CMSA CHICAGO

SERVING ILLINOIS AND NORTHWEST INDIANA

Elite Care Management, Inc.

GENTLE HOME SERVICES

THANK YOU TO OUR SPONSORS FOR EACH ONE TEACH ONE

EACH ONE TEACH ONE 2022

CMSA CHICAGO

WELCOME!

- Thank you for your attendance today and your continued support of CMSA Chicago.
- Thank you to our members!
- Thank you to our guests; we hope you will consider joining CMSA Chicago!
- Thank you to the phenomenal CMSA Chicago BOD for all their hard work!

AGENDA FOR TODAY

- 0800-1230
  - 0815-0915: Peter Miska RT
  - 0915-1015: Maureen Rafa RN
  - 1015-1030: BREAK
  - 1030-1130: Amy Jackson AT and Kristen Maurice, CCC-SLP
  - 1130-1230: Hina Rehman, President & Founder-Calling Care Services

CMSA CHICAGO

2022

- Membership
- Nurse Licensure Compact
- Annual Conference: March 29, 2022

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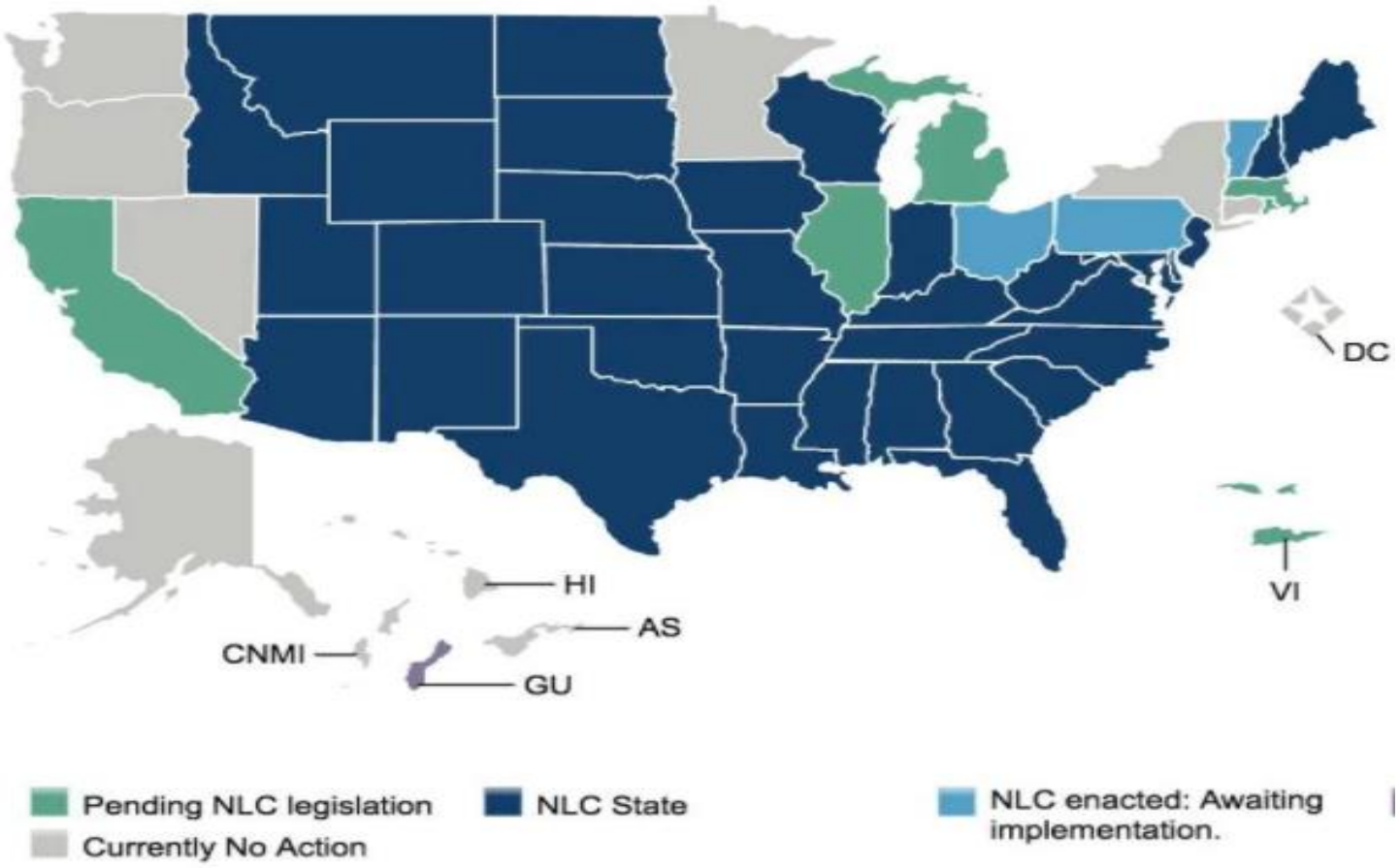
THE VALUE OF MEMBERSHIP

CMSA CHICAGO

NURSE LICENSURE COMPACT



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#NLCYES

Benefits: Patients, Families, Nurses, Labor and State of Illinois

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2022 CMSA CONFERENCE

Improving Lives Together: Case Managers Leading the Way

March 29, 2022

Drury Lane Theatre, Oak Brook

Early Bird Rate – 3/1/22:

Member: $40 (virtual); $50 in person

Non-Member: $150 (virtual); $175 in person

Non-Early Bird Rate:

Member: $80(virtual); $100 in person

Non-Member: $200(virtual); $225 in person

This event has been certed for 4.0 RN, SW and CCM (NO ETHICS) credit.

HOUSEKEEPING

How do I get my certificate?

- After the event, you will receive an email with a link for the evaluation. Look in your spam/junk folders!
  - Click on the link, complete the evaluation, click done
    - You will receive your certificates immediately. SAVE or PRINT IMMEDIATELY!
    - When you close the document, it will be gone!

Virtual Attendees format

- All attendees have been muted upon entry.
  - If you have any questions or comments, please enter them in the Q&A section at the bottom of your screen.
  - The event facilitators will communicate your questions/ comments to the speaker at the end of the presentation

CMSA CHICAGO

Phoenix Home Care, L.L.C.
A Medicare Certified Home Health Agency
RN - PT - OT - ST - MSW - HHA
Home Health Referrals Welcomed 24 Hours a Day, 7 Days a Week
Phone: 630-321-9400 Fax: 630-654-5705
CMS Quality of Patient Care Star rating of ★★★★★

IT'S ALL ABOUT ACCESS UPDATE

2020 AND BEYOND UPDATES TO THE MEDICARE HOME HEALTH BENEFIT

PETE MISKA

ADVISOR

PETER MISKA OWNER AND ADMINISTRATOR OF PHOENIX HOME CARE, LLC

- 36 years Medicare Care Continuum
  - Home Health, Hospice, infusion, DME
  - Administrator of Phoenix Home Care, LLC for 20 years
  - Low cost/High quality Home Health Agency.
  - CMS 5 star rated agency for four consecutive years
  - Contracted with multiple insurance companies
  - 8 county coverage area in the Chicagoland area.

THINGS TO KNOW ABOUT THE 2022 FINAL RULE FOR HOME HEALTH

- Value-Based purchasing is going nationwide.
  - CMS has been testing the program in 9 states since 2016 and now plans to expand it nationwide.
  - Originally expected to begin implementing HHVBP in January, CMS is now going to use 2022 as a “pre-implementation year.” This change means the first year for payment adjustments will be 2025, with 2023 as the first performance year.
  - The maximum payment adjustment will be +/-5%.
    - 1/3rd will be for process outcome measures
    - 1/3rd will be for claims data
    - 1/3rd will be for HHCAPS (patient satisfaction)

WHAT DOES THE HHVBP EXPANSION MEASURES

OASIS Based Measures	M-Item	M-Item Name
Improvement in Management of Oral Medications	M2020	Management of oral medications
Improvement in Dyspena	M1400	When is patient dyspneic or noticeably SOB
Total Normalized Composite Change in Mobility	M1840	Toilet transferring
	M1850	Improvement in transferring
	M1860	Ambulation/locomotion
Total Normalized Composite Change in Self Care	M1800	Grooming
	M1810	Curretn abiity to dress upper body
	M1820	Current ability to dress lower body
	M1830	Bathing
	M1845	Toileting Hygiene
	M1870	Feeding or Eating
Discharge to Community	M2420	Discharge to the Community

Claims Based Measures
Emergency Care without hospitalization
Acute Care Hospitalization in 60 Days

HHCAHPS
Care of Patients; Communication; Specific Care Issues; % Who Rated Agency 9,10; % Who Would Recommend

THINGS TO KNOW ABOUT THE 2022 FINAL RULE FOR HOME HEALTH

- Payment rate changes
  - Sequestration will resume in 2022 at -2%
  - PAYGO -4% for 2023
- Case mix weights and groupings are changing.
- The total estimated increase in payments based on the rule would be $570 million, or 3.2%.

THINGS TO KNOW ABOUT THE 2022 FINAL RULE FOR HOME HEALTH

- Changes becoming permanent.
  - Occupational therapists (OT) to conduct the initial assessment visit and complete the comprehensive assessment for therapy-only cases that must include OT in the plan of care.
  - Nurse practitioners can order and sign the plan of care for home health.

THINGS TO KNOW ABOUT THE 2022 FINAL RULE FOR HOME HEALTH

- Quality reporting program changes proposed.
  - Removing Drug Education on all Medications Provided to Patient/Caregiver measure
  - Replacing Acute Care Hospitalization during the First 60 Days of Home Health measure
  - Removing Emergency Department Use Without Hospitalization During the First 60 days of Home Health measure
  - Replacing removed measures with a claims-based measure, Home Health Within-Stay Potentially Preventable Hospitalization.
  - Public reporting of Percent of Residents Experiencing One or More Major Falls with Injury measure

THINGS TO KNOW ABOUT THE 2022 FINAL RULE FOR HOME HEALTH

- Changes to the Hospice Survey Process.
  - A minimal survey frequency of every 36 months
  - Requiring multidisciplinary survey teams for hospice when there is more than one surveyor
  - Imposing Surveyor Conflict of Interest limitations
  - Establishing a Hospice Program Complaint Hotline
  - Requiring transparency of survey findings

THINGS TO KNOW ABOUT THE 2022 FINAL RULE FOR HOME HEALTH

“Most importantly, CMS is expanding enforcement remedies for hospices,” said Kim Skehan, SimiTree’s Compliance, Regulatory and Quality Director. Remedies include the imposition of Civil Monetary Penalties (CMPs), payment suspension, temporary management, and directed in-service and plans of correction. In addition, CMS plans to create a special program for poor-performing hospices with continued survey compliance issues.

MORE INFORMATION

Read the 2022 final rule in its entirety by downloading a PDF from the Federal Register:

https://www.federalregister.gov/public-inspection/current

THANK YOU

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GENTLE HOME

SERVICES

DO YOU HAVE A LIFECARE PLAN(LCP)?

MAUREEN RAFA, BS RN PMHBC ELDER CARE COORDINATOR

LAW OFFICES OF STEPHEN SUTERA, P.C.

