MINUTES
Utah Commission on Aging
August 19, 2009
12:00 – 2:00 pm

Commission Member Attendees:	**Representing:**
Maureen Henry	Executive Director
Norma Matheson	Honorary Chair
Mark Supiano	Higher Education
Kim Soper for Diana Kirk	Financial Institutions
Scott McBeth for Shauna O'Neil	Area Agencies on Aging
Michael Deily for David Sundwall	Department of Health
Deborah Bayle	Charitable Organizations
Laura Polachek for Rob Ence	Advocacy Organizations
Nels Holmgren for Lisa-Michele Church	Department of Human Services
Kent Alderman	Legal Profession
Gary Kelso	Long-Term Care
Suzanne Allen (via phone)	Public Transportation

Other attendees:

Donna Russell	OPG

The meeting was called to order by Norma Matheson.

1. **Welcome, Approval of Minutes, and Lunch**
   The minutes from June 16 were not approved, due to a lack of quorum of members.

2. **Introduction to Aging and Disability Resource Centers**
   In late June, a grant opportunity was posted on the grants.gov website for Aging and Disability Resource Centers (ADRCs). The ADRCs have been around as pilot opportunities since 2003, and are a cooperative effort between CMS and the AoA. The theory behind this federal program is that better cooperation is needed between the disability services offered through Medicaid, Medicare, and the aging side of services; also, better cooperation is needed between facility-based care and community-based care, especially in regard to long-term services within states. Funding was awarded in 2003, 2005, and 2008. In 2009, Utah was one of five states that does not have ADRC funding. The overall assessment of the program is mixed; however, it is clear from a press release that the federal government would like to see an ADRC in every state, and is willing to fund them.

   Mandatory state partners in ADRCs are: Medicaid, DAAS, and DSPD. None of these agencies wanted to take the lead on the ADRC; however, all agreed that they would be supportive of another agency taking the lead. 211 was considered as a possibility; however, it is not an instrumentality of the state, which is a requirement of the grant. After some research, it was determined that the Commission is eligible and would be the

lead agency for submission of the grant for an ADRC in Utah. The grant is $750,000 over three years. Nels explained that the state agencies he represents did not apply for this grant because their sense was that there was a general dissatisfaction from those states that had applied for the grant; Nels also felt that it was more worthwhile for the Commission to apply for the grant, as the Commission has other options that are not available to state agencies. Nels also expressed concern that the grant is seed money, and that it will take much more in the way of dollars to sustain the ADRC; the state does not want to affect funding for the AAA's. The state agencies support the concept and wish to be involved should the Commission receive the grant. Maureen stressed that the Commission does not want to interfere with the funding streams or the missions of the AAA's or DHS. Maureen wrote a very strongly-worded letter to the program officer at AoA stating that the Commission would not and could not apply for the grant if the obligations for the state were bigger than the grant document indicated. As this will be a cooperative agreement with AoA, it will be more of an interactive process with AoA than if it were simply a grant. The Steering Committee will ultimately decide what will be done with the funds.

Mark stated that, while there may be some risks in applying for the ADRC, there may also be greater risks in not applying in terms of future funding. Future funding may be tied to the existence of an ADRC. The Commission's proposal was to put a plan in place for an ADRC, according to the minimum requirements of the RFP. The plan will create a Steering Committee and then have one pilot site operational within one year; the pilot site will provide individualized counseling. The Steering Committee will be comprised of the mandatory parties under the grant; to include, DAAS, DSPD, Medicaid, CILs, AAAs, 211, Access Utah Network, and others.

Scott stated that future funding will be tied to whether or not Utah has systems that provide access to long-term care. The Older American's Act is the key piece of legislation at the national level; it was reauthorized in 2006, and states that the AAA's have the authority to be involved in long-term care. There is current legislation titled "Project 2020," promoted by the state units on aging for seamless, person-centered access; an ADRC will serve this purpose. Other areas of this legislation include evidence-based programs and nursing home diversion.

Maureen presented a Powerpoint titled "**Aging and Disability Resource Centers: An Overview of AoA'sVision and the ADRC National Initiative: December 2008."** The mission of AoA is to help elderly individuals maintain their independence and dignity in their homes and communities through comprehensive, coordinated and cost-effective systems of long-term care, and livable communities across the U.S. The strategic priorities of AoA are to:

1.Empower older people and their families to make informed decisions about, and be able to easily access, existing health and long-term care options.

2.Enable seniors who are at high-risk of nursing home placement to remain in their own homes and communities for as long as possible if that is their preference.

3.Empower older people to stay active and healthy through evidence-based disease and disability prevention programs.

4.Ensure the rights of older people and prevent their abuse, neglect and exploitation through adequate Elder Rights Programs.

5.Promote effective and responsive management of AoA human capital resources and grants funds through implementing a system of sound financial controls.

The strategic plan is important due to the boomer phenomenon, rapid growth in Medicare and Medicaid Program expenditures, and the current economic downturn and state budget crises. The aging population climb in Utah is steeper than the national average. Utah does not follow the national trends in regards to usage of nursing facilities. The average cost of nursing home care in the US is $74,095. The average cost of assisted living in the US is $34.860. Utah falls below these national figures. AoA wants to focus on the high-risk to nursing home placement and spend down to Medicaid group. Utah does not have a lot of data on this risk group; an ADRC can be used to research the data and develop models. The individual living in the community is the center of the ADRC program, there needs to be coherent systems of management; the person should be self-directed and have individual control in legislation, policy and practices. Access is necessary in the form of comprehensive information, simplified eligibility, and single access points.

