Healthcare Transformation Collaboratives Cover Sheet

1. Collaboration Name: GrouptoCare Metro East

2. Name of Lead Entity: GrouptoCare, Inc.

3. List All Collaboration Members:

GrouptoCare, Inc.
Addus
AgeSmart
Coordinated Care Alliance
Senior Services Plus
Southwestern Illinois Visiting Nurses Association

4. Proposed Coverage Area:

The Metro East Area of Illinois

5. Area of Focus:

Preventing the illnesses, injuries, and emergencies that lead seniors to finally seek assistance would result in better outcomes for the seniors themselves, less cost to the financial systems that pay for senior care, and an overall healthier aging experience in Illinois. This project seeks to reach low income, minority seniors before those tragic events that currently drive care and give them control over the resources available to keep them healthy. Additionally, this project provides paths for addressing caregiver and nursing shortages.

6. Total Budget Requested: $760,825.00

GroupToCare Metro East

Prepared by GroupToCare LLC
for Department of Healthcare and Family Services Healthcare Transformation Collaboratives

Primary Contact: Roger Kuhn

Opportunity Details

Opportunity Information

Public Link
https://il.amplifund.com/Public/Opportunities/Details/25595216-6cc7-40f0-9aa5-0b550dddc17c

Question Submission Information

Question Submission Open Date
10/01/2021 12:00 AM

Question Submission Close Date
10/15/2021 11:59 PM

Question Submission Email Address
HFS.Transformation@illinois.gov

Question Submission Additional Information

1. CONSIDER THE HTC INSTRUCTIONS GUIDE REQUIRED READING FOR HOW TO COMPLETE THE HTC APPLICATION.

Please read the HTC Application Instructions guide thoroughly, from beginning to end, before beginning your application. These instructions clear up many potential sources of confusion and provide instructions that are essential for submitting a complete and viable HTC application.

In this resource, we provide videos and slides for navigating the HTC application in Amplifund and instructions for completing specific sections of the application. (e.g., how to fill out a budget).

We also provide additional information about the content of the application to help you understand what HFS is looking for in an effective application.

The HTC Application Instructions Guide can be found at this address: https://www2.illinois.gov/hfs/HealthcareTransformation/Documents/HTCApplicationInstructionsGuide.pdf

For a brief checklist to keep your application on track, navigate to https://www2.illinois.gov/hfs/Pages/htcappinfo.aspx and find a link.

2. QUESTIONS ABOUT HTC AND THE SUBSTANCE OF THE APPLICATION ARE DUE BETWEEN OCTOBER 1 AND OCTOBER 15.

Questions seeking clarity on the HTC program and the substance of the application (as opposed to technical questions) should be sent to HFS.Transformation@illinois.gov. Questions are due before 11:59 pm on October 15, 2021. Answers will be published on the FAQ Page of the HTC website (https://www2.illinois.gov/hfs/Pages/htcfaqs.aspx).

HFS will answer questions as soon as possible. Interested parties should regularly check for new questions and answers at the FAQ web address listed above.

For more information about HTC and the application, you may also consult the September 30 informational webinar video and slide presentation, as well as the many resources available to support you in your application. All of these resources are located at the HTC Application Information page (https://www2.illinois.gov/hfs/Pages/htcappinfo.aspx).

3. AMPLIFUND WILL RESPOND WITHIN 2 HOURS TO ALL TECHNICAL SUPPORT QUESTIONS.

If you are having technical difficulties with Amplifund, you may email your question to support@il-amplifund.zendesk.com or call 216-377-5500, though callers to this number will likely be directed to the online system. Amplifund guarantees responses to support requests within two hours of questions submitted during business hours.

You may also consult the Amplifund customer support website at https://il-amplifund.zendesk.com. At this site, you may submit support tickets and access instructional content. Access to this site requires registration of a new account specifically with the Amplifund Zendesk site.

For a general overview of how to submit an application using Amplifund, you may access a tutorial video provided by Amplifund here: https://il-amplifund.zendesk.com/hc/en-us/articles/360053747153-Introduction-to-the-Applicant-Portal

Additional Information

Additional Information URL
https://www2.illinois.gov/hfs/Pages/htcappinfo.aspx

Additional Information URL Description
Please refer to the Application Information page of the Healthcare Transformation Collaboratives website for all information related to the application process.

For information about the program, visit htc.illinois.gov.

Project Description

0. Start Here - Eligibility Screen

HELP AND SUPPORT INFORMATION

If you need help or have a question:

- *For guidance on this form, consult the **HTC Application Instructions resource**.*
- *If you have a question about the subject matter of the application, email HFS.Transformation@illinois.gov before October 15. Questions will not be taken after that date. Check for answers at the **HTC FAQs page**, which will be updated continuously between October 1 and October 15.*
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Eligibility Screen

Note that applications cannot qualify for funding which:

1. **fail to include multiple external entities within their collaborative (i.e. entities not within the same organization); or,**
2. **fail to include one Medicaid-eligible biller.**

Does your collaboration include multiple, external, entities?

- (●) Yes
- ( ) No

Can any of the entities in your collaboration bill Medicaid?

- (●) Yes
- ( ) No

Based on your responses to the two questions above, your application meets basic eligibility criteria. You may proceed to complete the remainder of the application.

When you're finished answering the questions on this page, click Mark as Complete. An application cannot be submitted until all pages are marked as complete.
Not finished with this page yet? Click **Save** or **Save & Continue** to fill out the missing information at a later time.

1. Participating Entities

HELP AND SUPPORT INFORMATION

***Note on work process:** We strongly recommend that applicants draft responses to long-form narrative questions locally (i.e. in Microsoft Word) and then copy and paste these responses into Amplifund. Many Amplifund response fields will preserve formatting (e.g. a table, bullet list, or text style) copied from word processing applications, allowing applicants flexibility in how they format their responses.*

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Contact Information for Collaborating Entities

1. What is the name of the lead entity of your collaborative?
   GrouptoCare Metro East

2. Please provide primary contact information, secondary contact information, and the Tax ID # of each entity in your collaborative. Please list the lead entity in the top row.

Entity Name	Tax ID # (xx-xxxxxxx)	Primary Contact	Position	Email	Office Phone	Mobile Phone	Secondary Contact	Secondary Contact Position	Secondary Contact Email
GrouptoCare, Inc.		Roger Kuhn	President	roger.kuhn@grouptocare.com	1-866-721-6085		Cynthia Cunningham	Partner	
Senior Services Plus		Emily Jackson	Grant Writer	ejackson@seniorservicesplus.org	618-465-3298 ext. 117		Pam Jones	Director of Programs	psmith@seniorservicesplus.org
Coordinated Care Alliance		Bailey Huffman	Executive Director	bhuffman@coordinatedcarealliance.org	715-851-5098		Tish Rudnicki	President of the Board of Directors	trudnicki@nssc.org
Southwestern Illinois Visiting Nurse Association		Lori Webb	Executive Director	lori@sivna.com	618-236-5863		Jennifer Porter	Services for Seniors Director	jennifer@sivna.com
Addus HealthCare, Inc. dba Addus HomeCare		Nicole Gebke	Agency Director	ngebke@addus.com	618-632-1810		Natalie Benda	Regional Vice President of Development	nbenda@addus.com
AgeSmart		Joy Paeth	Ex. Dir	jpaeth@aesmart.org	618-222-2561				

3. Please confirm that you have entered the required information for each entity in the table above, including secondary contact information and Tax ID #.
   ◉ I confirm

4. Please upload the most recent IRS Form 990 (including Schedule H, if applicable) for all participants in the collaboration. (Note: These 990s will all have to be compiled into a single PDF file.)
   Collaborating partners 990s

Participating Entities

Glossary of Key Terms - Download Here

Note on the centrality of collaborations to HTC:

We believe that to truly transform health, patients' physical health, behavioral health and social needs must be addressed in a coordinated way within their community. Given this, we are looking for collaborations that represent a broad and meaningful spectrum of the healthcare, behavioral health and social determinants of health delivery system at the community-level.

Form 1 Glossary of Key Terms.pdf

Please answer the following questions regarding the various entities that would comprise your collaborative.

If you are unfamiliar with any key terms on this form, consult the glossary linked below.

1. Are there any primary or preventative care providers in your collaborative?
   ○ Yes

◉ No

2. Are there any specialty care providers in your collaborative?
○ Yes
◉ No

3. Are there any hospital services providers in your collaborative?
○ Yes
◉ No

4. Are there any mental health providers in your collaborative?
○ Yes
◉ No

5. Are there any substance use disorder services providers in your collaborative?
○ Yes
◉ No

6. Are there any social determinants of health services providers in your collaborative?
○ Yes
◉ No

7. Are there any safety net or critical access hospitals in your collaborative?
○ Yes
◉ No

8. Are there any entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that that are majorly controlled and managed by minorities?
○ Yes
◉ No

9. Please list the Medicaid-eligible billers (firms that can bill Medicaid for services) in your collaborative, and the Medicaid ID for each.
Senior Services Plus- 370975762918, 370975762907, 370975762802, 370975762801, 370975762302, 370975762203, 370975762202

Southwestern Illinois Visiting Nurse Association - 370673557002

10. Below are high-level descriptions of project types that appeared in the Transformation funding statute. Check any that apply to your project; if none apply, please provide a brief description of what kind of entities comprise your collaboration. (This question is informational only and will not affect your eligibility).
☐ Safety Net Hospital Partnerships to Address Health Disparities
☐ Safety Net plus Larger Hospital Partnerships to Increase Specialty Care
☐ Hospital plus Other Provider Partnerships in Distressed Areas to Address Health Disparities (led By Critical Area Hospitals, Safety Net Hospitals or other hospitals in distressed communities)
☐ Critical Access Hospital Partnerships (anchored by Critical Area Hospitals, or with Critical Area Hospitals as significant partners)
☐ Cross-Provider Care Partnerships Led By Minority Providers, Vendors, or Not-For-Profit Organizations
☐ Workforce Development and Diversity Inclusion Collaborations
☒ Other

10A. If you checked, "Other," provide additional explanation here.
The collaborators on this project are a mix of mostly not for profit organizations that provide Medicaid Long Term Services and Supports under the Medicaid Elderly Waiver.

[10A. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

When you're finished answering the questions on this page, click Mark as Complete. An application cannot be submitted until all pages are marked as complete.
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2. Project Description

HELP AND SUPPORT INFORMATION

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Brief Project Description

1. Provide an official name for your collaboration. NOTE: Please ensure that this name matches the name given in the "Application Name" field in the Project Information form at the beginning of the application.

GrouptoCare Metro East

2. Provide a one to two sentence summary of your collaboration's overall goals.

Preventing the illnesses, injuries, and emergencies that lead seniors to finally seek assistance would result in better outcomes for the seniors themselves, less cost to the financial systems that pay for senior care, and an overall healthier aging experience in Illinois. This project seeks to reach low income, minority seniors before those tragic events that currently drive care and give them control over the resources available to keep them healthy. Additionally, this project provides paths for addressing caregiver and nursing shortages.

Detailed Project Description

Provide a narrative description of your overall project, explaining what makes it transformational.

Specify your service area, identify the healthcare challenges it faces, and articulate your goals in addressing these challenges; explain your strategy and how it addresses the causes of these challenges, and lay out the expected timeframe for the project.

Describe any capital improvements, new interventions, delivery redesign, etc. Your narrative should explain the need for each significant item in your budget, clarifying how each connects to the overall goals and operations of the collaboration.

Provide your narrative here:

The Community Care Program (CCP) of the Illinois Department on Aging has grown and matured over the last 50 years to become very efficient at diverting people who are over age 60, with limited assets, to be eligible for state funded nursing home care from entering nursing homes. Home and community-based care is preferred by care recipients, who prefer to live at home. The state of Illinois benefits financially from the use of CCP as it is about one third the cost of institutional care. Historically, though, CCP services are provided in reaction to a serious illness, hospitalization, loss of a caregiver, repeated emergency department use, or other critical incidents that attract the attention of clinical case managers or informal caregivers such as family members who then reach out to a case manager for help. The Medicaid waiver requires that services are provided to avoid institutionalization and that recipients of care in the Community Care Program must, as determined by an assessment, qualify for state funded nursing home care. In the last 30 years, the program has diverted seniors from institutional care very successfully.

The continued success of CCP is threatened by a few factors. First, the number of seniors is rising dramatically while our state revenue to pay for care is not. Second, the number of caregivers available and willing to provide care is also dwindling. Agencies hiring caregivers are increasingly challenged to do so as wages can't be raised high enough in many areas of the state, and in particular, the Metro East area, to attract and retain good, professional caregivers because the state's rate of reimbursement is not high enough to further raise wages. Third, the vast majority of care is being provided one on one in seniors' homes rather than in adult day programs or other congregate sites which is not very cost effective and contributes to the fact that seniors are socially isolated. Fourth, limited resources and increasing caseloads leads to a case management system that only minimally utilizes input from care recipients in the delivery of their care.

In addition to the threats to the Community Care Program, our state's most powerful tool for preventing institutionalization of seniors, there are growing threats to their health and welfare, especially among those who live in poverty, in areas with few services and options. These threats are even more dire for people who are not white. According to the University of Illinois at Chicago's report, Transformation Data & Community Needs Report: East St. Louis Metro Area February 2021, seniors in the Metro East area make up a big number of people being hospitalized for bacterial pneumonia, diabetes complications, congestive heart failure, and hypertension. These diagnoses are called "Ambulatory Care Sensitive Conditions" in the UIC report. By definition, ACSCs are health conditions for which either good outpatient care can potentially prevent the need for hospitalization or early intervention can prevent complications and progression to more severe disease. Addressing some of the social determinants of health, applying preventive care, and breaking down the barriers for accessing both services and preventive care are the basic ways this collaboration will transform an illness based senior care program into a wellness model.

The collaborators on this project believe that the Community Care Program can become even more effective by becoming more proactive and address both the threats to CCP and to the health and welfare of seniors. Since the majority of participants enter the program after a critical incident such as the loss of a caregiver, emergency department visit, hospitalization, fall, or other serious event, the current system requires that seniors be ill before they can access care. The Medicaid waiver is designed to deflect participants from institutional care and into home and community-based services but doesn't pay for preventative care that could go a step further keeping our seniors healthy and out of hospitals and emergency rooms. Medicare skilled care is focused on rehabilitation after a critical incident, once again requiring seniors to be ill before they can receive care.

The collaborators on this project believe that we can transform this illness-based model of care into a much more positive situation. We intend to reach seniors with preventative care interventions, such as better nutrition, socialization, very minor homecare interventions in the home to prevent accidents and injuries, preventive medical care such as pneumococcal pneumonia and COVID vaccines, and monitoring of chronic conditions such as congestive heart failure, diabetes, and hypertension, so fewer would suffer critical incidents and the heavy use of long term services and supports, which are becoming difficult to staff, could be postponed.

Another threat to the Community Care Program is the caregiver shortage. Even prior to the pandemic which had led directly and indirectly to difficulty in hiring all workers, staffing shortages in hospitals, long term care facilities, and home and community-based services were becoming more commonplace as workers sought opportunities that paid similar wages for work that was more appealing to them. With the burnout caused by COVID care, the concern around bringing a potentially life-threatening virus home to family members, and continued stagnant wages, even more homecare aides and nurses have left the caring professions. The vast majority of care provided in the Community Care Program is provided on a one-to-one basis, which is entirely unsustainable in not only the current environment, but going forward as our senior population is set to grow exponentially and the workforce available to care for those needing care does not grow in proportion. Another goal of this collaboration is to create another possible option for the Community Care Program—Group Care—which enable as many as three participants to receive services from the same homecare aide simultaneously for services that would benefit from congregate care, such as nutrition services. Providing GPS scheduling of homecare aides would also allow for consecutive appointments grouped by location, better utilizing the time of the homecare aide, allowing care recipients to schedule in hours convenient for them, and potentially allowing the use of shorter appointments to accomplish tasks rather than a two-hour minimum.

The coronavirus pandemic has further isolated seniors as they are most vulnerable to the worst outcomes if they should contract the disease. According to the National Institute on Aging, research has linked social isolation and loneliness to higher risks for a variety of physical and mental conditions: high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even death. Just as significantly, seniors living alone are at risk nutritionally, both for eating too much of the wrong food and for not eating much at all.
The University of Illinois at Chicago study lists many barriers by social determinants of health that seniors living in poverty in the Metro East area experience to improving their health and wellness. Through numerous interviews, the researchers identified five basic barriers to receiving preventive care that could result in better wellness outcomes. A lack of knowledge and information about the doable lifestyle options they could adopt that could positively affect their health and a lack of awareness of community options that could help with their wellness had a negative impact on wellbeing. Economic factors such as economic instability which results in the inability to afford healthy food and difficulty in arranging transportation to places where they can receive care are another barrier. A third barrier is the healthcare services themselves. Many have had previous negative health care experiences such as poor quality of local facilities, long wait times, and some people even cited situations where the healthcare provider did not listen to them about what medications their insurance paid for or about their lack of options for healthy foods which led them to avoid traditional healthcare services. Socio-cultural factors play a role in preventing people from improving their wellness status. Culturally ingrained food and cooking habits lead to poor nutritional choices. The desire to conceal health issues from family and friends results in people having reduced options for seeking healthcare or pursuing healthy options. Further, there is a hesitancy to seek care due to historic healthcare system mistrust following deceptive practices of studies in the healthcare community that put people of color at risk of even further declining health rather than the improvement that was promised. Additionally, many people have a personal history of being treated by providers who didn't take the time to listen to them about their concerns and resources and assigned treatment without regard to their ability to comply with the treatment plan. The last social determinant of health identified that is interfering with the ability of people in the Metro East to improve their health is environmental. There are significant resource, service, context and infrastructure obstacles in the community that limit their ability to maintain health and engage in healthcare. Of particular relevance to the population of people 60 and older are the presence of unhealthy food, exposure to ongoing crime, street violence, domestic abuse, neglect, discrimination, air pollution, and a lack of resources for healthy food, recreation, transportation, and walking infrastructure.
The GrouptoCare Metro East collaboration project has multiple goals. The overall purpose of the GrouptoCare Demonstration Pilot is to test the concept of small group care within a Community Care Program-like context, demonstrate the effectiveness of wellness visits and education on prevention of critical incidents, test the level of care recipient satisfaction and participation with their ability to control the services they receive, and prove out a system of geographic scheduling to better utilize the time of homecare aides, formal case managers, and other service delivery. We intend to increase the use of preventive services among seniors by achieving a level of trust that they have with us, in addition to giving them control over the circumstances, by empowering them with the ability to choose and schedule services, make those services accessible to them by offering them in their own community, and building relationships between people at risk for critical incidents by being a presence in their community. The collaborators on this project believe that people who can socially interact with each other while receiving care will experience less social isolation. The group care treatment modality should prove to be less expensive to payors. Wages for professional caregivers should be higher than what they receive providing one on one care. We believe seniors who are served a nutritious meal in the company of others are much more likely to eat that meal than they are when they are alone. Our goal is to provide another path for the Illinois Department on Aging as they look to continue the important work of supporting our seniors at home.
Our collaboration will be transformational as it turns the current model upside down. Instead of treating conditions after a tragic event or critical incident, our project focuses on the relationships, elimination of barriers, and addresses the social determinants of health that preclude the implementation of a preventive care approach. A further bonus of our approach is that it is sensitive to the caregiver/nursing shortages and applies approaches for maximizing our available human resources, which is an absolute necessity for senior care as the baby boom generation ages into care.
The attached flowcharts detail how our model will work.

Specify your service area, identify the healthcare challenges it faces, and articulate your goals in addressing these challenges; explain your strategy and how it addresses the causes of these challenges, and lay out the expected timeframe for the project.

Service Area

Our service area is the Illinois side of suburban St. Louis, Missouri, often referred to as the Metro East area. Our project is focused on services for seniors. The area and the senior population in the area face multiple healthcare challenges, most of them with significant impact from social determinants of health. This collaboration is focused on wellness issues and social determinants of health that most affect people aged 60 and older. In particular, we're concerned about nutrition, access to healthcare via formal and informal case management, self-determination in the process of wellness, creating more efficient use of resources which would enable the provision of more care for people who need it, and decrease the excessive use of hospital and emergency department services for medical conditions seniors have, such as diabetes, congestive heart failure, hypertension, and bacterial pneumonia that could be managed more efficiently in the community through addressing some of the social determinants of health that are having a negative impact on these medical conditions.
The chart below shows the buildings we plan to target, which were chosen based upon needs identified by AgeSmart in their process of determining needs in the community that they do every three years, and by anecdotal evidence from both Senior Services Plus and Southwestern Illinois Visiting Nurses Association.

Community	Name	Population Type	Total Units
Alorton	Hawthorne Terrace Apartments	Mixed	44
Alton	Oakwood Estates	Mixed	100
Alton	Alton / East Alton	Mixed	100
Alton	Alton Manor	Senior Only	44
Alton	Alton Pointe	Mixed	84
Alton	Marion Heights	Senior Only	128
Alton	Skyline Towers	Senior Only	158
Alton	Hillcrest Apartments		100
Belleville	Amber Court Apartments	Senior Only	64
Belleville	Plaza II Apartments	Senior Only	38
Belleville	Bel –Plaza 1	Senior Only	48
Belleville	Westfield Manor	Senior Only	62
Belleville	Cottages at Cathedral Square	Senior Only	32
Belleville	Carriage House Place		30
Brooklyn	Thomas Terry Apartments	Mixed	158
Centreville	Private Mathison Manor	Mixed	233
Centreville	Adeline James Building	Senior Only	40
Centreville	Touchette I	Senior Only	75
Collinsville	Braner Building	Senior Only	69
Collinsville	Woodland Park	Mixed	80
East Alton	Township Village Apartments	Senior Only	122
East St. Louis	Touchette	Senior Only	50
East St. Louis	Jazz @ Walter Circle	Senior Only	74
East St. Louis	Central city	Mixed	84
East St. Louis	Orr - Weathers Apartments	Mixed	248
Edwardsville	May Building	Senior Only	46
Granite City	Parkside	Mixed	64
East Alton	Olin Building	Senior Only	59
Granite City	Anchorage Homes	Mixed	200
Granite City	Vintage Garden Apartments		26

Lebanon	Cedar Ridge Apartments	Senior Only	24
Lebanon	Cedars of Lebanon	Senior Only	120
Madison	John Hamm	Mixed	55
Madison	Washington Ave Apartments	Mixed	85
Marissa	Clayton Manor	Primarily Senior	26
O'Fallon	O'Fallon Senior Apartments	Senior Only	132
O'Fallon	Regency Manor	Senior Only	75
Swansea	Metro Landing Apartments	Senior Only	62
Venice	Meacham Crossing	Senior Only	78
Wood River	Steven's Building Apartments- Mad Co Housing		56
Total			3373

Healthcare Challenges, Barriers, Strategies, and Goals

Persons included in the UIC study of health disparities in the Metro East identified several barriers to participation in the activities that they recognized as being important in the improvement of their health conditions. Primary among them was access to care. Respondents to surveys and in interviews in the UIC study stated multiple times that lack of transportation to appointments, wellness services, and even to grocery stores with nutritious options was a huge barrier to accessing those things. Our collaboration will provide for services and the access to those services onsite, in the affordable housing buildings that we have identified as needing them via data in the UIC study, identification of service areas through our local providers, and through the studies done over the last several years by AgeSmart.

