

DHCS ADHC STAKEHOLDER MEETING – MAY 13, 2011 VIA WEBINAR AND IN PERSON MEETING AT 1501 CAPITOL MALL

Franklin:

So good morning, everyone. We're getting ready to get started. We're also, this is sort of a simulcast so we have a webinar going at the same time. So we're giving the tech people an opportunity to do a quick little sound check, make sure we're connected, the folks on the phone can hear me, I just got the thumbs up, so we will begin. So good morning, I'm Greg Franklin. I'm the deputy director of health care operations for the Department of Health Care Services. I'm the deputy that's leading the work on the effort to create a transition plan and certainly to continue to look at all the data that we need to collect to understand the work that's ahead of us. So just by way of sort of framing this meeting, we've been for the last few months, as a result of the passage of AB 97, which eliminates the 882 program thinking, regarding how we can best assist the current ADHC participants into transitioning into other services, other programs that provide services.

Lastly, we attended a stakeholder meeting and presented some information, some data, presented what our framework, mission framework would be for these transition efforts and at the same time, we were planning to have our stakeholder meeting, the Department, because the last week's meeting was with the legislature. So as a result of that, here we are today having our stakeholder meeting. What I want to do first is just sort of frame what our purpose is and I know you have an agenda and I know you have thoughts and things that you want to talk about today as well, but we really, the Department, would like to use this time as an opportunity to hear from you and as well as the folks on the phone, we have about 290 folks who've registered on the phone, by the way, hear from you as well as the folks on the phone, _____, as well as the folks on the phone regarding issues regarding things, quote things that we should be thinking about as we settle and develop what's going to be ultimately our plan. Clearly this is something that can't be cook-booked. I mean, it'll be, our, the plan will be a living document and something that between our sister departments, Department of Aging, Department of Developmental Services, Department of Social Services, excuse me, that will continue to progress until we've completed our task.

So before I get into a little bit more about detail, I want to acknowledge that Ed Long, deputy director of long-term care is here and he too will also be participating, Denise _____, who's chief of the ADHC programs over at the CDA, Department of Aging, is also here as well and she too will be available to answer, you know, some questions. But ideally, what we're hoping is to get, you know, commentary, constructive from you regarding, you know, how we should be shaping our thinking, how we should be shaping our planning and how we should be going forward. The format will be one of, I'm gonna present to you some data and Doug Robbins, who's my chief of the utilization management division for the Department, will talk about the framework and outline that. At the end of those two presentations, we'll turn to the audience as well as the folks on

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the phone and then get your comments and get your suggestions as to how we should go forward.

So first let me start by talking about and presenting just the high level overview of some of the data that we've been collecting and clearly this is a fluid process. We really, you know, we're continuing to collect different pockets and pots of data. We're looking at it in different ways, but first and foremost, I can't move away from the mic, first and foremost, we wanted to understand the number of ADHC centers that were out there and so clearly, you know, that was the first piece of data that we needed to grab. Looking at what we pulled as of two months ago, we got a total of 309, we see a total of 309 centers. That's the number that we're gonna use to work with initially. I don't know if that number will change. It probably will if centers close and we're hearing that centers are closing, but we'll continue to update ourselves and continue to look at the numbers.

One of the other data factoids that we wanted to understand was where, you know, where are the, where are the participants. Clearly most of them were in the Los Angeles area as well as most of the centers are in the Los Angeles area, but we also wanted to understand that, _____ get an understanding of the number of ADHC days per week that participants spend. So as of the date that this data was collected, which was in, which was just last April, we see that the majority of folks tend to spend mostly around three days in the centers. And again, these are, these are data that will continually be refreshed. I mean, this is our initial pull, this is what we're hoping to, you know, to use to get started as we go through this fluid mechanism of getting our plan developed. But it was important to us, it was important for us to know and understand, you know, where the ADHC centers are, who they are, number of days spent in the center and that will give us the framework.

The other piece of information, and granted, we collected data from two sources. One, our own internal source, which is our TAR data, our _____ authorization data and then from our sister department and partners over at Department of Aging, but in total, we found in our TAR data 34,700 and some odd participants. That's looking at the TAR data. When we looked at our, when we looked at our claims data though we found a slightly lesser number around 32,000. The number we're choosing to work with is the larger number. Obviously we want to be prepared in case our, in case, you know, we don't want to undershoot our work, but rather overshoot. More importantly, and I'm sure many of you know this as well, 83% of the individuals that we've looked at happen to be dual eligible; another important factoid as we start thinking about programs to help folks transition to.

And then, of course, again, as I had pointed out before, it seems that the majority of folks spend three days in the ADHC centers. This is the list

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that we wanted to put together, and again, initially just to get an understanding of where the additional services, what additional services ADHC participants use and as you can see at the very top of our, the very top of our list is IHSS, 67% of the folks use IHSS services, and then, of course, followed by pharmacists, pharmacy and then other DME. Again, this too is important, you know, I'll talk about, a little bit more about that later, but this too is important because if you have 67% of the population, the current participant population, using IHSS services then it kind of gives us a valuable clue that perhaps maybe the _____ might be looking at IHSS hours and maybe expanding those where we can.

In terms of long, other and Medi-Cal long-term care services, not too terribly different other than you see we've added the MSSP waiver services in there and that's a relatively small number. But again, sort of reinforcing our thinking that, you know, IHSS services are, is the predominant service being used by our ADHC participants. Here's another, as I talked about, you know, potentially expanding the use of IHSS services, you know, on average, you know, we want to see the average IHSS hours per month based on what we have pulled in terms of number of days of services used in the ADHCs. Again, about 83 hours, you know, is, came out to be the average that participants are using. IHSS maximum number of hours is in the 200s, so we do have room to expand and, of course, if there's any expansion we'll be working with our sister department and partners over at Social Services, who in turn will be working with the counties. But again, this is, this is all to help frame and get us thinking in terms of creating our plan.

So let me stop here and we'll do questions and then comments at the end, but I'd like Doug Robbins to come up and talk about the transition framework.

