

## **2006 STREAMLINING ACCESS SURVEY RESULTS**

In the fall of 2006, 23 of the 24 grantees comprising the 2003 and 2004 cohorts of ADRC grantees (12 and 11, respectively) were interviewed to assess the process for how financial eligibility determinations are made for Medicaid and other public LTC programs, as well as how level of care assessments are conducted in their states, both before and after the establishment of the ADRC program.

In addition, grantees were also asked questions related to other access functions such as whether the ADRC has a role in nursing facility transitions, provides formal options counseling, or intervenes in critical pathways (see **Appendices A** and **B** for the complete survey and tabulated streamlining access question responses, respectively). This information was collected to allow for a more detailed understanding of what states have achieved and are working on, as well as to provide AoA and CMS the opportunity to better measure the progress ADRCs are making toward streamlining access.

### **Fully Functioning ADRCs and Streamlined Access:**

In 2007, the ADRC-TAE assisted the Administration on Aging in developing a set of criteria and recommended metrics for measuring the extent to which an ADRC might be considered “fully functioning.”<sup>1</sup> In measuring streamlined access, it is important to place grantee progress in terms their overall efforts toward becoming a fully functioning ADRC. Streamlining access is related to numerous program components, their designated criteria/description, and the recommended metrics for measuring achievements toward ADRCs becoming fully functioning. See **Appendix C** for a complete list of the recommended “fully functioning metrics” related to streamlining access.

Four recommended metrics for fully functioning ADRCs are directly related to specific questions in the streamlining access survey. These are as follows:

- SEP/ADRC has a single, standardized entry process. For decentralized models in which operating entities retain responsibility for their respective services, the entry process is coordinated with each other to integrate access to those services and administered and overseen by a coordinating entity.
- Eligibility data for public programs are communicated to appropriate SEP/ADRC staff and SEP/ADRC is able to track consumers’ eligibility status.
- Financial and functional eligibility determination is highly coordinated.
- SEP/ADRC has a plan for reducing the average time from first contact to eligibility determination and the average time is below current time requirement.

Recommended metrics that are indirectly related to specific streamlining access survey questions are:

- In localities where waiting lists for public LTC programs or services exist, there is a process by which the SEP/ADRC is informed of consumers who are on the wait list and the SEP/ADRC conducts follow-up with those individuals.
- There is a process by which the SEP/ADRC is informed of consumers who are determined ineligible for public LTC programs or services and the SEP/ADRC conducts follow-up with those individuals.
- There is a reduction in the rate of institutional placement in the SEP/ADRC service area.
- SEP/ADRC tracks diversions and transitions (i.e., # nursing home diversions attempted and # of successful diversions; # nursing home relocations to community completed).

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<sup>1</sup> “Fully Functioning Single Entry Point System/ADRC – Revised 2008” available online at: [www.adrc-tae.org](http://www.adrc-tae.org)