Another significant barrier to care identified in the UIC study was the frustrating relationship many people looking for care in the Metro East identified that they had with their providers. They said that their doctors didn't listen to them, prescribed medications not covered by their prescription insurance plan, made wellness recommendations that they were not able to follow because of the area in which they lived, lack of transportation, and/or cultural preferences that made change, particularly in the area of nutrition, very difficult. Our collaboration will utilize case managers and nurses assigned to each building and will work in conjunction with Resident Services Coordinators within the affordable housing communities identified as having low-income seniors who were likely in jeopardy of having poor health outcomes. By creating and maintaining relationships, we intend to earn the trust of seniors living in the affordable care buildings so they will be more likely to accept recommendations. Further, with good relationships in place, we believe that we will decrease the likelihood that case managers and nurses will recommend plans of care that the care recipient will not be able or willing to implement. Services will be provided onsite, eliminating the complication of transportation. Services will also, with safety precautions in place and when the pandemic environment becomes safer, arrange for congregate care especially with regard to meals, to address the social isolation that is well known to cause negative healthcare outcomes. We plan to utilize both formal and informal case management strategies. Resident Services Coordinators will be trained by the Coordinated Care Alliance in the observation and intervention techniques that will enable them to spot potential issues before they become emergencies. Southwestern Illinois Visiting Nurses Association case managers will accept referrals from these informal case managers and meet with people potentially needing care to do a needs assessment. Once their eligibility is determined, we will use our kiosks in each building to give the property managers, case managers, family members, and seniors access to GrouptoCare software which will allow them to view a calendar of services available within their buildings and to schedule into them, determining the services, times, and options most helpful to the senior living in the building. Additionally, wellness services and education will be provided in each building and will be staffed by the same nurse and nurse educators so that residents of the building can develop a trusting relationship with the people recommending and providing needed care, such as immunizations, a little supportive care, wellness education, and nutrition support and services.

Our goals:

To reduce social isolation in community living seniors with care needs.
To improve nutritional status in community living seniors with care needs.
To improve wellness in seniors diagnosed with diabetes, hypertension, and congestive heart failure.
To reduce hospitalization of seniors in the Metro East area for bacterial pneumonia.
To improve recruitment and retention of professional caregivers by improving job satisfaction.
To demonstrate a path to reducing Community Care Program expenditures.

Our outcomes:

Seniors participating in GrouptoCare will show improvement in social isolation assessment scores from pre-programming to end of the project.
Seniors participating in GrouptoCare will show improvement in nutritional assessment scores from pre-programming to the end of the project.
Professional caregivers working in the GrouptoCare project will receive higher salaries than their counterparts working in traditional one to one care or adult day services in the area.
The cost of care plans for GrouptoCare participants will be lower than the service cost maximum allowable under the Department on Aging's Community Care Program for their assessed Determination of Need score.
The number of seniors hospitalized for bacterial pneumonia will decrease.

To summarize, our strategy is to develop and/or improve relationships between individuals over the age of 60 in congregate living arrangements with case managers, care providers, and informal caregivers. The purpose of developing and improving these relationships is to develop trust that will enable people in jeopardy of experiencing negative consequences because of their age, diagnoses such as diabetes, congestive heart failure, hypertension and the fact that they live in a community with a high rate of bacterial pneumonia to learn about and engage in both medical and non-medical management of chronic conditions that will prevent misery, emergency department and hospital use, as well as disability and premature death. Our model will enable people to be the drivers behind their own plans of care, working with trusted case managers who will determine eligibility for financial assistance for care and facilitate their development of their own strategy for maintaining or improving their health. Care strategies include nutrition services, wellness education, health monitoring, assistance with chores, housekeeping, and activities of daily living, congregate care and education to reduce loneliness. All care and education will take place on the premises where the identified participants live with individual care taking place in individual apartments and congregate care and education in apartment building community rooms.

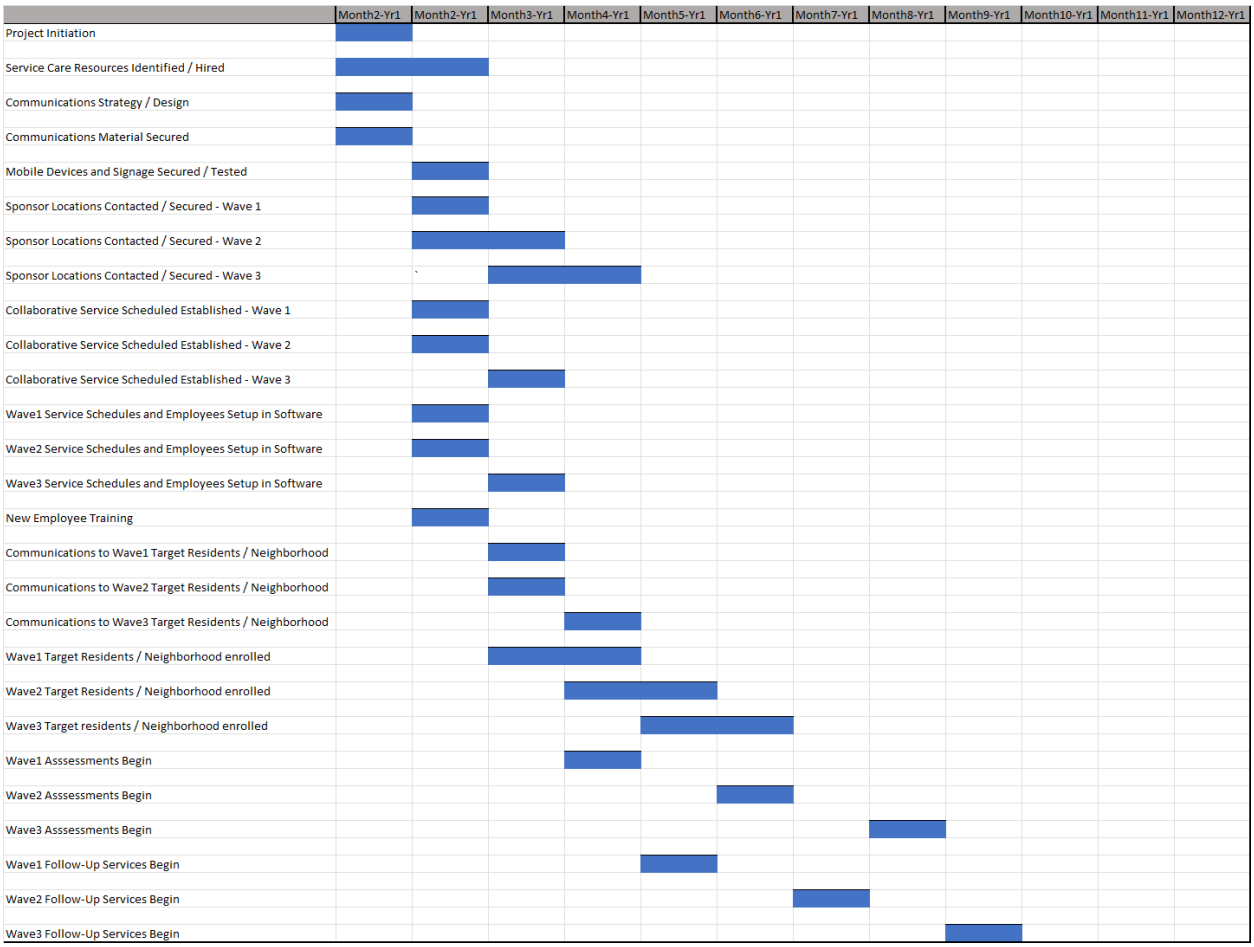
Timeframe

The Ganntt chart below demonstrates graphically how our collaboration intends to phase in each part of the project. Advertising will begin at the onset of the program and continue through its completion. The Gantt chart follows this page.

Describe any capital improvements, new interventions, delivery redesign, etc. Your narrative should explain the need for each significant item in your budget, clarifying how each connects to the overall goals and operations of the collaboration.

Our collaboration focuses on redesigning key elements of the delivery of Community Care Program services and adding services to prolong the need for entering the Community Care Program. All services are aimed at preventing unnecessary misery, emergency department use, hospitalization, institutionalization, and premature death. Our collaboration will use existing capital resources—the buildings that house our collaboration partners, the buildings where the targeted seniors currently live and the community rooms within those buildings. The software to be used has been developed and all software development costs will be considered "in kind."

Our budget will be used for overcoming the barriers that are inherent in any kind of systems change. We've included money for advertising—to increase knowledge and acceptance of this new idea in senior care. Advertising will be necessary not only to let people know about the service, but to also win people over to the idea that health care can and should be preventative, not sickness oriented. According to the UIC research, a big barrier to accessing care in the communities we will serve in the Metro East is the


Month2-Yr1
Month2-Yr1
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Month6-Yr1
Month7-Yr1
Month8-Yr1
Month9-Yr1
Month10-Yr1
Month11-Yr1
Month12-Yr1
Project Initiation
Service Care Resources Identified / Hired
Communications Strategy / Design
Communications Material Secured
Mobile Devices and Signage Secured / Tested
Sponsor Locations Contacted / Secured - Wave 1
Sponsor Locations Contacted / Secured - Wave 2
Sponsor Locations Contacted / Secured - Wave 3
Collaborative Service Scheduled Established - Wave 1
Collaborative Service Scheduled Established - Wave 2
Collaborative Service Scheduled Established - Wave 3
Wave1 Service Schedules and Employees Setup in Software
Wave2 Service Schedules and Employees Setup in Software
Wave3 Service Schedules and Employees Setup in Software
New Employee Training
Communications to Wave1 Target Residents / Neighborhood
Communications to Wave2 Target Residents / Neighborhood
Communications to Wave3 Target Residents / Neighborhood
Wave1 Target Residents / Neighborhood enrolled
Wave2 Target Residents / Neighborhood enrolled
Wave3 Target residents / Neighborhood enrolled
Wave1 Asssessments Begin
Wave2 Asssessments Begin
Wave3 Asssessments Begin
Wave1 Follow-Up Services Begin
Wave2 Follow-Up Services Begin
Wave3 Follow-Up Services Begin

concern and stigma around seeking care. We will launch a public information campaign aimed at seniors to normalize the management, both pharmacological and non-pharmacological, of chronic conditions. Another barrier to the implementation of this project without grant support is technology that allows for scheduling of care and services geographically and for enabling self-scheduling of services by participants. So, in the budget, money is budgeted for an enhanced rate of pay for CCP in home services and case management services to enable agencies to train staff, work through programming and computer issues, and for the extra time case managers will need to explain the concepts of newly available services to participants and their family members. There are funds budgeted for training of Resident Services Coordinators and for kiosks for the software platform in each building where we will offer care. Because, in order to eliminate the transportation barrier to access to healthcare and nutrition, services will need to be onsite of the affordable housing most used to by seniors who have low income. Also, in order to put seniors in charge of their own care and enable them to self-determine their plans of care, they will need to have access to the software themselves. There is money in the budget to train informal caregivers in the use of the software platform. Another budgeted item is the labor for the wellness projects. There are existing wellness services in the area. What is missing is the tie in between services that could address issues noted in wellness visits, give access to seniors who need them, and give control to the seniors and/or their responsible parties to schedule them. Our wellness component of the project will provide targeted nursing wellness visits and wellness education into areas identified as having seniors in most jeopardy of experiencing a critical incident as a result of unaddressed health, social, or supportive needs. Budget items needed for the delivery of the project's wellness services include GrouptoCare software, travel, labor, equipment, PPE, GrouptoCare service support, and advertising/marketing. We have had to ask for significant support for labor costs because it is currently expensive to hire and retain caregivers and nurses. We believe that this support will not be necessary in coming years as we are able to implement some of the efficiency measures to address workforce shortages.

Our project is divided into six main components—nutrition, formal and informal case management, alleviating social isolation, self-determination, efficient use of resources, and a focus on wellness. By working on these components, the collaborating partners believe that we can improve the lives and well-being of seniors living in the Metro East.

The first area of our requested budget is nutrition. While there are senior nutrition programs in the Metro East area, our collaboration seeks to increase the value of those programs by coordinating congregate meals within affordable and market rate senior living apartments, thereby addressing both nutrition and socialization needs. The congregate use of meal delivery within the Community Care Program could work to simultaneously improve the consumption of healthy meals that are better for people with diabetes, congestive heart failure, and hypertension. The social aspect of the meal will increase the likelihood that the people in care will actually eat.

Socialization costs are also included in the budget, in particular for the use of community rooms and for meals. We believe once we've proven out our model, we won't need to pay for rent of community rooms as the buildings will want services like this in their buildings are they will create a level of service in a no service building and if we keep their residents healthy, the turnover rate for the buildings should go down, hopefully considerably, saving our partners in the affordable housing industry money. We feel that adding a socialization component to our project is very important because we know that loneliness is one of the key social determinants of health that leads to hospitalizations and other poor health outcomes. The current socialization options in the Community Care Program are not available statewide. For a variety of reasons, access to adult day services in Illinois, which is the primary means of providing socialization for seniors within the Community Care Program is severely limited. There is only one adult day center remaining in the Metro East area. Using congregate care, once it is safe, will address the loneliness experience by so many seniors, but especially by those living in areas where there is little transportation available to social functions, uncertainty about the safety of accessing social opportunities in the neighborhoods in which they live, and even uncertainty around a senior's ability to physically access social opportunities because of their own diseases or chronic conditions.

Case management, both formal and informal, make up the third component of our collaboration. Participants in the UIC study stated that they did not have the information that they needed to make good informed decisions about the care that they need, both medical and non-medical. Case managers from SIVNA will assess the needs of seniors in our targeted buildings and help them access the services they qualify for and the means to pay for them. Additionally, Resident Services Coordinators will be trained by CCA to recognize signs and symptoms of people who may need preventative services and will instruct them how to reach out to those people and connect them with the services that could help.

The fourth element of our project is self-direction. Through this software program, participants are given the power to choose what services they would like to receive and when. Property Managers and Resident Resource Coordinators will be trained as informal case managers to be able to identify potential solutions for residents and direct them to the building's kiosk to then select services. Case managers from SIVNA will do assessments to determine eligibility of Department on Aging funding for services and will determine the level and number of services each participant qualifies for, entering that information in the GrouptoCare software so that the participant will not be able to exceed allowed service maximums but will be able to self-direct care. A common concern in the UIC study of healthcare barriers was that participants were not able to comply with care plans assigned by their healthcare providers. In this project, participants will design their own care plans. Money for enhanced case management that would include the group care concept is included in the budget as are kiosks, software support, tablets, and Internet connection.

The fifth element is efficiency. Through geographic focus, social service provider staff would be able to visit/serve clients in a region that would lead to less travel time and more seniors cared for. There is a workforce shortage that significantly impacts the services provided in this Collaboration and through increased efficiency provided by this software, the organizations will be able to better utilize current staff while cutting down on travel time from client to client. Eventually, as prevention and treatment of COVID-19 improves, congregate care will become safer and people will be able to receive some services in a group setting, enabling the sharing of caregivers and nurses.

Sixth, nurses will be involved in wellness interventions and will be able to monitor chronic conditions, such as hypertension, diabetes, and congestive heart failure which account for so much avoidable misery, hospitalization, and early death. The nurses will assist with communication with participants' physicians to make sure that medications and care plans can be adjusted to meet the ongoing needs of the people served in the project. They will also provide educational programs about the diseases and conditions and what can be done to avoid negative outcomes. Also, as one of the most common reasons for hospitalization among the senior population in the Metro East is bacterial pneumonia, our project will also include in person, onsite immunization clinics. Money is budgeted for the staff, travel, PPE, and educational components of this part of the program.

[Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

GTC Flow charts are attached as Appendix One

When you're finished answering the questions on this page, click Mark as Complete. An application cannot be submitted until all pages are marked as complete.
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3. Governance Structure

HELP AND SUPPORT INFORMATION

***Note on work process**: We strongly recommend that applicants draft responses to long-form narrative questions locally (i.e. in Microsoft Word) and then copy and paste these responses into Amplifund. Many Amplifund response fields will preserve formatting (e.g. a table, bullet list, or text style) copied from word processing applications, allowing applicants flexibility in how they format their responses.*

If you need help or have a question:

- *For guidance on this form, consult the **HTC Application Instructions resource** and the **HFS Guide to Collaborations.***
- *If you have a question about the subject matter of the application, email HFS.Transformation@illinois.gov before October 15. Questions will not be taken after that date. Check for answers at the **HTC FAQs page**, which will be updated continuously between October 1 and October 15.*
- *If you need technical support in Amplifund, email support@il-amplifund.zendesk.com with your question. All emails sent within business hours (7am-5pm) should receive a response within two hours.*
- *If you'd like to consult support resources provided by Amplifund: Visit the vendor's **support website** for user guides, tutorial videos, and other resources. You will have to register a new and separate account to access content on this site.*

Note on the significance of governance structure:

We recommend you consult the HFS Guide to Collaborations for your reference as you develop your governance structure.

The governance section should reflect serious thought regarding the execution, management, accountability, and inter-reliance of the participating members of your collaboration. It should be clear how the structure and governance will bind the various participating organizations into an interrelated enterprise to accomplish the scope of work and the promised outcomes of the proposal. A well-developed governance process is the engine that will drive the effective implementation of the project. Absent quality governance, great ideas and good intentions often fall short or fail altogether

Structure and Processes

1. Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated and priorities set?

Distribution of Authority and Responsibility
Our collaboration is made up of a group of providers of care for seniors who have worked together in various capacities over the course of, in some cases, 20 years. Our lead applicant in the collaboration is GrouptoCare. This is the company that conceived of the idea of congregate care in the community care program and in similar types of care structures as well as the concept of geographic scheduling to enable both congregate and consecutive appointments and developed the software to do so. Our lead fiscal agent is AgeSmart, the region's Area Agency on Aging. AgeSmart has policies and procedures in place for the distribution and monitoring of the use of grant money—it's part of what they do as an agency. In addition to monitoring and distributing the grant money, AgeSmart will also manage and analyze outcome data to determine how well our project is impacting the health issues of seniors in this project. GrouptoCare will collect both outcome data and quality assurance and AgeSmart and Coordinated Care Alliance will be responsible for the analysis of the data as they do not have a financial interest in the outcome of the project. GrouptoCare will provide the software, training on the software, and support of the product. The GrouptoCare software will be used for scheduling and data collection. GrouptoCare will also set up kiosks in apartment buildings and teach resident coordinators how to use it. GrouptoCare will bill provider agencies a small fee per care transaction on the platform to the agencies providing care. Senior Services Plus will provide homecare aides and meals, as determined by the assessment process. They will bill the Medicaid waiver program for services through the Illinois Department on Aging and the MCO's in the region. Senior Services Plus bills Meridian, Aetna, and Blue Cross Blue Shield. SIVNA will do Determination of Needs assessments for participants with Medicaid, CCP enrollment, and/or MCO enrollment. They will bill the Medicaid waiver for their services via the Illinois Department on Aging. Addus will provide homemaker services for areas outside of Saint Clair and Madison Counties and will also provide wellness education programs. Addus will bill the Illinois Department on Aging for Medicaid waiver services as well as any MCOs that cover participants for their care needs. The wellness education programming will be billed to the grant. Coordinated Care Alliance will be responsible for quality assurance of this project. Data will be collected on participant satisfaction, standardization of services to ensure equity within the project, equity oversight, analysis of critical incidents, and will train resident service coordinators and/or family members the basics of informal case management. The members of the collaborative have been discussing this project at various points in the past two years, beginning before the pandemic started in 2020.
Policies and Procedures
Decisions are made in joint, virtual meetings. The Collaborative's Executive Team will meet at least monthly during Year One, with the option to move to quarterly meetings in subsequent years. One representative from each Collaborative will be present for decision making. Every member has an equal voice in the collaboration with recognition that each organization brings its own individual expertise to the collaboration. Policies and procedures for the provision of services will be the existing policies and procedures that each agency brings to the collaboration.

[1. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Accountability

2. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally, and with extensive participation from each participating entity? What methods will be used to enforce policy and procedure adherence?

Accountability
Both quality assurance and outcomes measurement will be completed by entities with the least to gain financially from positive outcomes of this project to ensure that our data is accurate, analyzed without bias, and that the successes, troubles, and outcomes of this project are measured appropriately and that changes are made to implementation strategies in order to maximize positive outcomes for the seniors of the Metro East area.
Adherence
The collaboration consists of several agencies that have been in business for many years and have solid reputations for integrity and quality care. The newest provider is GrouptoCare which was formed by two people known for their integrity in their industries. The organizations providing services have internal controls and systems for quality assurance over the functions they will provide. GrouptoCare has quality mechanisms and a team of technicians to ensure the software and scheduling goes smoothly and that needed adaptations can be made quickly.
Coordinated Care Alliance will be responsible for quality assurance activities. AgeSmart will be responsible for fiscal management of the program and for management and reporting of outcomes data.

[2. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

New Legal Entity

3. Will a new umbrella legal entity be created as a result of your collaboration?

- ○ Yes
- ◉ No

[3A. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Payments and Administration of Funds

Note: It is likely that transformation funds for proposals will come in the form of utilization-based Directed Payments to a healthcare provider(s) or behavioral health provider(s) in the collaboration. These entities will receive a report earmarking these payments as transformation funds. These funds must then be distributed among the collaborating entities.

4. How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's intended purpose? If the plan is to use a fiscal intermediary, please specify.

SIVNA, Addus, and Senior Services Plus will bill their usual payor sources for services provided under the grant. We are asking for an enhanced rate of reimbursement for these providers under the normal billing procedures. GrouptoCare will bill a small per transaction fee to the agency using the software that will be less than the difference between their normal rate of reimbursement and the enhanced rate of reimbursement. All collaborating partners will keep track of grant expenses and submit funding requests to AgeSmart. AgeSmart will bill the grant for the services to make the transformation successful—advertising, equipment, and wellness services not covered by any current Medicaid/Medicare program—and reimburse collaborating partners for those expenses.

[4. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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4. Racial Equity

HELP AND SUPPORT INFORMATION

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If you need help or have a question:

- *For guidance on this form, we especially recommend reviewing the recording of the 9/30/21 Informational Webinar (accessed via the HTC **Application Information** page) in which the racial equity section received extended explanation. You may also consult the **HTC Application Instructions resource** and HFS' **Racial Equity Impact Assessment Help Guide** posted on the HTC website.*
- *If you have a question about the subject matter of the application, email HFS.Transformation@illinois.gov before October 15. Questions will not be taken after that date. Check for answers at the **HTC FAQs page**, which will be updated continuously between October 1 and October 15.*
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Background on HTC and racial equity:

This form contains a racial equity impact assessment, or REIA. An REIA is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision. REIAs are used to minimize unanticipated adverse consequences in a variety of contexts, including the analysis of proposed policies, institutional practices, programs, plans and budgetary decisions. The REIA can be a vital tool for preventing institutional racism and for identifying new options to remedy long-standing inequities. (Source: Race Forward - **"Racial Equity Impact Assessment"**)

High-Level Narrative

A fundamental focus of healthcare transformation is racial equity. Please provide a high level description of how the design of your proposal incorporates racial equity. (Greater detail will be requested in the questions below.)

It is the purpose of this collaboration to prevent the misery, avoidable emergency room use, avoidable hospitalizations, loss of income, financial burden upon state funding sources, and premature death prevalent in populations with lower income in Illinois. A disproportionate number of racial minorities and senior citizens over the age of 60 have lower incomes. We have targeted our project to serve lower income seniors and have insured that we will do so by choosing the locations for services that we did. Also, the partners in this collaboration—AgeSmart, Southwestern Illinois Visiting Nurses Association, Coordinated Care Alliance, Senior Services Plus, Addus, and GrouptoCare were all formed with the purpose of this collaboration at the center of their business. Each agency has worked separately to achieve that overarching objective since their inception, often partnering with each other in the service of the same population. It has been a source of frustration for all partners that despite our individual efforts, these health disparities remain. To be sure, people who are white, have middle to upper income and assets, have no history of systemic discrimination, no history of interacting with a health care system that has used them as guinea pigs without their knowledge or permission, do not have these rates of unavoidable critical incidents and misery from conditions that can be prevented, like bacterial pneumonia or managed, like diabetes, hypertension, and congestive heart failure.
We chose our target buildings based upon the age of the population that they serve, fee structure focused on serving people with low incomes, and based upon the experience of the agencies already providing care in those buildings, which created insight into further needs not being met there. Our collaboration built our project around the barriers and needs identified in both UIC's study and AgeSmart's public information document as those that could have the most positive impact on the populations that currently experience the worst outcomes.

[High Level Narrative - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Racial Equity Impact Assessment Questions

1. Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?