708-857-7255

OAK LAWN AND OAK BROOK OFFICES

MRAFA@SUTERALAW.COM

LEARNING OBJECTIVES

Participants will:

- Understand what a Life Care Plan is and how it differs from traditional Elder Law
- Learn reasons to have a plan
- Grasp the reality of increasing cost in aging
- Find out the best time to develop a plan
- Discover the role of an Elder Care Coordinator

WHAT IS A LIFECARE PLAN (LCP)?

- A plan to help aging adults find, get, and pay for the care they need now or in the future.
- Life Care Planning is a holistic, elder-centered approach that helps families respond to every challenge caused by chronic illness or disability of an elderly loved one.
- Goal of Life Care Planning is to promote and maintain the good health, safety, well-being, and quality of life of elders and their families.
- Life Care Plan is a relationship and a planning process. The Plan can provide a road map that allows the client to follow through to achieve their quality of life and long- term care goals.

LIFE CARE PLANNING LAW FIRM ASSOCIATION (LCPLFA)

- Sutera Law and AZ Health and Elder Law are members of this organization
- Established in 2007.
- Specialty evolving in response to the complexity of the health care system and payer sources.
- Membership includes approximately 100 Law firms across the country.
- In addition to helping with retirement and estate planning, firms have people that provide navigation for healthcare needs; usually an RN or Social Worker.

- The heart of the elder-centered law practice, a Life Care Plan defines, organizes, prioritizes, and mobilizes every aspect of an elder's care. It is a customized “Roadmap For Life” to fit one’s desires, needs and goals.

LCP INCLUDES

- In addition to traditional asset-focused elder law services such as estate planning, asset preservation, and public benefits qualification, a Life Care Plan typically includes:
  - provisions for care coordination
  - family education
  - health care and financial decision-making
  - care advocacy
  - crisis intervention
  - support and other services

Makes sure the elder gets appropriate care, whether at home or in a residential facility, to maintain the quality of life that he or she desires.

Locates public and private sources to help pay for long-term care while resolving issues created by the high cost of care.

Offers peace of mind that results when the right choices are made to ensure loved ones are safe and getting the right care while preserving family resources.

AGING

- Aging is a process that is inevitable with the passage of time and is a stage of life that brings challenges and rewards, just like any other stage of life.
- Successful aging: decrease risk of disease and disability. Increase level of mental and physical functioning.
- People with illnesses, lost relationships and other stressors consider themselves successfully aging. Why? Coping skills, they can see the positive aspects of their life and focus on them. (also, resiliency)
- Amidst the losses of age are precious lessons and graces. To find these is to age successfully, whether in a wheelchair or on cross country skis.

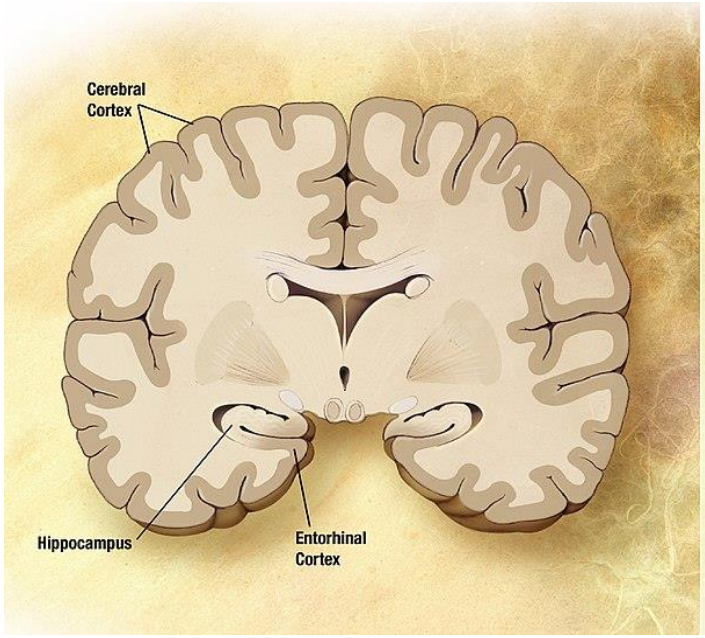
- Everyone needs a reason to get out of bed in the morning. Sense of worth and purpose.
- What is yours?
- What do you consider quality of life?
- Life is a Journey. What is your plan A? What's your plan B or C?
- What are your goals for this chapter?
- What are your leisure activities? Excitement?
- Socialization, love and belonging?

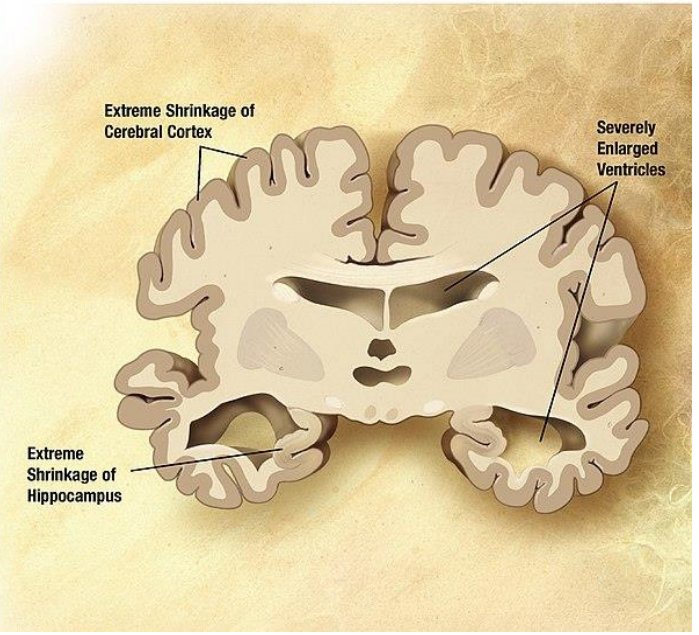
KEYS TO SUCCESSFUL AGING

TIMING IS EVERYTHING WITH A LCP

Most effective when planning is done **early**

It’s important to know how to recognize the signs of trouble.


Cerebral
Cortex
Hippocampus
Entorhinal
Cortex


Extreme Shrinkage of
Cerebral Cortex
Severely
Enlarged
Ventricles
Extreme
Shrinkage of
Hippocampus

G N S

FRAILTY

- Many older adults find it difficult to do everything they once did without help.
- “If you observe your loved one becoming frail, you need to start thinking ahead,”
- “What's your action plan if they can't care for themselves?

A MEDICAL EVENT

- Stroke
- Heart attack
- Diagnosis of a chronic illness
- Alzheimer’s disease
- Other Dementia

CRISIS SITUATIONS

- Accident, a fall, a fire, or a medication mishap.
- Many families come to us after something happens.
- “Mom has already fallen. She's broken her hip. She's in rehab, and they're going to discharge her because they've exhausted their money to pay for it.”
- “Dad is being discharged from the hospital tomorrow and we can’t care for him at home ourselves.”

WHAT DOES AGING LOOK LIKE FOR YOU?

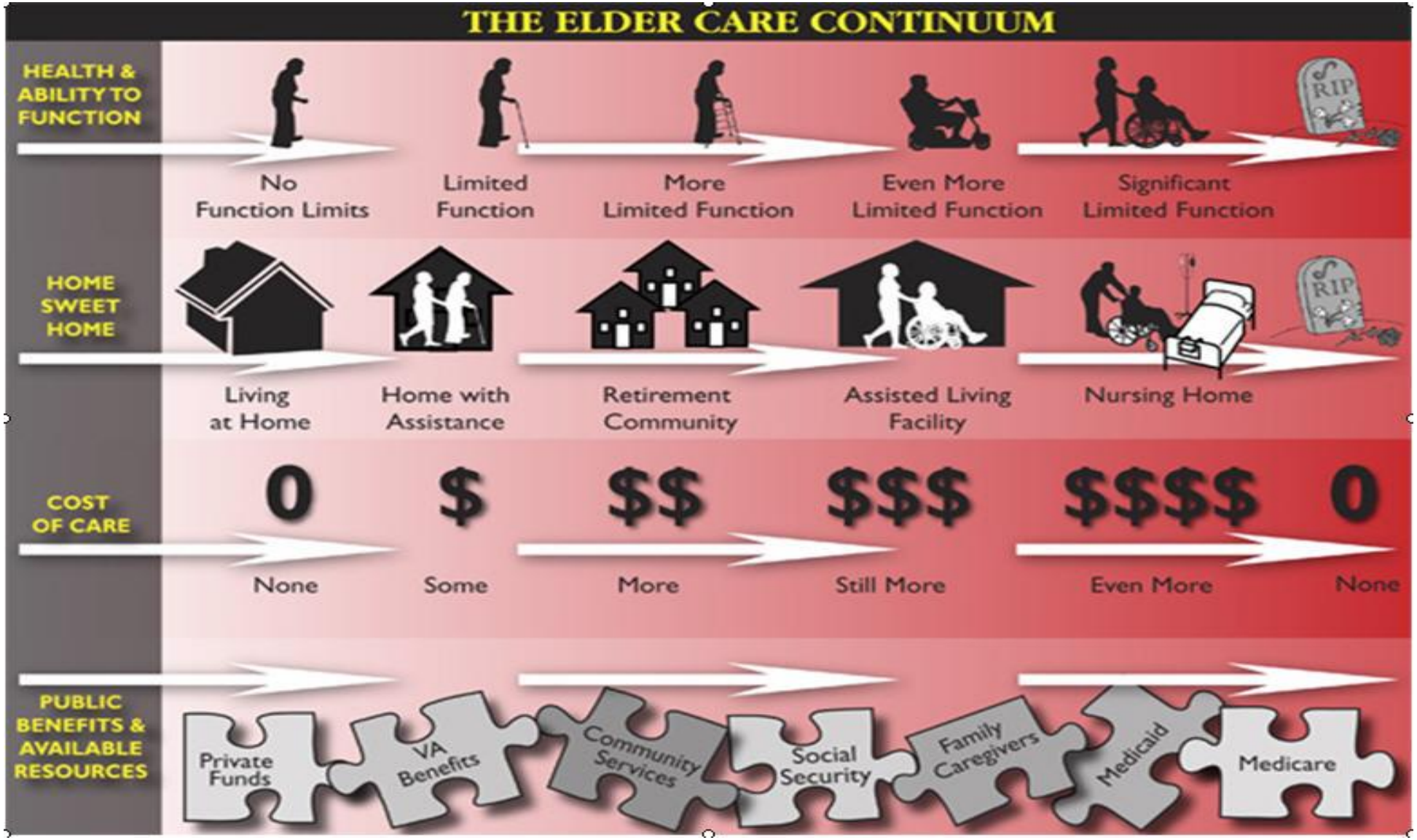
- Most people do not think about aging or plan for it.
- It's almost taboo in this country that focuses on youth.
- Most people don't or don't want to think about dying.
- How many of you have planned your future including end of life care?
- If you fail to plan you plan to fail. The crisis is too often when older adults or their adult children look for help for their parents.

