Tuesday, June 7, 2022, 9:30
Health and Wellness Committee

Attendees:
Neal Brown, Marsha Weber, David Engel, Virginia Cain, Betsy Carrier, Laurie Pross, Joyce Dubow, Rev Vikoram
Guest: Marcia Pruzan
Staff: Tina Purser-Langley

Approval of minutes: Minutes from May 3 were approved

- Meeting in September will be rescheduled—likely to be in the third week in September.

Discussion of Possible Budget Priorities for 2023

1. Access Hears- Tina provided an update on ARPA funding. She is waiting to learn whether Access Hears is funded with ARPA funds. Tina is putting together contracts so she will be ready to move ahead immediately if there is ARPA funding as those dollars have to be used by 2024. Tina is hopefully that the project can begin October 1, if this project is not funded with ARPA money David Engel suggested the project be submitted to Office of Departmental Grants.

   Discussion how CoA best support this project in the future, could the project be supported by a foundation? Question as to whether keep on the list.

2. In-Home Aid Services (IHAS): The Health and Wellness Committee discussed some possible solutions to address the IHAS backlog:
   - Hire personnel for IHAS

- Provide additional monies to IHAS contractors and specify specific salary increases for employees.
- Increase Care Partners and Community Reach Budgets for FY24 (add money to County contracts)
- Expand cluster care in HOC buildings

However, Joyce Dubow and other committee members urged that before making a budget recommendation there needs to be a better understanding of the root cause of IHAS' current waitlist of 113 clients. Is it due to lack of resources? Are current resources being used efficiently? Has an evaluation of the program been done? The discussion pointed to the need for these questions being answered before a budget recommendation was made.

Following the meeting, on 6/8 David Engel sent a detailed interview that he previously conducted with Hirsch (attached as Appendix A) documenting problems and possible ways to improve the IHAS program.

3. Create and fund full time Coordinator Position for Communications. This would be a fulltime position similar to Pazit Aviv and Lylie's positions. It is important that this position be put in HHS and not in the Communications Office. Possible title: Director of Communications for Older Adults.

   Clarification was made that the Coordinator Position for Communication is different from the Senior Fellow Position. Hans Reimer and Gabe Albornoz are both very supportive of the senior fellow position, so there will be follow-up with them regarding the funding for the senior fellow position.

Items Raised But Not To Be Included As Budget Items:

1. Funds for printing the current Health and Wellness *Planning for Life Transitions* A*s We Age* materials. Tina indicated that funding was not needed as there was already funding available.
2. Support for final product on Direct Care Workforce. This was not included as a budget item as it is unclear what will be included in final report; however, can be moved to an advocacy item.

Possible Advocacy Items

1. Address needs to improve Assisted Living/ Nursing Home Facilities. To include work force training, evaluations and standards.
2. County to continue focus on long-term effects from COVID on seniors.
3. Support programs for seniors surrounding mental health issues.
4. Support programs/legislation to assist seniors with drug prescription costs and access.
5. Follow-up on Meals on Wheels program presentation re identifying clients needs for additional services. Refer this to AIC.

Meeting adjourned at 11:30

Appendix 1

Sent by David Engel on 6/8

Questions given to Nina and Hirsch —

What ideas they would have to improve/expand their programs?
How do we get home service to more seniors at reduced rates?

Are you either of you aware of other innovative ways to provide home care to the "gap" population? (this meaning just over Medicaid eligible)

The answers/info is specific to Montgomery County HHS/A&D and does not necessarily translate across counties/jurisdictions as each run the In-Home Aide Service (IHAS) program differently:

- The main barrier to increasing Home Care numbers/services to the client base we serve (i.e. adults with disabilities who require aide service to meet personal hygiene needs while not qualifying for a Medical Assistance Program or having funds to pay privately for this service) is the lack of Social Services to Adults (SSTA) Case Managers and Assessors. Per Comar a client cannot receive IHAS service unless enrolled in an affiliated SSTA program. At this time there is a long waiting list for the SSTA program resulting in decreased appropriate referrals. Instead, new referrals are being generated almost exclusively via Adult Protective Services (APS). Client's coming via APS investigation tend to be inappropriate for our services as their needs exceed our scope of care. If more SSTA workers/assessors were in place it would increase appropriate referrals and ensure a higher level of Case Management (i.e. SSTA workers would have lower caseloads and more of an ability to effectively manage challenging cases) which would improve our retention of cases.
- More resources for our Adult Services Intake (ASI) team and assessment teams. This would allow for more effective screening, resulting in more appropriate cases being referred. IHAS's targeted population is meant to be individuals living independently in the community with moderate support who do only need supportive, not all encompassing, services to remain safe and stable in the community. The more resources available for ASI/Assessment the more likely "inappropriate" or "high care needs" will be screened out and referred to more appropriate places. This would decrease the amount of IHAS cases closed quickly due to being inappropriate for the service (i.e. needing 24x7 case as opposed to 4 to 16 hours per week).

