Franklin County Office on Aging (FCOA)
2017 1.3 Mill Renewal Levy with .45 Mill Increase Proposal

HSLRC Meeting Minutes
September 29, 2016

The Human Services Levy Review Committee (HSLRC) meeting was called to order by Jesse Hemphill on September 29, 2016 @ 3:13 pm.

ROLL CALL

HSLRC members present: Jesse Hemphill, Jerry Friedman, Jim Bowman, Nathan Wymer, and Zak Talarek.

HSLRC members absent: Denise Bronson and Jean Carter Ryan.

Office of Management and Budget (OMB): Heidi Hallas and Garrett Crane.

County Administration: Erik Janas.

Franklin County Office on Aging (FCOA): Toni Carroll, Director, Amy Funk, Manager of Finance and Operations, and Barb Sullivan, Senior Options Program Manager.

REVIEW AND APPROVAL OF MEETING MINUTES

Mr. Hemphill stated the next agenda item is the review and approval of the September 15th minutes. Mr. Friedman made a motion to approve the minutes. Mr. Bowman seconded the motion. All members voted "Aye" and Mr. Hemphill said the motion carried.

DISCUSSION OF THE LEVY REQUEST

Mr. Hemphill opened the meeting: Going back to revisit the meeting today, we had initially expected a presentation of the Consulting Firm that did the consulting work. I understand that they're not going to be here today to make that presentation and that's being delayed until our next meeting?

Ms. Hallas: Correct. She had a family emergency and is out of town. Our next meeting is on October 13. Initially we were going to do an hour of the consultant and then with any agency questions after. So what I've done is split the two meetings in half. We'll have the agency here today for any direct dialoging and questions, following up on the questions we've already asked. We'll relieve them and then you guys can deliberate some more. At the next meeting Direct Effect Solutions will go first and then you'll have more time to deliberate.

Mr. Hemphill: Ok. With that introduction, let's deal with any questions and answers that were sent to management, and that's part of this handout here?

Ms. Hallas: Yes sir, and there's a one pager after the stapled packet. I didn't send it because we just got it today. It is a response from MORPC on the number of aging that they are anticipating. Jean had asked that question when they talked about the increasing number of folks that are moving into our community, what percentage they're anticipating would be of the aging population. There number is 50 and over, but at least gives you an idea. I don't know if we want to go through each one, I did send them out last Friday, so it would give you a chance to review them, or if you want to ask additional questions. That's up to the

committee. This will probably be the last time we'll really dedicate to sitting with them. So please, if you have any outstanding or want follow-up on what we just got, you can ask.

Mr. Hemphill: I have not had time to digest it yet. I don't have any questions, but that doesn't prevent any other committee members seeking any answers to questions they may have.

QUESTIONS & ANSWERS

Mr. Friedman: I had some questions regarding purchasing and I don't know whether it's FCOA or whether it's County Purchasing. When we talk about lowest and best and we see in here multiple vendors at various price ranges, how does that really work? Are we basically saying we accept all vendors with lowest and best, and if they can't provide the service, we allow people to move up in the terms of the expenditures?

Ms. Carroll: One of the things we have to address when we do a bid, we need large numbers of providers in order to have the capacity that we need to get our clients served. What we've typically have done on the homecare side, we have established a couple of things. We have established a ceiling rate, we're not going above the ceiling rate and we've also established how many providers we think we need. So if it's ten (10) providers for a particular service, we'll take the ten (10) lowest and best that is underneath the ceiling rate. What will happen over the course of the contract, particularly if we give opportunities as we did last time for a 1% increase every year, you'll see some vendors moving closer to the ceiling rate during the course of the five (5) period. But we do what we can to control by designating a ceiling rate.

Mr. Friedman: Does the ceiling rise as well at 1%?

Ms. Carroll: No. The ceiling stays, but they keep moving towards the ceiling.