CHRONIC CARE

"Most people are simply unaware of their potential need for long-term care and their financial exposure to costs. Research shows that most Americans still equate long-term care with nursing homes and that many believe that Medicare pays for long-term care. When older people or their family members do seek out information or care, they face a complex, and often mind-boggling maze of publicly supported and private options, administered by a wide variety of providers operating under different, sometimes conflicting and often duplicative, rules and regulations."

Josefina G. Carbonell

Assistant Secretary for Aging


THE ELDER CARE CONTINUUM
HEALTH & ABILITY TO FUNCTION
No Function Limits
Limited Function
More Limited Function
Even More Limited Function
Significant Limited Function
RIP
HOME SWEET HOME
Living at Home
Home with Assistance
Retirement Community
Assisted Living Facility
Nursing Home
RIP
COST OF CARE
0
None
$
Some
$$
More
$$$
Still More
$$$$
Even More
0
None
PUBLIC BENEFITS & AVAILABLE RESOURCES
Private Funds
VA Benefits
Community Services
Social Security
Family Caregivers
Medicaid
Medicare

POTENTIAL COST OF CARE

- Someone turning 65 today has a 70% chance of needing some type of long- term care services in their remaining years according to the US Department of Health and Human Services.
- Women need 3.7 years and men 2.2 years.
- Average lifetime cost of formal long- term care is $172,000.
- (CNBC Business News)

MONEY FOR LEISURE AND CARE?

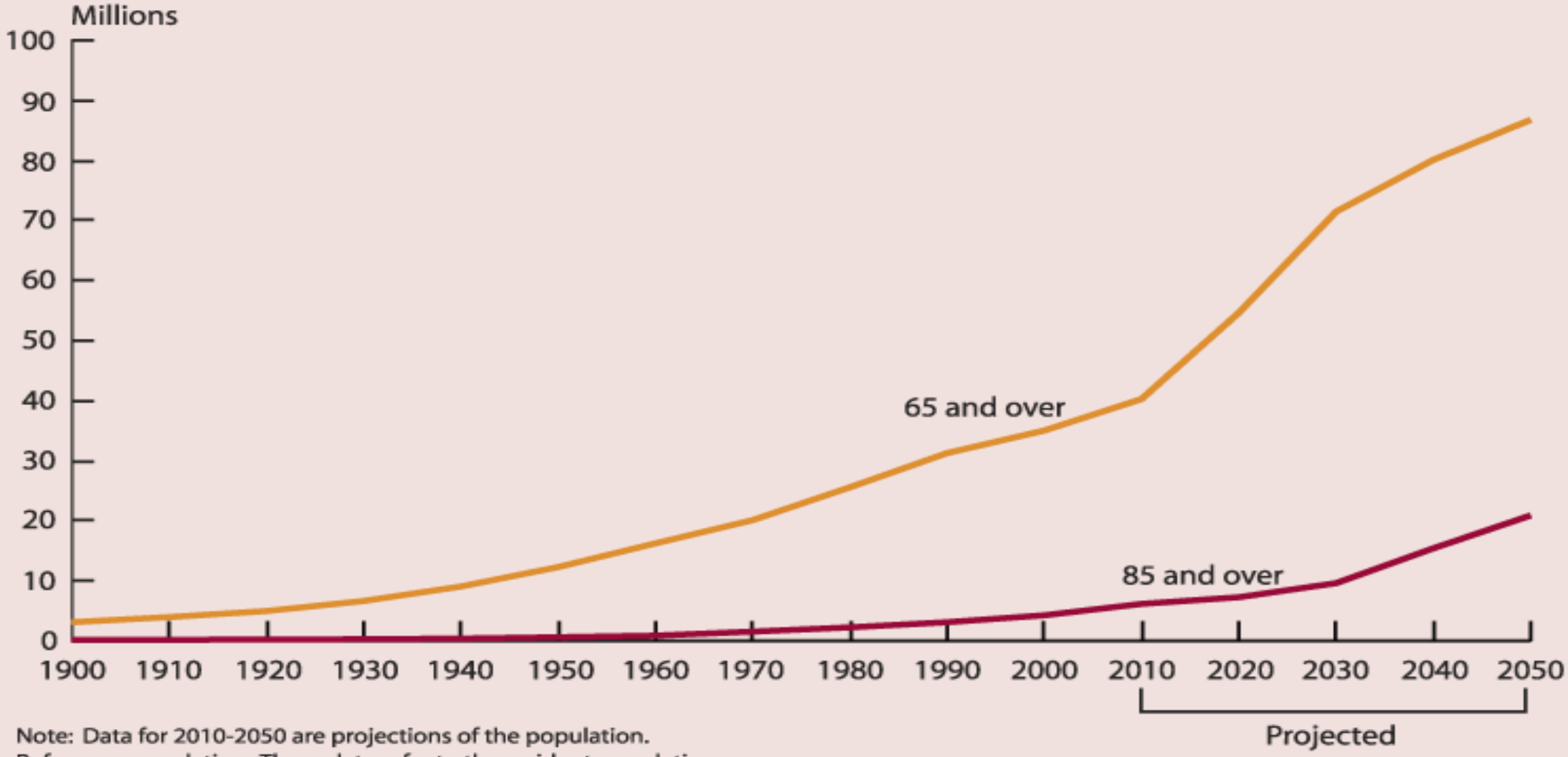
- A lot of people wish to leave something for their heirs. It is a noble goal.
- A lot can happen during your aging. Usually, aging is a gradual process where illness and or disability happen that impacts one's independence and ability to care for themselves.
- Plan the care you would like with your hard earned and saved funds. Is this in your home or transition to senior living? Can you afford to maintain your home and pay for care?

WHY DO A LIFECARE PLAN?

- People are living longer
  - 1900 – 47.3 years
  - 2000 – 76.9 years
  - 2005 – 77.9 years
- More resources are needed to last a life span
  - For seniors, each year of increased life expectancy costs about $84,700

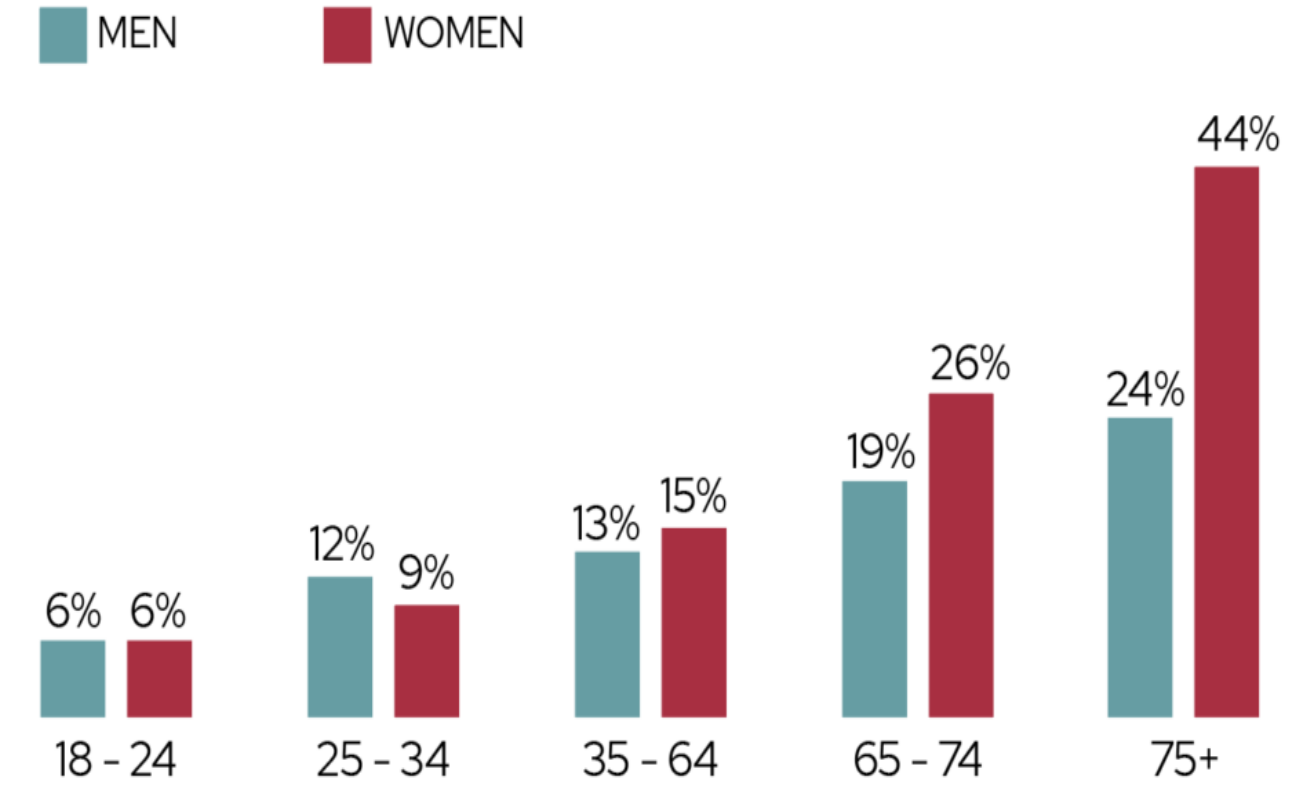
www.kaisernetworking.org/daily_reports

Number of people age 65 and over, by age group, selected years 1900-2000 and projected 2010-2050



Note: Data for 2010-2050 are projections of the population.
Reference population: These data refer to the resident population.
Source: U.S. Census Bureau, Decennial Census and Projections.

Percentage living alone by age



SOURCE: U.S. CENSUS BUREAU, 2018

- Assess your home for safety risks
- Explain complex senior issues
- Devise short and long term care plans
- Help with referrals to legal or medical professionals
- Identify social services and community programs you may be eligible for
- Coordinate medical appointments and arrange transportation if needed
- Help evaluate, hire and monitor in home caregivers
- Arrange for respite for stressed out caregivers
- Assess current medical status and the impact for long term care needs

ELDER CARE COORDINATOR(ECC) SERVICES

AN ECC ENCOURAGES CLIENTS AND FAMILIES TO HAVE THE CONVERSATION

QUESTIONS TO HELP INITIATE THE CONVERSATION

- “What do you understand about your disease?”
- “What are your fears and concerns about your worsening health?”
- “What is important to you?”
- “What do you want your medical care to look like moving forward?”
- “Are you ready to put your wishes and goals for care in writing so that you, your family, and your medical care team know your preferences?” A living will or Five Wishes Booklet, or Compassion and Choices Booklet

TOOL TO DETERMINE YOUR WISHES REGARDING CARE

- Have you completed a Value Assessment Survey?
- 2 pages, outlines different scenarios, and you answer what is and is not valuable to you.
- Includes medical procedures and you rank whether you want them, whether you want to try them and then stop, or if you're unsure or you know you don't want it. It includes CPR, chemotherapy, mechanical breathing by machine for examples.
- This tool along with any of the 3 mentioned on previous slide can help you plan your care as to how you want to live before dying.

READ POEM BY MARIO DE ANDRADE

- My Soul Has A Hat

PHILOSOPHY FOR PLANNING

- *If you are planning for a year, sow rice; if you are planning for a decade, plant trees; if you are planning for a lifetime, educate people". Chinese Proverb*
- *Goal for LCPLFA and Elder Care Coordinators*

VALUABLE ADVOCATE FOR YOUR LOVED ONE

- To summarize the value of a LCP:
- The client gets the right care sooner, maximum independence, ability to age with dignity and
- The families get help finding the right care and services, guidance with legal, health care and long-term care decisions as the elder's condition progresses.