- Comar limits the population we can serve. As a IHAS client must also receive SSTA services client's assets are capped at $20,000.00 ($23,000.00 for a couple). If someone's assets exceed this limit, they are not eligible for SSTA, hence not eligible for IHAS. Also, per COMAR, IHAS cannot exceed 20 hours per week. It is for this reason we are only meant to be supportive, not the sole means of care/assistance.
- Past studies have shown that, for clients who require high levels of assistance, increasing service hours does not positively impact outcomes (i.e. hospitalization, nursing home placement etc.). Increasing hours without need (or increasing hours by a little but not to the needed 24x7) may not have the desired impact if the client is to high need.
- Improved accessibility and quality of alternate living arrangements (i.e. moving into a Group Home, Assisted Living Facility, or supported independent living environment). If clients/families can more easily access these types of living (which currently are either very expensive, confusing to apply for, or have very long wait lists) it would decrease the need for home care in general and improve quality of life. There are a few programs that subsidize ALF's/Group Homes however the client cannot apply directly and generally requires A&D assistance/time. If families/clients can do this independent of HHS/A&D it would free up SSTA/IHAS for other clients. Increasing services offered by Independent Living Communities (i.e. Revitz or HomeCrest House who provide some support but not Home Care) would also decrease IHAS/SSTA caseloads, freeing up space for new clients. Perhaps grants/funding can be provided to Independent Living facilities so that personal care assistance can be managed "in house" without relying on SSTA/IHAS?
- Improved funding/services via community service programs such as the Villages or Community Grants from which smaller programs/areas/communities can have some home care needs met without using Mont. Co. IHAS/SSTA programs. Each area/community has a specific set of needs, many of which we cannot accommodate due to various cultural/language barriers, Comar and/or SSTA shortages. If a community had access to affordable care they would be better able to assist the communities instead of relying on HHS and the associated "red tape barriers."
- Often supportive families do not really need Case Management/SSTA as families/communities handle these needs, however they do need assistance with personal hygiene. Currently, these families/individuals are "forced" onto a SSTA Case Manager's caseload just so they can receive the IHAS service. If there was a way to provide IHAS without taking up a spot in SSTA (as mandated by Comar) many SSTA cases could be closed/transferred out, freeing up spots for new clients who need both SSTA and IHAS.
- Increased funding for programs such as Respite Care which would allow clients/families to manage their own care/hours without the use of SSTA. Any program that would allow the "money to follow the client" would be of assistance as the client/family can determine how to best use allocations instead of following mandated Comar regulations.

- "Emergency Home Care" programs that would allow clients to receive needed personal care/supervision without needing to be brought in as an APS emergency. Perhaps something run out of hospitals or community clinics/programs?
- Prevention/planning for families. Since we have not been able to complete SSTA assessments we rely on APS for referrals. APS is a reactionary, not preventative, service that is only triggered when a crisis occurs. If individuals/families were better informed and linked to preventative services (or able to get assessed and started with SSTA quickly), IHAS could be initiated before a crisis occurs.
- A program/service designed to assist with housekeeping or other specific needs. IHAS is meant to assist with personal care/hygiene. We have a large population that does not need/want assistance with bathing but does need assistance with laundry, meal prep, cleaning, etc. These individuals are largely screened out or, inevitably, they say they want assistance with personal care, start IHAS, only to be closed when they refuse personal care. Similarly, our program cannot transport clients, handle client money, assist with wound care, provide custodial care/supervision or transport clients. Any program that offers these services at an affordable rate would make it easier to target our intended population.
- Subsidized/affordable private care. Private pay rates are very high, often more than $20.00 per hour for a minimum of 4 hours. If a low-income individual/family only had to pay, say, $5.00 a hour for 10-20 hours per week they could avoid APS/SSTA all together and meet the need without any HHS assistance. Perhaps a voucher of some sort?
- Just to reiterate, the biggest barrier in the inability to complete SSTA assessments for our targeted population, not APS. Smaller caseloads would also render the SSTA worker to be more effective in mitigating the issue's that sometime result in a case being closed.
-

This is not an exhaustive list, just the idea's we could come up with.

Hirsch