Mr. Hemphill: Using that scenario where there is a service that cannot be supplied by the lowest provider, do you kick up to the next provider?

Ms. Carroll: Yes. The case managers' guidance with the regard of who gets the referral is cost, quality and capacity. So they're always going to be going to the lowest cost provider first, unless or until the lowest cost ones are full. So then you have a capacity issue or we have had historically people who price themselves really low and they can't make the business work at a low price and so the quality falls off. So in that circumstance the case managers are going to move up the list. Because the last thing they want to do is to be constantly having to say to a client, sorry that your service really bad, and we are going to do the best we can to try to find somebody else for you. We are in a bit of a struggle now because of the worker shortage. We just lost a provider for268 clients because from their perspective our contract was not profitable enough for them to stay with us. So, we're having some challenging times, but its cost, quality and capacity. But right now, quality and capacity are very significant. Because finding a provider who can serve our clients for some of the services.

Mr. Hemphill: Is it the case manager that monitors the quality and makes the decision to move to the next level if the quality is not adequate.

Ms. Carroll: Case managers are in contact with the clients and so they are the first ears that hear about quality issues, in terms of quality. We have a whole quality improvement team, whose job it is to monitor the quality. The case manager electronically can send what we call a provider feedback form to the team and say we are having trouble with this particular client, this particular provider, and then the QI people get in gear to try and resolve it. While that's going on, the case manager is working with the client to decide do they want a new provider or would they be happy with another staff member from that provider. So the case manager is trying to negotiate these things, QI is trying to resolve the issue and so at the end of the day, yes it may go to another provider or it may go to different staff person from the same provider after the issue is resolved. Now another place where quality can become a problem is on the finance side. So we

do go out and monitor in a variety of ways how the provider is doing their billing. Are they billing appropriately, are they getting their billing in on time. The whole array of issues that also sends a signal to us about whether or not this is a good business and those also can come into play if somebody's having trouble billing properly we can ask for a plan of correction and we'll monitor them So we look at both the clinical side and the finance and billing side of our providers.

Mr. Hemphill: What percentage of your provider's population does not make it through their duration of the contract because of quality and or billing issues?

Ms. Carroll: I couldn't tell you from the beginning. We just renewed contracts for the last renewal of this contract period. We made the decision to not renew with two providers whose quality we felt was not good. And we probably had five (5) or six (6) providers on their initiative saying that they were not wanting to re-up with us for the last year. So we can lose them because they are wanting out of their contract or because we do not want to renew, either way.

Mr. Hemphill: With that, could that result in a shortage of providers to fulfill the need?

Ms. Carroll: We're now working on our bid for 2017. I think we'll be ok getting into 2017, but I expect we will want to take in quite a few new providers in 2017 to accommodate for the ones that we lost.

Mr. Bowman: Is there a single contract per provider for different services, or are there separate contract for each service?

Ms. Carroll: Yes. I can't remember how that goes. Do they have one contract that lists all the services and the rates?

Ms. Sullivan: Yes.

Ms. Carroll: Ok. So each vendor, like Lifecare Alliance would have a contract for the meals and the rates for the various meals and they would have a contract for homemaker and they would have a rate there. So it's just one contract for each of the providers for each of the services.

Mr. Bowman: I would be interested in seeing what it looks like.

Ms. Carroll: To see what a contract looks like?

Mr. Bowman: No, to see this table sorted by service instead of by agency, so you have all the Respite Services and then within that category the highest amount and sort by service, not necessarily by provider. I don't know what that would tell any of us, but it would be interesting.

Ms. Hallas: So compare apples to apples.

Mr. Bowman: I don't know, like how many different people are doing transportation.

Ms. Carroll: There are a lot of people doing transportation. We've got about twenty to twenty five transportation vendors. That's a separate contract by the way. We bid transportation separately and apart because the things we require of a transportation provider are different from the things we require of a home care provider. So those are done differently.