Robbins:

Thank you, Greg, and good morning, everyone, both folks here in the audience and on the teleconference. So I am gonna be talking about the, our first thoughts on the transition plan, our transition framework and as Greg mentioned with the data, this is something that's gonna be an evolving process and it represents kind of a high level overview of the process and I'd like to start by talking about the goal that we have in mind for this and the goal as it indicates on the slide is to assist Medi-Cal ADHC participants with the process of accessing available services that one, address their needs, two, helps keep them in the community and three, minimizes their risk of institutionalization. I think that's a pretty clear and a pretty strong goal that we are striving for, but it's not an easy thing to achieve. I think we can all pretty much agree on that also and it's gonna take a lot of work on all of our parts and it's gonna take a collaborative effort and so the Department, we're collaborating and working with our, some of our sister agencies. That would be Department of Aging, Department of Social Services, Department of Developmental Services

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and we likely will be reaching out to others as well. But equally as important and Greg mentioned the stakeholder process of getting input from you, from stakeholders on how we can move forward in a way that's really going to be as smooth as possible and as beneficial as possible. So we really do value your input on that process.

Now the actual transition process begins with the discharge planning on behalf of the ADHC centers themselves. This past week, last week, the Department of Aging sent out information to the ADHC centers just informing them of their, you know, continued responsibilities, but also recommending that they begin the, updating their discharge plans and begin their parents with the discharge process and this was just a, an initial bit of communication from the Department to the Adult Day Health Care centers. And I've listed on this slide, as part of this discharge planning process, there is ongoing communication and coordination with the Department of Aging that the ADHC centers do and in terms of providing access to different services in the community, I listed some potential services on this slide and the following on that may be available in the community. Now I'm not saying that these, all of these services are going to be available to everyone or that they are, they exist in each and every community, but these are, this is a sample of some potential services that are out there. And I'm not gonna read them off. They are listed there on the slide and on the following slide as well.

The next step in the process is a review of the individual plans of care or IPCs that will be reviewed for Medi-Cal participants that the ADHC centers themselves identified as needing further assistance in accessing alternate services. So in addition to reviewing the IPCs, staff would also be looking at potentially additional health record documents as well in an effort to get as full and complete a picture of the participants as possible so that we can identify their needs, their health care needs, the services and supports that they may have and other relevant factors.

The Department of Health Care Services and Aging will be involved in the process, but we have not fully planned that out at this point in time. I'm sorry. You asked who was going to be doing the review of the IPCs and whether centers send us the complete medical records. Staff from the Department of Health Care Services already have the individual plans of care as part of the TAR process, so we have that already so that wouldn't be necessary. And if further records are necessary, we would work with the individual centers to see what's the easiest way to access those, okay? Alright.

And following the review of these IPCs, for those particular participants there will be assistance provided with the process of accessing other programs and services and again, on this slide I've listed some of those

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potential services that there may be some assistance provided for accessing them and they're listed here on this slide.

Female: [Inaudible]

Robbins: The question was who will be providing that assistance and that again is going to be a partnership between the Department of Health Care Services and Aging and potentially others. We have not fully worked out those details yet, okay? But that...

Male: [Inaudible]

Robbins: The question was could the counties potentially be involved in this and then...

Male: [Inaudible]

Robbins: Right. And if possible, I'd like to hold off on questions until I get through the rest of the slides and then Greg will open it up for further comments and questions just so we can get through the presentation. Okay, thank you.

So the participants will be assisted with the process of accessing of the programs and services and I've listed some of those there. An example of how the Department of Health Care Service can work in this fashion is, for example, with physical therapy that's the service that a particular participant would need or the Department could assist with facilitating and expediting TAR, the TAR process to insure that this person would have that type of service available.

The last slide is regarding if, still after this process, the participant cannot be transitioned to another program or service, a person may continue to receive short-term transition related therapy and treatment short-term program to the extent that funding continues to be available as appropriated by the legislature and allocated by the department.

Okay, and with that I will turn it back over to Greg.

Franklin: Before we get into questions, let me provide a little, another piece of information I gathered. It is not on the agenda, I just got this e-mail last night. So the question at the last meeting regarding the SPA, the State Plan Amendment, that we needed to submit to CMS for CMS's approval of elimination of the program, so that was just submitted last night. I wanted to share that, that's something you folks need to know in full disclosure, and so that's now in the process so that procedure has been done. So what I would like to do if at all possible at this point, we've got folks on the phone that we want to get to and some folks in the audience, and I have to apologize, but we have hard mics today, but if you have

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questions, I would like to ask that you can come down to the mic. Obviously, you know, if you can't come down to the mic for whatever reason, raise your hand and we have a roving mic in the back that I can kind of have come over to you. But I would like you to come down, one, give your name and organization so that we're clear on who we are getting information from, and then proceed to give your comments as well. We may not be able to answer every questions, I want to say that, because as Doug had pointed out, we are in the process of working through this ourselves and really what we're hoping to do is just get commentary regarding how we can create a better plan. So, Ed, let me ask that you come up, Ed Long from Department of Aging, and Doug come up as well, and we're ready for your comments, questions.

Male: Greg, I was just wondering is the SPA available on your website or the SPA amendment or can we get it?

Franklin: Yes, so I talked to our legal people, our legal person regarding that, and clearly our policy, I'm told, he's telling me it's been sort of back and forth, but our policy has been not to release these SPAs until they've been approved. So certainly you can request it through a public records _____ request and get a copy of it. So it will not be available on the website just to answer your question. Alright.

Hicks: Randy Hicks with California Disability Rights. I ask my question I asked in the back. Attorneys are part of the IHSS program with counties being cut, how would you make sure that counties would be funded so that they continue to provide service that they are and _____ public authority?

Franklin: As Doug mentioned and I'll reiterate, we haven't begun to sort of dig into that yet. And remember the expenses of _____, you know, we're talking about that as a possible opportunity although it looks like one of the better opportunities. So all of that would have to go into our thinking as to how do you deal with the issues and how do we investigate at the county level? So, clearly, we recognize that it's been an issue, but we just can't give you that information right now. Alright.