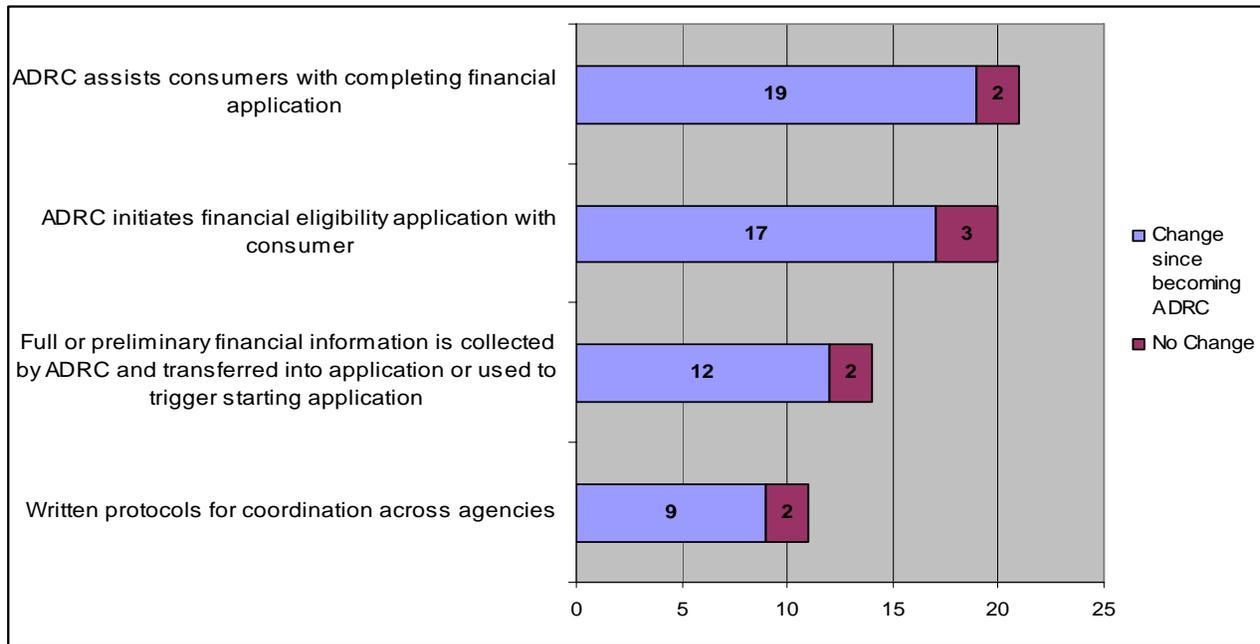
- SEP/ADRC uses uniform criteria to assess risk of institutional placement in order to target support to individuals at high-risk.
- SEP/ADRC can report the proportion of consumers requesting services that actually receive them.
- SEP/ADRC has a plan for streamlining access to long-term care signed by the State Medicaid Agency, State Unit on Aging and the State agency(s) representing target population(s) of people with disabilities. (Streamlining Access Plan).

The sections that follow include examples provided by grantees on the streamlining access survey organized according to the relevant recommended metrics for a fully functional ADRC. Additionally, the questions are divided between financial or functional eligibility determination processes. Questions to which grantees reported the greatest level of change before and after the ADRC are listed first.

As indicated in the figure below (**FIGURE 1**), the highest levels of changes reported by grantees in the financial eligibility determination process were generally found in the following areas:

- *The entities that assist consumers with completing the financial application for each target population:* **Nineteen** grantees responding to this question reported a change since the ADRC in their state in the entity(ies) that assist consumers with financial application completion. Reported entities involved in this process included the ADRC, the Medicaid agency, and/or other agencies and organizations.
- *The entities that initiate the financial eligibility application with consumers and perform the initial financial intake for each of the target populations:* **Seventeen** grantees reported a change since the ADRC in their state in who initiates the financial application and performs initial financial intake with consumers. Reported entities involved in initiating the financial application included the ADRC, the Medicaid agency, and/or other agencies/groups.
- *The initial information that is collected from consumers:* **Twelve** grantees reported a change since the ADRC in whether initial financial information (and what type) is collected from consumers. Among grantees reporting information being collected, the types included the full set of required financial application information, or preliminary financial information that may or may not be transferred into the financial and/or other relevant applications.
- *Whether there are written protocols (e.g., MOUs/MOAs) for coordination across agencies with Medicaid related to financial eligibility:* **Nine** grantees stated a change since the ADRC in whether there are written protocols for coordination across agencies with Medicaid related to financial eligibility. Grantees reported having these written protocols, that they were planning efforts toward the creation of protocols, or that they do not currently have protocols in place (sometimes, because it is unnecessary due to where the ADRC is housed, or whether co-located eligibility determination staff were present at the ADRC).