Mr. Bowman: I'm not in this business, but it seems like maybe if you had larger contracts with fewer providers, you'll get more consistency.

Ms. Carroll: If you had providers who had the capacity, and that's been historically where the issue is.

Mr. Bowman: It could be like a chicken and egg too. If you had bigger contracts you'll find whether you'll get more capacity. I'm just talking off the top of my head.

Mr. Hemphill: So for the transportation, the categories are with lift and without lift?

Ms. Carroll: Yes.

Mr. Hemphill: Ok.

Mr. Bowman: I would like to see that chart.

Ms. Carroll: Ok, we can do that.

Mr. Friedman: Are the transportation services also scheduled by the case manager or is that done directly by the individual using the service?

Ms. Carroll: By the individual using the service.

Mr. Friedman: Do they have a number of options they can basically take anyone off the list in terms of what they need?

Ms. Carroll: I'm sorry, ask your question again.

Mr. Friedman: Who schedules? I need to go to the doctor tomorrow. I don't have any way to get there, I need transportation?

Ms. Carroll: We would assign a particular client a transportation provider. Like Columbus Green Cab (also known as Yellow Cab). We would work with that particular client, what are the doctors you go to within a period of a month, and we would do a quick estimate of what that mileage amount would be and then we authorize that mileage amount for the month. It then becomes the client's responsibility to actually schedule. But as soon as that's done, because of our case management system, Columbus Green Cab knows that Ms. Smith is authorized 100 miles of medical transportation and when Ms. Smith calls in, they pull her up, she's there, she's authorized, she's got mileage, they schedule everybody's, and go on about their business.

Mr. Friedman: You also provide, I think under engagement, opportunities for people to utilize transportation the same way. They have something within their case plan that basically said they're going to utilize this for that purpose.

Ms. Carroll: Yes, an estimated number of miles and those are authorized thorough the vendor, knows how many are authorized. At the point where the number has been used up, the vendor cannot bill any longer, so that's the point where they're going to be calling the case manager, Ms. Smith had an extra need to go to rehab, chemo or whatever, would you consider authorizing ten (10) more miles, fifteen more miles for this month. The case manager can go into the system and authorized those miles and the vendor can get paid.

Mr. Friedman: Prospectively or can they do it retroactively as well. I mean if someone needed a transport for whatever reason, the billing and the authorization weren't matched up.

Ms. Carroll: I think you can go either way. When billing time comes if the miles in our system are not authorized, they won't be able to bill for it.

Mr. Friedman: I noticed that you have small group transportation. Is that an area that has grown in the last couple of years?

Ms. Carroll: Yes.

Mr. Friedman: It seems much more efficient.

Ms. Carroll: It is and it isn't. It is for some purposes. I think they don't use it at all for medical transportation because those appointments are so specific. It's used for banking, grocery shopping, and maybe going to the social security office, things of that nature; things that don't need to be as precise as medical. I don't think any of our small groups does; I could be wrong. I know the big one, Community Resources out of Clintonville which serves a large part of the county, probably doesn't do the medical. Some of the small might. Some of the small ones that are within municipalities might do some medical transportation, but I bet they don't do much.

Ms. Sullivan: It's usually limited when the medical facility is within their particular service area.

Mr. Friedman: It's been a number of years since I looked at it. There used to be a provision under Medicaid for medically necessary transportation, anything like that still exists?

Ms. Carroll: Anyone who is on Medicaid, we do insist that they do go onto Medicaid transportation. I don't know what it's called, but there is a Medicaid transportation benefit for those folks who are on Medicaid. There's both a lift and a non-lift, which sometimes is a source of contention because people don't find that Medicaid transportation as consumer friendly as ours is. But if they are Medicaid eligible, then they use that source for medical transportation.

Ms. Hallas: So then you won't approve that piece as part of their plan for medical transportation?

Ms. Carroll: Correct. We will help them, but we won't give them medical transportation. I think we put it on the care plan just so case managers know, Medicaid is the primary source.