Yungling: Jill Yungling from ESKATON Adult Day Health Care Center in Carmichael, and I'm representing about 62 participants and these numbers are lovely, but they do not represent individuals. On the, where you're saying that average people come three days a weeks, I think it is critical for you to remember that those people are coming three, four, and five days a week are very significantly impacted so using the average doesn't mean anything. Also, on the 37, or 34,000 people, when we sent our TARs in for approval, it takes a considerable amount of time for those TARs to be reviewed and looked at and I have zero amount of faith that within a 60 or 90-day window that 34,000 plans of care. Somebody asked me today why I'm saying this stuff, and I know as an opposition person

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there's very little chance that anything is going to change based on what I say or anybody else says, but I want it to be on record when this is all said and done and our people are institutionalized or dead that somebody stood up for them. You're going to be assisting the participants with the process of figuring out what their needs are and all that stuff and minimizing the risk of institutionalization. You need to know that once they've lost their care management portion of adult day health care, they are going to fall off the grid and you are not going to know if they are dead in their home, if they've been institutionalized, any of that kind of stuff. So that will be an easier thing for you to track because they won't be around. I love the collaboration effort between the various agencies, but none of these agencies deliver services on the ground or know what the people actually experience.

As far as the framework for transition, I would like to address first positions with the newly-instituted co-pay and the cap on the number of visits that a participant, a Medi-Cal eligible person can have with their physician of being seven and then an extraordinary approval process for them to have more than that. Physicians are going to stop seeing Medi-Cal participants because they may get a person who has already had their seven visits, they're not going to get paid for that visit at all, the participants have to pay a co-payment which will even limit whether or not they can go to the physician because they don't have that money. Home health is not available to adult day health participants within the exception of a hospitalization and an acute flare up and there it is very limited. IHSS, as you know, the May revise coming out on the 16th with word on the street is _____ again and the cutbacks proposed and without ADHC the need will increase and the most important thing is IHSS is not a medical program. It is taking care of helping with personal care which is very critical. It is not, they can't assess any medical needs, they can't make decision medically, they can't do therapy. It's not medical and everybody keeps thinking IHSS can't save the world, it's not the same as adult day health.

I would like to address some of the other services, adult day programs, those are available only to private pay participants. Our folks that go they only pay privately. Senior centers, people come to us in adult day health who have been in senior centers, are no longer safe and have been asked not to return to the senior center, they are totally unsafe and inappropriate for the level of those. Regional transits, this one I love, the idea of our folks being able to know what a bus route is, stand out there and wait in the rain, in the sun, get to the bus stop is just ludicrous. And I'm on the Board of Directors for Paratransit here in Sacramento, and I believe we do a really good job, but for our people in adult day health, our staff are the ones that get them registered, call to make the ride, and all of that stuff, and it's a complex project for a person particularly cognitively impaired, which the vast majority of the adult day health care are. A local Area

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Agency on Aging, those services have been cut. They're not a replacement for health services, and the one about reviewing the IPP, as I already told you, I thought that one was kind of interesting. And I tell you, if my center is in the process of closing, the last thing I'm going to be doing is spending my days on record research to send you folks, I'm going to be dealing with the affairs and fears and anxiety of the participants and what's going to happen to them that day when the doors close. So this whole record transfer to me is absurd.

I'm still going, but ...

Franklin: Just take your time.

Yungling: Alright. Participants will be assisted with the process of assessing the other programs. We don't have assistance from you all to help us find services now. In fact what we're finding is the services are becoming more and more fragmented, so how in the world without all these adult day health care staff people are those services going to be coordinated? And IHSS right now is taking currently for our participants two to three months on a waiting list and some of them haven't heard back for four months. Regional centers, they had a four and a half percent cutback in their funding, they're not going to, and we have a lot of regional center people in our program who are now paying way less than the Medi-Cal rate, we can't even afford to keep them, but we're keeping them. So that regional center thing is a joke.

Home and community based service waivers, MSST is maybe going to be cut on Monday, assisted living waiver serves like this many people, age waivers, all those things. And then the medically necessary service, home health physical therapy and non-emergency medical transportation, our folks do not get physical therapy as out-patient here and our home health, I already talked about that.

And then the part about continuing to receive short-term transition-related therapy and treatment, I don't know what that means that some ADHCs will remain open, that people would be plugged into, I don't know that, but participants form a strong trusting bond with staff members. And if you're a 92-year-old person who has dementia, has little or no family support, no transportation, all those kind of things, the idea of sending them somewhere else to get equivalent treatment just doesn't work. Think about your own family, people, and now I'm on discussion, that's all I have to say.

Franklin: Thank you, Jill, and I want to point out that even though we are not feverously writing, we are recording today and we'll capture all of your comments. Over here.

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Passmore: Hi, Greg. Gary Passmore with the Congress of California Seniors and let me amend my name to Jill's comments. Some of the things that I want to talk about are similar, but I'm going to go ahead and say them for the record.

My first one is a question to you or someone else here. Throughout the legislative process of reviewing this budget proposal, you and the Department of Finance insisted that there were 27,000 people in adult day health care. Every advocate that I know insisted that there were 35,000 plus, and I'm just wondering how you could have such a monumental screw up because you're now admitting that you have 34,700. I mean it's a factor of 30%, this isn't rounding. Do you have an answer?

Franklin: I do, Gary, actually. I appreciate your question. I like questions that I can answer. Here's what, as I pointed out, we even had differences in our own collection, so let me talk about the differences between the TAR data and the claims data, so if you look at our claims data, it's really like 32,000, you know, we can identify 32,000 folks. If you look at our treatment authorization data, it's like 34,000 folks. So there's obviously a claims lag that occurs, so that explains that schism in the number. The 27,000 number that was moving around, and we're still looking into this as well because you're right that was an aggrievement with Lydia and her folks early in the year and 27,000, her 35,000. The 27,000 we believe that it was an averaging of numbers at some point in time and that 27,000 number emerged because of the various lists of the data, so, but for this purpose, and I have to say this because, again, I know it's going to be a difficult process. I know the sensitivity. I know the hill of work that's ahead of us. We're happy to sort of admit when we're wrong because we want to get it right. And if there are 35,000 folks out there that need to be accounted for, I mean, that's what we're going to work with. We're not going to be hung up on the number per se, but we know whatever the work is, it could be 50,000, that we're going to have to get at it. So, but that's the explanation to date. I'll have more information as we go forward about the 27,000 number, but right now our thinking is that somewhere along the line there was an averaging of these data sources. I think we're at a stage right now where we just need to pick a number and if you're doing planning you want to gravitate to the largest amount of work because that's what you want to plan for. So that's how the monumental screw up occurred.