8% of Madison County's population of seniors age 60 and older are minorities as well as 28% of St. Clair County's population of seniors age 60 and older. In the East St. Louis region, 76% of the total population is white, 19% is black, 3.5% is Latinx, and 1.4% is listed as "other". A disproportionate number of minority seniors have low incomes. We have pinpointed the medical diagnoses of hypertension, congestive heart failure, and diabetes for intervention because these conditions cause the highest rates of avoidable hospitalization in East St. Louis, in particular, according to the University of Illinois at Chicago study among the senior population that our collaborating partners serve. In order to make sure that we reach the people that make up the largest portion of the population experiencing unnecessary negative outcomes based upon their income, race, ethnicity, and culture, we have located our services in the buildings where the people likely to have negative outcomes live.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2. Have stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities — been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged?

This program was conceptualized to fill a gap identified by senior-focused community agencies and seniors in the East St. Louis metro area. The gap in access to care was identified through the Public Information Document released by AgeSmart Community Resources. 207 diverse seniors responded to a survey and 36 reported needing assistance with cooking and meal prep, activities provided by non-medical in-home services. This was the second highest need reported on the survey. We also used the UIC document, "Transformation Data & Community Needs Report: East St. Louis Metro Area" to determine our target populations, diagnoses for the wellness portion of the grant, and to determine the barriers to care. Different racial/ethnic groups were surveyed and consulted in the formation of both documents and in determining the needs for care and barriers to overcome.
Missing from this project is direct involvement in the design of the project by the people we are serving. However, the care plan portion of the project will be directly designed by each individual to meet the needs they have in a way that is meaningful for them. So, while the overarching design of the program came from documents that assessed needs and barriers and not direct interaction with the people being served, ultimately, the service they receive will be determined by the participants which will then inform changes and additions that will need to be made to the program. Further, we will train Resident Services Coordinators to recognize signs and symptoms of the diseases targeted in this project and empower them to contact appropriate resources/people who can intervene.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

3. Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

This project takes place in the Metro East area of Illinois which has been identified by the UIC Transformation Data & Community Needs Report: East St. Louis Metro Area as having the highest rates of hospitalization for conditions that can be managed medically and through non-medical approaches. Not coincidentally, this area has suffered from disinvestment, white flight, loss of industry, lack of investment in the community, and lack of protection of the environment that has led to mistrust by the residents of the area in institutions and resulted in multiple health issues. This area is one of the most disadvantaged in the state as a result.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

4. What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

An overall distrust of institutions created by the loss of jobs, lack of investment, disappearance of services, lack of transportation, food deserts, pollution, crime, and lack of safe recreation opportunities perpetuate the barriers to wellness in the Metro East area. This proposal addresses portions of the root causes listed here by eliminating the need for transportation, creating social opportunities within the residents' own buildings, and providing health and wellness services within those communities as well. Resident Services Coordinators, already known because they work in the buildings, will be part of our partnership to assist with bridging the trust gap.
Additionally, limited access to internet/broadband, smart phones, and the mobile phone applications required to access some services can lead to inequity. These inequities arose as the cost of internet service and mobile phone service including data came into play years ago. The increased cost proves a burden for low-income seniors. By providing kiosks with the Group to Care application in low-income, independent senior living apartments, we are eliminating this burden for the building participants. The kiosks will "level the playing field" so all in that particular building can access programming, regardless of technical knowledge/capability, should they choose to.
The collaborative will use the services of Coordinated Care Alliance to ensure services are being offered equitably across partners and programming. CCA will provide quality oversight and assurance through analyzing multiple data sources, such as Group to Care utilization and participant satisfaction surveys. Policies and procedures developed by this Collaborative will be reviewed with a health equity lens and will be reviewed ongoing to ensure programming continues to reach all who are eligible/in need. Our quality oversight will ensure equitable caregiving is being provided.

[4 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

5. What does the proposal seek to accomplish? Will it reduce disparities or discrimination?

The Collaborative will promote equitable access to community-based services in senior care through the implementation of the GrouptoCare application available via kiosks in low-income, independent senior apartment buildings. Through this program we intend to serve seniors through preventative means in order to reduce hospitalizations and crises. Through the availability of the kiosks, we expect to reduce disparities. Through quality assurance monitoring provided by project partner, CCA, we intend to ensure equitable care to participants throughout the service area.
Additionally, this proposal addresses socioeconomic inequities: lack of access to care, transportation, social isolation, and lack of access to affordable healthy food.
While our proposal will not reduce discrimination, it will reduce disparities in wellness between white middle class people and lower income people and minorities by reducing some of the barriers to care experienced in these lower income communities.

[5 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

6. What are negative or unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized?

While there are no guarantees, it is anticipated there will be no negative or unforeseen consequences to the implementation of this collaborative. All of the ideas in the project have been tried before, the difference in the project we propose is their implementation in a coordinated manner in the places where our targeted population lives. When the GrouptoCare project is successful, the residents of the Metro East, the organizations that serve them, and the aging network overall will be strengthened. The methods used in this collaboration have been used individually by each of our providers in other areas with no harmful outcomes.
The untested portion of the project are this specific type of congregate care. An unintended outcome, if we are not careful in implementation, is the potential for communication of infectious disease. To avoid that outcome, we will be sure that all participants in any congregate service have been vaccinated against COVID-19, practice good social hygiene, will use social distancing when indoors, and will postpone the implementation of congregate services until COVID-19 can be effectively and reliably treated in hospitals that have room for more patients. We will additionally pay attention to any other potential public health threats and follow directions provided by the CDC and state and local health departments.
A very positive impact will be the increased usage of preventative community-based services decreasing the frequency of ER visits, hospitalizations, and improving the management of chronic illness. (Transformation Data & Community Needs Report pg. 29)

[6 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

7. Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

One way to reduce disparities is to reimburse community-based organizations, health systems, and insurance providers to address social determinants of health in a holistic, comprehensive way. By increasing efficiencies in social service delivery, more time would be available to address social determinants that stem from inequality; however, there is an overall lack of reimbursement for these activities. True transformation would require funding systems to tackle the major inequities in our systems, such as housing, transportation, and lack of access to physical and behavioral heatlh services. The immediate investment would lead to long-term cost savings with healthier communities. Our proposal addresses a small portion of the inequities and sickness-based model of care for low-income seniors that is perpetuating poor outcomes. It is our hope that by proving that preventative care can be a cost-effective solution, the state of Illinois will invest in further opportunities for a wellness-based model of care.

[7 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

8. Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

This project is built on aging services infrastructure with the considerations of where existing structures and systems are failing. Therefore, if funded, there is an opportunity to enhance and even transform aging services program delivery to better meet the needs of not only the older adults served but of the agencies tasked with service delivery. Coordinated Care Alliance will provide quality assurance and oversight of programming to ensure there is consistent and equitable offering and delivery across partners and sites. Data will be collected through the GrouptoCare software that can be exported and analyzed. Additionally, partners in the collaborative have demographic data of their clients, so cross-analysis of these data sources is possible.
The design of the program includes stakeholder self-determination in determining their plans of care. The stakeholders will be driving usage and usage will drive the changes and adaptations of the model to make it more effective.
AgeSmart will be doing outcome analysis for the project and will be able to drive hearings and meetings regarding the work accomplished and goals achieved.
Mechanisms to ensure successful implementation include kiosks available in buildings provided through funding, funding for internet services, multiple providers of various services, QA oversight by CCA, and financial management outcomes measurement by AgeSmart. The data collection will be done through the software and exported to Excel for analysis by the agencies managing the data.

[8 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

9. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

Success indicators include:

--Reduced emergency department use by seniors for diabetes, hypertension, and congestive heart failure
--Reduced emergency department and hospitalization of seniors for all conditions as a result of comprehensive, preventative case management and nursing care
--Improved management of diabetes, hypertension, and congestive heart failure by patients with these conditions as a result of wellness education
--Improved homecare aide, nurse, and case manager satisfaction with their jobs as shown by lower turnover rates
--Seniors participating in GrouptoCare will show improvement in social isolation assessment scores from pre-programming to end of the project.
--Seniors participating in GrouptoCare will show improvement in nutritional assessment scores from pre-programming to the end of the project.
--Professional caregivers working in the GrouptoCare project will receive higher salaries than their counterparts working in traditional one to one care or adult day services in the area.
--The cost of care plans for GrouptoCare participants will be lower than the service cost maximum allowable under the Department on Aging's Community Care Program for their assessed Determination of Need score.
--The number of seniors hospitalized for bacterial pneumonia will decrease.

[9 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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5. Community Input

HELP AND SUPPORT INFORMATION

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Service Area of the Proposed Intervention

1. Identify your service area in general terms (e.g., "West Chicago", "East St. Louis Metro Area", "Southeastern Illinois").
East St. Louis Metro Area

2. Please select all Illinois counties that are in your service area. (NOTE: Selecting a county does not mean that your intervention must service the entire county.)
(Hold CTRL+click on a PC or command+click on a Mac to select multiple counties).

Select counties:
Madison, St. Clair

3. Please list all zip codes in your service area, separated by commas.
Madison County: 62040, 62234, 62025, 62002, 62035, 62249, 62294, 62034, 62010, 62095, 62024, 62062, 62088, 62201, 62293, 62060, 62275, 6201, 62097, 62281, 62067, 62087, 62061, 62001, 62084, 62048, 62074, 62090, 62021, 62046, 62058, 62026
St. Clair County: 62269,62226, 62221, 62220, 62223, 62208, 62236, 62206, 62258, 62232, 62260, 62205, 62207, 62203, 62254, 62243, 62204, 62239, 62285, 62265, 62225, 62264, 62257, 62240, 62255, 62202, 62282, 62222, 62289, 62071, 62059, 62224

Community Input

Note on the importance of community input:

For collaborations to meet the real-world needs of the community members they intend to serve, it's imperative that projects be designed with community member input. We are looking for projects that engaged community members in the design of the intervention being proposed. Methods of community participatory research are encouraged.

1. Describe the process you have followed to seek input from your community and what community needs it highlighted.

This project was developed based on input from local direct service provider agencies. The Case Workers and Care Coordinators are each certified by the Illinois Department on Aging and meet criteria in the field of social work to navigate and advocate for older adults and their families. Personnel participating in this project contribute decades of experience serving older adults in the Metro East, often under extremely resource-deprived circumstances. Meeting older adults in their homes is an integral aspect of their work and these team members have gained expertise in assessing and connecting with needed social support programs aimed at fostering independence and health longevity. These individuals are fiercely dedicated to serving their clients in their homes in their community. They understand how systemic and individual circumstances contribute to health. Case managers and Care Coordinator team members are trained in active listening and basic social work principles. Senior Services Plus has been plugged into the needs of the Metro East community and has its finger on the pulse of the needs in contrast with the resources to deliver those needs. For example, during the budget impasse, there was not enough money to provide home delivered meals on a daily basis as had been done in the past for people who were too ill to manage their own nutritional needs. Senior Services Plus responded by delivering frozen meals that could be reheated in the future, planting gardens to grow food to provide to the people they serve as seeds are cheaper than food, and constantly seeks to innovate to accommodate the needs of the most vulnerable in their service area. AgeSmart is also a collaborator on this project and has been assessing the needs of vulnerable seniors in the Metro East area for decades. Their most recent public information document that shows the results of their assessment is attached. Also included in their document are AgeSmart's plans and budget for addressing those needs. This collaboration will work together to meet the identified needs and make the services more available to the identified populations via the collaboration utilizing GrouptoCare software.

2. Please upload any documentation of your community input process or findings here. (Note: if you wish to include multiple files, you must combine them into a single document.)
PID and Alton support

Input from Elected Officials

1. Did your collaborative consult elected officials as you developed your proposal?
◉ Yes
○ No

1A. If you consulted Illinois federal or state legislators, please select all legislators whom you consulted.
(Hold CTRL+click on a PC or command+click on a Mac to select multiple legislators).

Select legislators:
Elik, A. - Ill. Representative - 111th State Representative District

1B. If you consulted local officials, please list their names and titles here.

Amy Elik, State Representative - 111th State Representative District

[Input from Elected Officials - Optional] Please upload any documentation of support from or consultation with elected officials. (Note: if you wish to include multiple files, you must combine them into a single document.)

SSP Grant Support 2021

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6. Data Support

HELP AND SUPPORT INFORMATION

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Note on the importance of data in proposal design:

It is imperative that applicants use data to design the proposed work. HFS is seeking applications that are "data-first." This means that applicants used data to determine health needs and designed and targeted the proposed work to meet those needs.

Examples of relevant data include, but are not limited to, data from the **community data reports** produced by UIC, data analysis of healthcare utilization data, qualitative and quantitative surveys, literary reviews, etc.

1. Describe the data used to design your proposal and the methodology of collection.

Data regarding the specific needs of the Metro East community was obtained from the UIC community data reports and from AgeSmart's Public Information document. The data from the UIC document was obtained through the Healthcare Transformation Collaboration website.
Data regarding the caregiver shortage in the Metro East area and throughout Illinois was derived anecdotally through discussions with homecare agencies and case coordination units around the state. This data is a little more difficult to quantify because agencies, case management units, families, and persons needing care are all coordinating together informally to work to make the current situation around shortages work using strategies that best fit the particular area experiencing the shortage. Currently, agencies are managing care needs in the Metro East by providing less than the total hours assigned by case management units so that all persons requiring care will get as much care as possible and no one will go without. Because the Community Care Program is an entitlement program, waiting lists are prohibited. The Aging network is working to together to address the shortages.
AgeSmart is an independent non-profit organization and is one of over 600 Area Agencies on Aging across the country authorized by the Amended Federal Older Americans Act (OAA) to plan and administer services to persons 60 and older, their caregivers, and grandparents raising grandchildren. AgeSmart is one of 13 Area Agencies in Illinois authorized by the Illinois Act on Aging and designated by the Illinois Department on Aging. AgeSmart plans, coordinates, and acts as an advocate for the development of a comprehensive service delivery system for over 150,000 individuals aged 60 and older in Planning and Service Area 08 (PSA). The PSA is comprised of two high-density counties (Madison and St. Clair) and five low-density* counties (Bond, Clinton, Monroe, Randolph and Washington), two of which are rural (Randolph and Washington). *Low Density: Community with population under 5,000. AgeSmart is one of the collaborating partners on this grant.
AgeSmart assesses service needs of older adults in the seven-county region every three years as a part of the planning process and establishes a priority service list annually. The service priorities reflect those services found to be the greatest need for those older adults in the planning and service area (PSA). A variety of methods are used to identify the needs of older adults, caregivers, and grandparents raising grandchildren in the PSA as outlined below.
• Studying national trends and reports on the needs of older adults, caregivers and grandparents raising grandchildren
• Analyzing U.S. and local census data and other relevant demographic statistics
• Analyzing service utilization using National Aging Program Information System and Enhanced Services Program
• Collecting community input through surveys
We used the UIC data to determine the social determinants of healthcare that were barriers to care in the Metro East area. We also used this data to determine which medical diagnoses that were causing unnecessary emergency department and hospital use as well as unnecessary suffering to seniors in the community that our collaborative was most able to have a positive impact on. We chose diabetes, congestive heart failure (a sub diagnosis of the cardiac area most common to seniors and most treatable with non-pharmacological interventions), hypertension, and bacterial pneumonia.
We used the AgeSmart data to look at the social determinants of health impacting seniors in the Metro East area and identified nutrition and social isolation.

2. Attach the results of the data analyses used to design the project and any other relevant documentation. (Note: if you wish to include multiple files, you must combine them into a single document.)

AgeSmart UIC references combined

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7. Health Equity and Outcomes

HELP AND SUPPORT INFORMATION

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1. Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes.

According to a recent community needs assessment completed by the Department of Healthcare and Family Services, the average life expectancy in East St. Louis Metro area is only 76 years. In neighboring communities, the life expectancy increases by five years or more. The disparity is stark, and community-based providers are uniquely poised to help move that needle. By focusing on addressing what the UIC study calls Ambulatory Care Sensitive Conditions (ACSC) we believe we can improve life expectancy and quality of life. These are conditions, for which timely and effective primary care or outpatient care can potentially reduce the risk of hospitalization. The conditions this collaboration addresses are most often experienced by seniors and have a number of non-medical interventions that can prevent poor outcomes.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

East St. Louis' population is 19.2% Black, and 15.2% of the population are living below the poverty level. This collaborative is meant to enhance the case management system, which largely serves individuals living below the poverty line who are enrolled in Medicaid. Only 19% of Medicaid recipients in our target area receive hospital-level outpatient care prior or after a hospitalization for ACSCs (Ambulatory Care Sensitive Conditions). This project improves ease of scheduling and managing post-acute care, so we expect to see a higher percentage of clients in our cohort engagement with their providers after hospitalization.
This collaborative will also focus on social isolation, which recent studies have shown can be as detrimental to one's health as smoking several cigarettes every day. The Group Care model will relieve isolation.
Source: https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportEastStLouisDigitalCMP.pdf

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

3. Why will the activities you propose lead to the impact you intend to have?

Our activities directly impact the barriers to care and social determinants of health that UIC documents as being detrimental to wellness in the Metro East, for people over the age of 60. Eliminating the need for transportation will result in access to medical care, better nutrition, social interaction, immunizations, and supportive services that will improve wellness and decrease the need for urgent medical care. The ability to create one's own care plan will empower people to accept meals, care, and services because they created the schedule and selected that will work for them. Services provided where they live in a manner that makes sense for their building makes them possible for the person receiving them.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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8. Access to Care

HELP AND SUPPORT INFORMATION

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1. Name the specific obstacles or barriers to healthcare access you are targeting in your service area. Describe the causes of these obstacles that your project specifically seeks to address and explain why you have chosen to address these causes.

The obstacles addressed in this collaborative mainly relate to social determinants of health and are intertwined. Limited access to healthy foods has a negative impact on ACSCs because the overconsumption of salt has a negative impact on congestive heart failure and hypertension, raising blood pressure and causing water retention. People with Type Two diabetes have lower blood sugar and less of a need for medications when they consume a diet lower in carbohydrates and higher in protein. But people with these ACSCs can't eat a healthy diet if they can't buy food that is good for them because they don't have a way to get to a grocery store or the money to buy healthier food. Therefore, transportation, low incomes, and poor nutrition are tied together. But further complicating access to good nutrition are attitudinal barriers. Cultural eating and cooking habits are caused by a lifetime of cultural practices passed down generations as well as lack of access to affordable, healthy food due to inadequate public transportation infrastructure and food deserts. According to the National Institute on Aging, research has linked social isolation and loneliness to higher risks for a variety of physical and mental conditions: high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even death. Just as significantly, seniors living alone are at risk nutritionally, both for eating too much of the wrong food and for not eating enough. Access to transportation negatively impacts access to food, medical care, socialization, and the ability to self-determine, all of which negatively impact ACSCs.
Homemaker workforce shortages are causing seniors eligible for services through the community care program to receive fewer hours than they're approved for. These workforce shortages are due to nationwide low wages and impacts of the COVID-19 Pandemic.
By providing opportunities for socialization, within their own building, this collaboration will have a positive impact on wellness.
Through the collaboration we intend to offer group home care settings that capitalize on affordable senior apartment buildings allowing the participating seniors to receive socialization as well as homemaker services. This helps decrease the demand for home care aides while serving more seniors.
Access to healthy food is a problem in many areas of the Metro East as many low-income areas are also food deserts. Coupled with transportation issues and social isolation, poor nutrition leads to seriously poor outcomes for the conditions that could be manageable, but are not managed in the presence of poor nutrition. Gas stations and convenience stores that are typically situated within low-income neighborhoods sell the high fat, high salt, high sugar types of foods that exacerbate congestive heart failure, hypertension, and diabetes. Providing tasty food that is lower in salt, fat, and sugar and, when possible, served in a congregate setting to encourage everyone to eat while socializing, are proven to lower emergency room use for all of the conditions listed.
Access to care is also threatened by finite state and private sector resources. The growing population of seniors in Illinois, as they age, is requiring a growing amount of care. This care has to be provided by people and there are not enough people to care for everyone needing care in the ways currently prescribed by the rules of the Community Care Program and limited by the lack of adult day centers in Illinois. But even if Illinois had enough caregivers, there is not enough money nor is it a good idea for a variety of reasons, including the lack of socialization and the illness model that rewards failing health with increased services, to provide care solely through one-to-one homecare aide cares.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

Nutrition is large factor in overall wellness and this collaborative provides a solution-- homemaker and home delivered meals services. Home delivered meals will supply up to 5 meals per week based on need and meeting qualifications at no cost to the client. The meal is approved by a Registered Dietitian and represents 33% of a senior's daily nutritional needs. The homemaker services can provide transportation to actual grocery stores where food lower in salt, fat, and sugar can be purchased with the homemaker also available to cook some meals. As this project progresses, and the diets of the seniors within the collaboration improve, the number of emergency department visits and hospitalizations will decline.
As immunizations for pneumococcal pneumonia are encouraged, as the senior population living in affordable housing are educated about the potential impact of bacterial pneumonia, and as vaccines are brought to the residents in the affordable housing buildings, the number of emergency department services and hospitalizations for pneumococcal pneumonia will decline.
As socialization opportunities improve, which will be toward the end of the project because of the fragility of the population the collaboration targets combined with the COVID-19 pandemic will limit in person socialization until vaccination rates improve and more and better-quality treatments are approved, health outcomes in ACSCs will also improve.
Changing the focus of senior care from treating and compensating for illness to a wellness model will prove itself to be working by a decrease in expenditures for nursing home care, emergency department use, hospitalizations, and supportive living care. The savings in emergency department use, hospitalizations, and institutional care even with the increase costs to the state in this grant, will be significant. For example-- the GrouptoCare annual budget is $2m to provide nursing, meals 2 days a week (to subset of the 675 people targeted), activities (to the subset) and preventative care (for the subset). The cost of providing care to that group in supportive living or nursing homes is roughly 675 x $36000 ($3k x 12 mos) = $24,300,000 and up. The cost of hospitalization for a portion of this group is far more costly than preventative care. The cost of hospital care when 25% of the group require hospitalization at $25,000 per stay is roughly $4.2million and up. Shifting the model from treating illness to promoting wellness will free significant resources in Illinois's budget to do other transformative projects. The reduction in costs for other healthcare services will quantitatively prove the effectiveness of the program.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

3. Why will the activities you propose lead to the impact you intend to have?

If the research into the social determinants of health is accurate, improving those social conditions and eliminating the barriers discussed and listed throughout this grant should logically result in better health for the participants targeted in this project.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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9. Social Determinants of Health

HELP AND SUPPORT INFORMATION

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Note on the significance of social determinants of health:

A full 50% of a person's health outcomes can be attributed to social determinants of health (that is, factors such as education, economic stability, housing, access to healthy food, access to transportation, social support and environment). Given this, we are looking for collaborations that meaningfully address social determinants of health in coordination with physical and behavioral health.

1. Name the specific social determinants of health you are targeting in your service area. Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes.

We used the AgeSmart and UIC data to analyze the social determinants of health impacting seniors in the Metro East area and identified economic stability, access to healthy food, access to transportation, and social isolation. We chose these social determinants to address because addressing them is part of each of our individual agency's mission, all of the partners in the collaborative have been individually working on them for years, and all partners are frustrated with lack of significant progress in alleviating the ill effects they cause.

We chose the means to address these social determinants of health that we did because they are consistent with the work that we currently do. While we cannot provide financial resources to this impoverished community, we can apply solutions to address the barriers to wellness while others with different missions and resources can tackle the root cause.

The root cause of all of these social determinants of health is poverty. Without money, people can't live in areas that have good transportation options or have reliable transportation themselves. Without transportation and money, people can't get to grocery stores that carry healthy foods when they live in a food desert and even if they could get to the grocery store, they can't afford to buy leaner proteins and produce. Generations of poverty has created a culture that is accustomed to a diet of unhealthy foods, so even if people could get to the grocery store and could afford the food there, generations of cooking and using unhealthy foods make it unlikely that they would choose food, that, while healthy, is not something that would provide them comfort due to their unfamiliarity, so they wouldn't choose them on their own.