Mr. Friedman: I think the way they've handled it, it needs to be medically necessary. So it just not the fact it's a medical visit, it's just that individual cannot take public transportation because of some disabling limitation or they need a lift or they need an ambulance to actually get there. So it's medically necessary.

Ms. Carroll: I think what they do in transportation is a little broader than that, or am I wrong? If they can take the bus, I mean it's like the same thing with us. If they can take the bus to a doctor's visit, we are going to expect that's how you're going to do it.

Ms. Sullivan: I think part of that authorization process for that transportation, I think they refer to it as NET Transportation, (Non Emergency Transportation), is basically a qualifying step. Basically there's not a car in the home, the person can't drive, the person can't take the bus, etc. Then once they're assessed as eligible for Medicaid, that transportation benefit is open for them if they are able to demonstrate that need.

Ms. Carroll: I think in their system, which is part of what makes it a little more cumbersome, I think they do have to work with someone at the county who is the intermediary to scheduling with the vendor, correct? They can't call the vendor directly?

Ms. Sullivan: I don't believe so.

Mr. Friedman: It's on the administrative side not the service side of the program at the county level. What about Medicare, does Medicare cover any transportation?

Ms. Carroll: Hardly anything at all.

Mr. Hemphill: Dealing with capacity, of all the services that you offer and there's a vast variety of services and the available providers that provide those services, of any services that have capacity related issues? Are you running out of providers?

Ms. Carroll: Right now?

Mr. Hemphill: Yes. If there are, what are they?

Ms. Carroll: Yes. We are experiencing a serious work, for people doing this work. What we are finding is, particularly in the area of homemaker service, we have a serious capacity issue. Not at the provider level, because, very few providers do homemaker only. They do homemaker, personal care and respite, so their staffing of personal care and respite is at a different level of worker. They're having difficultly on the homemaker side. So for instance we can send referrals out to five (5) or six (6) agencies and have all five (5) or six (6) agencies say they can't staff a client. Which is causing us to have to figure out strategically what we're going to do to identify how we're going to deal with this.

Mr. Hemphill: So is that shortage continuing to multiply year after year?

Ms. Carroll: It's just started. I think what Becky said it was 2014, that we really start seeing it. I don't know. As the economy continues to improve and with these lower paying jobs these folks can go work at Costco and get more money and have more benefits than they can in the homecare industry, it's going to continue to be an issue for us.

Mr. Hemphill: So could we consider raising the rates for any of these services?

Ms. Carroll: I would expect that even though we will maintain a ceiling rate in our next bid, we're going to see more people at or near the ceiling rate than we do now. That's the only way they're going to be able to be competitive too as if they can attract workers to serve our clients.

Mr. Bowman: Question on the cost summary. The cost summary for the services, is that the Social Services line item in the income statement, the revenue expense?

Ms. Funk: Yes, that's the biggest piece of it.

Mr. Bowman: Do you know what these add up to?

(Small discussion amongst FCOA).

Mr. Bowman: Well when you re-do it, could you add them up on your spreadsheet?

Ms. Funk: Sure.

Ms. Hallas: And I'll have them add whatever the piece is that doesn't go by vendor so we'll make sure it ties up.

Mr. Bowman: Sure.

Mr. Friedman: I have a similar line of concern about the Emergency Response System. Some of those are national vendors. Is that possible to aggregate that under a single vendor? Do they also have this capacity issues or if there was the ability to bid a volume purchase arrangement, would a national company like ADT or one of those companies actually be willing to increase their local capacity?

Ms. Carroll: What we see is they offer different things, like the one that we've worked with the most over the years, VRI. They offer more of the things that we need for a few of our clients than some of the other

providers do. We would never want to just have one or two providers because of quality issues. So if a provider does want to get out of business with us, we'll need to have a fallback. But I think the Emergency Response System, we don't have as many vendors in that area we do in homecare because you're right, we don't need as many different vendors. We can certainly take a look at that when we bid again.