Utah is already doing well in many of these areas. The e-REP Program has been working to modernize the Medicaid application and eligibility process. One portion of this program will begin rolling out in October 2009. This computerized single-access eligibility system already has 10,000 enrolled in the program. One of the requirements of the ADRC is a single-application point for federal programs. Utah can say it is already complying with this requirement, as well as other components of the ADRC; Utah could actually be a model very quickly, as procedures are working well already.

One very important issue for the ADRC is to get people educated on the very complex nuances of long-term care, and Medicare versus Medicaid; the goal is to get everyone in a position to do so to provide the same accurate information. Another very important issue is quality of care in the home, which does not have the same rigorous oversight as in nursing facilities.

Using the model for the AoA investment in coherent systems management, access is provided by the ADRC; services provided by the Older American's Act are delivered by the AAAs and CILs. The information must be uniform; 211 or the Utah Cares Database will probably be the primary statewide source. Individualized counseling will be provided in the ADRC(s). DWS' newly created Eligibility Division has committed to

provide the training to the counselors. Telephone counseling would be provided to those in communities not served by the ADRC(s). Quality control will be a necessary component of the ADRC.

The ADRC needs to focus on everyone, not just low-income adults. Clients with assets need to understand the cost and options of long-term care, so they do not end up wiping out all of their assets and ending up on Medicaid. The ADRC will hopefully eliminate fragmented systems of I & R and services for aging and disability populations, multiple access points, and multiple eligibility criteria and funding sources. The number of long-term support services options has increased dramatically and, with choices, confusion has arisen. The consumer may never know all of the services or options available. ADRCs build consumer trust through objectivity and by enhancing individual choice, supporting informed decision-making, and streamlining access to services. The goals of the ADRC are to:

•Better coordinate aging and disability service systems

•Raise visibility about the full range of options that are available

•Provide objective information and assistance

•Empower people to make informed decisions about their long term supports

•Serve as convenient entry points for all public and private long term-care programs and support services

The key functions of an ADRC are: public information, options counseling, benefits counseling, employment options counseling, referral, crisis intervention, and planning for future needs. Access will be made available for private pay services, as well as one-stop access to all public programs. Eligibility screening for public services will be accessible, as well as comprehensive assessment, programmatic eligibility determination, and Medicaid financial eligibility determination. Many of these functions are already in place.

The critical elements for an ADRC are:

•Seamless system ***from consumer perspective –*** 211 can be the central database; a phone system can also be in place to transfer calls unbeknownst to the caller.

•High level of public visibility and trust – link into community action centers knowing that the information provided will always be the same

•Coordinates or integrates aging and disability service systems

•Formal partnerships across aging, disability and Medicaid agencies

•Serves individuals of all income levels

ADRCs are not about replacing existing organizations and networks. They're about building a better, more coordinated network.

Critical ADRC partners are: Area Agencies on Aging, Centers for Independent Living, State Health Insurance Assistance Program (SHIP), 211, Adult Protective Services, Medicaid, services providers, and providers along critical pathways to LTSS. The Commission had 12 letters of support for the grant; there will most likely be more partners in Utah than the national average.

The model laid out in the application is one in which there will be a Steering Committee; this committee will consist of the mandatory partners. There will also be a board of community partners that will include the Health Care Association, the Home Health Association, AARP, United Way, Zion's Bank, OPG, and other informal partners. There will also be a Consumer Advisory Board that will be active in shaping the aspects of the ADRC. There will be focus groups and town meetings around the state early on in the process to collect input from communities; this information will feed into the Steering Committee as work is done to get the RFP written to create the first ADRC that must be up and running within 12 months of receipt of the grant monies. If approved, funding will be received by September 30; notification will occur prior to that time.

Action Item: Maureen will forward the final draft of the grant application to the Commission members.

If funded, the Commission will continue to exist beyond June 30, 2010. The Commission currently has enough funds to operate at a 50% level through June of next year.

The Commission does not want to participate in mission-creep; this will be more of a hands-on approach for the Commission, which is how the Commission committees worked for the first two years. The LTC Subcommittee has been looking at a global approach for the future of long-term care; the ADRC will continue the work of this committee, as well as the majority of the other activities that the Commission is currently working on. The grant is for a three-year period. The two deliverables for the grant are: one operational site delivering individualized counseling by 12 months, and by 18 months there is a five-year plan delivered to the federal government. Maureen will be .65 time; Louise will be 100% time, and there will be a .50 administrative assistant. The University of Utah waived its indirect costs for the grant; this served as more than the required match. Also, the VA Rural Health Resource Center for the Western US is

located in Salt Lake; if the ADRC is funded, collaboration will take place to submit applications for the AAAs to get funding under this VA program.

The discussion on guardianship was postponed until the next meeting.

Action Item: Maureen will check with the Governor's Office to confirm the terms of the Commission member appointments.

The meeting adjourned at 2:00 p.m. The next meeting is Monday, October 19.