Passmore: Okay, thank you.

My second one was brought up by Jill and it has to do with the newly planned caps and co-pays for Medi-Cal services. People in nursing homes will not have those, they will not have the restrictions on the optional services that have been denied the people in the community. And I'm wondering whether or not you intend to exempt people who are receiving

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long-term care health care services in the community from your caps and co-pays so that you're not creating an incentive for people to go into institutions?

Franklin: Yeah, you know, again, we haven't even started discussing alternatives like this. I can't tell you yes and I can't tell you no.

Passmore: Yeah, I think it's worth noting that people who attended adult day health care centers and do, that are there for three or four times a week, are seeing a range of therapists and medical personnel three or four times per week, which means in a typical year under your new scheme after the first ten days of January these folks will not have any eligibility for service, if your system of caps remains in place. So, I mean, it's almost to the point of a ridiculous comparison. It's way off, so I would hope that you folks would take a look at that and at least try to provide the same level of access for people that are in the community as those who are in institutions.

The third one I have gets to the idea that IHSS can somehow make up or take up some of the slack that is going to occur when 88C ceases to exist as we know it or at least they reimburse under the state plan. I'm wondering if you folks have data that you can share on the number of licensed nurses, nutritionists, mental health providers, physical, occupational, or speech therapists, who right now are IHSS care givers.

Franklin: I don't have it at hand, and I'm sure it's something that we can request and take a look at. Do a data request and look at it. Let me take a phone, do we have anything on the phone?

Male: [Inaudible]

Franklin: So _____ Heppernin on the phone has a question about 514 in regards to the statement short-term transition-related therapy and treatment. Please describe what that is and...

Male: [Inaudible]

Franklin: Okay. She wants to know what does that include and who would provide the services. Doug, do you _____?

Robbins: Well, by short-term transition-related services, we're referring to those that would be provided to the participants until he or she is able to be transitioned to another more longer-term service. As far as who would be providing and how that actually would be implemented, we have not gotten to that point in the development yet to be able to identify that.

Franklin: Let me take one more question from the webinar.

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Male: Amanda Simmers is asking “Are you looking at the transition program _____?”

Franklin: So Amanda is asking are we looking at the transition program to be a provider of services until the KAFI program kicks in. Okay. We are not, the transition program, the transition activities, the assisting of individuals to other services is in a process. So it’s not a program in and of itself, it is a process. So it’s a process of finding additional services that match the current service needs of the ADHC participants and then assisting them in accessing those programs.

Toth: Hi, I’m Debbie Toth and I am the administrator of the Mt. Diablo Center for Adult Day Health Care and the Bedford Center. I want to first echo everything that Jill Yungling said, and I will try not to go over anything she’s already covered, but I’m going to have a similar format. I’m going to start with a question, which is in sitting through all of this process and in going to Sacramento three out of five days a week for the last six months and spending numerous evenings and weekends going to town hall meetings and speaking with my legislators, it was my understanding that the legislature’s intent in the language that they wrote was that there would be a waiver program, KAFI, which would be similar to ADHC and its services serving the same type of folks with high acuity needs. My question is, why would the state submit a SPA requesting the elimination of adult day health care without first submitting a SPA requesting the waiver?

Franklin: So you are actually right, the language in AB 97 is intent language on the KAFI program. So the SPA, the law still requires the elimination of the current ADHC program. So eliminating the program is already statutorily required. The KAFI program because it’s intent language it’s not clear as to what is the waived is it, and I’m going to use the term here, it is a 1915(c) waiver, which _____ services waiver, is it a (j) SPA that creates another different sort of program. So the direction or the intent, I should say, the intent is not quite bared out. So, what is clear is that the program has been eliminated, so that’s SPA had to be submitted. So that’s the sequence of events that we’re operating under.

Toth: I hear you and I don’t necessary agree with that.

Franklin: I understand, I understand.

Toth: And I also should have said from the get go, I’m not here to attack anybody who’s is here. I understand that you did not make the rules and that you are doing what’s being dictated to you to do. I just feel that there is some error happening in this process and I want to be able to speak to those errors.

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So first of all, when you're expecting to have these discharge plans, the discharge plan is going to be naturally quite different when we're looking at discharging 160 people at one time as opposed to discharging one person. It's also an involuntary discharge as opposed to a voluntary discharge, so the circumstances surrounding that discharge are uniquely different, and if we get to a point where CMS says yes, you eliminated adult day health care and you say here's the 60 day time bomb, what do you think's going to happen to my staff? They're not going to be sitting there figuring out how to get people, they're going to be figuring out how to get a job so they can keep their families. So it's probably going to be left to the administrator and/or program director to try and figure this out for their entire population. We serve 160 people, so 160 people I'm gonna to have to do these unique and different transitions for now.

Now let me paint the picture of Contra Costa County because that is where we provide the services. The home health services that you reference as being a possible option, in the nine years that I have been working in adult day health care, I have seen one instance of a participant receiving home health care services when it was not related to a hospital discharge and that was really within the last three weeks and it was because a man's body was covered in weeping wounds, and he will be getting that services until he's no longer weeping, I suppose, but that's the end of that service. It is only tied directly to that incident and so it begs the question should my discharge plans for all my participants be discharge to ER and hope for hospitalization so that they can get home health?

I want to reiterate that IHSS is not a skilled service and no matter how many times you say that this is going to be a solution, it's not gonna change the fact that it's not the solution. IHSS is a necessary service, absolutely, which is why you see so many ADHC clients receiving both IHSS and adult day health care because they work together. You don't just put gas in a car to make it run, you have to have oil and a ton of other things happening to make that car run. It's the same thing with this population. Adult day programs are an option. In Contra Costa County there are 15 adult day programs, three are which adult day health care programs, the other 12 programs such as which are social day programs do not provide event toileting, so is it possible for the people that I serve in my adult day health care program to go to an adult day program that is two hours in duration, that's one day a week, that doesn't provide toileting. I'm just painting a picture here.