Mr. Hemphill: What percentage of your population of providers has the need for the Emergency Response Devices?

Mr. Friedman: 5,033 were identified in the list.

Ms. Carroll: We have a lot of folks who do get the Emergency Response System. It's a relatively low cost intervention. I may have mentioned this before; it's one of those, when you talk about how technology has helped us. Back in the day, the way out of town family members could deal with their folks that were home alone all the time was to have a human being go over and check on mom, because mom may have fallen. That was prohibitively expense and never really ever going to have enough staff to check on mom to see if she has perhaps fallen. Emergency Response is a wonderful alternative if mom's lives by herself, she's 75 and still going down to the basement to do her laundry because that's where the washer and dryer is. If she got the Emergency Response button,, depending on what kind of things come with i, she'll be able to press the button. Some of them have for a particular client with an identifying need, they also have fall detectors so she doesn't need to press, she just has to fall and whoever is monitoring that gets the notification. It's a very nice and low cost intervention for people.

Mr. Hemphill: I would imagine, given that nature of the device, the majority of your population of clients have that device, is that correct?

Ms. Carroll: A lot of them have it. For us, they need to be alone most of the time.

Mr. Hemphill: That's one of the criteria's?

Ms. Carroll: That's one of the criterias, or a have a particularly fragile medical condition where they need to be able to call, say they are alone, not all the time but enough of the time where we have concern where they will be able to call someone because of their medical condition. For some people with certain impairments, we're able to do link them to a smoke detector or things of that nature if have some who is wheelchair bound and would have to have help getting out of the house, we would link them up with smoke detectors as well.

Ms. Hallas: And those are all based on assessment of need right, not just based on if they want it?

Ms. Carroll: Yes, everything, it's always a struggle with wants versus needs. Practically this younger generation, people want, they want a whole hell of a lot, and they're very cranky about it. Case managers they struggle with, no you don't need this at this point, and this is for people who actually have a certain level of impairment. Those baby boomers are cranky.

Mr. Hemphill: So you obviously in determining must have a sophisticated system to monitor the number of units a person is allotted and then tie that into the population of the budget to identify to stay for that population?

Ms. Carroll: Most everyone occasionally you'll see an extra charge for a pendant, but most everyone is just a single pendant. In some circumstances when there are two people in the home, they'll be a pendant for two and somebody loses a pendant we'll give then another pendant. We've had the units and pendants infested with bedbugs too. We've had to pull them out and put new ones in.

Mr. Bowman: What is your response to finding bedbugs?

Ms. Carroll: We are still struggling. We do our best to make sure everybody knows. It feels somewhat like it did back in the early days in figuring out what to do for a senior with HIV; you just presume every house you go into has a bedbug infestation and start from there.

Mr. Bowman: How many do?

Ms. Carroll: I don't know.

Mr. Bowman: I mean with the houses that you serve, how many?

Ms. Carroll: A lot. Barb is very active in the bedbug coalition. It's hard to answer, because we don't always know. If it's a big infestation, we have clients coming into our office and you can see them, then you know. Sometimes you can see them on the client in their homes, sometimes you can't. So we have to have the home care agency staff understanding that basically they have to presume everybody has them. We try to council people about not bringing things in from flea markets, being aware if they got family members who know that they have a bedbug infestation, being careful about what's coming inside the home. We haven't done it, but it's not uncommon, I guess our AAA case managers do carry a stool when they go in, which is awkward, because it's kind of much for establishing a rapport. Typically what we'll say is that we just come seeing our last client and we don't want to risk bringing bedbugs into your home and so therefore I'm going to sit on this chair that I'll then take out when I leave.

Mr. Bowman: I assume there are no resources for mitigation?