The pandemic has exacerbated loneliness and isolation for many, but in particular for older adults. Fear of the virus forced many to stay indoors and away from friends and family. But also, people living in poverty, in high crime areas, with little to no access to recreation opportunities are isolated. Further isolating the people over the age of 60 targeted in this project are their health issues. It is difficult for people who don't feel well to seek social contact. Instead, they stay in their apartments, watching tv by themselves because that is easy to do. This collaboration seeks to enhance the normal mechanisms by which the Aging Network serves older adults to make it more efficient and effective, meaning we are able to serve more older adults despite limited resources.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

Our activities directly impact the barriers to care and social determinants of health that UIC documents as being detrimental to wellness in the Metro East, for people over the age of 60. Eliminating the need for transportation by providing services onsite will result in access to medical care, better nutrition, social interaction, immunizations, and supportive services that will improve wellness and decrease the need for urgent medical care.

The ability to create one's own care plan will empower people to accept meals, care, and services because they created the schedule and selected that will work for them. Healthy meals prepared, delivered, and when possible, served in a social setting, will improve the likelihood that people will improve their nutritional status versus the status quo, where people are expected to listen to a doctor during a twenty-minute appointment describe what people with various ACSCs should be eating and then be left to their own devices to determine how to make that happen. Improved nutrition options and a social situation to enjoy them in will improve the health of individuals with diabetes, hypertension, and congestive heart failure. Emergency department utilization and hospitalizations will decline from the current usage.

Wellness services provided where they live in a manner that makes sense for their building makes them possible for the person needing them to access them.

The Group to Care shared caregiver model can directly relieve social isolation, which is a contributor to poor health outcomes. Care recipients of Group to Care will be more engaged with their social service and medical providers, delaying or even avoiding costly emergency care or hospital utilization.

Measurable outcomes indicators include:

- Reduced emergency department use by seniors for diabetes, hypertension, and congestive heart failure
- Reduced emergency department and hospitalization of seniors for all conditions as a result of comprehensive, preventative case management and nursing care
- Improved management of diabetes, hypertension, and congestive heart failure by patients with these conditions as a result of wellness education
- Improved homecare aide, nurse, and case manager satisfaction with their jobs as shown by lower turnover rates
- Seniors participating in GrouptoCare will show improvement in social isolation assessment scores from pre-programming to end of the project.
- Seniors participating in GrouptoCare will show improvement in nutritional assessment scores from pre-programming to the end of the project.
- Professional caregivers working in the GrouptoCare project will receive higher salaries than their counterparts working in traditional one to one care or adult day services in the area.
- The cost of care plans for GrouptoCare participants will be lower than the service cost maximum allowable under the Department on Aging's Community Care Program for their assessed Determination of Need score.
- The number of seniors hospitalized for bacterial pneumonia will decrease.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

3. Why will the activities you propose lead to the impact you intend to have?

The activities that we propose are designed to eliminate the barriers identified in the UIC study. If the study data is accurate, and it is consistent with every other study on the social determinants of health, the proposed means of addressing them will result in positive wellness outcomes.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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10. Care Integration and Coordination

HELP AND SUPPORT INFORMATION

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1. Describe how your proposal improves the integration, efficiency, and coordination of care across provider types and levels of care.

The program leverages an innovative technology program that allows case coordinators, care service providers and location sponsors to efficiently collaborate on the delivery of service programs to targeted residents. Using the platform, care service providers can build and communicate onsite schedules and the availability of open 'slots' which care coordinators, location sponsors and even residents can access to view and reserve time (and/or sign-up for meals). Most importantly, coordinating those requiring assistance into these available onsite times, allows for shorter and more efficient and cost-effective visits and significantly reduces costly drive time. This is vastly more efficient and cost effective than the current model that forces care service providers to cover travel time through longer and more extended visits.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2. Do you plan to hire community health workers or care coordinators as part of your intervention?

- (●) Yes
- ( ) No

2A. Please submit care coordination caseload numbers and cost per caseload (stratified by risk, if applicable).

675 seniors will be provided weekly wellness monitoring that includes both assessment and education. The cost per caseload to provide this care is approximately - $38.67 per visit.

169 seniors will be provided congregate or delivered meals 2x a week. The cost per congregate meal is approximately $10 per unit.

135 seniors will be provided additional personal assistance 2x a week. The cost per each personal assistance visit will be $10.67 per visit/caseload.

202 seniors will be provided additional nursing follow-up care each week. The cost per each visit/caseload is $38.67

[2A - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

3. Are there any managed care organizations in your collaborative?

- ( ) Yes
- (●) No

3A. If no, do you plan to integrate and work with managed care organizations?

- (●) Yes
- ( ) No

3B. Please describe your collaborative's plans to work with managed care organizations.

Managed Care Organizations are incentivized to participate in shared caregiver models because it is more efficient and less costly. The Collaborative will disseminate success of this project in Year Four to interested MCOs with hopes of engaging them in sustainability discussions.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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11. Minority Participation

HELP AND SUPPORT INFORMATION

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1. Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise Program (BEP) and/or not-for-profit entities majorly controlled and managed by minorities that will be used on the project as subcontractors or equity partners.

Note on BEP partners/vendors:
If one of the members of your collaboration already contracts with a BEP-certified firm or a not-for-profit entity that is majorly controlled and managed by minorities, only include the services of the firm that will be used on this project. To be included, these services must increase the entity's volume of work above the level of services already provided to the collaborating member.

Resource to help you search for/identify BEP-certified vendors in Illinois:
If you are seeking BEP-certified entities to partner/collaborate with, you may consult our resource guide linked below on How to Look Up BEP-Certified Vendors in the State of Illinois.

Download resource:
How to Look Up BEP-Certified Vendors in the State of Illinois.pdf

List entities here:

According to the search results in the BEP Certification Portal, there are no BEP certified vendors for aging services, nutrition services, case management in Madison and/or St. Clair Counties, so we were not able to include one of these vendors in our collaboration.

2. Please describe the respective role of each of the entities listed above, and specify whether they will have a role only during the implementation of your proposal or if they will have a role in the ongoing operation of your transformed delivery system.

To ensure minority participation and enrollment in our project, we have located all services provided within the affordable housing apartments in Madison and St. Clair Counties, where a significant number of minorities over the age of 60 reside. As part of the informal case management aspect of the project, the resident service coordinators in these building will be trained in case management and the use of the sheduling/care planning software.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Note for those wishing to apply for BEP certification:

We recognize that some individuals encountering this application may wish to gain BEP certification. Follow this link to the state's Business Enterprise Program webpage to begin the application process.

When you're finished answering the questions on this page, click Mark as Complete. An application cannot be submitted until all pages are marked as complete.
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12. Jobs

HELP AND SUPPORT INFORMATION

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Existing Employees

1. For collaborating providers, please provide data on the number of existing employees delineated by job category, including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these job levels.

All employees required to support the program will be newly hired from the communities served.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

New Employment Opportunities

2. Please estimate the number of new employees that will be hired over the duration of your proposal.

17

3. Describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve.

We estimate approximately 17 new employees will be hired for the duration of the project. We are targeting the communities served for hiring in order to take advantage of existing relationships, geography knowledge, etc. Longer term, these are excellent opportunities for those within the community to both improve their skills and provide much needed aide to neighborhoods they live. The list below reflects the forecasted employment needs of the program.

2 Location Service Coordinators
8 Onsite Case Manager / Wellness Professionals
1 Community Communications Manager
6 Onsite Aides

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

4. Please describe any planned activities for workforce development in the project.

All employees will be provided annual training on case management strategy, health equity training and technology training on the underlying software platform. Funds have been budgeted to support the various training initiatives.

[4 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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13. Quality Metrics

HELP AND SUPPORT INFORMATION

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Alignment with HFS Quality Pillars

In order to complete this section, you will need to reference the HFS Quality Strategy document linked below.

HFS Quality Strategy:
https://www.illinois.gov/hfs/SiteCollectionDocuments/IL20212024ComprehensiveMedicalProgramsQualityStrategyD1.pdf

1. Tell us how your proposal aligns with the pillars and the overall vision for improvement in the Department's Quality Strategy.

Our proposal fits under the pillar of improving opportunities for people to be treated in their communities. The UIC transformation study of the Metro East area lists many times that one of the biggest barriers to better health in the community is the lack of access to transportation that makes all other predictors of good health difficult to attain--good nutrition, socialization, compliance with a medical treatment plan, and use of resources such as immunization and health education.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2. Does your proposal align with any of the following Pillars of Improvement?

2A. Maternal and Child Health?
- ○ Yes
- ◉ No

[Maternal and Child Heath - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2B. Adult Behavioral Health?
- ○ Yes
- ◉ No

[Adult Behavioral Health - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2C. Child Behavioral Health?
- ○ Yes
- ◉ No

[Child Behavioral Health - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2D. Equity?
- ◉ Yes
- ○ No

Equity: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

GrouptoCare Metro East proposes the following metrics for insuring quality based upon HFS's quality strategy:

1. Identify and prioritize reducing health disparities

2. Implement evidence-based interventions to reduce disparities

[Equity - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2E. Community-Based Services and Supports?
- ◉ Yes
- ○ No

Community-Based Services and Supports: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

GrouptoCare Metro East proposes the following metrics for insuring quality based upon HFS's quality strategy:

1. Improving health outcomes, care delivery, and utilization of community-based services.

2. Rebalancing Medicaid LTSS systems from a primary reliance on nursing facility services to expanded utilization of community-based services and supports

[Community-Based Services and Supports - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

3. Will you be using any metrics not found in the quality strategy?

◉ Yes
○ No

3A. Please propose metrics you'll be accountable for improving and a method for tracking these metrics.

3. Reducing the use of emergency departments and hospitals by providing wellness programming in MLTSS

[3A - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Note: Once metrics are agreed upon in the negotiated funding agreement, HFS will proceed to establish a baseline for the service community, a tracking process, and negotiated improvement targets.

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14. Milestones

HELP AND SUPPORT INFORMATION

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For all activities described in your proposal, please provide a calendar of milestones to show progress (e.g., when IT will be purchased, when IT will be operative, when construction projects will begin and end, when people will be hired, etc.) The timeline should be in months from award.

The attached graph shows our timeline for implementing the stages of the project during the first year of operation. Following implementation, the project will work to serve more people living in affordable housing in the Metro East area.

[Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

First Year Gantt

When you're finished answering the questions on this page, click Mark as Complete. An application cannot be submitted until all pages are marked as complete.
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15. Budget

HELP AND SUPPORT INFORMATION

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If you need help or have a question:

- *For guidance on this form, consult the **HTC Application Instructions resource**. HFS has also prepared **technical video instructions** on how to fill out and submit a budget.*
- *If you have a question about the subject matter of the application, email HFS.Transformation@illinois.gov before October 15. Questions will not be taken after that date. Check for answers at the **HTC FAQs page**, which will be updated continuously between October 1 and October 15.*
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1. Annual Budgets across the Proposal

In order to fill out budgets correctly, please view these technical video instructions for completing a budget.

Use the Excel template below to list the line items of your budget. Working within one single Excel file, fill out sheets for each year that you are requesting funds.

Please check that all totals are correctly calculated, especially if you have added new rows to the spreadsheet. Applicants are responsible for submitting accurate totals. *Note: This spreadsheet has been locked, but not password protected.*

Some aspects of your budget request may be funded out of state capital dollars and not transformation funds. HFS will make decisions on funding source. Include all expenses for which you seek reimbursement in your budget regardless of funding source

NOTE: Your budget should demonstrate a clear ramp down of reliance on Transformation funding and a ramp up of reimbursements for services and other funding sources that show sustainability over time.

HTC Annual Budgets Template
HTC Budget Template.xlsx

When completed, please upload your spreadsheet here.
HTC Budget GTC Metro East

[Budget - Optional] Please upload here any additional documentation or narrative you would like to provide around your budget. Include any documentation regarding budget items in the Construction category (drawings and estimates, formal bids, etc.) (Note: if you wish to include multiple files, you must combine them into a single document.)

2. Number of Individuals Served

Please project the number of individuals that will be served in each year of funding.

Year 1 Individuals Served
675

Year 2 Individuals Served
675

Year 3 Individuals Served
675

Year 4 Individuals Served
675

Year 5 Individuals Served
675

Year 6 Individuals Served

3. Alternative Payment Methodologies

Outline any alternative payment methodologies that your proposal might utilize for receiving reimbursement for services from MCOs.

The MCOs will be charged the same rate as the Illinois Department on Aging's Community Care Program for in-home services. Additionally, the preventative care model, once proven effective in this project, will demonstrate the cost effectiveness of providing onsite wellness programming and nursing visits in preventing much more costly emergency department use, hospitalizations, and institutional care. Based upon outcome data derived from this project, reimbursement rates for these currently not reimbursable expenses could be established.

[Alternative Payment Methodologies - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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16. Sustainability

HELP AND SUPPORT INFORMATION

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Include a narrative that describes how your budget will decrease reliance on Transformation funding over time and how reimbursements for services and other funding sources will increase and establish sustainability over time. (i.e. how will your project continue to operate without HTC funding?)

In particular, include how services that address social determinants of health will be funded on an ongoing basis (for example, through existing payment models, alternative payment methodologies for Medicaid services, or through other funding sources).

In your narrative, highlight any key assumptions that are critical to making your project sustainable.

Provide your narrative here:

If this project is successful in the Metro East area, the partners in this collaboration recommend application for a Medicaid waiver demonstration project under section 1115 of the Social Security Act.

The GrouptoCare Metro East project is a significant departure from current Community Care Program services and delivery systems and takes a broader look at services for seniors than the traditional Medicaid elderly waiver. A radical change as proposed in this project should be carefully tested before wider implementation. Within the 1115 waiver application, services for targeted wellness interventions, tailored to the specific barriers and needs of the individual communities as based upon studies of the area should be included. Congregate and sequential scheduling of Community Care Program In Home Services should receive a higher rate of reimbursement under the 1115 waiver demonstration project in order to facilitate higher rates of reimbursement to enable higher compensation of homecare aides. Additionally, funding for both congregate and home delivered meals should be included in the demonstration project because we know that one of the most effective and inexpensive way to control treatable conditions so prevalent among low income seniors, such as diabetes, hypertension, and congestive heart failure, is through a healthy diet. Current reimbursement models do not have a sustainable, affordable means of promoting good nutrition.

Throughout the implementation of this project, evaluations of funding amounts and quality metrics will be made by the collaborating team. We will look at the reimbursement model set up here and determine the effectiveness of the budget proposed in offsetting expenditures later on hospitalizations, emergency department use, and institutionalization. After five years of work on this project, there should be good data for designing an 1115 waiver demonstration project.

After this HTC grant and an 1115 waiver demonstration project, stakeholders, providers of care, HFS, and IDOA should convene to study and discuss what we were able to accomplish and learn in the Metro East and make plans for expansion statewide.

[Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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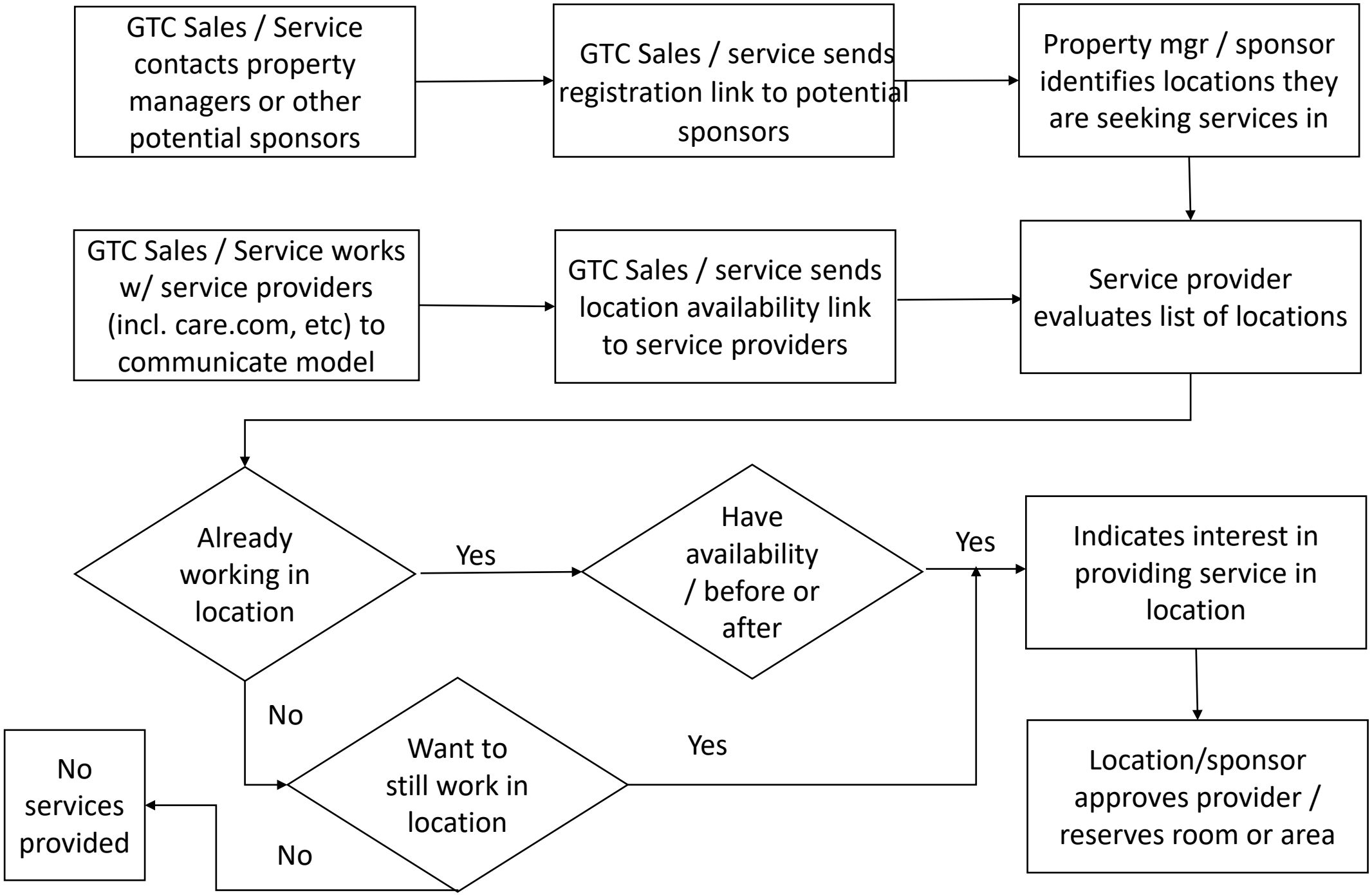
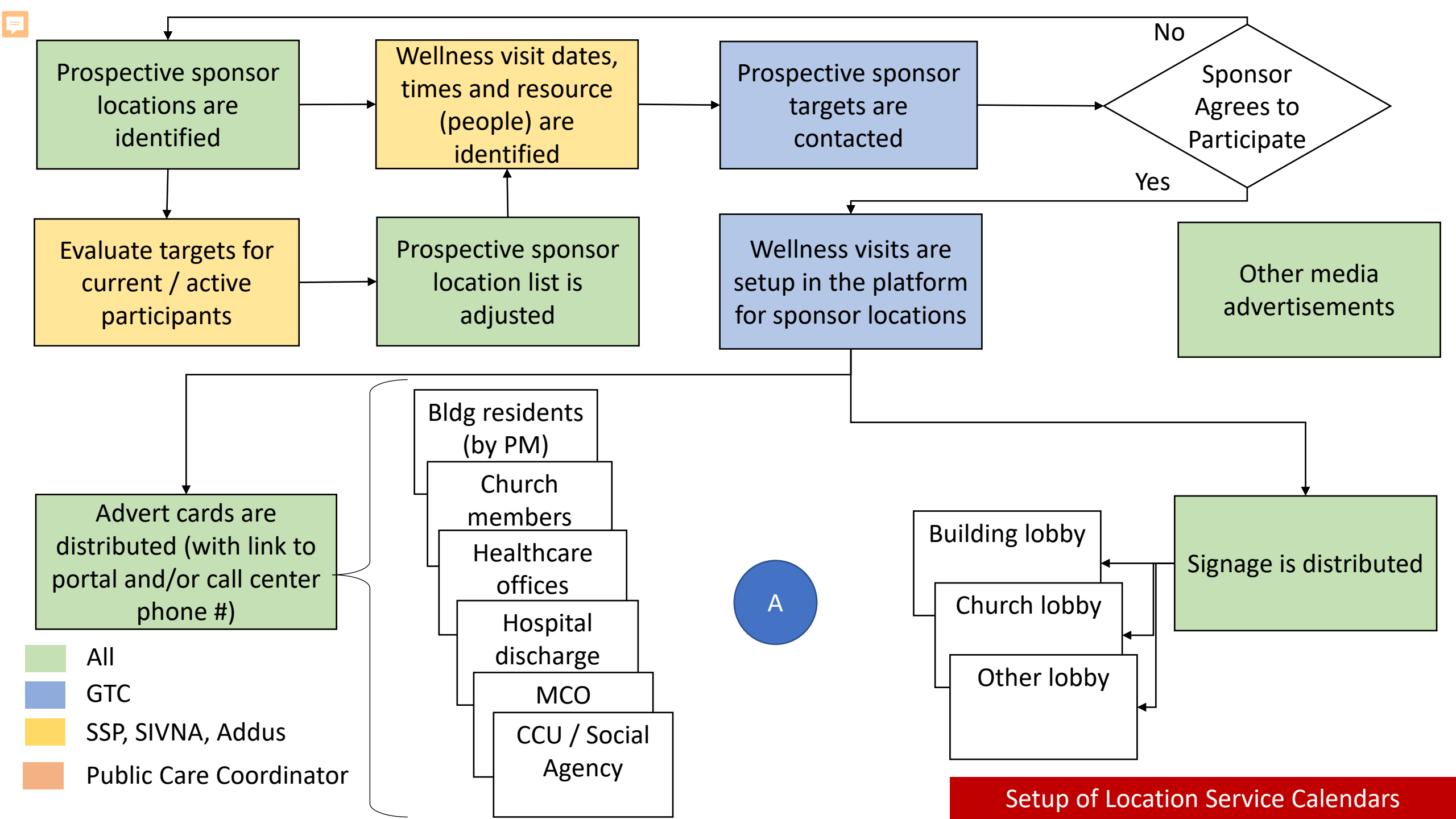
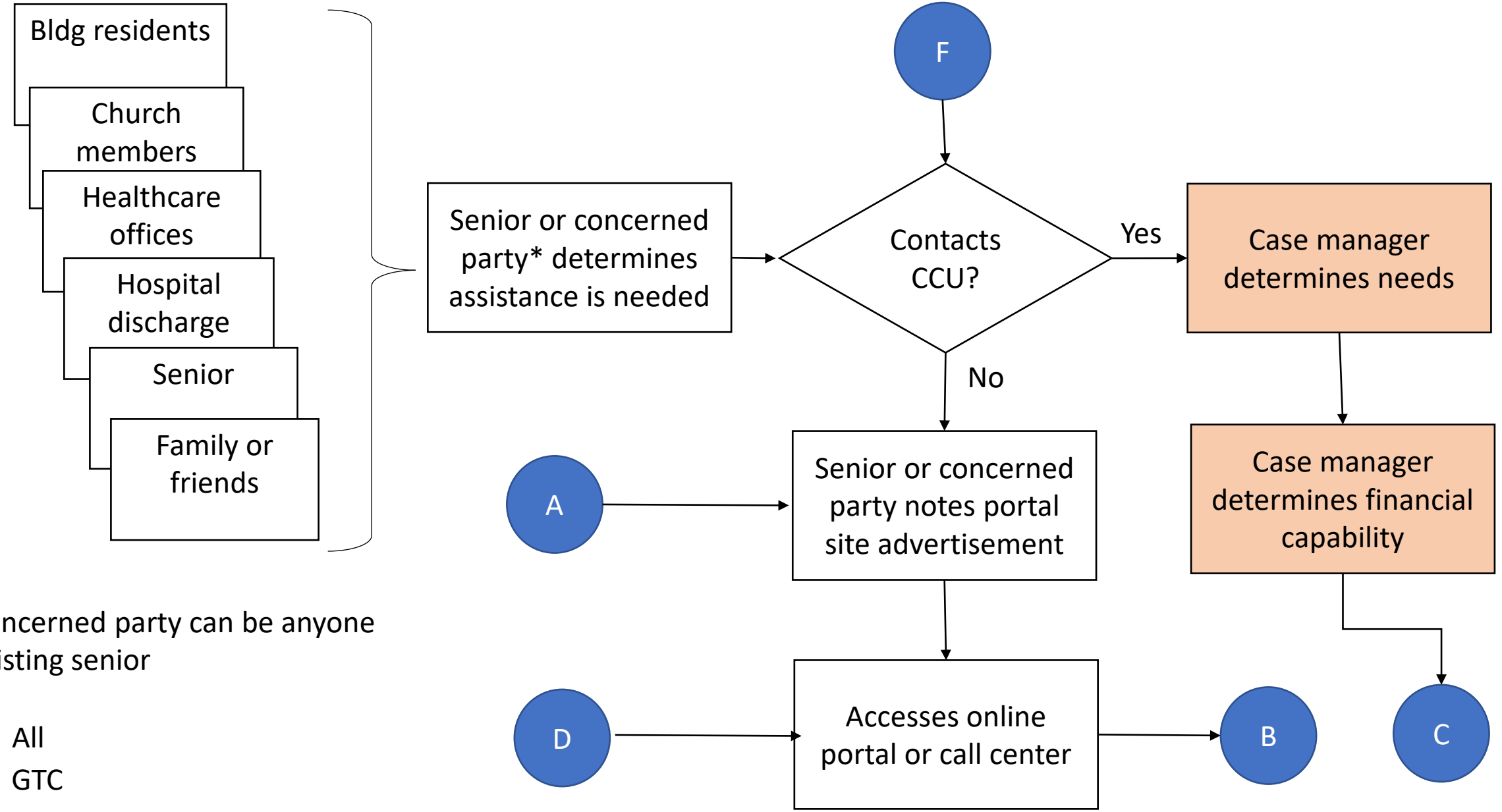
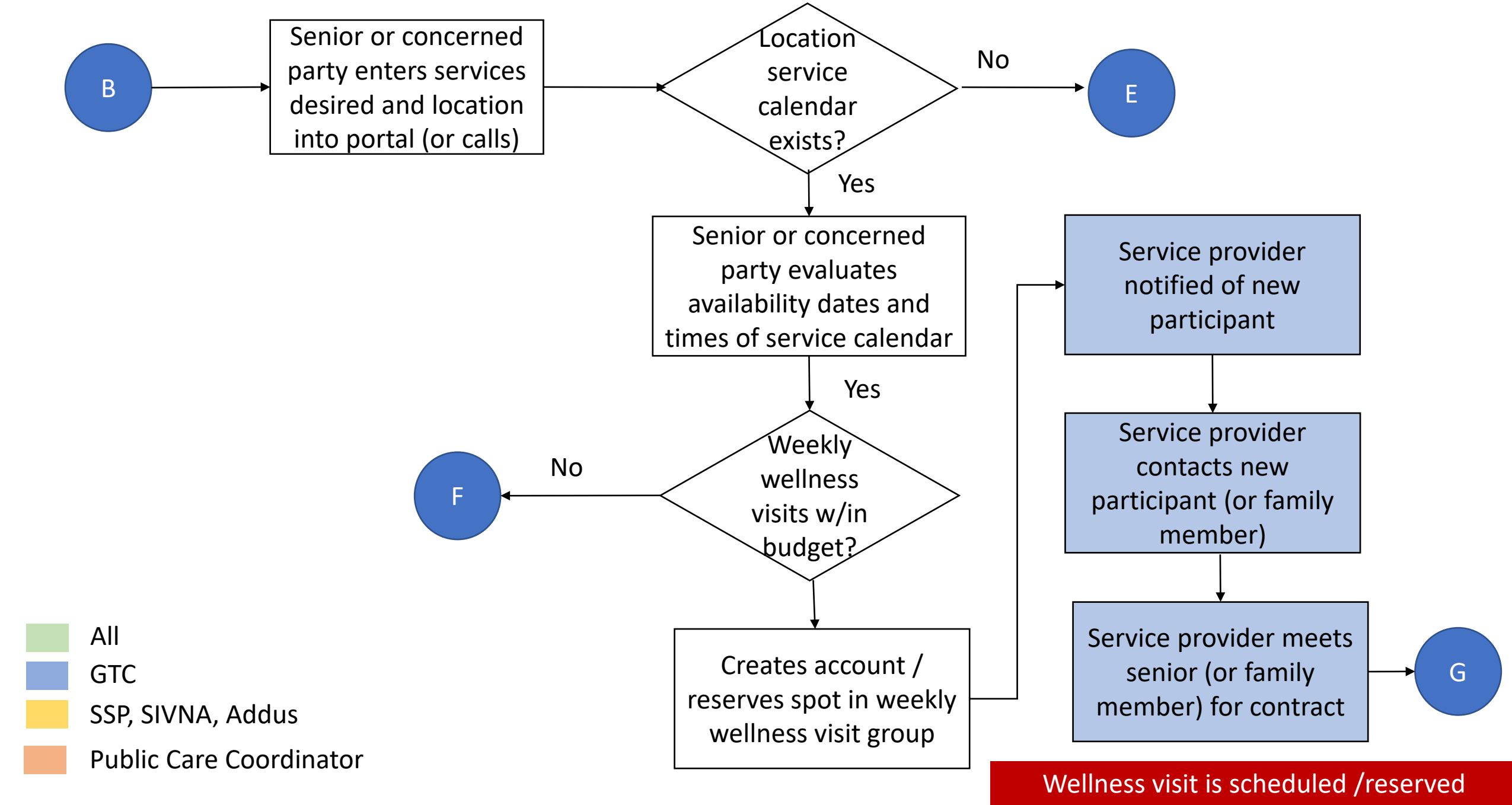
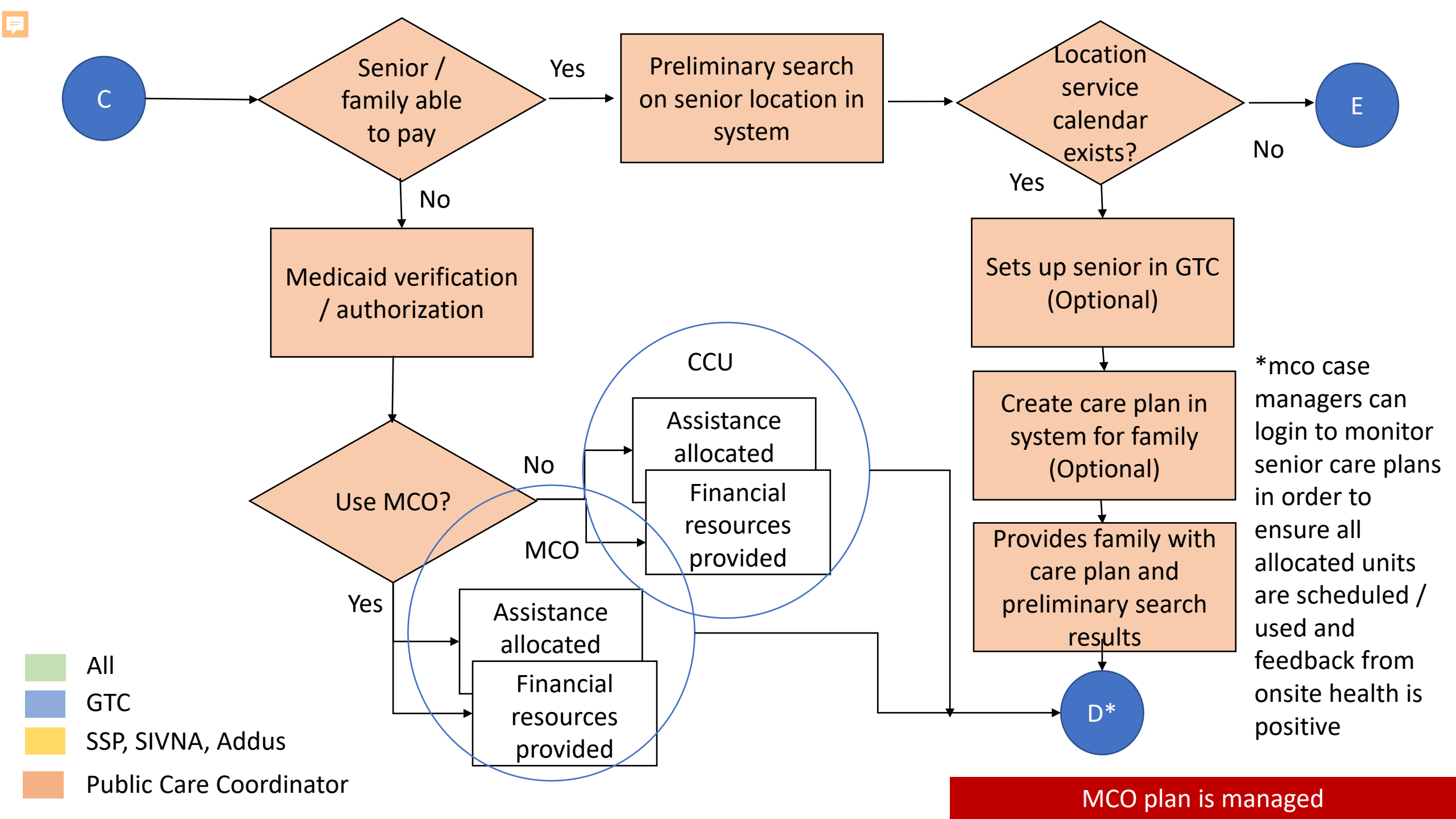

GTC Sales / Service contacts property managers or other potential sponsors
GTC Sales / service sends registration link to potential sponsors
Property mgr / sponsor identifies locations they are seeking services in
GTC Sales / Service works w/ service providers (incl. care.com, etc) to communicate model
GTC Sales / service sends location availability link to service providers
Service provider evaluates list of locations
Already working in location
Yes
Have availability / before or after
Yes
Indicates interest in providing service in location
No
Want to still work in location
Yes
Location/sponsor approves provider / reserves room or area
No services provided
No

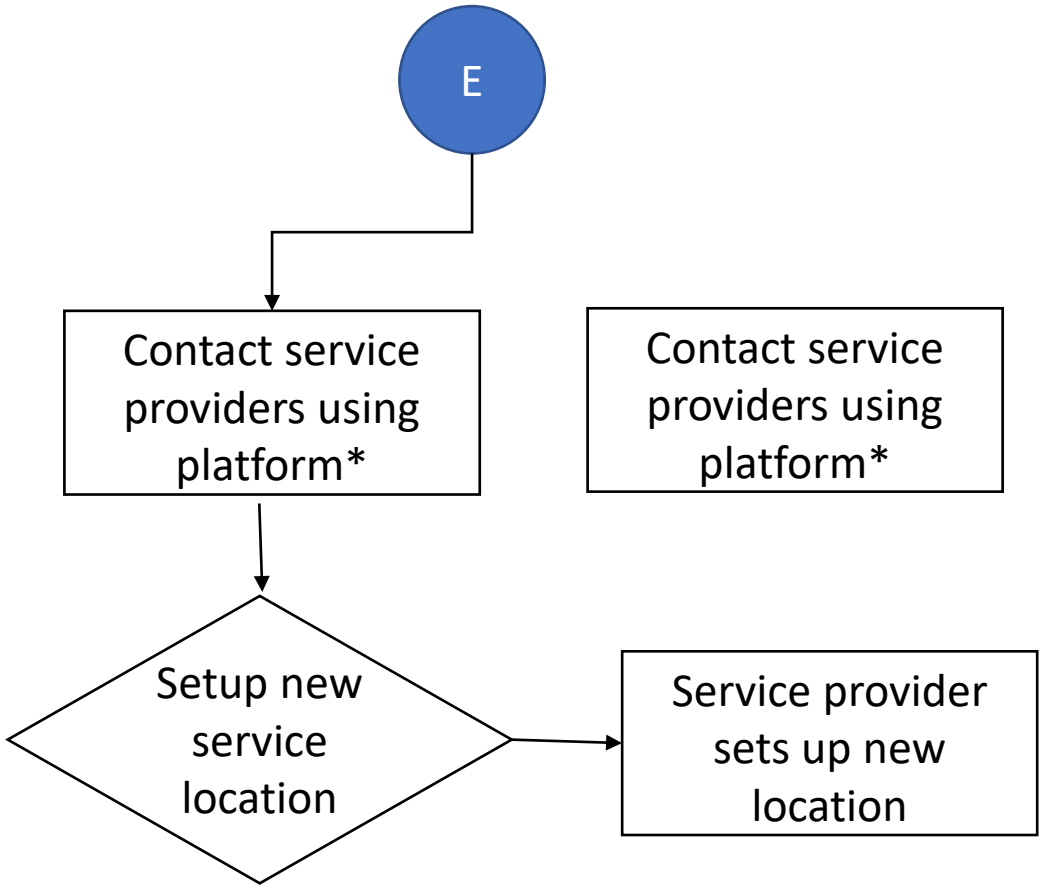
Sponsor Name	Address	Services Desired	Common Area y/n	Fitness Room Area y/n	Fee for Use	Marketing Assistance


Prospective sponsor locations are identified
Wellness visit dates, times and resource (people) are identified
Prospective sponsor targets are contacted
No
Sponsor Agrees to Participate
Yes
Evaluate targets for current / active participants
Prospective sponsor location list is adjusted
Wellness visits are setup in the platform for sponsor locations
Other media advertisements
Advert cards are distributed (with link to portal and/or call center phone #)
Bldg residents (by PM)
Church members
Healthcare offices
Hospital discharge
MCO
CCU / Social Agency
A
Signage is distributed
Building lobby
Church lobby
Other lobby
All
GTC
SSP, SIVNA, Addus
Public Care Coordinator
Setup of Location Service Calendars

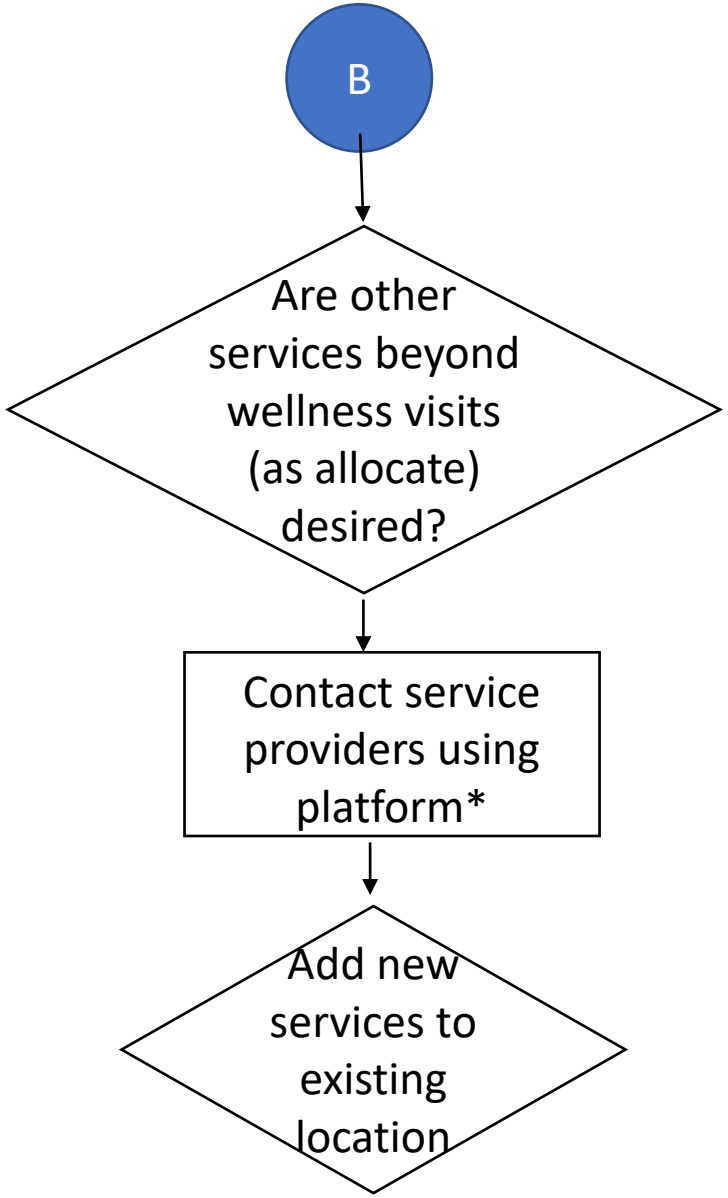

Bldg residents
Church members
Healthcare offices
Hospital discharge
Senior
Family or friends
Senior or concerned party* determines assistance is needed
F
Contacts CCU?
Yes
No
Case manager determines needs
Case manager determines financial capability
A
Senior or concerned party notes portal site advertisement
D
Accesses online portal or call center
B
C
*concerned party can be anyone assisting senior
All
GTC
SSP, SIVNA, Addus
Public Care Coordinator
Senior assistance is determined


B
Senior or concerned party enters services desired and location into portal (or calls)
Location service calendar exists?
No
E
Yes
Senior or concerned party evaluates availability dates and times of service calendar
Yes
Weekly wellness visits w/in budget?
No
F
Creates account / reserves spot in weekly wellness visit group
Service provider notified of new participant
Service provider contacts new participant (or family member)
Service provider meets senior (or family member) for contract
G
All
GTC
SSP, SIVNA, Addus
Public Care Coordinator
Wellness visit is scheduled /reserved


C
Senior / family able to pay
Yes
Preliminary search on senior location in system
Location service calendar exists?
No
E
Yes
No
Medicaid verification / authorization
Sets up senior in GTC (Optional)
CCU
Assistance allocated
Financial resources provided
No
Use MCO?
MCO
Yes
Assistance allocated
Financial resources provided
Create care plan in system for family (Optional)
Provides family with care plan and preliminary search results
D*
*mco case managers can login to monitor senior care plans in order to ensure all allocated units are scheduled / used and feedback from onsite health is positive
All
GTC
SSP, SIVNA, Addus
Public Care Coordinator
MCO plan is managed



Contact service providers using platform*



All

GTC

SSP, SIVNA, Addus

Public Care Coordinator

Other locations and services are added

Appendix Two: AgeSmart Public Information Document

PUBLIC HEARING

AgeSmart Community Resources will be holding a **virtual public hearing** on Tuesday, May 4, 2021 to share the Area Plan on Aging for FY2022.

Older adults, caregivers, community members, and organizations interested in learning more about aging services, are encouraged to attend. It is an opportunity for you to help us identify gaps in services and make recommendations for future possibilities. Make your voices heard!

Date: Tuesday, May 4, 2021
Time: 9:30 AM CST
11:00 AM CST
Visit www.AgeSmart.org to register.

Written comments accepted until 4:00 p.m. May 11, 2021 at:
AgeSmart Community Resources
801 W. State St.
O'Fallon, IL 62269

Purpose of the Public Hearing and the Public Information Document

AgeSmart Community Resources (AgeSmart) is conducting the public hearings on the FY22 Area Plan on Aging for the three-year cycle FY22-24. The public is welcome and encouraged to attend the public hearings to discuss and make comments on the Area Plan on Aging.

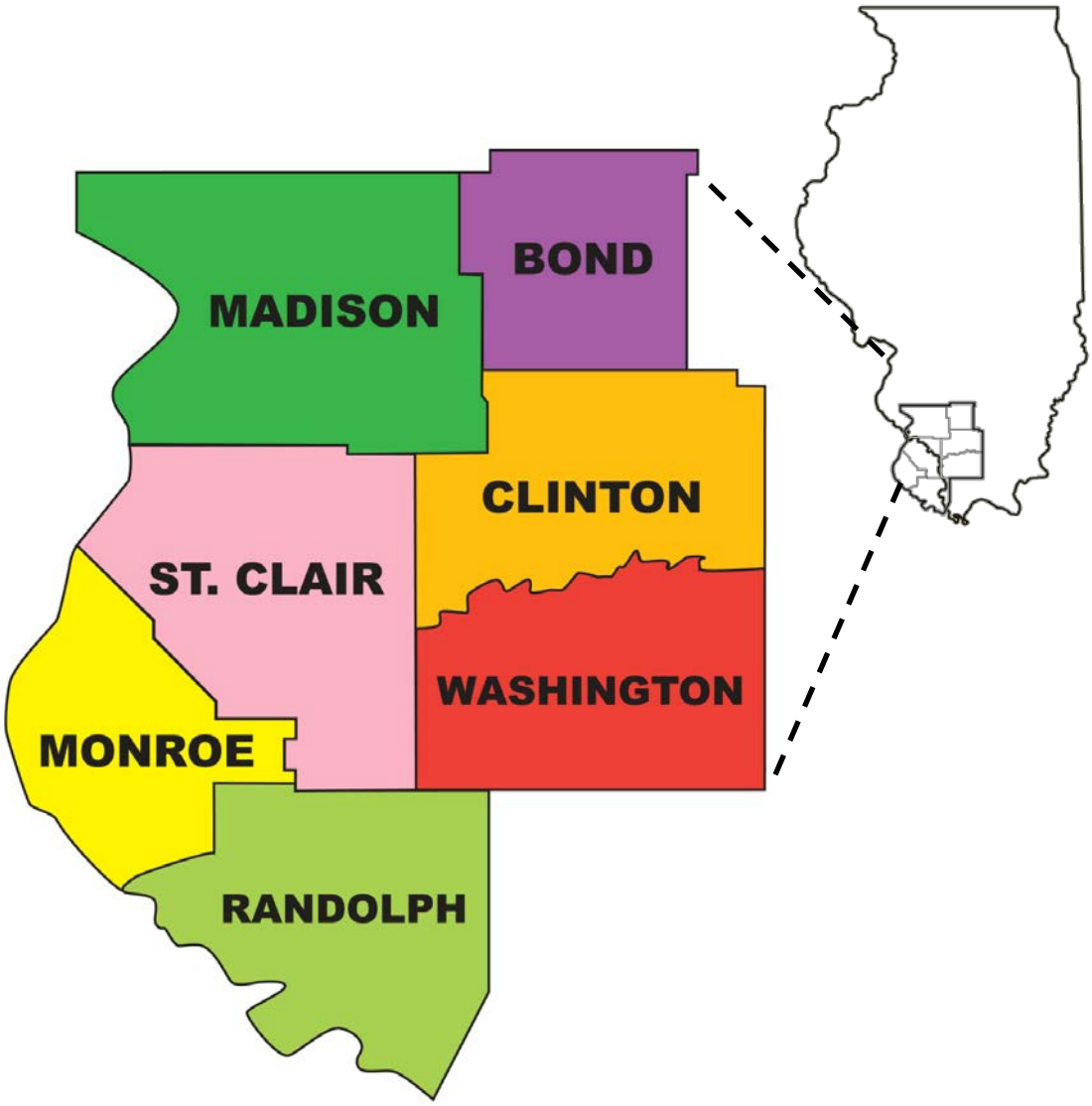
The Area Plan on Aging is a planning, management and grant award document. The full Area Plan format is prepared by the Illinois Department on Aging (IDOA). The Area Plan may be fine-tuned or even redesigned during the year as activities and funding dictate. Some proposed activities might be reconsidered after research and feedback during the planning stages. AgeSmart submits amendments to the Area Plan each year in the format required by IDOA.

This Public Information Document is the official summary of the proposed Area Plan for FY22 beginning October 1, 2021 and ending September 30, 2022. All activities are subject to available funding.

The Public Information Document is for the reader to use as a tool to stimulate comments and questions at the Public Hearings. (See above for the date and time.) Comments must be written and presented orally at the Public Hearings or in written form only and delivered to AgeSmart no later than 4:00 p.m. on May 11, 2021.

What's Inside…

Planning and Service Area (PSA) 08



In accordance with the federal Older Americans Act regulations, the Illinois Department on Aging has divided Illinois into thirteen Planning and Service Areas. The thirteen Planning and Service Areas in Illinois are each managed and served by an Area Agency on Aging. AgeSmart is a nonprofit organization serving the seven counties in Southwestern Illinois highlighted above.

