP. A question was raised regarding what was meant by core services versus optional services under CRP. Lora clarified that CRP will be modeled after CCP and core services include EHRS, In Home Services, Adult Day Services, Home Delivered Meals and Medication Dispensing Machines when it becomes part of CCP. The Department is currently making changes to the CCP rule for Medication Dispenser providers as there are currently no providers that meet the current rule requirements. For CRP, each PSA will determine what their geographic needs and services will be developed to respond to those needs (e.g., home modifications and/or fitness club memberships) and maintaining a quality life in their home. Jose Jimenez added that all available services under CCP, Title III services, Nursing Home Diversion services (transportation) will be included under CRP. The PSA's will have flexibility in the areas to combine Title III services and CCP services in a holistic person-centered approach.

OASAC members had many questions and comments regarding CRP. A member asked what the funding streams for CRP would be. Jodi Becker, the Department's Chief Fiscal Officer, responded that funding would come from the Commitment to Human Service Fund.. Clarifications were requested by Dave Lowitzki regarding the estimated $93.3 million dollars needed over the next 6 years to sustain CCP and the CCP growth rate; that this amount is too low given a growth rate of 8-12% annually. The Department responded that the purpose of CRP was not only to address the dollar amounts but to have flexibility in meeting the needs of a growing older adult population. Phyllis Mitzen questioned how the Department anticipates saving $197 million dollars and report that no persons will lose services. The Department responded that the savings would come from the actual service that needs to be provided; perhaps the actual service could be obtained and provided at a lower cost. Another question was what type of evidence the Department has for the savings being anticipated. Again, the response was the need to look at individual care plans and see how many hours of services a person is receiving. It was noted by the Department that they looked at what other States were doing with alternative programs like CRP (e.g., Minnesota, Indiana and Wisconsin). It was mentioned that Area Agencies on Aging (AAAs) were not designed to be able to look at what kind of service gaps are occurring with their service areas. The Department responded that the funding for the AAA's was not changing, each Planning and Service Area is different and each AAA can customize the way services are delivered, similar to how AAA's deliver Title III services at this time. The Department has scheduled a call with the AAA's for tomorrow to further discuss CRP

and detailed roles of entities. Members continued to express concern regarding the anticipated spending and savings amounts reported and the limited details provided by the Department on this new program.

One Member mentioned that it was a good idea to look at each Planning Service Area's needs to determine how we can best deliver these services. Another concern raised by the Members regarding CRP was if the AAA's would be able to service the limited English speaking populations, as the CCU's have been able to. Clarification regarding the role of the CCU's with CRP was provided by the Department. The CCU's will request services, determine the DON scores, assess eligibility (just like they do for CCP) and if the person is non-Medicaid, then they will contact the AAA to determine what services are available in that specific area. CCU's will have the responsibility to work with the AAA's to meet the needs of the individual. Care Coordinators will make sure that the needs are met. Carol Aronson noted that just like under the Bridge Program and the Nursing Home Deflection Project, a determination needs to be made on the spot because time is of essence. The Department responded that the communication between the AAA's and the CCU's will be crucial. Again the issue of AAA's not being aware of the service gaps was mentioned. Jose responded by stating that trainings will be needed to break these silos. Other questions asked were if the package of service has already been developed and are interim services going to be available under CRP? Questions regarding CRP and people under Spend-down were asked. One Member asked if CRP would conflict with the Balancing Incentive Program (BIP) goals. Lora responded that CRP does not conflict with any of the BIP goals (NWD, Core Standardized Assessment, or Conflict Free Case Management).

A concern was raised regarding the initial applications that have not been approved for Medicaid, the CCU assists the applicants in applying for Medicaid, will these individuals that have a pending Medicaid application be able to receive CCP services or will they receive CRP services? The response was that CRP services would be received while the Medicaid application was pending and if approved the individual would be transferred back to CCP. The issue about needing services right away was raised. The Department requested ideas from OASAC regarding putting in place Emergency Interim Services, perhaps for those individuals being discharged from the hospital. It was also reinforced that CRP is a flexible program that will need to be evaluated as it is implemented at least for the first couple of years. It was noted that communication between the Department and Aging Network will be critical. Some of the data that the Department will be looking at are the additional services provided, for example the utilization of a home modifications (e.g., installing a ramp) and then look into adding these services to the Waiver. An OASAC Member advised the Department to look at other critical need areas that affect Nursing Facility placement.

Fiscal Update:

Jodi Becker, CFO reported that the FY'17 budget request included an addition of $3.3 million for home delivered meals and for a HDM rate study. $1.0 million was requested for AAAs to implement the No Wrong Door/UAT Level I. And $1.9 million requested to implement a revised Case management client data base. There were no new additional funding requests beyond the three noted.

Adjournment:

Jon Lavin made a motion to adjourn. Cindy Cunningham seconded the motion. The motion was approved unanimously. The meeting was adjourned at 3:07 p.m.