Ms. Carroll: We've done a little bit. We had a pilot project trying to work with clients, trying to do contracting with them, trying to say we can do some treatment, and then would you agree to do the following things. We are still in the pilot phase with that because enough time has gone by to see whether the contracting really worked. But the problem is the bedbugs in this community are resisted to the treatment or getting resisted to the treatment.

Mr. Hemphill: So in your budget, the line item for remediation of bedbugs?

Ms. Carroll: We have a line item for lots of different kind of pest control issues, rodent removal and things like that; I think that's the line we pull it out of. We have a line item for that.

Mr. Bowman: Big problem.

Ms. Carroll: It's a huge problem all over the county. We had to look for furniture for our reception area that you could wipe down with alcohol and which didn't have any crevices or anything on the bottom, no upholstery but also looked nice and didn't make people feel bad. So Amy found some for us. We don't want people to feel bad, but it's a problem.

Mr. Hemphill: In the press, I thought it was way prevalent in the Cincinnati area and it moved to Columbus?

Ms. Sullivan: It is everywhere, it really is. I felt bad for Cincinnati initially, they were in the paper so often, but we were dealing with problems at the same scale. So there's really no place in the country that you can go, especially major cities that are not dealing with this.

Ms. Carroll: You have a kid who travels. We have students who have traveled to foreign lands where they have been dealing with bedbugs for years and they bring them back. You should have Ms. Sullivan tell you what to do whenever you check into a hotel.

Mr. Bowman: Let's hear it.

Ms. Carroll: First place all your things in the tub. Do not put it on anything cloth.

Ms. Sullivan: Bring a very bright LED flashlight and look at the bed.

Ms. Carroll: The sheets and bed spread gets washed, but the bed skirts do not. Lift the mattress. Check under any bed skirts. Look inside all the drawers.

Ms. Sullivan: Do not use the drawers.

Ms. Carroll: Basically, do not put anything on the floor that you bring into the hotel room.

Mr. Hemphill: Does anyone has any additional questions for management in regards to the items in our handouts?

Mr. Friedman: I did in regards to your copayments. I know that it is a substantial amount that you bring in. How does that compare to the amount that you bill? What percent of your accounts are collectable?

Ms. Carroll: We used to talk about a very high level about 96-97%. I do not think it is that high now.

Ms. Funk: I will have to calculate it.

Ms. Carroll: I bet it is over 90%. Older adults are usually good about paying, unless they die. Then that is a whole other arena we are trying to take a look at. Sometimes it is hard to get the adult kids to pay. We have a point of non-payment where we turn the services off. Usually that is a measure of if they really need them or not as well. I do not know off the top of my head what we collect.

Mr. Friedman: I was really more concerned about the process of what you do when someone is not paying. How you evaluate the services are essential, but they are having financial problems?

Ms. Carroll: That is a conversation that the case manager and client can have about what they expenses are. Our fees schedule shows what they should be able to pay. Then we work through that. We can also put them on a payment plan. I think we decided that it was they pay your current and one-fifth of the original until you get caught up. They are in good standing as long as they keep making payments. If there is any point where payment stops, we will put their services on hold. Then we dis-enroll them. Then we flag the case for future purposes in case they decide they want to come back. They will have to pay it all back before we can re-enroll them.

Mr. Hemphill: How often do you have to do that?

Ms. Carroll: Not a whole lot, but we do it. We'd rather not, but we do. We have a couple of cases flagged now. Their statement tab is lit up.

Ms. Hallas: They are still sent an invoice every month.

Ms. Carroll: Correct.

Mr. Hemphill: What percentage of your copays do you have to write off every year?

Ms. Carroll: We write some off. I will have to do some research this. We try to collect payments from the kids, but they are not obligated to pay. Every once and a while they will.

Mr. Hemphill: Any other questions for management? The next item is discuss levy request?

Ms. Hallas: The next thing we will do is release management from the panel. If there are any other questions while they are here or any topics management wants to address.