The next is in Contra Costa County, APS three years ago, I believe, three or four years ago was cut by 75%. Whose going to be there to protect these people when we're not there noticing that their relatives are taking advantage of them, noticing that their bank accounts are diminishing, noticing that they're coming in with wounds on their body from caregivers, I mean, that's also a major thing, not to mention how many of them will

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be on the streets and various other things and there will be no APS safety net there to help them. I mean, in Contra Costa County if you're not literally being beaten and it's not viewed by your neighbor that somebody is beating you, APS is not going to your home. MSSP, we provide MSSP services. MSSP, just to clarify it for everybody who thinks that adult day health care clients can go to MSSP. MSSP is a care management model. It is in the person's home on a quarterly basis. It is on the telephone a minimum of once a month. It is working with the networks to get people connected to services, to purchase transportation for them to get to and from their doctor's appointments, to ensure their medication management is happening. It is glue that holds the system together. It is not direct care services, it is not in a congregate setting, and of my MSSP program at our agency, 30% or so of the people in MSSP also attend adult day health care.

So would those people if given a choice, let's just look at their choice, would you rather go to adult day health care and have your diabetes, your insulin measured throughout the day and injections given when necessary as well as being helped toileted, as well as being in a congregate group of people who are having similar issues to you, receiving psychological therapy services, nursing services, etc., or would you like to make sure that you make it to your every other week doctor appointment because you can't afford the transportation? I mean, these are realities.

The short-term transition, again I want to go back to the fact that if we do get to that day where the SPA is approved and you say here's our 60-day timeline, we're not gonna have the staff there to do this short-term transitioning that you're referring to. And I have some real concerns in many of the responses happening today regarding this part of the plan or that part of the plan or reviewing these things, your response to all of these questions how that is going to happen is that we really haven't planned the operationalization of this yet. So if the SPA is approved tomorrow and you have 60 days, how are you going to operationalize the labor of 7,000 workforce staff and 34,700 participants? And thank you, and I'm sorry, it's not directed at you.

Franklin: That's all right, I appreciate it. You go here.

Risley: Carol Risley with the State Council on Developmental Disabilities. Exactly a week ago I sat in the chair right there and had the same conversation with another department about how they can't serve and we need to look for alternatives for those people in other places, so while again I appreciate this isn't your problem in terms of making the decision, it is not as simple as go some place else, which I think is kind of what the core of this plan looks like. I do appreciate the opportunity to participate in this and having been on the other side not that many months ago, I also understand the painful nature of this.

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I'm very, very unclear about the timelines and would appreciate, not right now, but some written materials that actually explain sort of this process because what I hear in this room is for them to closing today, people are being transitioned today, maybe they don't need to be, but we get why people are because maybe opportunities are coming up right now that won't be there later, the staff won't be there later. I think the uncertainty for the participants is going to drive the need for services even greater because of the stress that they're going to be encountering. I also believe that most of the information that people get is not in plain language in a way that they would understand it. It is extremely complicated, it's worrisome and that our entire government needs to spend more time putting out information that people can understand.

And the other thing is, frankly, I think we just ought to be honest with people. I think the fact that we are shuffling the chairs on the Titanic, we need to be honest that some people are going to fall off the grid that unless they have family members and we need to engage those family members, unless those family members can step in, that people will fall off the system and we ought not to run into the legislature and all these other places and say whether it is 20 some odd thousand or 30 some odd thousand, everything's gonna be fine. It's not going to be fine and we need to find other more generic ways and circles of support to help people because the government, frankly, is just not gonna be there.

Myers Purkey: Dawn Myers Purkey, I'm from Yolo Adult Day Health Center. I understand this week you visited the day health program?

Franklin: Actually, it was Doug that go out to see it.

Myers Purkey: Right, and so now you have a picture in your mind, and I assume that some patients and _____, and so my question, initial question really is can you now see the concerns we have about your list of proposals for transition purposes now that you've seen this population and recognize how frail and debilitated they are?

Robbins: [Inaudible]

Myers Purkey: And so if you have heard for, I don't know, February we were trying to enforce this idea that home health is not an option in some of these services and yet they continually appeared on the list. So that makes me really question the value of these meetings in terms of the information as the front line people, people on the ground, sharing with you what we know about these individuals. How much are you really taking that into consideration that home health continue and I'm curious about the research that you've done on home health services to provide the confidence that you have to keep that on the list?

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Franklin: You know I, it's not gonna be one side said all, one solution, we understand that the many IHSS participants, sorry, ADHC participants receive multiple services, so, I mean, I'm not sure the quote, unquote, competent, statement, I think we look at it as a possible, one of the possible prongs to the solution. Where we are now, again, we're putting together the picture, we're trying to get an understanding of who the population is, and then we're trying to get an understanding of how do we match the current service needs with what's available. It may not be one, it may not be IHSS by itself, it may be multiple services. So, again, that's the work we have to settle on and try to go forward with. So, we're in the beginning and I know it was said earlier how do you get to where you're going to get to if you're just now starting, but there are a lot of moving parts that we're trying to capture and we're trying to do our best just to get the right start so we can do the most for all the ADHC participants.

Myers Purkey: In lines of these services, so a discharge plan will be designed and perhaps there's state level care plans or discharge plans and then, of course, as has been pointed out, we certainly will be trying to make them realistic. However, it's quite clear, and we know this now, that the referrals that we'll be making in order to try and create some sort of an alternative facing us for these patients will be quite challenging and we'll be hitting a lot of walls and there will be a lot of waiting lists and there will be denials and unavailability. I mean, I live in a small county with some towns and the rest is rural. I know every nursing home that's in there, I know every agency that's out there, I know what our county can do and what our county can't do, so I understand that the discharging of these patients is not going to be a welcoming or availability in other services. So what kind of a system are you putting in place so that these discharge plans, when they don't work, that the patients have a fair hearing in a way to advocate either for themselves or their family or for us to ensure that they're not a, they're not going directly to a skilled nursing facility?