The Aging Network

In 1965, Congress enacted the Older Americans Act (OAA) in response to concern by policymakers about a lack of community social services for older persons. The Act created an interconnected structure of agencies and services known as the National Aging Network.

Administration for Community Living
(U.S. Department of Health & Human Services)

Provides national leadership on aging issues. Recommends policy, develops regulations to implement the OAA, allocates and administers the OAA budget, and disseminates grants for research, training, and model projects.

State Units on Aging
(Illinois Department on Aging)

Serves as the state governmental agency for aging issues. Administers, designs, and advocates for benefits, programs, and services for the older persons and their caregivers. Also designates Area Agencies on Aging within the state.

Area Agencies on Aging
(AgeSmart Community Resources)

Planning agency at the local level. Responsible for advocacy on behalf of older persons, planning and service development, and administration of a wide variety of funds for community-based services.

Our Mission

AgeSmart enhances the lives of older adults, persons with disabilities and veterans through advocacy, action, and answers on aging.

Who We Are

AgeSmart is an **independent non-profit** organization and is one of over 600 Area Agencies on Aging across the country authorized by the Amended Federal Older Americans Act (OAA) to plan and administer services to persons 60 and older, their caregivers, and grandparents raising grandchildren. AgeSmart is one of 13 Area Agencies in Illinois authorized by the Illinois Act on Aging and designated by the Illinois Department on Aging.

AgeSmart plans, coordinates, and acts as an advocate for the development of a comprehensive service delivery system for over 150,000 individuals aged 60 and older in Planning and Service Area 08 (PSA). The PSA is comprised of two high-density counties (Madison and St. Clair) and five low-density* counties (Bond, Clinton, Monroe, Randolph and Washington), two of which are rural (Randolph and Washington). **Low Density: Community with population under 5,000*

FY21 Board of Directors

A 11-member Board of Directors governs AgeSmart chaired by Michael Niermann of Madison County, IL. The Board sets policy and makes decisions about programs and funding distribution. Over 60% of the Board members are over the age of 60.

Rita Boyd……..Randolph County
Terrance Duncan..... St. Clair County
Eugene Dunkley……..Bond County
Anita Ewing ..... St. Clair County
Donna Frederick..... St. Clair County
Rafael Him…… Clinton County
Cynthia Johnson.....Monroe County
Michael Niermann ……Madison County
Klay Tiemann*…….. Randolph County
Connie Turner ……Monroe County
Steven Wolf ……..St. Clair County

**President*

FY21 Advisory Council

A 13-member Advisory Council is led by Larry McLean of St. Clair County, IL. The Council advises AgeSmart on assessing the needs of older adults and their caregivers and makes recommendation on service priorities.

Angela Banks	Dorene Hoosman
Kelly Barbeau	Bhagya Kolli
Connie Barre	Larry McLean*
Deborah Carter	Erin McNamara-Stafford
Venita Dixon	Cheryn Sutton
Judy Hevner	Lori Vernier
Cindy Hill	

**Chairman*

FY21 Staff

Joy Paeth.....Chief Executive Officer
Nancy Lonsdale. .....Chief Fiscal Officer
Chris Fulton…….…. Community-Based Services Manager
Kiyeon Yoch .....Grants/Planning Manager
Nathan Caron ..... Options Counselor
Sarah Gorline……..…….…..… Accountant
April Hausman……..…… Benefits Specialist
Abigail Lagermann……..…….. Administrative Assistant
Hali McKenzie…….. Program Compliance Specialist
Melanie O'Brien..... I & A Resource Specialist
Nicole Prindable……..…….. Options Counselor
Michelle Schmidtke…… Benefits Specialist
Taylor Schwartz……..…… Program Compliance Specialist
Christina Sellers ……..…...… Options Counselor
Pamela Woods……..…… Billing Specialist

FY21 Grantees

Bond County Senior Citizens Center, Inc.
Greenville, IL
(618) 664-1465

Centerstone
Alton, IL
(618) 462-2331 ext.412

Children's Home & Aid
Granite City, IL
(618) 452-8900

Clinton County Collaborative
Carlyle, IL
(618) 594-2321
New Baden
618-224-9913
Trenton
618-224-9913

Collinsville Faith in Action
Collinsville, IL
(618) 344-8080

Edwardsville/Glen Carbon-Faith in Action
Edwardsville, IL
(618) 692-0480

Health Visions
East St. Louis, IL
(618) 271-7000

Human Support Services
Waterloo, IL
618-939-4444 ext 1220

Land of Lincoln Legal Aid
East St. Louis, IL
Senior Citizens Legal Services Project
(618) 398-0958 ext.2236

Lessie Bates Davis Neighborhood House
East St. Louis, IL
(618) 271-2522

Mascoutah Senior Services Program
Mascoutah, IL
(618) 566-8758

Millstadt Township Senior Services
Millstadt, IL
(618) 476-3731

Northeastern Randolph County Senior Services, Inc.
Sparta, IL
(618) 443-4020

Senior Services Plus, Inc.
Alton, IL
(618) 465-3298

South Central Illinois Mass Transit District
Centralia, IL
(618) 532-8076

SWIC Programs & Services for Older Persons (PSOP)
Belleville, IL
(618) 234-4410

St. John's Community Care
Collinsville
618-344-5008

Southwestern Illinois Visiting Nurse Association
Swansea, IL
(618) 236-5863

The Oasis Institute
St. Louis, MO
(314) 862-2933

Village of Steeleville
Steeleville, IL
(618) 965-3134 ext.5

Washington County Senior Services, Inc.
Okawville, IL
(618) 243-6533

Western Egyptian Economic Opportunity Council
Steeleville, IL
(618) 965-3458

Waterloo Senior Center
Waterloo, IL
(618) 939-8880

Chester Senior Center
Chester, IL
(618) 826-5108

Member, Answers on Aging Network
Information and Assistance Provider

Centers for Independent Living		
IMPACT	**LINC**	**OFACIL**
Alton, IL 618-462-1411	Belleville, IL 618-235-9988	Mt. Vernon, IL 618-244-9212

Area Plan on Aging

Planning Process

AgeSmart assesses service needs of older adults in the seven-county region every three years as a part of the planning process and establishes a priority service list annually. The service priorities reflect those services found to be the greatest need for those older adults in the planning and service area (PSA). A variety of methods are used to identify the needs of older adults, caregivers, and grandparents raising grandchildren in the PSA as outlined below.

- Studying national trends and reports on the needs of older adults, caregivers and grandparents raising grandchildren
- Analyzing U.S. and local census data and other relevant demographic statistics
- Analyzing service utilization using National Aging Program Information System and Enhanced Services Program
- Collecting community input through surveys

AgeSmart presents the findings from the assessments to AgeSmart's Board of Directors and Advisory Council to establish service priorities and develop new programs. Through monitoring efforts, open dialogue with service providers, and contact with the public, AgeSmart gathers information to make nuanced or significant changes in programs within the planning cycle. The service priorities reflect those services found to be the greatest need for the older adults and their caregivers in the region.

2019 Population Estimates for PSA 8

County	Total 60+	60+ Poverty	60+ Minority	60+ Live Alone	75+
Bond	4,363	308	211	1,045	1,379
Clinton	9,384	809	297	2,235	3,004
Madison	65,070	4,847	5,259	16,540	19,955
Monroe	9,102	506	196	1,660	2,762
Randolph	8,347	622	393	2,095	2,812
St. Clair	60,295	5,482	17,103	15,065	17,712
Washington	3,954	185	68	935	1,337
PSA TOTAL	**160,515**	**12,759**	**23,527**	**39,575**	**48,961**
STATE TOTAL	**2,852,208**	**241,486**	**781,376**	**669,050**	**866,759**

(2019 Census Population Estimates)

Summary of the Needs Assessment for FY22-24 Area Plan

In November 2020, AgeSmart began distributing Older Adults Needs Survey throughout its seven-county region. Paper survey was disseminated to 230 older adults, which included curbside meals participants at twelve (12) senior centers and residents of four (4) senior apartments in St. Clair county. Responses from the surveys were entered in Google Form for analysis.

AgeSmart also conducted an online Community Needs survey targeting local professionals serving older adults to help identify gaps in the services. 88 individuals from different sectors of the community participated in the survey. The survey helped us better understand the needs of older adults in our planning and service area and identify the activities and programs needed in the communities.

In addition to the Older Adults Needs Survey, AgeSmart also surveyed family caregivers to learn about the challenges and needs of the caregivers we serve. 53 caregivers responded to the online survey. Further insight was obtained from a virtual caregiver conversation that was hosted by AgeSmart in January 2021.

The surveys were conducted for two months and closed in January 2021. The services proposed in the FY22-24 Area Plan reflect the needs of older adults identified from these surveys.

AgeSmart also reviewed the data from the FY20 Consumer Surveys that were collected during the service delivery by Information & Assistance (I&A) providers throughout the seven-county region. A total of 867 older adults participated in the survey.
Special attention was given to responses to “What services would help you stay independent and help you age well?”. 80 respondents answered this open-ended question.

Other methods to assess the needs of older adults, family caregivers, and grandparents raising grandchildren (GRG) include:

- Regular communication with caregivers who participate in respite program and conversation about their support needs
- Collecting information about gaps in services and consumer needs through I&A and Options Counseling
- Analysis of GRG gap filling service trends to identify needs and resources available
- Consult local groups and experts on the needs of older adults in the community

AgeSmart is also working with the Illinois Department on Aging and local organizations to help communities become Dementia Friendly and better support those individuals with cognitive challenges. This work also allowed AgeSmart to offer Savvy Caregiver Training and Stress Busting Program to older adults.

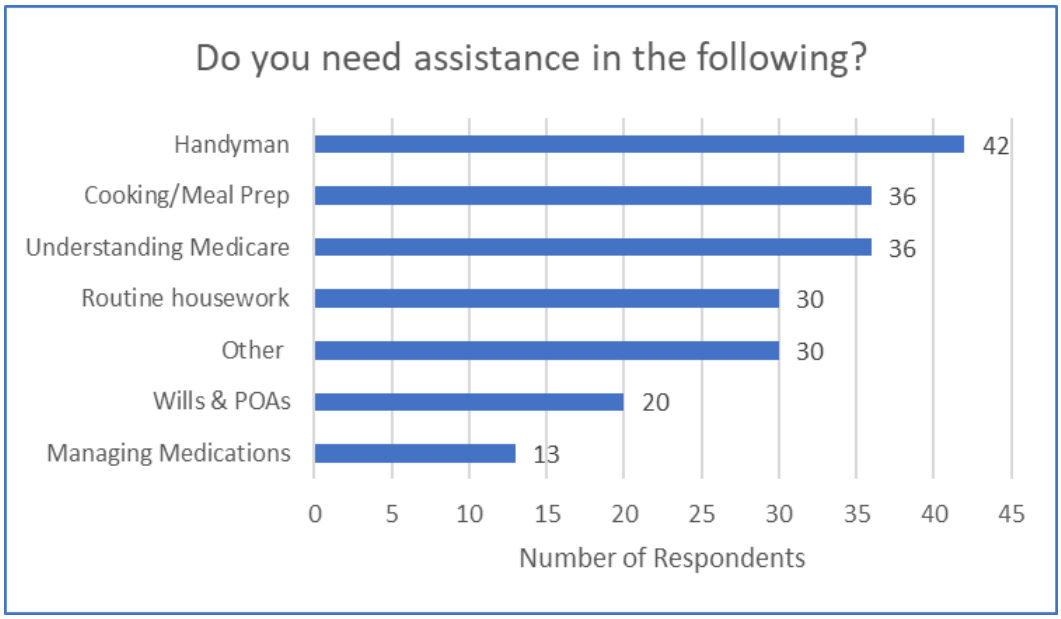
Key Findings

Some common themes emerged from both needs surveys for older adults and local professionals.

Need for Homemaker and Handyman Service

Many older adults reported that they needed help with routine housework including meal prep, cleaning, and laundry. Private-pay homemaker service is often too costly for many older adults. Homemaker service provided through Community Care Program is only available for low-income individuals and there are many older adults who do not meet the income requirements and are still unable to afford the private-pay service.

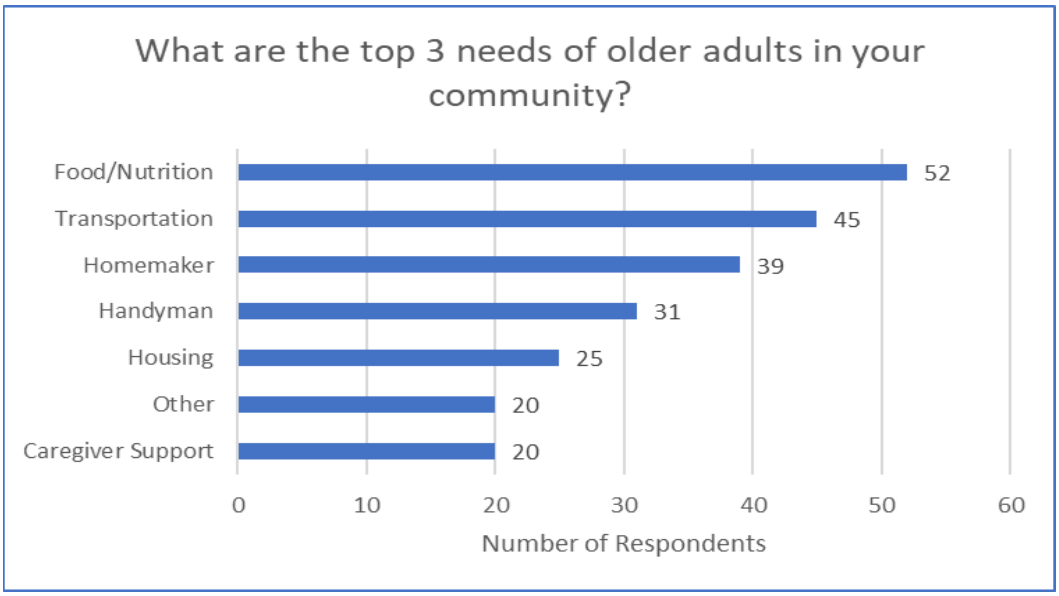
Similar to the need for an affordable homemaker service, another unmet need identified was handyman. Older adults who lack an informal support system need help with simple chores such as changing light bulbs and replacing batteries in a smoke detector. Assistance with yard work such as grass cutting, cleaning gutters, and snow removal is also often sought out by older adults. Regardless of the size of a job, it is challenging for older adults to find trustworthy and affordable contractors. For minor home repairs and small tasks, it becomes even more difficult due to the limited size of the projects.

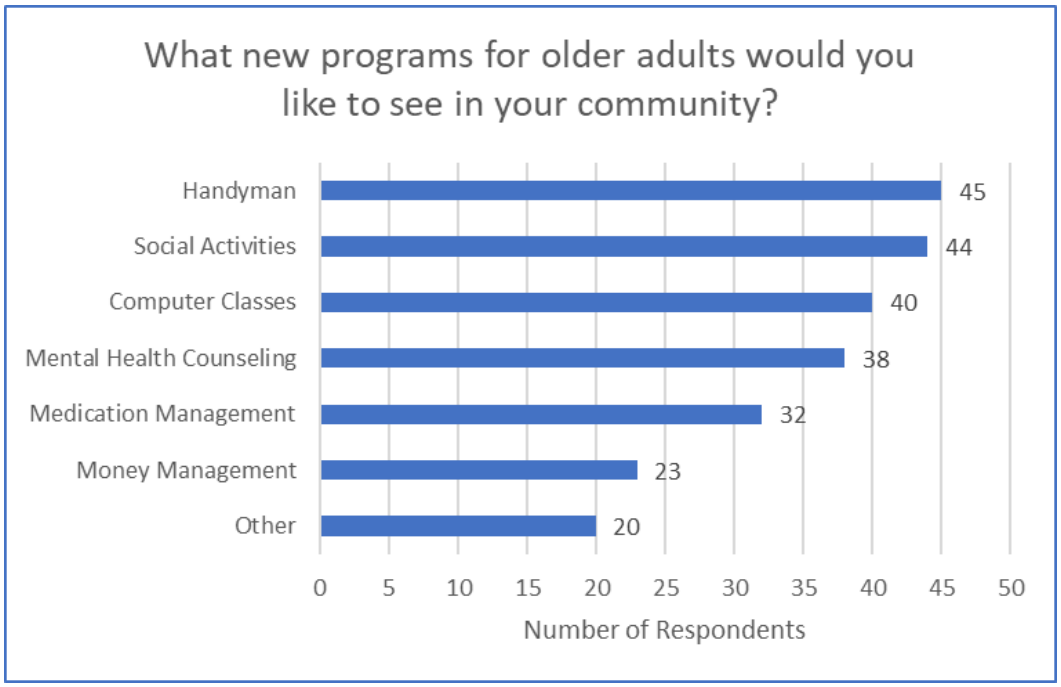


48% of the older adults survey respondents answered the question about the type of assistance they may need. Of those, nearly 50% reported that they needed assistance with handyman and 30-40% needed help with housework. Assistance with Medicare/Medicaid, medication management, and getting legal affairs in order were also mentioned.

The need for assistance with housework and simple repairs was also identified by professionals in the community. As shown in the chart below, outside of the OAA services that are already being funded (food & transportation), local professionals rated

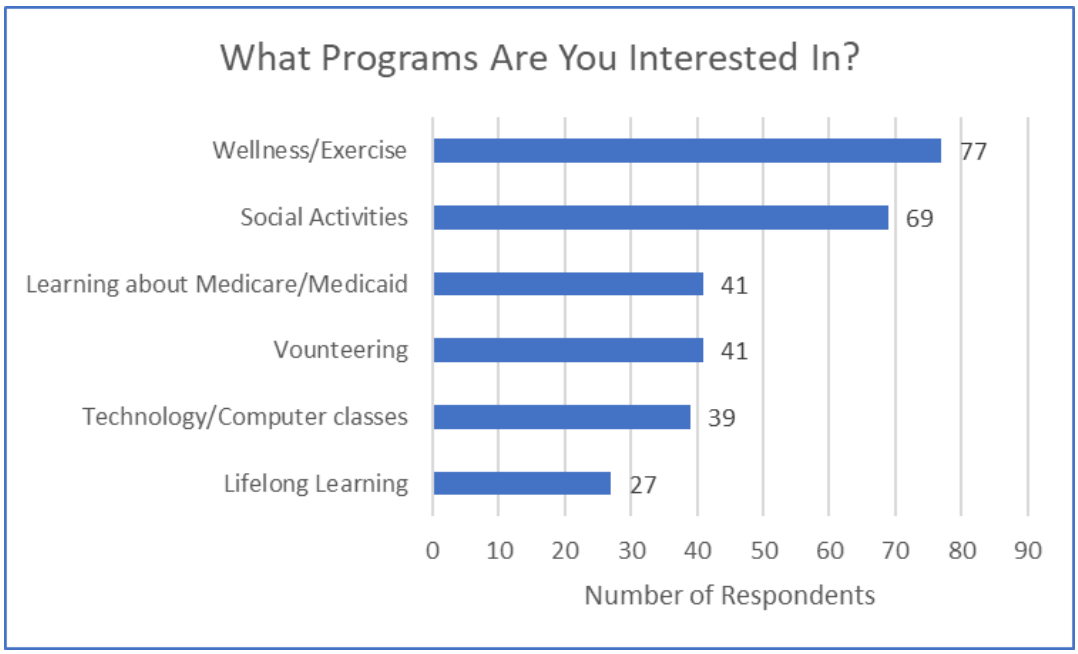
homemaker and handyman as the most needed services. Handyman was also at the top of the list of new services they would like to see in the community for older adults.



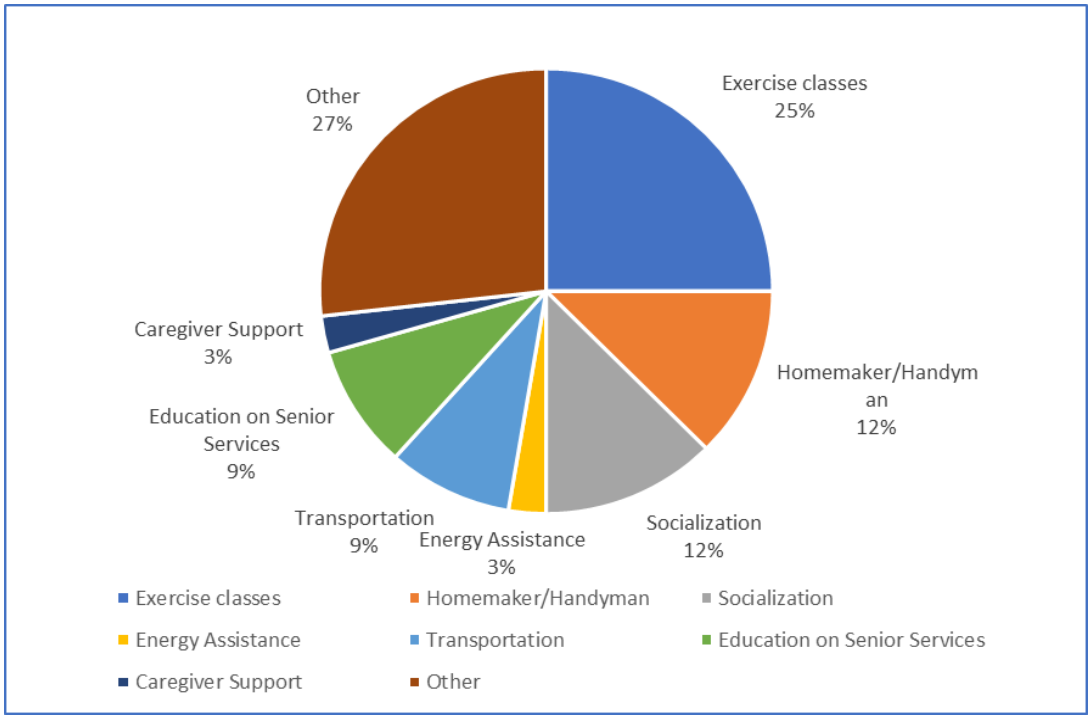


Local professionals also indicated that seniors in their communities would benefit from more robust social activities and computer classes. A similar trend was also observed in the older adults needs survey responses. When asked about the programs they are interested in, wellness/exercise and social activities were most frequently mentioned.

Other programs older adults desired include education on Medicare/Medicaid, computer classes, volunteering, and lifelong learning.

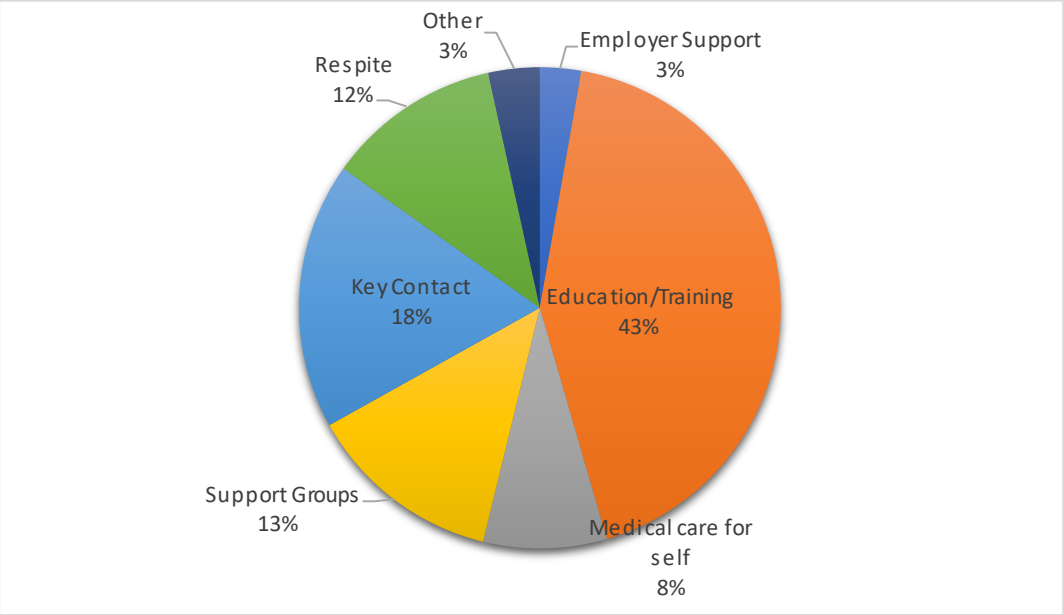


The need for homemaker/handyman as well as exercise classes was also demonstrated in the FY20 I&A Consumer Survey. 110 out of 867 older adults responded to the open-ended question "**What services would help you stay independent and help you age well?**". The chart below illustrates the results.