Ms. Carroll: The one thing that has emerged for us since the factbook was put together was workers shortage. There is one provider who had a big case load and decided not to renew their contract. That put us even further behind the eight ball. I also wanted to let you know that we did get some space and did a massive hiring. We have two more hires to go to be fully staffed. We will try to get you an updated table of organization.

Mr. Hemphill: The positions you are hiring, are they case managers?

Ms. Carroll: Yes.

Mr. Hemphill: I would like to say that you have been very responsive to our questions and I am thankful for that.

Mr. Friedman: Mr. Hemphill, I have one more question. There was a question about LifeCare Alliance supplementing the Medicaid. Are you actually providing them a lump sum to allow them to maintain the clinic?

Ms. Carroll: Yes. We provide them funding to support the nursing clinic. I believe the Osteopathic Heritage Foundation gave them funding as well. I have a feeling that this is an important service that our clients take advantage of. We are the only ones who support a nursing clinic.

Mr. Hemphill: Where is the funding in the factbook?

Ms. Carroll: It is in the grants. I think it is health and wellness with the other services.

Mr. Hemphill: Is that amount adjusted or increased in the next levy cycle?

Ms. Carroll: I think that Ms. Funk put in an annual increase.

Mr. Hemphill: Thank you very much for participating.

Ms. Hallas: We will see you in a couple of weeks.

Mr. Bowman: What will the consultant discuss?

Ms. Carroll: Operational review.

Ms. Hallas: An operational review done by Direct Effect Solutions. They are scheduled to present their findings on October 13th. They were scheduled for today, but unfortunately, there was an emergency. We are looking forward to their findings. At this point, is there any more discussion of the group? I know we are anxious for the findings of the operational review. I have allotted this hour if you want to have any discussion.

Mr. Bowman: I am puzzled, maybe because I do not know, why they have so many providers; that there are not enough capacity in one or two. If there is a $12 million contract, seems like they will be able to figure it out.

Mr. Friedman: Are you talking about transportation?

Mr. Bowman: I'm talking about them all, but transportation in particular.

Ms. Hallas: Well, I think to Ms. Carroll's point, if you put all of your eggs in one basket, and it closes up shop, they are going to have to reassign 10,000 people. They do handle large volumes. You will see that in

other social service agencies, where they at least have a handful of folks doing each, so when one company closes or merge, you have capacity to switch folks over. Do we need as many? I do not know, but if you put all of your eggs in one basket, like homecare where there is so much turnover, they are really not stable services.

Mr. Friedman: I was thinking about transportation and the emergency response services. The kind of non-hands on activity. I know of some large organizations are out there that has potential and we get a bond or guarantees to ensure the qualification up front.

Mr. Bowman: They should do there due diligence to have a stable enough company that you contract with.

Mr. Friedman: Many of our questions may be appropriate for the operational assessment that is being done. I am happy to wait and see what they covered.

Mr. Bowman: When did we do this last?

Mr. Friedman: 2012.

Ms. Hallas: It is a five year levy.

Mr. Hemphill: The meeting with the consultant is on October 13th, correct?

Ms. Hallas: Correct. It will be our next scheduled meeting. She will be coming in doing PowerPoint and there is time to ask the consultant questions. I did adjust the timeline. Since we canceled the first meeting, I wanted to make sure we had enough meetings for the committee to deliberate and come up with your recommendations. So I extended the end out a little further. There are now two meetings in December, instead of one in case we need to go that far out. It also gives me time to write the report. I wanted to present that to you as well. As we move forward, we can decide if we need it, but it is a placeholder for now.

Mr. Hemphill: I have a question about the meeting on October 13th. Is two hours, our normal allotted time, be adequate enough to cover everything?