REFERENCES

- Caregiving Magazine Winter Edition
- Life Care Planning Law Firm Association
- Law Offices of Stephen Sutera, P.C.
- AZ Health and Elder Law, LLC
- NAIPC- National Aging in Place Council

QUESTIONS /COMMENTS ARE WELCOME!

CMSA CHICAGO

SERVING ILLINOIS AND NORTHWEST INDIANA

Elite

Care Management, Inc.

GENTLE HOME

SERVICES

THE AMERICANS FOR BETTER HEARING FOUNDATION

Mission Statement- Provide comprehensive hearing services to hearing impaired individuals by serving a population who are confined to their homes or who lack private insurance and are financially distressed.

Vision Statement-We believe that hearing is crucial to the overall quality of one's life, and by providing hearing services to an underserved population we are allowing people to stay connected to their family and friends and to assist them with staying active in their community.

Presenters

Amy Lauren Jackson, MS/FAAA
Director of Clinical Services/Clinical Audiologist

Kristen D. Maurice, M.S., CCC-SLP, CBIS
Auditory Therapist/Aural Rehabilitation Specialist

Agenda

0-5 Minutes Introduction

5-15 Minutes Hearing versus Intentional Listening

15-30 Minutes Auditory Therapy Evaluation

30-45 Minutes Auditory Therapy Sessions

45-60 Minutes Summary, Q & A

Learning Objectives

- After this course, participants will have a clear understanding of the difference between hearing and active listening
- After this course, participants will be able to identify two benefits of hearing aids and two benefits of Auditory Therapy
- After this course, participants will be able to identify three behaviors for appropriate Auditory Therapy referrals

Who ABHF Is

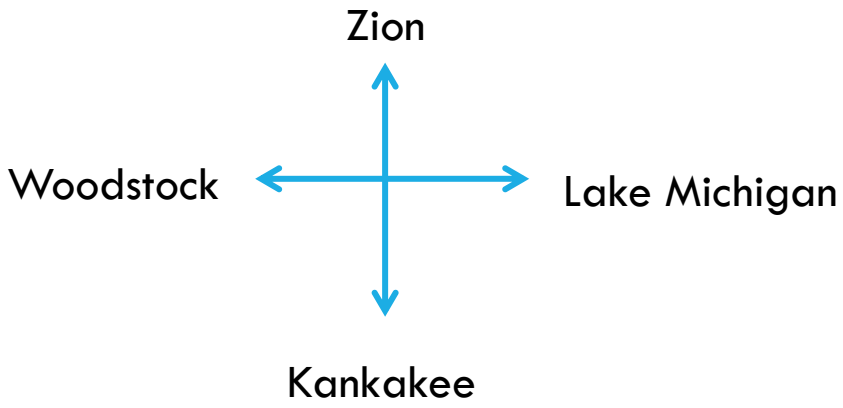
- Largest service provider of Medicaid hearing aids in IL
- We are mobile → visit approximately 125 nursing facilities
- We are stationary → have 5 clinics in Chicago area
- We have a Fair Pricing Program for uninsured/underinsured

Who We Serve

- Medicaid population
- Uninsured/Underinsured
- Persons with Intellectual and Developmental Disabilities

Where We Serve

Nursing/Supportive Living Facilities



Clinics

Burr Ridge
Blue Island
Loretto Hospital
Schwab Rehabilitation Hospital
Will County
***Mayfair Neighborhood

Services We Provide

Hearing Evaluations
Hearing Aid Fittings
Hearing Aid Repairs
Wax Removal

Auditory Therapy
Tinnitus Evaluations
Hearing Aid Clean and Checks
Hearing Aid Batteries
*Dizzy Clinic

"It's a special hearing aid. It filters out criticism and amplifies compliments."

Elements of Communication

Hearing

- The process, function, or power of perceiving sound

Listening

- Hearing with attention and intention

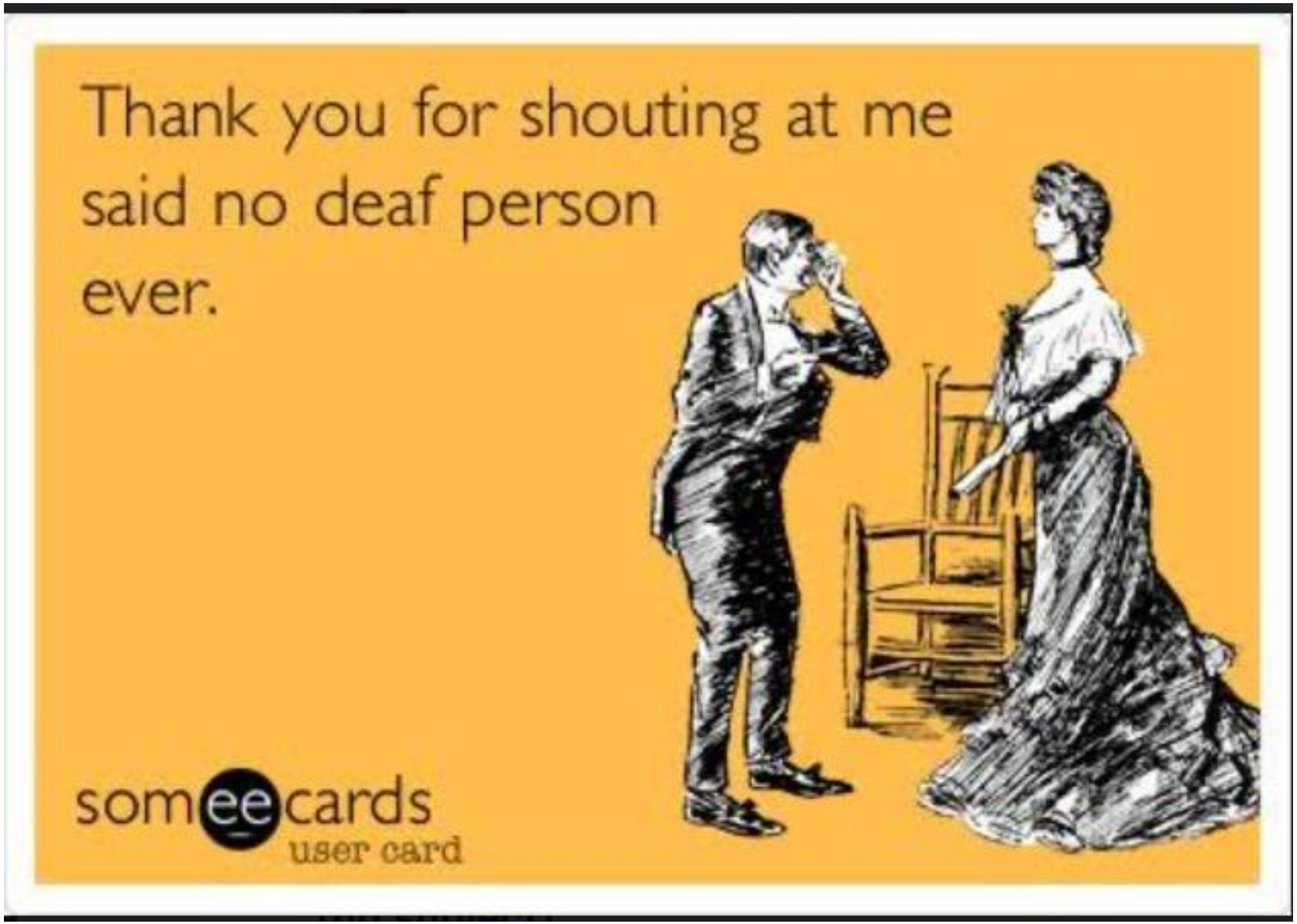
Comprehension

- Interpreting acoustic information

(Kiessling, et al, 2003; Sweetow and Henderson-Sabes, 2004)

What is Auditory Therapy?

"the reduction of hearing-loss-induced deficits of function, activity, participation, and quality of life through sensory management, instruction, perceptual training, and counseling" (Boothroyd, 2007).


Thank you for shouting at me said no deaf person ever.
someecards
user card

Why Offer Auditory Therapy?

"Hearing aids are for the ears, aural rehabilitation is for the individual." (Unknown)

What are the Benefits of AT?

- Can help people become more effective users of hearing technology (can even accelerate the adjustment period)
- Can help people become more effective users of communication strategies
- Has the potential to slow or prevent cognitive decline (Lin, 2011, 2013)
- Gives people the tools for lifetime management of hearing loss

Who To Refer

- Anyone who has a hearing aid and is still struggling to understand speech
- Anyone who has reduced/eliminated their activities due to not hearing well
- Anyone who you feels isolated and left out of a conversation

What Do We Use to Evaluate a Patient?

Questionnaires

- Consumer Confidence Profile (CCP)
- Hearing Handicap Inventory for the Elderly (HHIE)
- Client-Oriented Scale of Improvement (COSI)

History and Goal setting

Formal Assessment

- Scan-3

Informal Assessment

- Auditory and reading comprehension
- Cognition


"WHAT FOUR LETTER WORD DO FOLKS WITH HEARING LOSS USE MOST?"
"WHAT?!"
"YUP."
!
© 2016 STARKEY HEARING TECHNOLOGIES

What Areas do we Treat?

Boothroyd's definition of aural rehabilitation:
"the reduction of hearing-loss-induced deficits… ***through sensory management, instruction, perceptual training, and counseling***" (p. 63).

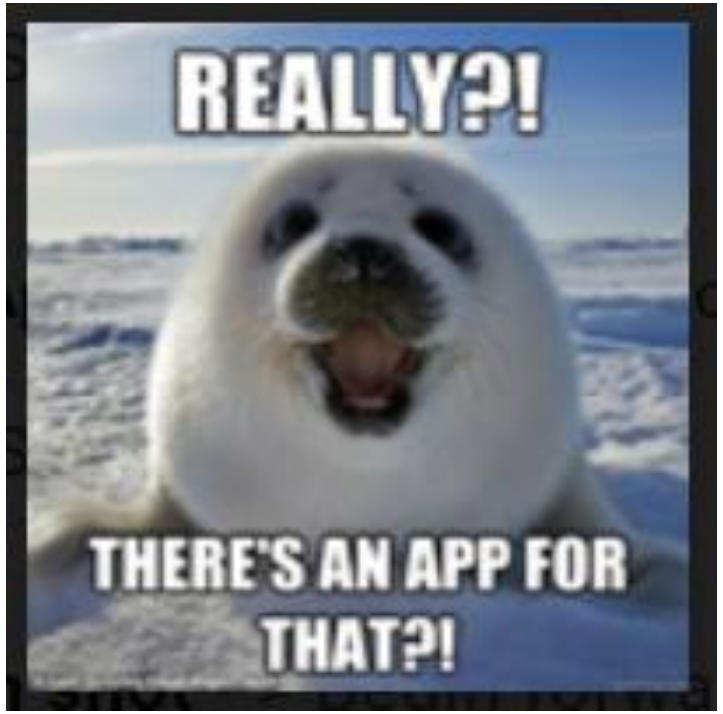
Components of the AT Plan of Care

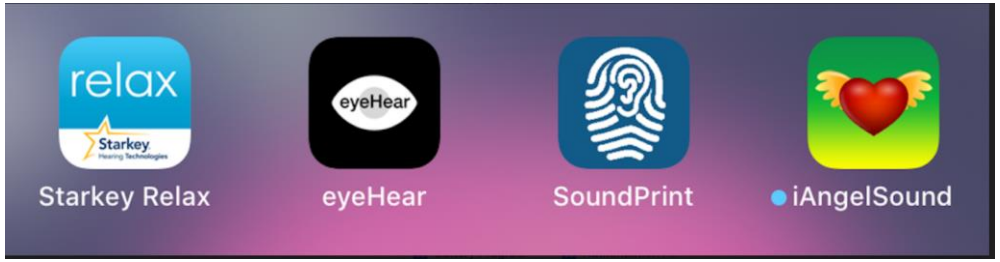
Sensory management

- Managed by the Audiologist with hearing aids.