Other services the older adults desired include financial assistance, affordable housing, legal assistance, and mental health counseling.

The family caregiver survey revealed the continued need for training programs and information assistance for caregivers. Since FY18, AgeSmart has been expanding caregiver training programs. It started with Savvy Caregiving in FY18 and since then AgeSmart has added Stress Busting classes and Memory Cafes. Caregivers feel more confident and have less stress when they have the knowledge and skills to provide safe and effective care. The chart below illustrates the services and support the caregivers needed.



Many caregivers wanted to work with a key contact person for questions and help. This corresponds directly to the response concerning how caregivers would prefer to receive information, which is by individual meeting with a counselor or an information specialist. The caregivers' desire for resources through education/training and individual support is the reason AgeSmart is expanding the use of Tailored Care (T Care). T Care is an evidence-based program designed to assess and build care plans for caregivers to help avoid crisis incidents and potential long term/skilled care placement. Beginning in FY22, AgeSmart will expand T Care to help enhance Information & Assistance and Respite service for caregivers.

The home and community-based services supported by the Older Americans Act are designed to promote health and well-being of older adults and to reduce isolation.
Without a doubt, the COVID pandemic has presented great challenges to the aging network. All senior center activities remain suspended at the time of writing.
The health, safety, and well-being of our older adults and caregivers are our highest priority. AgeSmart will continue to offer virtual programs that allow older adults to stay connected and help them feel less isolated. Evidence-based wellness programs such as "Tai Chi" and "Live Well, Be Well" will continue to be offered virtually.
AgeSmart will continue to promote the home and community-based programs exploring creative solutions to respond to local needs. Based on the results of the surveys and evaluation of the current service system, AgeSmart establishes the service priorities and develops local initiatives.

Statewide Initiative

Enhance Illinois' Existing Community-Based Service Delivery System to Address Social Isolation among Older Adults

During FY2022-2024, the Illinois Department on Aging and Area Agencies on Aging will continue to work in collaboration with local community-based service to address social isolation among older adults. The overall goal is to reduce social isolation and promote well-being in older adults.

Background

Social isolation and loneliness are associated with increased mortality in older adults. Social isolation also has been linked to other adverse health effects, including dementia, increased risk for hospital readmission and increased risk of falls. The AARP Foundation has called social isolation a "growing health epidemic" among older adults. It equates the health risks of prolonged isolation with smoking 15 cigarettes daily.

A recent study by researchers from the AARP Public Policy Institute, Stanford University, and Harvard finds that Medicare spends an estimated $6.7 billion more each year on seniors who have little social contact with others. About 14% of study participants were identified as socially isolated, which meant they had little contact with adult children, other relatives, or friends. The study found that Medicare spent about $1,600 per year more on older adults who are socially isolated than those who are not. They were one-third more likely to require care in a skilled nursing facility, perhaps because they could not be safely discharged home after a hospitalization.

Risk Factors associated with social isolation are:

- Living alone
- Mobility or sensory impairment
- Major life transitions
- Socioeconomic status
- Being a caregiver for someone with severe impairment
- Psychological or cognitive vulnerabilities
- Location: rural, unsafe, or inaccessible neighborhood/community
- Inadequate social support
- Language barrier

Older adults who feel lonely and isolated are more likely to report also having poor physical and/or mental health, as reported in a study using data from the National Social Life, Health, and Aging Project.

Addressing social isolation among older adults has been one of the Illinois aging network's priorities for the past three years and the COVID-19 pandemic has exacerbated an already serious problem. Avoiding social contacts and practicing social distancing for extended periods of time have certainly affected mental health and well-being of older population. Older adults are at higher risk for severe illnesses from COVID and require extra safety measures to help prevent the infection, which means limited social activities for possibly a longer period of time. And for this reason, senior centers will likely be among the last facilities to reopen. In response to the pandemic, AgeSmart has implemented the following strategies to combat social isolation.

AgeSmart's strategy to reduce social isolation among older adults

Connecting seniors with social resources, such as senior centers and volunteering programs, is one way to combat subjective feelings of isolation. Home and community-based services are designed to connect people to communities. From nutrition services to transportation to caregiver support programs, community-based services enable older adults to maintain and strengthen their ties to family and friends and the community. AgeSmart along with other Area Agencies on Aging in the state will continue to focus on promoting the aging network as part of the social isolation awareness campaign.

During the COVID-19 pandemic, AgeSmart's network of providers modified the service model to continue to provide vital services to vulnerable older adults. Special initiatives to address social isolation also pivoted to adapt to the new environment created by the pandemic.

1. **Telephone Reassurance**

AgeSmart has expanded its telephone reassurance program to all 7 counties during the pandemic. In FY20, AgeSmart's network of providers made 10,597 well-being check calls to 2,659 vulnerable older adults who were quarantined.
As of March 2021, weekly reassurance calls are being provided to a monthly average of 1,000 homebound older adults who have very limited social contact and support.
AgeSmart-funded community organizations will continue to provide telephone reassurance to at-risk older adults, particularly those who are living alone, low-income, or living in rural area. Home delivered meals consumers will be prioritized.

2. **Memory Café**

Memory Café is a social gathering for individuals living with dementia, or another form of cognitive impairment, and their caregivers. It provides safe and supportive environment where caregivers and their loved ones can socialize and enjoy activities together in a café-like setting to reduce feelings associated with stigma and isolation. During the pandemic, Memory Café was modified to be delivered virtually and it continues to connect the caregivers on the Zoom platform.

3. Virtual Learning Channel

In response to the COVID-19, AgeSmart has started offering an online Learning Channel through a partnership with GetSetup. This online platform provides a variety of classes from basic technology class to virtual social hours helping older adults stay connected and socially engaged. All classes are Zoom-based, small group classes. AgeSmart's Learning Channel serves not only as an educational platform but also a space where older adults can meet new people and socialize virtually. Group classes are available to older adults and caregivers free of charge.

AgeSmart has also provided Zoom licenses as well as tablet devices to its grantees to help them connect with their consumers virtually. Our long-term goal includes offering these classes as innovative programming resources at the senior centers when they reopen.

4. Senior Skip Day

AgeSmart and Greenville University developed Senior Skip Day to raise awareness of Social Isolation and its impact on the health and wellbeing of older adults. The goal is to celebrate and connect across generations to help alleviate loneliness and social isolation. Students are paired with seniors to visit, help with tasks and to assist at the local senior center. A "How-to" implementation guide has been developed for other area agencies on aging, schools, and universities to use.

During the pandemic, Senior Skip Day pivoted to a pen pal project. Freshman students are paired with older adults and they correspond through an act of letter writing.
As demonstrated in many other intergenerational pen pal programs across the country, it creates a positive impact on older adults' health and well-being reducing feelings of isolation and giving them a sense of purpose. AgeSmart will continue to collaborate with Greenville University and explore opportunities to expand the intergenerational programming in the PSA8.

5. Promoting Social Connectedness through BRIC (Building Resilient Inclusive Community) Program

AgeSmart is participating in the BRIC Initiative to promote opportunities to connect older adults who are socially isolated due to COVID-19. The BRIC program, which is funded through National Association of Chronic Disease Directors is being led by Healthier Together. It prioritizes older adults living in high burden communities and aims to improve safe access to physical activity, promoting healthy eating through improved nutrition security, and reducing isolation and loneliness.
AgeSmart along with the local aging service providers will be serving as key players as the coalition develops strategies to promote social connectedness in the communities.

AgeSmart will continue to work with the Department on Aging and the colleagues from the Area Agencies on Aging in Illinois to create a statewide impact to reduce social isolation. Public education materials designed to help raise awareness of this national issue have been disseminated throughout the network. The statewide brochure includes a checklist to self-measure the risk of isolation as well as resources to help older adults

stay connected. The Loneliness Scale survey will continue to be used as pre and post survey to measure their loneliness and effectiveness of the interventions.

Local Initiative

To address the unmet needs that were identified from the need assessment, AgeSmart will implement the following.

1. **Consumer-Directed Chore Service Pilot**
   Building on the consumer-directed Respite service model, AgeSmart will explore opportunities to offer flexible in-home chore assistance that empowers consumers to hire their choice of helper at reasonable cost.
   This pilot will provide limited financial resources for older adults who are not eligible for Community Care Program but cannot afford private pay homemaker service focusing on the individuals with greatest social and economic need.

2. **Reliable and Affordable Handyman through Collaboration with Local Community Partners**
   AgeSmart will investigate local handyman resources seeking reliable, trustworthy, and affordable partners. A preferred providers list will also be developed as resources for consumers. Gap Filling and Residential Repair and Renovation (RRR) program utilization data will be analyzed to help identify the types of assistance older adults need the most and the scope of services will be developed.

   Designing Handyman service as an expansion of the existing Gap Filling or RRR will be considered. Private funds raised by AgeSmart Development Association for the Aging may be utilized for the Handyman pilot.

FY22 Service Priorities

The service priorities for FY22 are outlined below.
Should the amount of federal or state funding for FY22 decrease, AgeSmart will revise the service priorities based on the needs of a service developing a plan that would cause the least harm to consumers.

Service Definition	Projected Persons Served in FY22	Projected Units of Service in FY22
Title III-B Access Services		
Assisted Transportation	250	4,200
(Provided by multiple grantees in portions of Clinton, Madison and St. Clair counties) Providing transportation and an escort to older persons who have difficulty using regular transportation. Assisted Transportation is "door-to-door", and the escort will often wait with the older person at the doctor's office or other destination.		
Information & Assistance (I & A)	25,000	35,000
(Provided by AgeSmart and multiple grantees throughout the service area) Providing current information on opportunities and services available within their communities; links the individuals to the opportunities and services that are available; and, to the maximum extent practical, ensures that the individuals receive the services needed by establishing adequate follow-up procedures.		
Options Counseling	450	800
(Provided by multiple grantees throughout the service area) Providing a person-centered, interactive, decision-support process whereby individuals receive assistance in their deliberations to make informed long-term support choices in the context of their own preferences, strengths, and values.		
Transportation	500	20,000
(Provided by multiple grantees throughout the service area) Transporting older persons to and from community facilities and resources for the purpose of acquiring and receiving services, participating in activities and attending events in order to reduce isolation and promote successful independent living.		
Title III-B In-Home Services		
Residential Repair & Renovation	200	200
(Provided by one grantee throughout the service area) Assisting older persons with physical or cognitive problems to maintain or adapt their homes to meet their needs.		
Title III-B Community Services		
Health Screening	25	100
(Provided by one grantee throughout the service area) Utilizing a community nurse, the service identifies and evaluates the health needs of older persons and linking them to the healthcare system.		

Legal Assistance	450	3,800
(Provided by one grantee throughout the service area) Services include arranging for and providing assistance in resolving civil legal matters and the protection of legal rights, including legal advice, research and education concerning legal rights and representation by an attorney at law, a trained paralegal professional (supervised by an attorney), and/or a law student (supervised by an attorney) for an older person.		
Title III-C1 Community Services		
Nutrition Services: Congregate Meals	2,000	24,000
(Provided by multiple grantees throughout the service area) Providing nutritious meals in congregate setting.		
Title III-C2 In-Home Services		
Nutrition Services: Home Delivered Meals	3,200	500,000
(Provided by multiple grantees throughout the service area) Providing nutritious meals delivered to older persons who are homebound because of illness or disability.		
Title III-D Community Services		
Disease Prevention & Health Promotion Program	100	300
(Provided by one grantee throughout the service area) Providing evidence-based wellness programs to promote better health among older persons.		
Title III-E Access Assistance Services		
Case Management for Grandparents Raising Grandchildren	40	150
(Provided by one grantee throughout the service area) A service that assists Grandparents Raising Grandchildren in obtaining access to the services and resources available within their communities. To the maximum extent practical, it ensures that the individuals receive the services needed by establishing adequate follow-up procedures.		
Information & Assistance for Caregivers	2,100	2,600
(Provided by AgeSmart throughout the service area) A service for caregivers that provides current information on opportunities and services available within their communities; links the individuals to the opportunities and services available. The term “family caregiver” means an adult family member, or another individual, who is an informal provider of in-home and community care to an older individual with Alzheimer’s disease or a related disorder with neurological and organic brain dysfunction.		
Title III-E Information Services		
Public Education	250	25
(Provided by AgeSmart throughout the service area) Information service that is directed to large audiences of current and potential caregivers.		

Title III-E Counseling		
Counseling	200	600
(Provided by two grantees for Bond, Madison, and St. Clair Counties) In-home personal counseling service for caregivers.		
Title III-E Respite Services		
Respite	125	19,000
(Provided by AgeSmart throughout the service area) Providing temporary, substitute support to allow Family Caregivers a brief period for rest or to attend to other needs.		
Respite for Grandparents Raising Grandchildren	1	60
(Provided by one grantee throughout the service area) Providing temporary, substitute support to allow Grandparents a brief period for rest or to attend to other needs.		
Title III-E Supplemental Services		
Gap Filling for Caregivers	2	2
(Provided by one grantee throughout the service area) A supplemental service for caregivers that provides financial assistance on a case-by-case basis.		
Gap Filling for Grandparents Raising Grandchildren	30	40
(Provided by one grantee throughout the service area) A supplemental service for Grandparents Raising Grandchildren that provides financial assistance on a case-by-case basis.		
Legal Assistance for Caregivers	85	370
(Provided by one grantee throughout the service area) Services include arranging for and providing assistance in resolving civil legal matters and the protection of legal rights, including legal advice, research and education concerning legal rights and representation by an attorney at law, a trained paralegal professional (supervised by an attorney) and/or a law student (supervised by an attorney) for caregivers of older persons.		
Legal Assistance for Grandparents Raising Grandchildren	20	200
(Provided by one grantee throughout the service area) Services include arranging for and providing assistance in resolving civil legal matters and the protection of legal rights, including legal advice, research and education concerning legal rights and representation by an attorney at law, a trained paralegal professional (supervised by an attorney) and/or a law student (supervised by an attorney) for grandparents raising grandchildren.		

Title III-B/VII Ombudsman
Long Term Care Ombudsman
(Provided by one grantee throughout the service area) Advocating for residents of long-term care facilities, developing rapport with residents and providing advocacy, support and education about their rights.
Title VII Elder Rights
Adult Protective Services
(Provided by one grantee throughout the service area) A service that responds to reports of abuse, neglect, and financial exploitation of older adults 60+ and adults with disabilities 18-59 providing investigation, intervention and follow-up services to victims.

FY2022 Alzheimer's & Social Isolation Initiatives

Title III-B In-Home Services		
Telephone Reassurance	2,500	22,000
(Provided by one grantee for St. Clair County) Weekly telephone calls to individuals to provide psychological reassurance and reduce isolation.		
Title III-E Services		
Memory Cafes	120	120
(Provided by one grantee for Madison County) A social gathering for people living with dementia and their family caregivers providing safe and supportive environment to socialize.		
Savvy Caregiver	48	384
(Provided by two grantees for Madison and Monroe Counties) The Savvy Caregiver Program is designed to train family and professional caregivers in the basic knowledge, skills, and attitudes needed to handle the challenges of caring for a family member with dementia and to be an effective caregiver.		
Stress Busting	54	432
(Provided by multiple grantees for Madison and St. Clair Counties) The Stress-Busting Program provides caregivers information about stress (particularly stress associated with caregiving), how to deal with stress through relaxation and problem solving, and how to care for themselves while caring for a loved one with dementia.		

Other Services

Veterans Directed Home and Community Based Services
AgeSmart works in partnership with the Marion and St. Louis Veterans Administration Medical Centers to help veterans live independently in the community. Options Counselors support veterans in developing a service package to meet their needs, helping them to maintain their independence.

Senior Medicare Patrol
Senior Medicare Patrol (SMP) empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education.
The Illinois SMP program is administered through AgeOptions in Suburban Cook County and AgeSmart participates in this statewide initiative serving as the SMP Coordinator for the Southern Illinois counties.

Senior Health Assistance Program
Senior Health Assistance Program (SHAP) offices offer seniors information and free help filling out applications for programs.

Senior Health Insurance Program (SHIP)
SHIP is a free health insurance counseling service for Medicare beneficiaries, their families, and caregivers. Consumers are provided information, assistance and resources about applying for and maintaining their Medicare coverage.

Senior Farmer's Market Nutrition Program
The Senior Farmers' Market Nutrition Program provides low-income seniors with vouchers that can be exchanged for eligible foods at farmers' markets and roadside stands. AgeSmart distributes the vouchers to eligible seniors who self-report their income.

NCOA Benefit Enrollment Center (BEC)
Benefit Enrollment Centers (BEC) are a national network that help low-income individuals with Medicare enroll in food assistance, energy assistance, healthcare benefits and more.

Adult Protective Services

Each year hundreds of thousands of older persons are abused, neglected, and exploited. Many victims are older, frail, and vulnerable and cannot help themselves and depend on others to meet their most basic needs. Abusers of older adults are both women and men, and may be family members, friends, or "trusted others." The **Adult Protective Services**, under authority of the Illinois Adult Protective Services Act, responds to reports of alleged abuse, neglect, or financial exploitation of persons 60 years of age and older, and of persons age 18-59 with disabilities living in the community. It is designed to build upon the existing legal, medical, and social service systems in place, and ensures the system is more responsive to the needs of abuse victims.

Types of Abuse

- Physical Abuse – inflicting physical pain or injury on a senior, e.g. slapping, bruising, or restraining by physical or chemical means.
- Sexual Abuse – non-consensual sexual contact of any kind.
- Neglect – the failure by those responsible to provide food, shelter, health care, or protection for a vulnerable elder.
- Exploitation – the illegal taking, misuse, or concealment of funds, property, or assets of a senior for someone else's benefit.
- Emotional Abuse – inflicting mental pain, anguish, or distress on an elder person through verbal or nonverbal acts, e.g. humiliating, intimidating, or threatening.
- Abandonment – desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that person.
- Self-neglect – characterized as the failure of a person to perform essential, self-care tasks and that such failure threatens his/her own health or safety.

AgeSmart serves as the Regional Administrative Agency for the Illinois Adult Protective Services as designated by IDOA and, in turn, grants funds to a local agency to insure direct client services are provided. Every month, approximately 80 abuse and neglect cases are reported to Adult Protective Services in PSA08.

To Report Abuse

Call the Southwestern Illinois Visiting Nurse Association: **1-800-642-5429** or 24-hour **Elder Abuse Hotline: 1-866-800-1409, 1-888-206-1327 (TTY).** Any person can voluntarily report. By law, anyone making an Adult Protective Services report in good faith has civil and criminal immunity from liability and professional disciplinary action. All reports are kept confidential and anonymous reports are accepted.

Administration

Administrative Activities

The OAA restricts AgeSmart administrative cost to 10% of the Title III funding. AgeSmart's proposed administrative expenses and activities for FY22 are as follows.

Budget: $325,000

Activities include but are not limited to:

- Implement Area Plan assurances
- Implement Area Plan Statewide and Local Initiatives
- Procure Federal and State funds
- Develop and implement RFP process to award grants for services
- Maintain NAPIS/ESP program databases
- Monitor grantees in program and fiscal performance including on-site reviews
- Provide technical assistance and training for grantees
- Comply with IDOA requests and requirements
- Complete annual Agency financial audit
- Write and disseminate an annual report
- Follow Civil Rights regulations and monitor grantees' adherence
- Provide Board Management training for the Board of Directors
- Provide Service Procurement training for the Advisory Council
- Provide administrative support for the Board of Directors and Advisory Council
- Maintain AgeSmart's website (www.AgeSmart.org) to provide the public with 24/7 access to comprehensive aging resources
- Administer and coordinate Farmers Market Coupon Program

Administratively Related Activities

In addition to the 10% administrative cost, AgeSmart retains part of III-B supportive service funds for the Administratively Related Direct Services, which are Advocacy, Coordination, and Program Development. AgeSmart's proposed administratively related expenses and activities for FY22 are as follows.

Advocacy

AgeSmart educates public officials and the community on aging issues and assist them in addressing the needs of the aging population. We also monitor proposed legislation and polices at the federal, state and local levels.

Budget: $93,000

Activities include but are not limited to:

- Coordinate advocacy campaigns to promote policies and services for older Illinoisans
- Participate in delivering policy and budget priorities to state legislators
- Participate in the National Association of Area Agencies on Aging's Policy Briefing and Capitol Hill Day; provide AAA board, Advisory Council, service providers, and the general public with advocacy alerts facilitating grassroots participation on issues of importance to seniors and persons with disabilities
- Provide legislators with information regarding constituencies including but not limited to demographics, service trends, number of consumers served to address the area's needs
- Visit legislators (2 senators, 2 congressional representative, 9 state senators, and 7 state representatives) and stay in constant contact regarding important issues regarding beneficiaries (locally and in Springfield)
- Seek contact with 7 county boards, over 50 mayors and village presidents, 133 township and precinct supervisors
- Advisory Council hosts monthly meetings throughout the Aging Network to address advocacy issues
- Serve as a catalyst for local community elected officials who are interested in programs for their 60+ citizens and meet with them individually on multiple occasions
- Encourage the media to highlight issues pertaining to older adults and their caregivers

Coordination

AgeSmart coordinates efforts with a variety of local organizations in the PSA to develop a comprehensive and coordinated system of community-based services for older adults.

Budget: $51,000

Activities include but are not limited to:

- Coordinate efforts throughout AgeSmart's PSA for the Senior Health Assistance Program (SHAP) / Senior Health Insurance Program (SHIP) / MIPAA (Medicare Improvements for Patients and Providers Act) / Aging and Disability Resource Center (ADRC) / Options Counseling
- Attend numerous health and senior fairs throughout the PSA
- Participate in quarterly meetings with the CCU and CCP providers

- Serve as a catalyst for local community elected officials who are interested in programs for their 60+ citizens by meeting with them individually on multiple occasions
- Serve as Senior Medicare Fraud Patrol Volunteer Coordinator
- Work with local Lions Clubs to offer eye screenings
- Serve on the following state and local committees:
    - Illinois Alliance of Information & Referral Systems (AIRS)
    - Illinois Nutrition Advisory Council
    - Illinois Coalition of Mental Health and Aging
    - Illinois State 211 Board
    - Southern Illinois Human Service Transportation Planning Committee (Region 9 & 11)
    - United Way of Greater St. Louis 211 Advisory Committee
    - Breakthrough Coalition Steering and Advocacy/Communication Committees
    - Southwestern Illinois Pioneer Coalition Leadership
    - Aging and Disabilities Resource Center Leadership Team
    - Belleville Chamber of Commerce Community Services Committee
    - Belleville Chamber of Commerce Healthcare Committee
    - St. Clair County Emergency Preparedness
    - St. Clair County Healthcare Commission
    - Southwestern Illinois College Human Services Department Advisory Council
    - O'Fallon Chamber of Commerce Healthcare and Wellness Committee
    - Older Adults Health Council
    - Madison County Mental Health Alliance
    - Madison County TRIAD
    - Southern Madison County Community Collaborative
    - St. Clair County Elder Justice Council
    - St. Clair County Suicide Prevention Alliance
    - Reveille Veterans Services Network
    - Community Engagement Network
    - St. Clair County Council of Partners
    - Tri-county Financial Fraud Coalition
    - Make Health Happen-Greater East St. Louis
    - St. Clair County Violence/Safety Committee
    - St. Louis Elder Financial Protection Multi-Disciplinary Team
    - Healthier Together St. Clair County

Program Development

Responding to unique local needs, AgeSmart develops new programs and services that promote health and independence of older adults. Through the process of assessing community needs and analysis of the existing service system, we identify the need and develop a pilot or expand existing programs to fill the gap.