Franklin: So I appreciate the question, but you know, again, we're putting together the plan, right? Hopefully, we can come out and talk to folks like you to understand what needs to be in this and this meeting should be a venue for that. What needs to be part of that plan? Do we have all the answers? I think we said no we don't, but that's why we convened what we feel to be the stakeholders, the experts, the people that understand the population certainly better than Doug or myself, but, again, it's a hill of work, we know that. We know it's not as simple...

Myers Purkey: I know you know that. We know that, but we've been sharing with you. We've been explaining the, I remember when 1755 came into place. It was very frustrating because when the eligibility changed, we essentially accepted it as designed, had to. It's sad that all the other services that are available to this individual, all the other potential support have been exhausted and, therefore, the last service, the only service left is ADHC.

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We have to prove every time we complete an IPC that home health can't handle this, IHSS can't handle this, out-patient rehab can't handle this, there's no MSSP, it needs more than share coordination, and we go down through and we tell you about all these avenues that we pursued and tried, didn't work, therefore, ADHC is the recommended service _____. So it's very frustrating for me after we've proved that for participant after participant that you now are saying well now let's punt them back into the community and see what, see what you can find.

Franklin: Yeah, you know, again, I can't respond to that what you've told people in the past. I wasn't there. Not to break it down to the individual level, what I can tell you is that this particular effort is staring us in the face. The SPA has been submitted, we've got 60 days, we've got to get a plan together, we've got to partner with Social Services. I can't, we've got to put something down.

Myers Purkey: Yeah, I realize that _____.

Franklin: Well, look at the bags under my eyes. Alright, let me take a webinar question.

Male: _____ any family members were not able to _____, financially or emotionally to become involved _____?

Franklin: _____.

Avacally: My name is Justine Avacally. I'm here from Turlock Adult Day Care Center. I don't know that what studies you have done about ADHCs includes the very isolated ones that one of them is ours. We are in a town with 80,000 people around with a couple little cities around and we cover that. I have participants coming from half and hour, 45 minute drive as we provide the transportation for them, but at the same time, when I'm looking at this list, I'm struggling in myself, how am I gonna discharge these people? I have about 100 members, 100 participants that really rely on our care.

In our town they've been having really hard time to even get the physicians looking at these participants every six months when we have to resubmit our re-assessment care plan because there is very little physicians, a number of physician that are even taking Medi-Cal anymore. We have to call so many different surrounding cities, even all the way to Stockton to find a specialist or Medi-Cal physician for them to see and we provide the transportation for them. As of home health, I haven't been able to get any, any of our participants to be seen by home health unless like what they said hospitalized for more than two weeks or so, so they can go home with home health and when every time our social workers call for home health, help is not available. Right now I have five people in the hospital

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for different reasons that they have stroke or a heart attack that was detected at the center and we were able to send them to hospital right away to get help for them, but the hospital is not even able to discharge them to a rehab center because Medi-Cal doesn't cover that and the hospital, the local hospital relies on our adult day care assistance for us to take over and do therapy at our center because these people cannot get therapy outpatient. IHSS, 80% of my participants have IHSS because when they came to the center we told them about the services, we started working with IHSS and we got IHSS for them otherwise they couldn't even have IHSS care, but that's not enough like they said. The IHSS caregiver is not even licensed to give them medications. I am a nurse myself and I know how important it is to give medications on time, to give insulin on time, and the IHSS caregiver, some of them they can't even read English. I'm sorry to say that, so how are they reading the prescriptions, the drug bottles and giving these medications. There is many medication mismanagement as we have found out is happening at home. The ADHC is now giving their medications.

Looking at adult day programs, we don't have any adult day program in our area, so that's not even an option for us. Senior center, we have a senior, we have a small senior center in our town with 300 members. We are helping our senior center with different programs that they have. The 100 people that I have, they are from different cultures, diverse cultures, different languages, none of them can go to the senior center because the primary language is English, most of them don't speak English. We are the one who are helping them with transportation, translation, helping them to get doctor's appointment, taking them to doctor's appointments. Regional transportation, we have Dial-a-Ride. You have to call a week before to make an appointment for Dial-a-Ride to take somebody to their doctor. That person, like they said 90 some years old with dementia goes two hours around the town to get to their doctor's appointment, if my buses or vans are not there to take them. I cannot rely on regional transportation. Local area agency _____, they're the ones who ask for our help.

They are short staffed, nobody is helping them, and every time we have meeting, they're the ones who refer patients to us. We have not been able to get their help. Like I said I have people with diverse culture, different languages. We speak 10 different languages in our adult day care center. I don't know how your visit was there to the day care centers you've been, but I have staff that they speak 10 different languages, and how in the world do you want the Department of Aging help them or home health help them or senior center help them, I don't understand it. So please look at this, you know, really deep and for isolated as all day care centers like ours, the closest to us is like 50 miles or Sacramento or Stockton, so it's not, it's not realistic. Thank you very much.

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- Franklin: Let me go to the webinar, do we have any other new questions?
- Male: _____ was asking do you have information about the length of the gap between ADHC closing and KAFI TARs _____.
- Franklin: Okay, Mary C. is asking do we have any information regarding the length between the ADHC closure and the development of KAFI, and as I said earlier, KAFI is in the bill as intent language. Don't have any information in regards to what that gap is because of the intent language and it may or may not be a KAFI program, don't know. The SPA in and of itself has just been submitted so we'll wait and see when CMS comes back with that, that will give us the date in which the ADHCs actually, when the program is officially closed. Casey.
- Young: Casey Young with AARP. You've been given a tough job, probably an impossible job, but we all hope the best that you will do as much as you can, but I don't think any of us believe there's not gonna be a whole lot of damage as a result of this. And what I'm wondering is, do you have the capability now and are you planning to track the people who are now in ADHCs and find out what's happened to them? How many end up nursing facilities, etc.?
- Franklin: Yeah, I can't say that we have that capability now. I mean, certainly if there are TARs submitted and wherever they go to or some other way of their special needs managed care plans, you know, those that find their way to an organized system or some system that it gets back to us, yeah, probably, but in terms of an official formal sort of tracking system to ADHCs, is something we certainly should be thinking about, but as of today there's no formalized system.
- Young: But you would be able to know whether they ended up in a nursing facility that's Medicare.
- Franklin: I think that would depend, I think that would depend.
- Young: Depends on?
- Franklin: Well, I mean, depends on sort of where that facility is, I mean, we don't get, we don't Medicare data. Right? And remember 83% of them are _____. So right now we don't get Medicare data, so it depends on how we coordinate that.
- Young: Thank you.
- Jang: Hi, my name is Harold Jang. I am an independent consultant that has worked with a number of centers across the state as state approved audit. First and foremost, yes, I've been through a lot of centers that, of course, we can all improve and like anything, no center or no person is perfect.