Ms. Hallas: The consultant said she needs one hour to do the presentation and you will have the second hour for questions and answers. I am not sure about the study, but I believe this is the preliminary findings and are still tweaking the final draft. Because of our timeline, they wanted to give us the big picture items and recommendations. This is not going to be the full blown report, but it is going to be everything they are working on. She is saying it is only going to take an hour to get through. They still need to talk to Ms. Carroll about the report before we have it. I am asking for it in advance, but it obviously gets to Ms. Carroll and her staff first. They need to have those conversations before the 13th. I am trying to see once that occurs if we can get you the presentation so you can look at it beforehand. I know it is a timing thing to make sure they get it first.

Mr. Bowman: I take it the agency requested this study.

Ms. Hallas: This committee actually requested the study.

Mr. Bowman: Who is the client?

Ms. Hallas: The client is the Board of Commissioners. We actually purchased it.

Mr. Talarek: We are paying for it from the Board of Commissioners' budget and not the Office on Aging.

Ms. Hallas: It is going directly to Mr. Janas and Mr. Wilson and they will meet with Ms. Carroll and her staff. That is why they needed extra time with the person leaving last week.

Mr. Hemphill: They are scheduled to hear it before the 13th?

Ms. Hallas: Yes. I believe it will be next week. As soon as they get through their process, I will try and get you a copy.

Mr. Friedman: Are we going to do this with all the agencies?

Ms. Hallas: This is the only agency that we are directly over.

Mr. Bowman: The other agencies have boards.

Ms. Hallas: Correct. The Board of Commissioners are their board. We can order it and do it. You may request it for the next process and have them propose it to their boards. That is definitely a possibility.

Mr. Bowman: How much does this cost?

Mr. Talarek: Just over $50,000.

Mr. Hemphill: Just for the agency?

Mr. Talarek: Yes, let me find it.

Ms. Hallas: It was a quick turnaround because of the timeline. I believe Ms. Carter Ryan asked about how much things are going to cost. It is not going to go that far. On the issue of getting a new IT system, which they know. Their platform was built in the 90s and will not be supported any longer. They are not going to say this is how much, but here is the need.

Mr. Hemphill: Does Children Services have their own board?

Ms. Hallas: Yes. This is the only Board of Commissioners' agency.

Mr. Talarek: The contract was for $59,850.

Mr. Friedman: Was there an RFP sent out? What is the scope?

Mr. Talarek: I believe there were three quotes that were obtained.

Mr. Friedman: Can we see the proposal that came in from the vendor that was chosen?

Mr. Talarek: Yes, I believe mirrored the resolution we passed.

Ms. Hallas: I believe we sent that.

Mr. Talarek: I believe the resolution is and exhibit in the contract. If it is easier to pull it out, we can.

Mr. Friedman: That will be good so we can wrap our minds around.

Ms. Hallas: I mentioned at the last meeting that they took what your recommendations were from the report, and I went through all of them to make sure they were getting checked off. I know we sent you questions from the meeting, on the information about the vendors, but I do not think the contracts were a part of that.

Mr. Friedman: I do not believe it was.

Ms. Hallas: I will send that.

Mr. Friedman: I am not as interested in the full contract, but scope of what they will be looking at.

Mr. Hemphill: Will we get this before the 13th?

Ms. Hallas: Yes. I will send that tomorrow. That is not a problem.

Mr. Talarek: Just from the background, the utilization and capability of an internal IT system, case managers' caseload, agency organizational structure, and service delivery efficiency. They had a separate IT consultant.

Ms. Hallas: They have been hunkering down on that with answering phone calls and really challenging the staff.

Mr. Bowman: Have they been cooperating?

Ms. Hallas: Yes.

Mr. Hemphill: I want to reiterate that we have a meeting on October 13th.

CLOSING REMARKS

The next HSLRC meeting will be held Thursday, October 13th from 3:00-5:00pm at 373 S. High Street, 26th Floor in the Briefing Room.

Jerry Friedman made a motion to close the HSLRC meeting and Jim Bowman seconded.

The meeting was adjourned at 4:14 pm.