Budget: $93,000

Activities include but are limited to:

- Encourage innovation through pilot programs and prototypes
- Provide grantees with training opportunities to assist in developing innovative solutions
- Develop and implement new programs
- Follow Request for Proposal procedures to procure service providers
- Utilize the Advisory Council throughout the granting process
- Participate as members on the following IDOA Councils: Nutrition, Elder Abuse, Caregiver, and Long-Term Care Ombudsman
- One staff member is certified in Federal Grants Management by Management Concepts, Inc.
- Train grantees in program, fiscal, and NAPIS reporting
- Attend Adult Protective Services and Ombudsman related trainings
- Maintain Illinois Food Service Sanitation Manager Certified staff member
- One staff member is trained as a Master Trainer for A Matter of Balance Program

Services Directly Provided by AgeSmart

AgeSmart proposes to continue to provide III-B/E Information & Assistance, III-B Options Counseling, III-E Public Education, and Respite and requests Direct Service Waivers in order to directly provide these services in FY22.

III-B/III-E Information and Assistance

AgeSmart provides area-wide Information & Assistance (I&A) and Options Counseling as a single point of entry serving older adults, their caregivers and people with disabilities in the seven-county region.

Synopsis of Activities

- Provide individuals with current information on opportunities and services available
- Assess problems and capacities of older adults and caregivers
- Establish adequate follow-up procedures based on the older individual's or caregiver's needs
- Maintain a resource database for PSA 08
- Provide Aging IS and ESP technical assistance to grantees
- Utilizing warm transfer feature to connect callers to grantees and Aging Network services
- Maintain Certified Information & Referral Specialists for Aging (CIRS-A)
- Maintain AgeSmart website (www.AgeSmart.org) to provide consumers with 24/7 access to aging resources
- Provide education programs to the public

Justification

AgeSmart funds eight local service providers to deliver I&A in their communities, additionally AgeSmart itself serves as a single point of entry responding to service requests from the entire planning and service area and beyond. The Elder Care Locator managed by the National Association of Area Agencies on Aging directs callers directly to their local Area Agencies for I&A. This single point of entry is necessary for older adults and caregivers not to be overwhelmed by multiple agencies and numerous phone numbers. At the same time, it is imperative that consumers find "no wrong door" when seeking information. AgeSmart's I&A service complements the area I&A efforts throughout the Aging Network with both grantees and other providers.

Expansion of Direct Service in St. Clair County.

In FY21 AgeSmart planned to pilot an expansion of I&A in St. Clair County, however this was put on hold due to the COVID pandemic. The expansion would include the communities of Dupo and Cahokia incorporating the service delivery model AgeSmart has been using with the NCOA Benefits Enrollment Center grant. This service delivery is based on meeting consumers where they are and following up with consumers who

inquire about one benefit but may be eligible for other services and benefits. Dupo and Cahokia have not had adequate I&A/OC services due to funding and staffing. AgeSmart is now positioned to provide these services to people in their own community.

AgeSmart's location in St. Clair County, which has nearly 40% of the region's 60+ and 70% of the minority population, allows AgeSmart to directly reach those with the greatest need and to serve as the information hub, providing training and technical assistance to local I&A providers. There is no other local agency for providing I&A at this capacity.

III-B Options Counseling

AgeSmart provides Options Counseling services throughout the entire PSA to all persons with disabilities aged 18+ and older adults who request current long-term support services and/or persons of any age who are planning for the future regarding long term support services without regard to income or assets.

Synopsis of activities:

- Outreach to all communities on the service and its value in planning
- Personal interview
- Exploration of resources
- Decision support
- Goal setting
- Links to available services
- Follow up with consumers

Justification

AgeSmart is the focal point in the seven-county region for Information and Assistance services for coordination of services and training. Options Counseling forces a paradigm shift from an older medical model approach in Information and Assistance services to a person-centered model. AgeSmart is already in the position to coordinate, train, and update the existing network in this more extensive manner of delivering Information and Assistance services. As with Information and Assistance, AgeSmart's Options Counseling complements the PSA efforts in providing consumers with the best, most up-to-date information and resources.

Expansion of Direct Service in St. Clair County.

In FY21 AgeSmart planned to pilot an expansion of I&A in St. Clair County, however this was put on hold due to the COVID pandemic. The expansion would include the communities of Dupo and Cahokia incorporating the service delivery model AgeSmart has been using with the NCOA Benefits Enrollment Center grant. This service delivery is based on meeting consumers where they are and following up with consumers who inquire about one benefit but may be eligible for other services and benefits. Dupo and

Cahokia have not had adequate I&A/OC services due to funding and staffing. AgeSmart is now positioned to provide these services to people in their own community.

Program	Budget	Projected Persons	Projected Units
Title III-B Information & Assistance	$60,000	4,300	8,000
Title III-E Information & Assistance for Caregivers	$24,000	2,100	2,600
Title III-B Options Counseling	$12,000	100	200

III-E Public Education

AgeSmart provides Public Education for family caregivers of older adults in the seven-county region. Through educational events, community presentations, and media campaigns, the program provides valuable information, resources, and support for family caregivers and encourages them to utilize available programs and services.

Synopsis of Activities

- Attend local Health and Information Fairs in the communities reaching out to caregivers
- Conduct community presentations which provide information and resources as well as link caregivers to needed services and benefits
- Provide caregivers with on-the-spot access to information through the resource database and website
- Co-Host the annual Surviving Caregiver Conference that is designed to educate and support caregivers
- Host the annual Aging Expo
- Use online newsletter and social media to engage public and promote Home and Community-Based Services

Justification

The area has many Health & Informational Fairs that AgeSmart spends considerable staff time attending. Due to limited time and the high cost of space rental, most grantees are not able to attend these events. AgeSmart also has the capability to have the Resource Database at the events using mobile devices. This allows us to provide on-the-spot individual assistance to caregivers. No other agency exists to fill this gap.

Program	Budget	Projected Persons	Projected Units
Title III-E Public Education	$30,000	250	25

III-E Respite

AgeSmart administers Respite care program for primary caregivers of persons 60 and older throughout the seven-county region. Respite care is a short-term relief designed to provide a break from the physical and emotional stress of caregiving. The service offers caregivers the flexibility and freedom in choosing their respite care providers.

Synopsis of Activities

- Assessments
- Verify monthly Respite service forms, assist in completing the form and make follow-up phone calls, if needed
- Maintain the Respite client database, tracking service utilization
- Reimburse caregivers up to $100 per month for Respite care
- Provide caregivers with information on educational opportunities and resources to help with their caregiving

Justification

In 2002 AgeSmart funded a respite service program using a community agency to provide services. This service was severely underutilized for several reasons: caregivers did not want strangers in their homes, cost did not allow for enough hours of service, service hours were not available when caregivers needed them. Efforts were made to find other agencies with the flexibility needed by caregivers, but none were found.

AgeSmart implemented a consumer-directed Respite program model in 2003 in response to underutilization of the service using a community agency. The consumer-directed model empowers caregivers to select the Respite care provider best suited to their needs and negotiate the payment amount. AgeSmart, serving as the administrator of the program, reimburses eligible caregivers up to $100 per month. Since implementation, the number of caregivers using Respite has significantly increased and the average cost per hour has decreased.

In FY20, 174 caregivers were provided with 18,689 hours of respite. The number of participants increased by 10% compared to FY19 and the average cost per hour was $9.24. In comparison, if the Community Agency Service Model had been used, the number of funded hours available would have been 3,946, which is less than 25% of actual provided hours. Cutting these costs increases the funds available to caregivers and AgeSmart is the most logical entity to provide the service directly to keep the costs down. Over 90 percent of the budget goes directly to the program and AgeSmart retains ***$12,000*** for administrative costs.

In FY20, AgeSmart began the implementation of Tailored Care (T Care), an evidence-based caregiver assessment and care plan program. T Care allows AgeSmart Staff and caregivers to assess the current caregiving situation and plan for future needs which helps avoid hospitalizations and skilled care placement. Since AgeSmart began funding

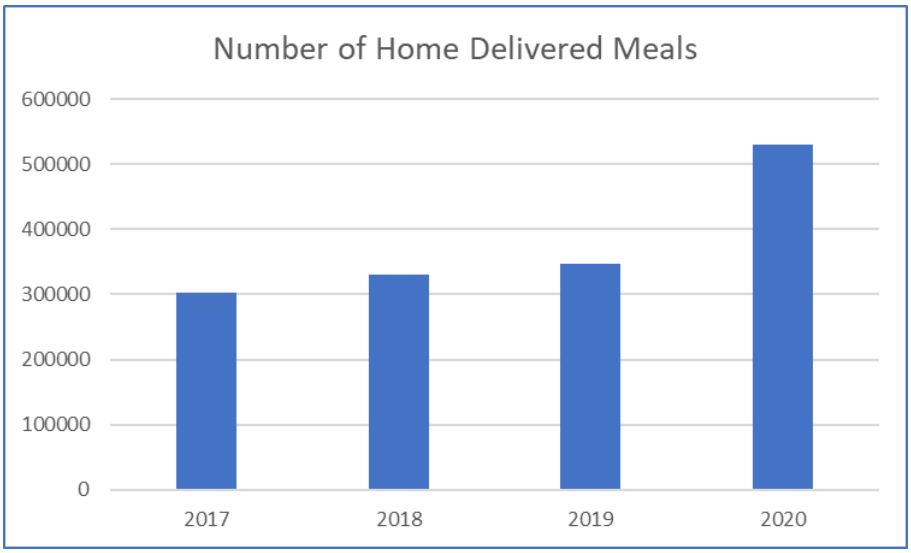
Respite, the local Case Coordination Unit has completed all initial and annual assessments of caregivers for the program. Beginning in FY22, AgeSmart will incorporate T Care into Respite assessment utilizing AgeSmart Options Counselors. It will allow AgeSmart to perform a holistic assessment of caregivers and assist in the development of care plans. This modification will enhance the care management for Respite clients and strengthen the communication between AgeSmart and the participants.

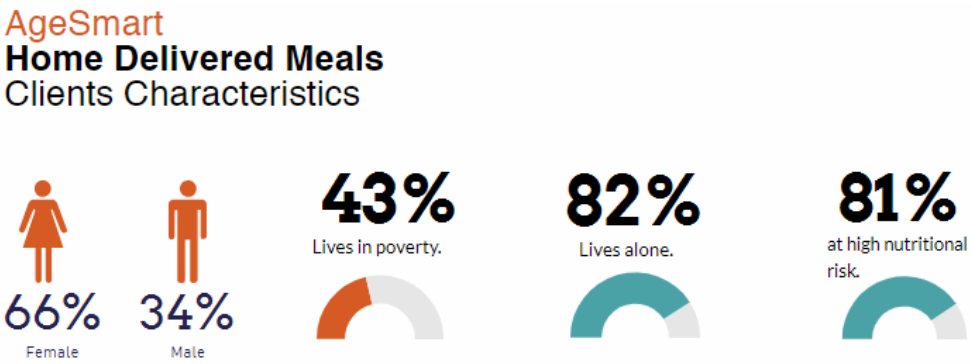
Program	Budget	Projected Persons	Projected Units
Title III-E Respite	$100,000	125	19,000

Home Delivered Meals

The region's nutrition programs are deeply impacted by the ongoing COVID-19 pandemic. The network has seen a significant increase in demand for home delivered meals. Our network of dedicated service providers continues to deliver meals to homebound seniors and check on their well-being to help reduce feeling of isolation and loneliness.

In FY20, AgeSmart provided 529,353 home delivered meals to 5,158 homebound older adults. The number of meals increased 53% from the previous year, while the total number of consumers increased by 2,858 over the period.
Over 34,000 shelf-stable meals were provided to all home delivered meal clients including congregate diners who were receiving meals at home during the pandemic. Shelf-stable meals serve as emergency meals when normal meal delivery is not feasible due to inclement weather or other emergency situations. Senior centers were able to utilize shelf-stable meals during the center closure due to COVID.
AgeSmart will continue to monitor the situation and ensure that social and economic needs of vulnerable older adults are addressed during this pandemic.
As of April 2021, there is no waitlist in PSA8.





Other Funding Possibilities

While AgeSmart's main sources of funding are the federal Older Americans Act and Illinois General Revenue Funds, AgeSmart has made progress in securing grant funds from sources other than the Older Americans Act to enhance current programs and develop new programs. The Advisory Council has an active Outreach & Development Committee to assist in accessing additional funds. Possible funding sources for AgeSmart include the following.

The Development Association for the Aging

The Development Association for the Aging (DAA) was created as a response to dwindling State and Federal Funds. The DAA is organized exclusively for charitable, educational, religious, or scientific purposes as a nonprofit organization to support the efforts of AgeSmart. The primary purpose of the DAA is to offer and provide support to older persons and the families of older persons as well as to agencies serving these populations. The region will see services for older adults increase and programs to be enhanced as the DAA grows and develops. The DAA is managed by a volunteer board of directors and currently employs no staff. Since FY11, DAA has provided nearly 1,300 home delivered meals to the older adults who would otherwise have been denied the service due to lack of funding. DAA also provided over $5,000 of emergency funds for older adults in need.

Veterans Directed Home and Community Based Services

AgeSmart is collaborating with the Marion, Illinois and St. Louis, Missouri Veteran's Medical Centers to offer the Veterans Directed Home and Community Based Services Program (VDHCBS). VDHCBS is a program to provide home and community-based services to help veterans stay at home and remain in the community. It is a collaboration between the Veterans Health Administration (VHA), the Administration on Community Living (ACL), the Illinois Department on Aging (IDOA), the thirteen Illinois Area Agencies on Aging (AAAs), and currently two Missouri Area Agencies on Aging. VDHCBS serves veterans of any age that are at risk of nursing home placement, and their family caregivers. This creates another source of revenue for AgeSmart.

Changes in Funding

For the purpose of this document, the FY22 Governor's proposed budget is used to estimate the funding level. When the actual funding allocation is received, AgeSmart will adjust in the way that causes the least disruption to services.

Funding Increase

Should the amount of Federal or State funding increase during the FY22 funding cycle:

- AgeSmart's Board of Directors will determine the services and funding level based on the needs of the communities.
- Considering greatest needs, any increases in funding by a specific title may be used to expand/enhance existing services, to fund new pilot programs, and/or to offer innovative grants.

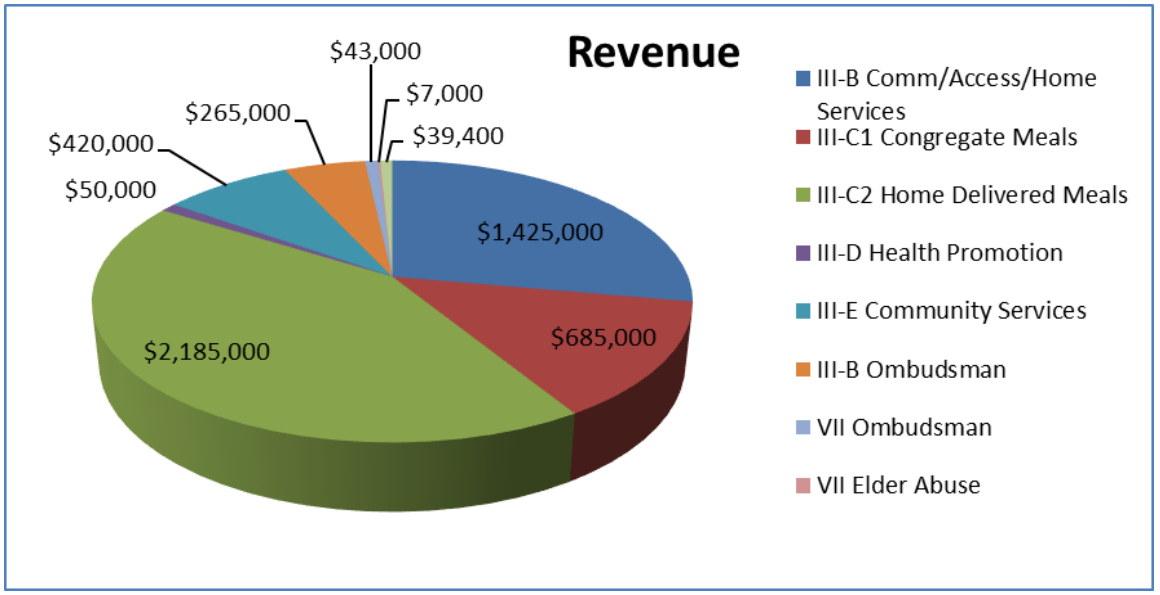
Funding Decrease

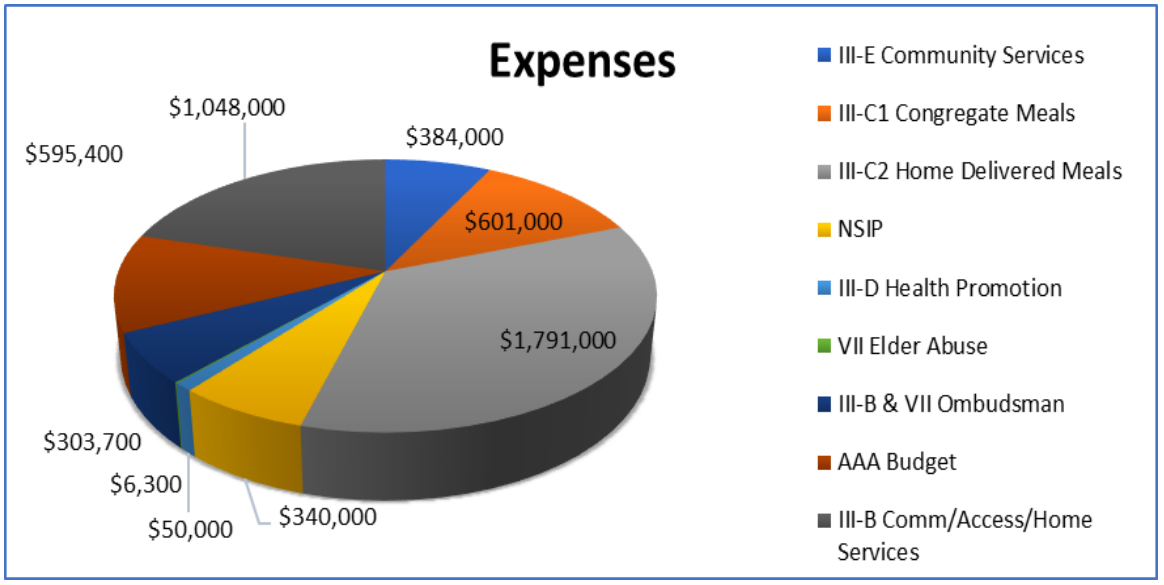
Should the amount of Federal or State funding decrease during the FY22 funding cycle:

- Decreases will come from the affected title.
- AgeSmart will revise the service priorities and appropriately adjust the funding to the services so that reduction of the funding will cause the least amount of harm to the consumers.

The following pages demonstrate estimated revenues and expenses for FY22.
This projection is subject to change based on changes to funding levels if there is a sequestration or other budgetary impacts from the Federal or State government.

FY22 Projected Revenues and Expenses





Revenues and Expenses Projected for FY22

Revenues Projected for FY22

SOURCE	IIIB	IIIC-1	IIIC-2	IIID	IIIE	III OMB	VII OMB	VII ELD	OTHER	TOTAL
ALLOCATIONS	650,000	850,000	500,000	48,000	340,000	44,000	43,000	7,000	0	2,482,000
TRANSFERS	50,000	-190,000	140,000	0	0	0	0	0	0	0
STATE FUNDS	700,000	0	1,200,000	0	75,000	221,000	0	0	39,400	2,235,400
NSIP	0	0	340,000	0	0	0	0	0	0	340,000
CARRYOVER	25,000	25,000	5,000	2,000	5,000	0	0	0	0	62,000
TOTAL AVAILABLE	1,425,000	685,000	2,185,000	50,000	420,000	265,000	43,000	7,000	39,400	5,119,400

Title	Older Americans Act Programs
III B	Transportation, Assisted Transportation, Information & Assistance, Options Counseling, Legal, and Residential Repair & Renovation
III C-1	Congregate Meals
III C-2	Home Delivered Meals
III D	Health Promotion Programs
III E	Caregivers & Grandparents Raising Grandchildren Services – Information & Assistance, Public Education, Case Management, Legal, Counseling, Respite and Gap Filling
III OMB	Ombudsman
VII OMB	Ombudsman
VIII ELD	Adult Protective Services

Revenues and Expenses Projected for FY22 (continued)

Expenses Projected for FY22

APPLICATIONS	IIIB	IIIC-1	IIIC-2	IIID	IIIE	III OMB	VII OMB	VII ELD	OTHER	TOTAL
Assisted Transportation	115,000									115,000
Transportation	240,000									240,000
Information & Assistance	328,425				24,000					352,425
Options Counseling	42,000									42,000
Case Advocacy/Management					7,500					7,500
Legal Services	200,000				40,000					240,000
Residential Repair & Renovation	15,000									15,000
Telephone Reassurance	59,575									59,575
Congregate Meals		601,000								601,000
Home Delivered Meals			1,791,000							1,791,000
NSIP		0	340,000							340,000
Health Programs	48,000			50,000						98,000
Public Education					30,000					30,000
Counseling					72,000					72,000
Support Groups					24,000					24,000
ADRD Education					45,500					45,500
Respite					116,400					116,400
Gap Filling					24,600					24,600
Ombudsman						265,000	38,700			303,700
Elder Abuse								6,300	0	6,300
AAA Budget	377,000	84,000	54,000		36,000		4,300	700	39,400	595,400
	1,425,000	685,000	2,185,000	50,000	420,000	265,000	43,000	7,000	39,400	5,119,400

Appendix Three: Letters of Support

ILLINOIS HOUSE OF REPRESENTATIVES

232-N STRATTON BUILDING
SPRINGFIELD, ILLINOIS 62706
PH: (217) 782-5996

192 ALTON SQUARE MALL DR.
SUITE C
ALTON, ILLINOIS 62002
PH: (618) 433-8046
EMAIL: Elik@ilhousegop.org

AMY ELIK
STATE REPRESENTATIVE · 111TH DISTRICT

November 15, 2021

Illinois Department of Health and Family Services
Attn: Patrick Lindstrom, Legislative Liaison
Via Email

Dear Patrick,

Senior Services Plus has collaborated with Community Care Alliance, Southern Illinois Visiting Nurses Association, AgeSmart, Addus, and Group to Care to apply for a grant that will streamline software and increase efficiency in case management, improve the paid caregiver work experience, and improve access for a variety of social and medical services to communities.

As State Representative, I give my full support to the Group to Care Pilot Program as outlined in the grant proposal. As our population ages, we must find innovative ways to support and care for our seniors, while acknowledging the realities of state budget issues, staffing challenges, and healthcare costs. We must continue to encourage leading-edge programs which care for the whole person, and this program will be an opportunity to do that.

Sincerely,

Representative Amy Elik

CC: Shawn McGady, Director of Legislative Affairs at IHFS
Emily Jackson, Grant Writer at Senior Services Plus

ALTON MEMORIAL HOSPITAL

November 16, 2021

HEALTHCARE AND FAMILY SERVICES

To whom it may concern:

I am writing in support of the application for grant funding for the Group Care Pilot Project. Supporting the needs of seniors as they live as independently as possible in their homes and in their communities remains a top priority for Alton Memorial Hospital. As Illinois' population continues to age, the core mission of the hospital system remains the same. The mission of Alton Memorial Hospital is to improve the health of the people and the communities we serve.

Alton Memorial Hospital is interested in seeing the outcomes of this pilot project and the collaboration of organizations as it addresses many of the challenges providers, caregivers, families, and care recipients encounter as we work together. We are all concerned about the social isolation our seniors face, especially during this pandemic and the many negative effects of that isolation as well as improving formal and informal case management strategies.

Alton Memorial Hospital, therefore, supports this application for HFS funding.

Sincerely,

Brad Goacher, FACHE, MBA
Chief Operating Officer