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However, from what I have seen, I've seen all the providers that have worked with diligently do their best, make whatever improvements they need to so that they can continue to serve these people. ADHC says they have a number of medical professionals located in a so called one-stop location. This itself which has been difficult to prove, itself is a huge therapeutic benefit which is, I think, is discounted and not given credit for in terms of ADHC services. We have to ask ourselves why are we here right now? Because there was a question about the ADHC importance. What role do ADHCs play in terms of providing medical services to the community, and so obviously there was a question or concern about well, are we wasting our money. Now, also related to that is perhaps a lot of providers are having beneficiaries admitted that do not need medical necessities. For example, they may not be displaying acute symptoms that they need to, for example, to meet criteria 1, 2 or for services that are required for 4 or 5. However, it is my understanding, it's my belief that the reason why you're not seeing this is because ADHC which was originally in its original plan and intent was to maintain, stabilize people and prevent them from going into higher level institutions. And in some way I feel like the ADHCs are being penalized for doing their job.

The reason why we're not seeing these symptoms, fluctuating blood sugars, blood pressures on a day-to-day basis is because I believe ADHCs are doing their job, but coming from a research minded perspective, I have a very important hypothesis that I would like to test. ADHC is an important and effective program that serves the clients and the community. It also saves the state thousands of dollars, albeit involuntarily the state may have an opportunity to test this hypothesis if one this transition services are not well planned, the discharge process is not well planned, because you will see, I can almost, if I could bet money on, the probability and the possibility that you will see a lot of these 37 some odd thousand individuals going into these higher levels of institutional care.

And as you pointed out, is there a way to track this? And, again, coming from a research minded perspective, I think it is a very important study to follow all of our participants to see what happens to them. And you talk about the discharge process and you talked about partnering. Again, I'm not attacking you or addressing issues related to you as individuals because this is undoubtedly a daunting process. However, you talk about partners and providing these transition services as noted in slide 14 of _____ short-term transitional-related therapy treatment services. Oh, yeah, there are some fundamental questions about how this would be processed and handled, who would _____ how it would be authorized, but I asked yourselves before and while we're waiting for new program models to be implemented, you have a community of partners that you can work with and those people are the ADHCs.

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So I think logically and reasonably, because I have _____ public agencies as well, while you're waiting to implement the new program, designing the new program, rather than prematurely completely cut off the ADHC program, keep some of the system in place. I understand that the date is fiscally challenged by now, but rather than completely eliminating the program, you have your resources here already because I guarantee you the existing service that we've discussed, MSSP, ADPs, it's not gonna to be enough. We need to be responsible not only as ADHCs we need to be responsible but also the state has to be responsible, for ensuring that our constituents are safe. So I know you have a challenging task in front of you and I trust and believe that yourself, the Department of Aging, your fellow colleagues will do your best to make sure that our participants, our patients remain safe. Thank you.

Franklin: One more. Okay. The mic right here?

Female: Mine's quick this time. Can you just in terms of timing and process explain when you would notify participants that their adult day health care center will be closing and will that include information about their hearing rights in it if they're not happy with their discharge plan so that they can take action?

Franklin: We wouldn't be notifying participants that the center is closing, we would be notifying participants that, you know, the program has been eliminated. They probably know state or outreach I've heard if they go _____ or whatever, in terms of their hearing rights, in Medicaid the hearing rights are always ever present. I'm just not sure in terms of what, I'm not sure what they would be appealing.

Female: So the discharge plan, if they weren't happy with what their discharge plan is.

Franklin: They can always, they can always avail themselves of the appeal process. I mean that's sort of the bottom line.

Female: And when, when would they be notified?

Franklin: Notified of their hearing rights?

Female: That the adult day care center is closing? I'm sorry, the adult day care benefit is eliminated within x amount of days. When, when?

Franklin: I'm not sure. I'm looking at our house counsel.

Female: Shaking his shoulder.

Franklin: Yeah, because that's something he has to think through, I mean, that's something he needs to certainly tell us. He's going to give me that answer.

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Female: And you'll get that information back to us?

Franklin: Yeah, I can do that.

Young: Third time. Casey Young. Just to be precise, you said the program's being eliminated. That's not really precisely what's going on, right? The benefit is not, it's no longer a Medi-Cal benefit. The center may well stay open because they may find other sources of revenue and so forth, but let's be clear.

Franklin: Right, right. We're eliminating the optional benefit. Thanks, Casey.

Pope: My name is Michelle Pope and I'm the Executive Director for Alzheimer's Services of the East Bay in Alameda County. My concern is in reference to the timeline. As a non-profit, I am already being charged up by board to have a budget by July 1st that speaks to not only the potential cut from funding from the Medi-Cal resource that was once paying for the Medi-Cal clients that came to our center, but trying to figure out what we will be come July 1st. And my question kind of mirrors the other question is, is it my responsibility as the provider to continually see what's happening up here in Sacramento to the participant when I'm not paying for the service that you guys are paying for the service as a provider or payor, shouldn't you be the one that is sending data and information to them rather than myself and my staff doing that every week, hours upon hours when I'm losing staff because of the elimination? Where do you stand with that and are you able to come and join us in our town hall meeting where we have people who are thinking that ASEB after 20 something years is walking away from them which is not the truth it's that we can no longer afford to be around if this benefit, is well, or can no longer serve them is actually what's happening.

Franklin: So, on your first point about sharing information with the beneficiary, it is our responsibility and as soon as we get that direction that the benefit has been eliminated, clearly we are going to go out and communicate with those beneficiaries. So, it's great that you help and that you do that and I we like that, but certainly we have the ultimate responsibility because they were utilizing our benefits, so you are absolutely correct there.