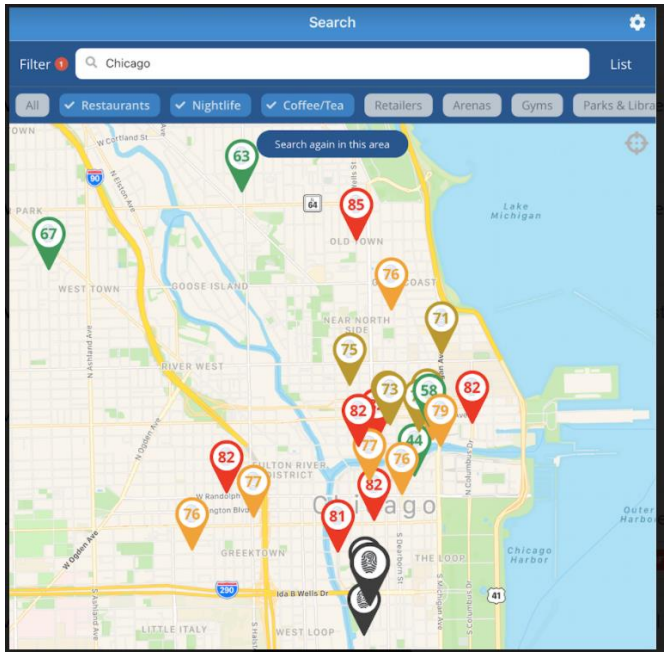
Instruction

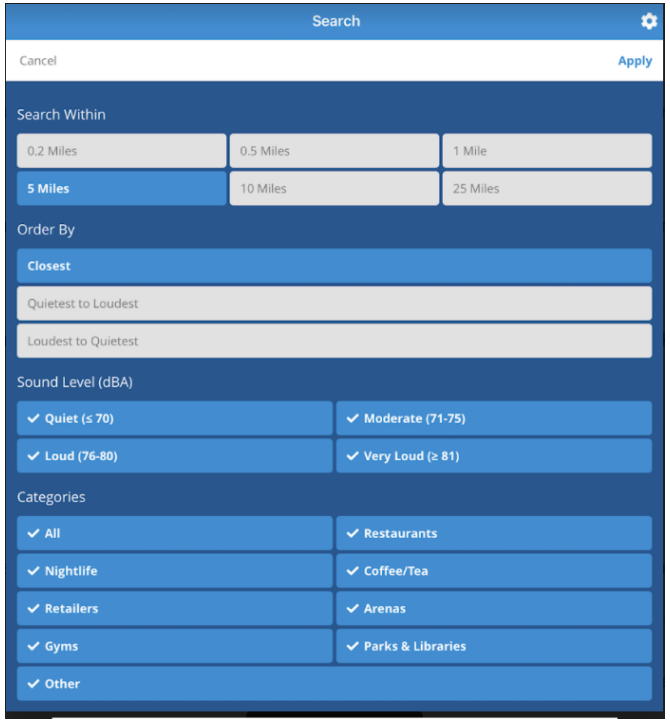
- Communication strategies
- Environmental modification
- Resources – Apps, websites, ADA
- Device instruction
- Home Exercise Program (HEP)

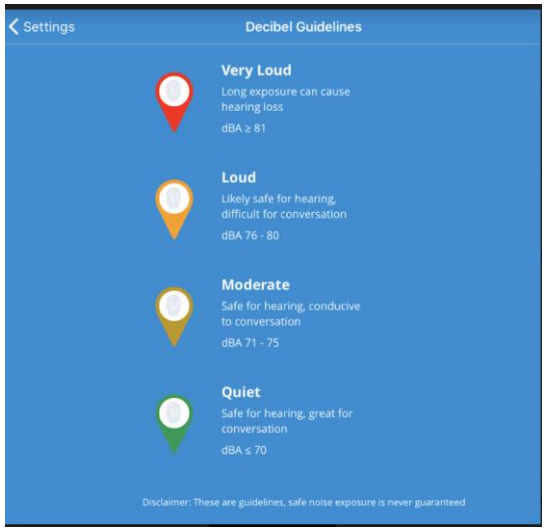

REALLY?!
THERE'S AN APP FOR THAT?!


relax
Starkey
Starkey Relax
eyeHear
eyeHear
SoundPrint
iAngelSound

SoundPrint App







The AT Plan of Care Continued…

Perceptual Training

- LACE®, Listening and Communication Enhancement program (web-based)
- Targets processing speed, attention, working memory, which are affected by age (Tye-Murray, 2014; Pichora-Fuller et al, 1995; Nicholas, et al 1997)
- Independent clinical trials have confirmed that LACE improves listening skills in noise by over 30%.

The AT Plan of Care Continued…

Counseling, Counseling, Counseling

- Informational
- Personal adjustment

> "When someone in the family has a hearing loss, the entire family has a hearing problem." (Mark Ross, Ph.D.)

Who To Refer

- Anyone who has a hearing aid and is still struggling to understand speech
- Anyone who has reduced/eliminated their activities due to not hearing well
- Anyone who you feels isolated and left out of a conversation

“When they smile, I smile; when they laugh, I laugh.”

Next Steps → Obtain a…

- Physician Referral for Audiology to Evaluate and treat hearing loss
- Physician Referral for SLP to Evaluate and treat (R48.8)
- Signed POC to begin treatment

Questions

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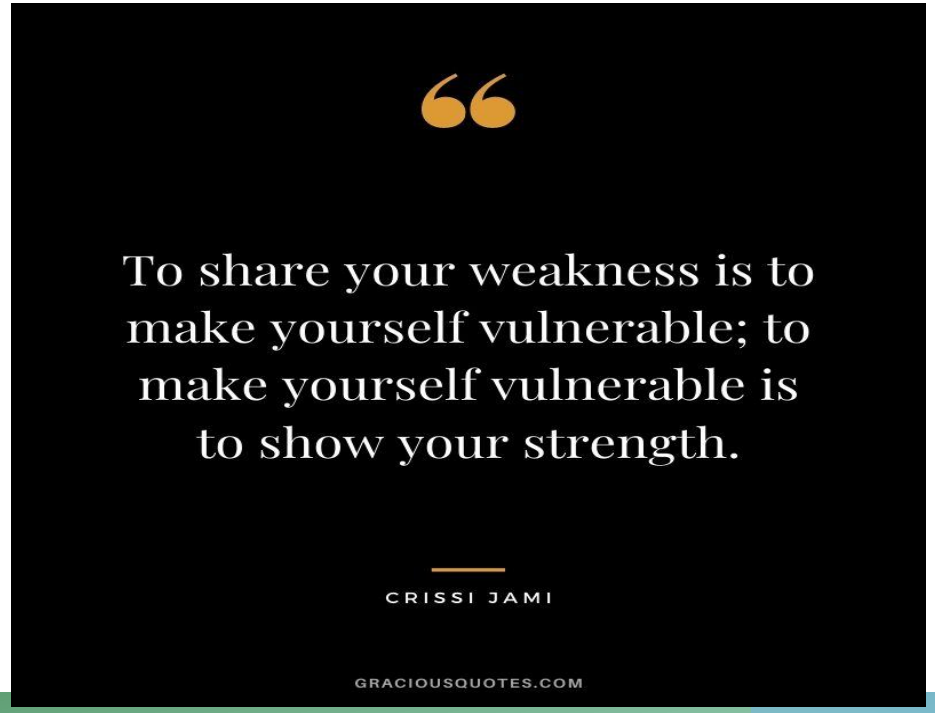
GENTLE HOME

SERVICES

BENEFITS FOR LOW-INCOME INDIVIDUALS

THINGS TO CONSIDER WHEN DISCUSSING BENEFITS WITH YOUR PATIENT/CLIENTS.



- Time Management
- Language
- Communication Methods
- Commitment and Expectations for both yourself and your client.

TIME MANAGEMENT

Based off your caseload it is important to schedule clients/patients to dedicate enough time to understand what the client needs.

Average assessment time should last between 20-30minutes. (This does not include other aspects mental health evaluation etc.)

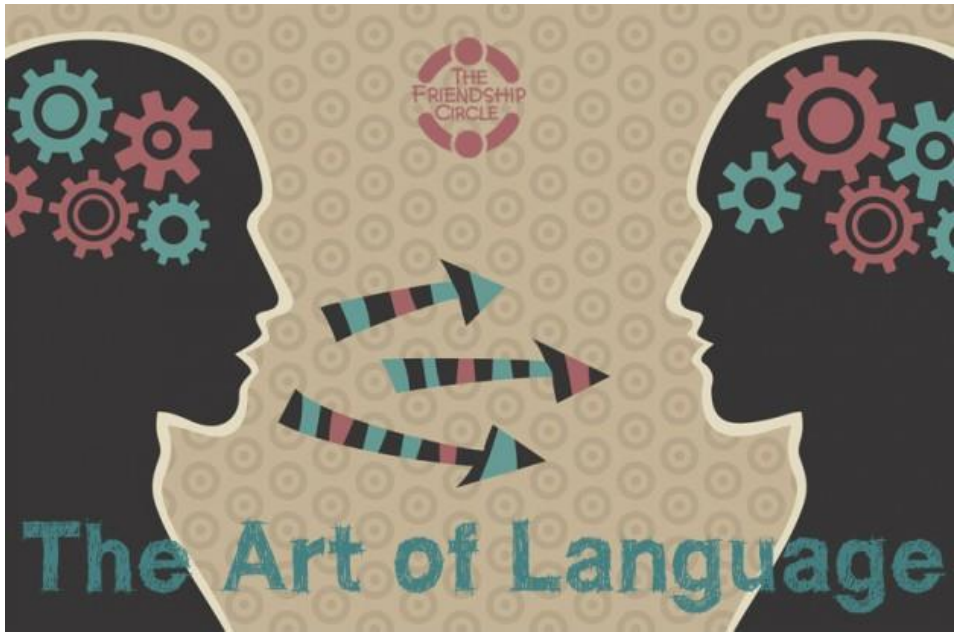
1. Assessment of what your client wants versus needs.
2. Offer a relm of different options to choose from (Examples of some):

- **Housing Assistance**
- **Food/Water Resources**
- **Clothing**
- **Employment**
- **Immigration**
- **Health Insurance**

Client Initial Intake (CCS)

3. By allowing the client to choose from the different areas of benefits this will help you and the client focus on specific benefit applications.