Pope: Well can you get to them soon? Because they are reading the newspaper and they're seeing what's happening on television, and my phone is being blown up, and so they are asking me to answer questions that I cannot answer because I don't know what the waiver program is going to be, I don't know what the transition time is going to be, I don't know anything about what the funding is going to be available, so I can't even put together a budget to say whether or not I can serve that 80% of the population that I currently serve. And so as an administrator, I feel kind of...

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Franklin: No, that's a good point. That's absolutely a good point. We'll put that into the _____ and figure out when we can get out with a letter or something. I think that's a good point.

Pope: And then during the transition period that was talked about, I believe it's in the last slide, when you're talking about something else in between, are you also talking about funding or are you just talking about a possible therapy program that people, I didn't understand that.

Franklin: Let me say something, so, let me, not to interrogate so what we're talking about simply is being able and again, it's back to looking up whatever we have available data-wise being able to match services, or to find additional service programs for people to go into, okay, that's first and foremost.

Pope: Right.

Franklin: So, that's why it's really just talking about that.

Pope: Okay, okay. With the understanding that that may not be available to everybody and that everybody may not be able to avail to get that _____.

Franklin: Absolutely.

Pope: Okay, my last thing is how are we as, how are gonna support us as the adult day health care with procedure and policy to transition into, or to morph into whatever this new things is going to be. Are you just expecting us to disappear into the sunset. What do you, what do you see us becoming? Are we going to help and support what you guys are doing up here or are we just, I mean is this our swan song?

Franklin: Well I, I can't answer that....

Pope: Well, yeah you can answer that because you're the people that write the policy, I've been obeying your policy, I've been collecting your fund in order to provide the services to the people that I serve, now the policies are changing, the program's changing, the funding is changing, you've given me memorandums of understanding and memorandums and policies to follow so what are my policies now going forward?

Franklin: Well, when I say I can't answer, I can't answer whether it's a swan song or not.

[Inaudible]

Franklin: Okay. But in regards to policies going forward, the policies going forward are going to be consistent with the actions of the SPA and that is the option of benefits have been eliminated. So clearly, it won't be a covered service of Medi-Cal. Now what that means is, is something we're not

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reimbursing for. What that means is that as providers or ADHC providers, we have to look at, one that relationship. So that will be all described in some policy or strikeout for the _____ policy and elimination. I mean, I think that we haven't shied away from saying that in cases that have brought it back home that the option of benefit, if the SPA is approved, I should say that. _____ is being eliminated. So policies will have to follow that are consistent with that decision.

Pope: Thank you.

Franklin: Alright, thank you. Anything on the phone? Okay. One more questions, couple more. Okay, so I just got a note from one of my _____ who said we are going to get the SPA to stakeholders. So, unbeknownst to my legal person sitting here. So you've been trumped so. So, I think we have e-mail addresses of folks and maybe we will do the same thing with the website, maybe we'll do that. Okay. Thank you. Who brought me that note, where'd she go? Oh, thank you. Gary?

Passmore: Gary Passmore again from the Congress of California Seniors. Greg, I'm wondering in light of the fact that you provided this information to the legislature on the number of participants in the program, your department actually, your bosses...

[Inaudible]

Passmore: It was Tobey Douglas okay.

Franklin: Alright.

Passmore: And I don't hold you responsible for his statements or actions.

Franklin: _____ Gary.

Passmore: There you go.

Franklin: Alright.

Passmore: You misinformed the legislature on the number of states that participated in an adult day health care type program saying that it was a small handful of maybe a half a dozen when it turns out to have been 49 of the 50. You have misinformed the legislature about the fact that there are alternative services available for the people that have been receiving adult day health care services as is coming out today and when you finally make some reports on where those services are and how accessible they are, I think it will be obvious that those services don't exist. Given all of that, I'm wondering what you plan to do to get back to the legislature to tell them that this was either a mistake or to explain how this policy is being implemented or are you folks done until next January, are you going to

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wait for a committee to hold a hearing about how the transition is going, what the numbers look like, what the timelines look like, I'm just curious about your relationship with the legislature moving forward on this issue.

Franklin: We should talk because I'm not of the mind we misinformed the legislature.

Passmore: I think it's probably in the record if you....

Franklin: I know but I'm saying I'm not of the mind. So I need to, I appreciate you folks hearing it but I need to find out if that's the case. If we erred, if we erred we'll correct that error but as of right now, I'm just not of the mind that we've done it. I saw a commercial for our department, I think we do good work and I think we try to be, particular with the legislature and all that others honest. So if there is was misinformation, certainly we'll address it but I'm just not willing to say that there was.

Passmore: Do you plan to make a report on how this process is proceeding to the appropriate policy committees in the legislature.

Franklin: We've been talking to _____ staff regarding what we're working on what we're doing so if that evolves into a place where we have to talk to the appropriate policy committee we will. But right now, we're talking to _____ staff and that appears to be the right course of action. So we'll see. We're not shying away from talking about this. If the legislation were to call today we'd come over and talk about what we know.

Passmore: Okay, thank you.

Franklin: Thank you. Any other questions?

Yungling: Hi, its Jill again.

Franklin: Hi Jill.

Yungling: Just my comment to add onto Gary's. If a body is making a decision and the information they receive is inaccurate they based their decision on those facts. So their decision very likely could be totally skewed by that. So I was in that hearing when I heard Tobey say that people can get home health and it was like, oh yeah just go out and ask for it and get it. Get home health, you can PT, you can get OT, you can get all of these services and also that, and the numbers being incorrect. And at that time there was noise in the room. There was noise in the room and of course us being so well behaved shut up. But I wanted to just run up there and grab somebody and say this is wrong. And when you say the wrong stuff over and over and over, you write it in the form over and over and over, it becomes to all of you folks, facts. And it becomes fact to the legislature.

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It's incorrect. Somebody needs to have the guts to stand up and say this is not factual, your decision was made on the wrong information.

Franklin:

Thank you. Any other questions from the audience, we're getting near our time here. Anything on the phone? No? I want to thank you all for attending today. We'll be hanging around a little bit afterward. So if there's individual questions that you want to ask in the open forum, we'll be here for awhile, but thank you.