LANGUAGE. THE IMPORTANCE OF LEARNING THE LANGUAGE OF BENEFITS AND ACRONYMS WHEN DISCUSSING QUALIFICATIONS FOR INDIVIDUALS.



"Language is a system of communication that relies on verbal or non-verbal codes to transfer information."

WHAT EACH ACRONYM MEANS:

ACRONYMS

Community Care Program Acronyms

AAA – Area Agency on Aging
AABD – Aid to Aged, Blind, Disabled (Medicaid)
ACA – Affordable Care Act
ACL – Administration for Community Living
ADL/IADL – Activities of Daily Living / Independent ADL
ADS – Adult Day Service
AMD – Automated Medication Dispenser
ANE – Abuse, Neglect, Exploitation
APS/APSPA – Adult Protective Services
BAA – Benefits Access (Ride Free Program)
BEAM – Benefits Eligibility Assistance Monitoring
CARP – Community Aging Referral Program
CAT – Case Authorization Transaction
CE – Critical Event
CER/CERA – Critical Event Reporting Application
CI – Critical Incident
CC – Care Coordinator
CCC – Comprehensive Care Coordination
CCP – Community Care Program
CCU – Care Coordination Unit
CMIS – Case Management Information System
CMS – Center for Medicare/Medicaid Services
CNA – Comprehensive Needs Assessment
CSRA – Community Spouse Resource Allowance
DD – Developmentally Disabled
DHS – Department of Human Services
DNR – Do Not Resuscitate

ICM/IM – Intensive Case Management / Intensive Monitoring
INH – In-Home Service
IPOC – Individualized Plan of Care
ISC – Independent Service Coordinator
I&A/I&R – Information and Assistance / Referral
IVMMP – Illinois Voluntary Money Management Program
LIHEAP – Low Income Home Energy Assistance Program
LTC – Long-term Care
MCO – Managed Care Organization
MH – Mental Health
MI – Mental Illness
MLTSS – Medicaid Long Term Services and Supports
MMAI – Medicare-Medicaid Alignment Initiative ("Duals")
MMSE – Mini Mental State Examination
MOU – Memorandum of Understanding
NF/NH – Nursing Facility / Nursing Home
O – Office
OBRA - Omnibus Budget Reconciliation Act
OCCS – Office of Community Care Services
OT/PT – Occupational / Physical Therapy
PAS – Pre-Admission Screen Agent
PASRR – Pre-Admission Screening and Resident Review
PC – Phone Call
PCP – Person Centered Planning
POA – Power of Attorney
POC/POCNF – Plan of Care Notification Form
POSM – Participant Outcomes and Status Measures Quality of Life Survey
PSA – Planning and Service Area
PSI – Prevention of Spousal Impoverishment
PSS – Participant Search Screen
RFCOS – Request for Change of Status
RIN – Recipient Identification Number
SCM – Service Cost Maximum
SHL- IDoA Senior Helpline
SHAP – Senior Health Assistance Program

CNA – Comprehensive Needs Assessment
CSRA – Community Spouse Resource Allowance
DD – Developmentally Disabled
DHS – Department of Human Services
DNR – Do Not Resuscitate
DOE – Determination of Eligibility
DON – Determination of Need
eCCPIS – electronic Community Care Program Information System EDD – Eligibility Determination Date
EHRS – Emergency Home Response System
EVV – Electronic Visit Verification
FHCA – Family Home Care Aide
FTF – Face to Face
GATA – Grant Accountability and Transparency Act
HCBS – Home and Community Based Services
HCA – Home Care Aide
HCO/HCOP – Home Care Ombudsman Program
HDM – Home Delivered Meals
HFS – Illinois Department of Healthcare and Family Services
HV – Home Visit
HOSC – Hours of Service Calendar
HOST – Home Care Supervisor Training
IATP – Illinois Assistive Technology Program
ICP – Integrated Care Program
IDD/DD – Intellectually /Developmentally Disabled
IDoA – Illinois Department on Aging

LANGUAGE CONT'D

- This will help you and your client narrow down the amount of work that can be conducted on both ends.
- This will also give you the ability of spending more quality time with the client versus trying to figure out what the client can do and what you can do.

Reading and Writing Skills

- This will help you and your client narrow down the amount of work that can be conducted on both ends.
- Empower your clients/patients

Fluency of Language

- Applications that are offered in different languages.
- They may want to take it home and read it on their own time or share with others.

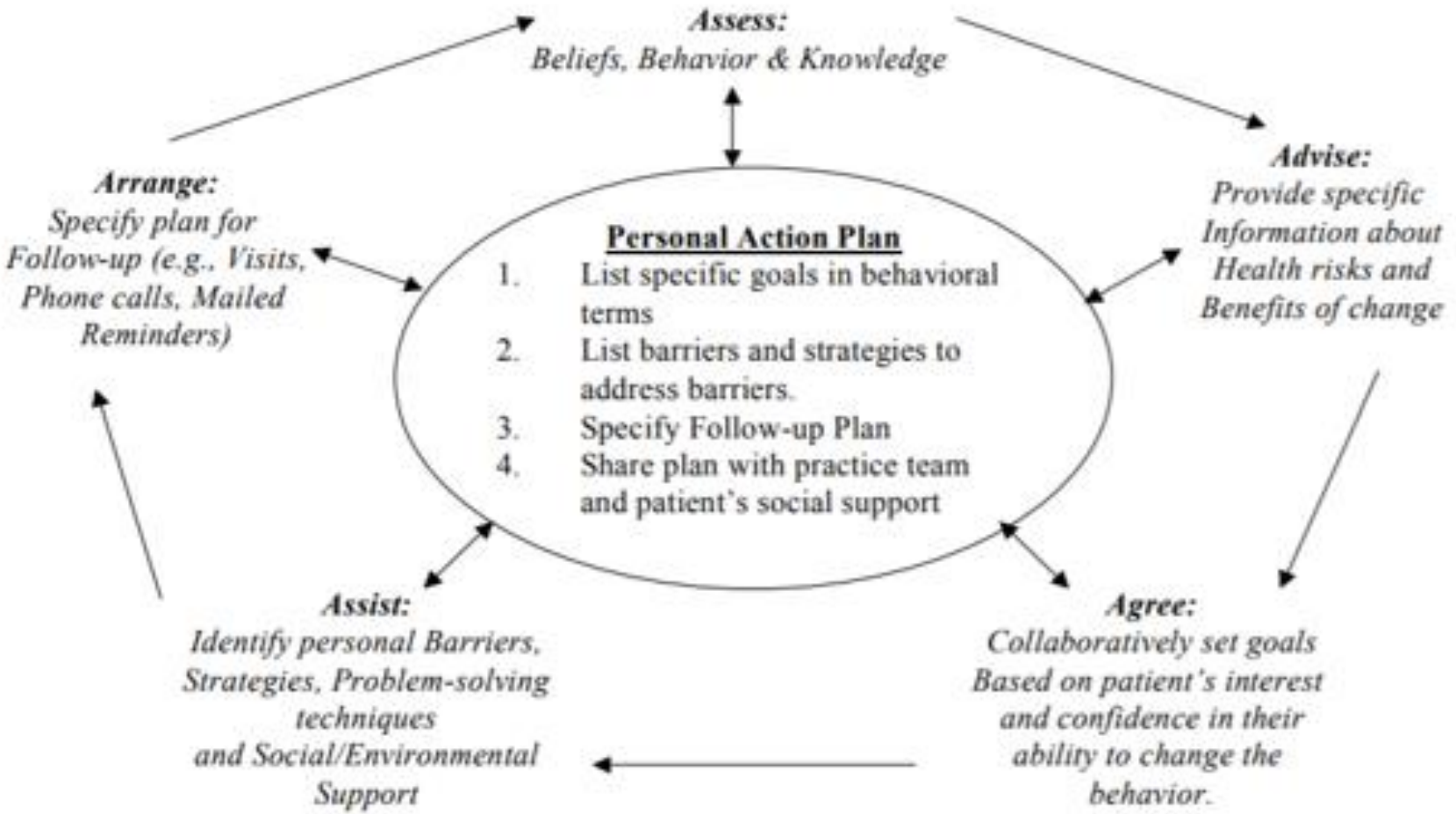
Text Comprehension

- What level of explanation may you have to do.
- You never want to over explain but you also want to keep the patient/clients time in mind.

ESTABLISHING A METHOD OF COMMUNICATION

- Email
- Phone
- Mail
- In Person
- Point of Contact
- Specific days and times

Self-Management Model with 5 A's (Glasgow, et al, 2002; Whitlock, et al, 2002)



COMMITMENT AND EXPECTATIONS

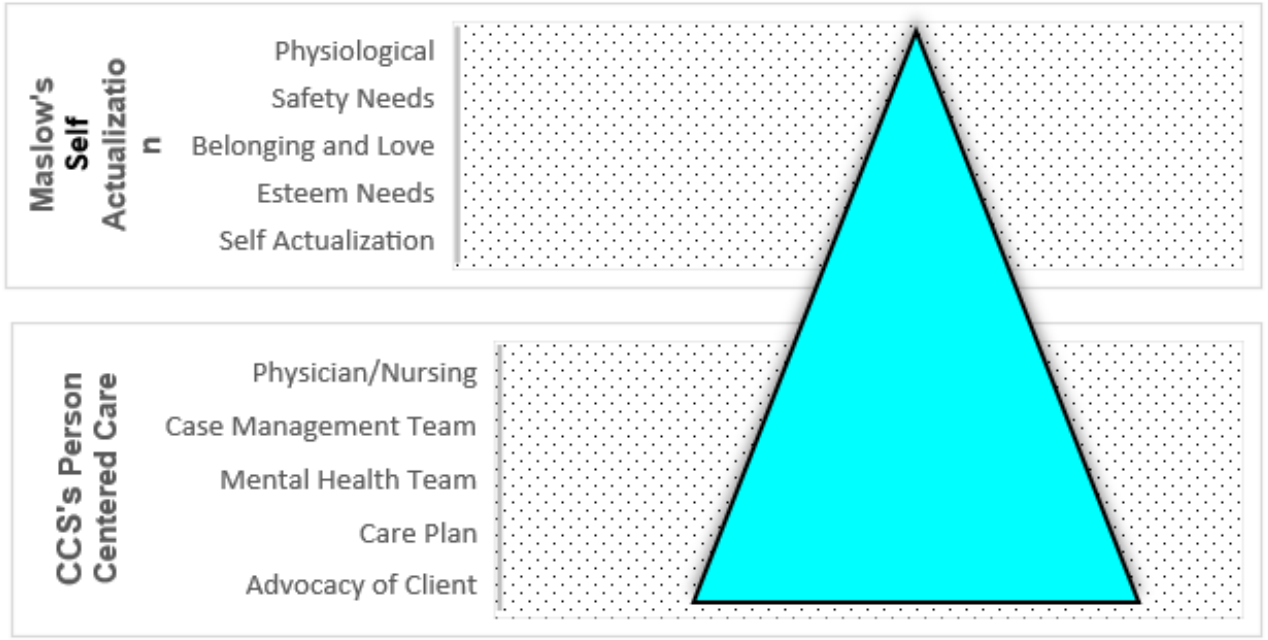
- **Case Manager/Care Worker Expectation Examples:**
- **Submission of application**
- **Understanding deadlines**
- **Translating patient information into application formats**
- **Utilizing the resources' the client already has (Social Security Card, ID, Passport).**
- **Problem Solving**
- **Keeping the client updated on status of applications**

- **Client Expectation Examples:**
- **Submitting Proof of Income**
- **Submitting Mailing address**
- **Proof of Identification**
- **Time Sensitive Information**

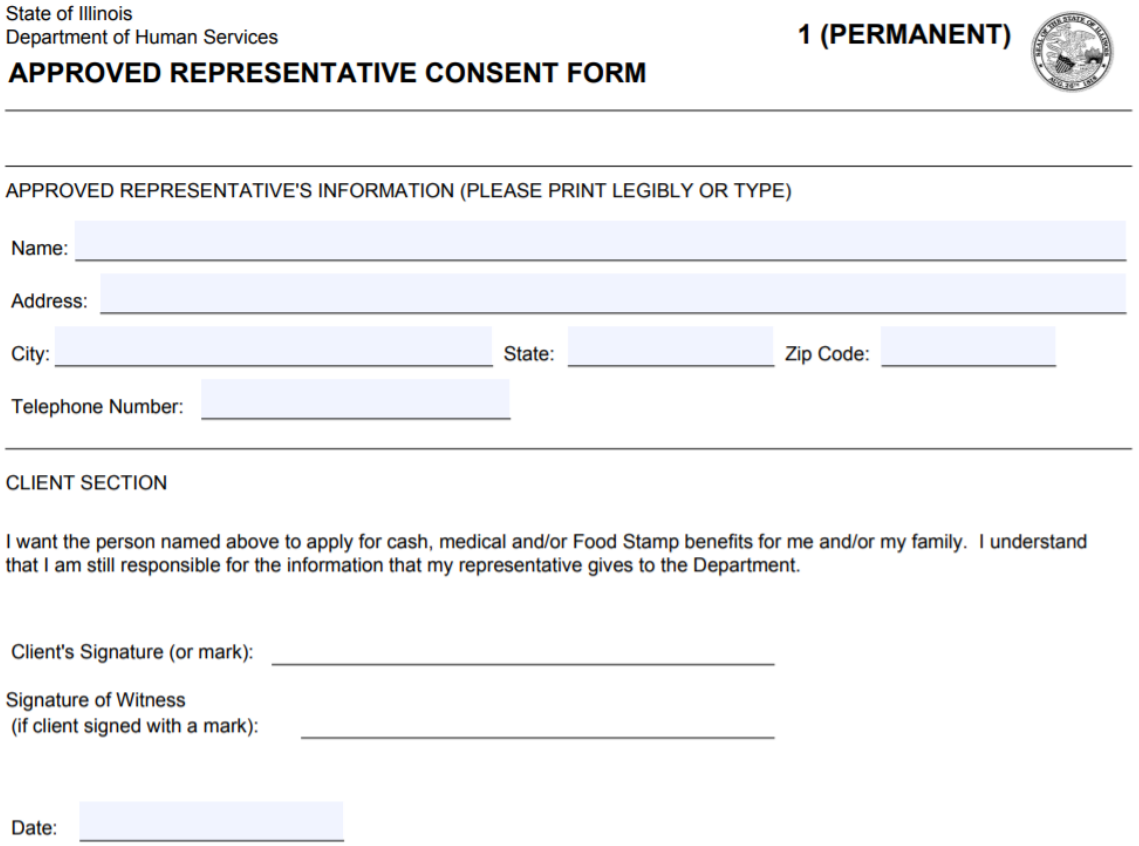
ESTABLISH SHORT-TERM AND LONG-TERM GOALS

- Priority: As the client's case-manager/care worker you have the ability and the resources to assess and determine what the client/patient's short and long-term goals are.

Calling Care Services incorporated Maslow's Hierarchy of Needs and formed a Person-Centered-Care Module with including all the levels of basic needs.



ESTABLISHING A REPRESENTATIVE:



State of Illinois
Department of Human Services

APPROVED REPRESENTATIVE CONSENT FORM

1 (PERMANENT)

APPROVED REPRESENTATIVE'S INFORMATION (PLEASE PRINT LEGIBLY OR TYPE)

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

CLIENT SECTION

I want the person named above to apply for cash, medical and/or Food Stamp benefits for me and/or my family. I understand that I am still responsible for the information that my representative gives to the Department.

Client's Signature (or mark): _____

Signature of Witness
(if client signed with a mark): _____

Date: _____

- This will help you speak on behalf of your client.
- However, you want to empower the client to speak for themselves if being interviewed by agencies. When having a client/patient interviewed prepare them for what types of questions they will be asked for so they know what to expect.
- Usually interviews should be conducted on the phone and the case manager should be on the phone with them to provide support.

CONTACTS TO KEEP ON HAND FOR BENEFITS.

MCO Plan Name	Contact Name	Contact Email	Contact Phone Number
Aetna Better Health	Mark Szymala	SzymalaM@aetna.com	(224) 355-5051
Blue Cross Blue Shield of Illinois	Chris McCorkle	Christopher_P_Mccorkle@bcbsil.com	(217) 862-7153
CountyCare	Brian Barrett	brian.barrett@cookcountyhhs.org	(312) 466-2920
Humana Health Plan	Erin Maday	Esmith35@humana.com	(847) 736-9031
IlliniCare Health	Keive Dixon	Keive.J.Dixon@illinicare.com	(630) 203-9162
Meridian Health Plan	Tasha Brown	Tasha.Brown@mhplan.com	(312) 705-2900 Ext 28301
Molina HealthCare	Michael Ace	Michael.Ace@molinahealthcare.com	(630) 203-2300 Ext 162300
NextLevel Health	Theodore Dixon	Theodore.Dixon@nlhpartners.com	(312) 300-5780 Ext.920

- Examples of contacts for Health insurance Plans.
- Each case manager should keep a list of contacts they could reach out to. This will make each case manager's role but easier.

LOW-INCOME QUALIFICATIONS: PRIOR TO COVID-19

- Emergency Medical Coverage for Non-Citizens Ineligible for Medicaid due to Immigration Status
- Individuals of any age who are ineligible for Medicaid due to their immigration status continue to be eligible for federally matched emergency medical coverage. The Department strongly encourages providers to continue to use the emergency medical process in place for individuals ineligible for Medicaid due to their immigration status. As federal matching funds are available for emergency medical services for non-citizens, the financial resources for the state-funded Health Benefits for Immigrant Seniors program above can then be better utilized to cover ongoing, non-emergency medical services.

Household Size *	Maximum Income Level (Per Year)
1	$17,775
2	$24,040
3	$30,305
4	$36,570
5	$42,836
6	$49,101
7	$55,366
8	$61,631

WOMAN, INFANTS, CHILDREN

Am I Eligible for WIC?

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

How to Apply | Learn More About WIC

- What is the purpose of this service?
- WIC is a food assistance program for Women, Infants, and Children. It helps pregnant women, new mothers and young children eat well and stay healthy.
- Who can receive these services?
- Women and their children who are:
- Pregnant, breastfeeding or just had a baby
- Infants and Children under 5 years old (including foster children)
- Families with a low to medium income
- Use the Pre-Screening Tool to find out if you might qualify for WIC benefits.

TYPES OF ACCEPTED IDENTIFICATION PROOF

Driver's license

State issued ID card

School ID

U.S. military ID

U.S. military dependent card

Other government ID (city, county, or U.S. state issued).

For children under age 16, school or day care records or a report card.

Please show us the original version of your documents. If you receive Medicare, SSI or Social Security Disability, you do not need to provide proof of your U.S. citizenship or identity.

REQUIRED DOCUMENTS

Alien Registration Receipt Card/Permanent Resident Card/Green Card (INS-3A)

Passport with the following stamps or attachments: Arrival-Departure Record with the stamp showing status (I-94), or Resident Alien Form (I-151 or I-551), or Temporary Resident Card (I-688)

A court ordered notice for Asylees;

INS documents with an A-number; or

Other proof of lawful immigration status.

Other adults who want medical benefits must provide proof of their immigration status. We will contact the U.S. Bureau of Citizenship and Immigration Services to check their status. Most adults must also have been in the U.S. for at least five years.

LTC NOTICES FOR SPOUSAL RESOURCE ALLOWANCE

This notice informs Long Term Care providers that the standards for the prevention of spousal impoverishment effective January 1, 2022, will remain the same as those in 2021.

The term "spousal impoverishment" includes the standards for the Community Spouse Resource Allowance (CSRA) and the Community Spouse Maintenance Needs Allowance (CSMNA). The prevention of spousal impoverishment standards should be included in the oral and written information that must be provided to residents and potential residents about how to apply for and use Medicaid benefits. Facilities are required by federal regulations (42 CFR 483.10) and state statute (210 ILCS 45/2-211) to give an explanation of resident rights at the time of admission and at least annually thereafter.

The CSRA standard will remain $109,560.00. This is the maximum amount of resources a resident may transfer to a community spouse or to another for the sole benefit of a community spouse. The actual amount a resident may transfer is determined by deducting non-exempt resources of the community spouse from the standard of $109,560.00.

The CSMNA standard will remain $2,739.00. This is the maximum amount of monthly income a resident may give to a community spouse. The actual amount a resident may give is determined by deducting any gross income of the community spouse from the standard of $2,739.00.

Facilities may print brochure, HFS 3191, Nursing Home Services and Information for Couples, which gives additional information relating to the prevention of spousal impoverishment.

If you have questions, contact the Bureau of Long Term Care toll free at 844-528-8444.

SUPPORTIVE LIVING FACILITIES

Provider Notice Issued 11/09/2021

Date: November 9, 2021

To: Supportive Living Program (SLP) Providers

Re: Supportive Living Program Room and Board Amounts for 2022

This notice informs Supportive Living Program (SLP) Providers that, effective January 1, 2022, the Room and Board amounts will increase based on the 2022 Social Security increases.

- The Room and Board amounts for a single occupancy apartment will increase from $704.00 per resident per month to $751.00 per resident per month.
- The Room and Board amounts for a double occupancy apartment will increase from $505.50 per resident per month to $540.50 per resident per month.

If you have questions regarding this notice, contact the Bureau of Long Term Care toll free at 844-528-8444.

VETERANS SUPPORT SPECIALIST

Date: December 21, 2021

To: All Medical Assistance Program Providers

Re: Coverage of Veteran Support Specialist Services Effective December 1, 2021 per Public Act 102-0043

Per Public Act 102-0043, services provided by certified veteran support specialists may be covered effective with dates of service beginning December 1, 2021. This impacts both the Medicaid fee-for-service and managed care programs.

The Act requires the Department of Healthcare and Family Services (HFS) to recognize veteran support specialists who are certified by, and in good standing with, the Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc. as Mental Health Professionals (MHPs) as defined in 89 Ill. Adm. Code 140.453.

Veteran support specialists working within a Community Mental Health Center (CMHC) or Behavioral Health Clinic (BHC) may deliver any of the services an MHP is qualified to deliver consistent with 89 Ill. Adm. Code 140.453. CMHCs and BHCs may seek reimbursement for services rendered by an MHP consistent with the Handbook for Providers of Community-Based Behavioral Services and the corresponding fee schedule.

Questions regarding this notice may be directed to the Bureau of Behavioral Health at 217-557-1000 or HFS.BHCompliance@illinois.gov.

Kelly Cunningham, Administrator

SPECIAL NEEDS PROGRAM
THROUGH THE STATE OF ILLINOIS

FAQ

- 1. What population of Special Needs Children will participate in Managed Care?
- Children under the age of 21 with a physical disability category, or
- Enrolled in the Division of Specialized Care for Children (DSCC) CORE program, or
- Receiving Supplemental Security Income (SSI)

- Beginning in mid-September, families of Special Needs Children will begin receiving enrollment packets from Illinois Client Enrollment Services to enroll in a HealthChoice Illinois plan. Special Needs Children include: · Children receiving Supplemental Security Income (SSI) · Children enrolled in the Division of Specialized Care for Children (DSCC) CORE program · Children with a physical disability category These children have historically been excluded from Managed Care, but they and their families will now be able to receive the care coordination and other benefits provided by the Department's HealthChoice Illinois Managed Care plans.

MONEY FOLLOWS THE PERSON

Illinois' Pathways to Community Living Program:

We Help Individuals Living in Nursing Homes or Long Term Care Facilities Move Back to the Community.

Our Mission

To promote individual choice and control and increase the use of home and community based services.

Services and Supports

Pathways transition coordinators help you with the whole process:

- They give one-on-one support.
- They help with your move.
- They follow up with you for one year after you move.
- They work with you to create a care plan with the supports and services you need.

Pathways has financial support to help you with your move. We also have housing support to help you find the right place for you to live.

Pathways to Community Living Partner Agencies:

For more information, contact your local transition coordinator or call the Senior Helpline at
1-800-252-8966 [V]
1-888-206-1327 [TTY] which can assist anyone with filling out an online referral.

Publication of the Illinois Money Follows the Person Demonstration Program. Funding provided by the Federal Centers for Medicare and Medicaid Services.

In Partnership with the Illinois Department on Aging, Illinois Department of Human Services – Division of Developmental Disabilities, Division of Rehabilitation Services, and Division of Mental Health, Illinois Housing Development Authority, The University of Illinois at Chicago, U.S. Centers for Medicare and Medicaid Services, Centers for Independent Living, Community Mental Health Centers, Care Coordination Units, and service providers for the elderly, people with physical or developmental disabilities, and people with mental health conditions statewide.

The Illinois Department of Healthcare and Family Services does not discriminate in admission to programs or treatment of employment in programs or activities in compliance with appropriate state and federal statutes.

HFS 6 (R-11-15)
5,500 copies
Printed by the Authority of the State of Illinois
IOCI16-0218

State of Illinois
Department of Healthcare and Family Services

Pathways

To Community Living

The Illinois Money Follows the Person Demonstration

Email us at:
HFS.MFP@Illinois.Gov

Visit us on the Web:
www.MFP.Illinois.Gov

DHS LINK

- https://www.dhs.state.il.us/page.aspx?item=29719

- Review link:

BASICALLY WHERE THERE IS A WILL THERE IS A WAY

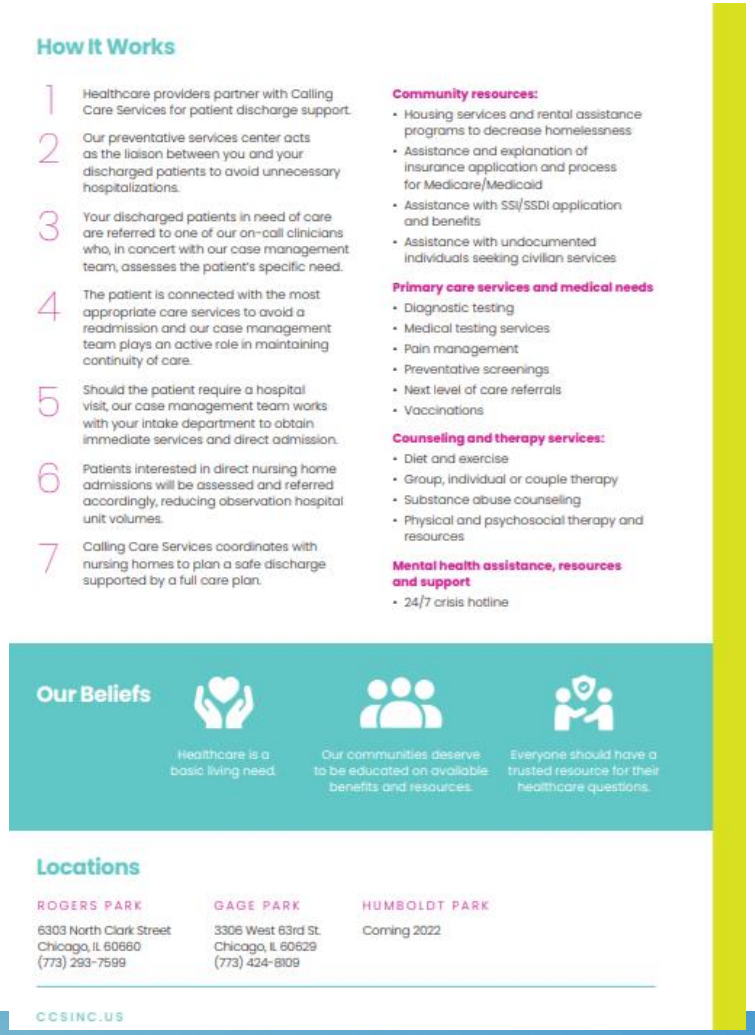
There are benefits out there for individuals during hardships.

It's about the time and dedication your willing to give your client/patient based off of the tools provided.

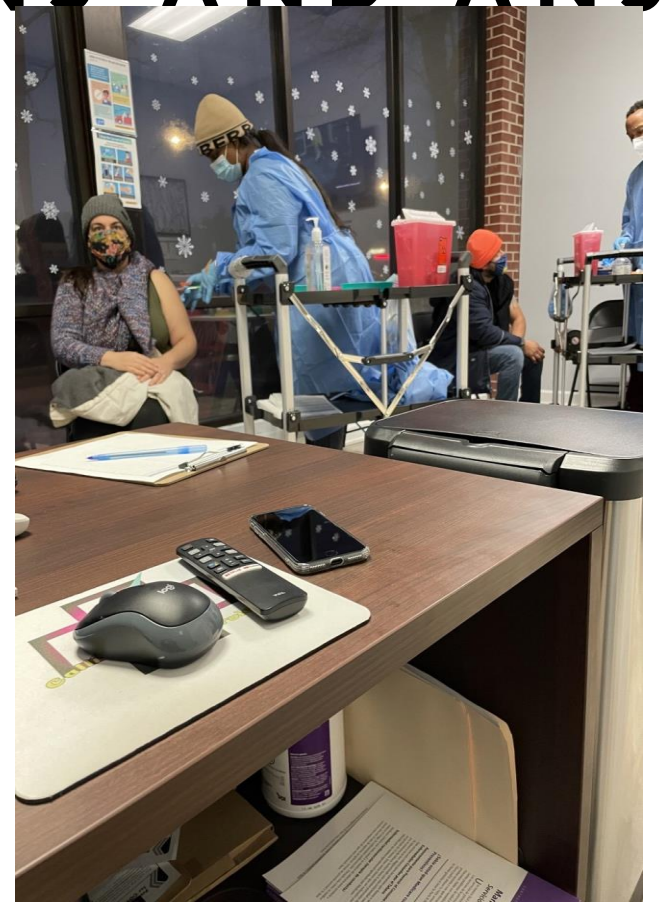
Everyday new benefits are being posted its about keeping upto date with all the new regulations and guidances!

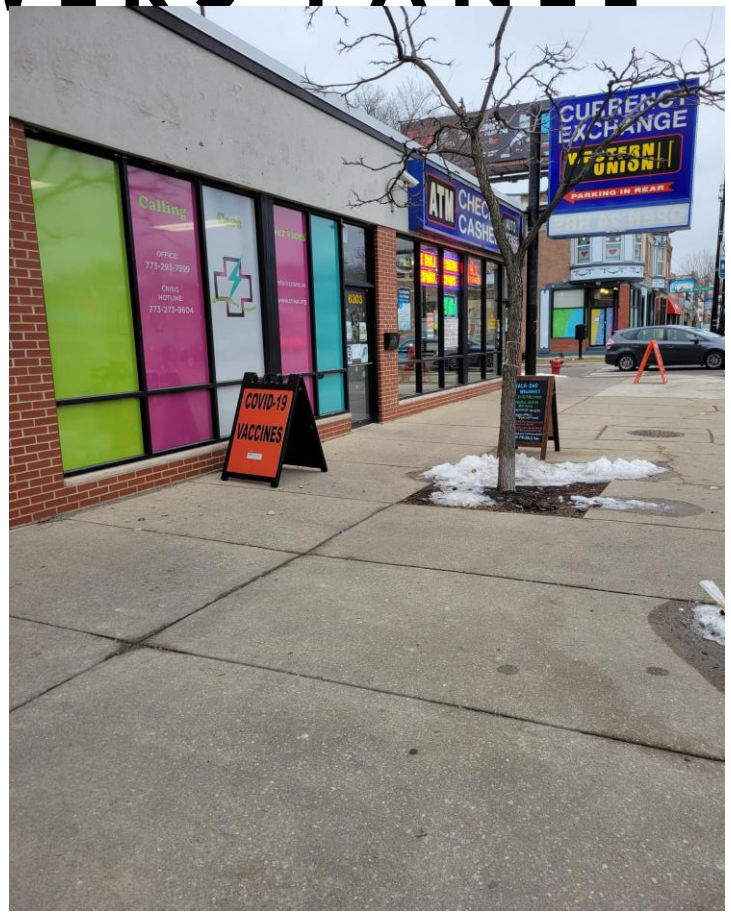
CALLING CARE SERVICES INC. HELPS WITH THE DISCHARGE PLAN PROCESS.

Click to add text



QUESTIONS AND ANSWERS PANEL





QUESTIONS AND ANSWERS PANEL

CMSA CHICAGO

SERVING ILLINOIS AND NORTHWEST INDIANA

Elite

Care Management, Inc.

GENTLE HOME

SERVICES

2022 CMSA CONFERENCE

Improving Lives Together: Case Managers Leading the Way

March 29, 2022

Drury Lane Theatre, Oak Brook

Early Bird Rate – 3/1/22:

Member: $40 (virtual); $50 in person

Non-Member: $150 (virtual); $175 in person

Non-Early Bird Rate:

Member: $80(virtual); $100 in person

Non-Member: $200(virtual); $225 in person