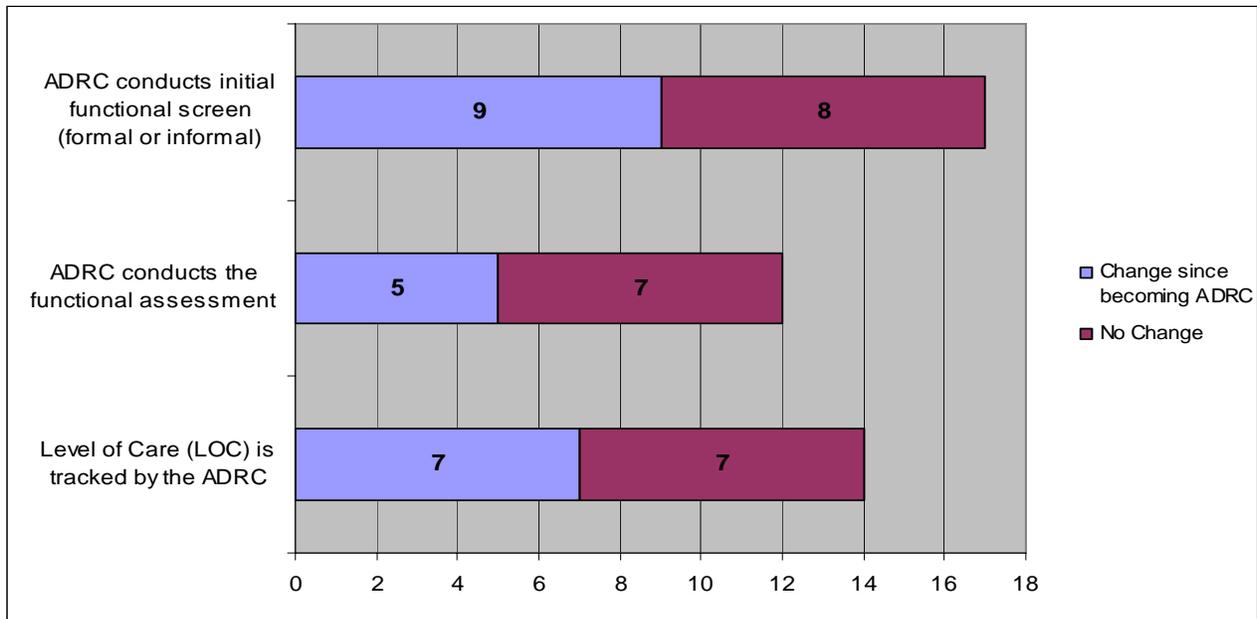
**FIGURE 1:  
FINANCIAL ELIGIBILITY DETERMINATION PROCESS LEVELS OF HIGHEST CHANGE**



As indicated in the figure below (FIGURE 2), the highest levels of changes reported by grantees in the functional eligibility determination process were generally found in the following areas:

- **The entities that conduct the initial screen for each target population:** **Nine** grantees reported a change since the ADRC regarding the entity that conducts the initial screen for functional/programmatic eligibility for target populations in their states. For the grantees reporting some form of ADRC involvement in this process, some indicated that the ADRC does the formal screening process with consumers, and others conduct an informal screening process with no screening tool used.
- **The entities that conduct the functional assessment for each target population:** **Five** grantees reported a changes since the ADRC in the entity(ies) that conduct the functional assessment for each target population in their state. Reported entities involved in the process included the ADRC or a co-located entity with the ADRC, or governmental or private/non-profit providers that are not co-located with the ADRC.
- **Whether the applicant's Level of Care (LOC)/functional eligibility status is tracked by the ADRC:** **Seven** grantees reported a change since the ADRC in how an applicant's LOC/functional eligibility status is tracked by the ADRC in their states. For grantees reporting the ADRC's ability to track this status, this was accomplished through co-location with the eligibility determination staff, over the telephone (at the ADRC's request), or electronically by the ADRC itself.

**FIGURE 2:  
FUNCTIONAL ELIGIBILITY DETERMINATION PROCESS LEVELS OF HIGHEST CHANGE**



*ADRC has a single, standardized entry process or is coordinated with other operating entities to integrate access to those services:*

**FINANCIAL ELIGIBILITY:**

- **Q1: Which entity(ies) initiates the financial eligibility application with consumer and performs the initial financial intake for each of your target populations?**

Twelve indicated that initiating the financial eligibility application with consumers was done by the ADRC and the Medicaid agency for any application. Four grantees reported the ADRC as the only entity initiating financial applications with consumers; four reported the ADRC along with other entities. In three states, Medicaid is the only entity that initiates the financial eligibility application. **Seventeen** grantees responding to this question reported a change since the ADRC in their state. For example:

- ADRCs in Illinois initiate the financial eligibility application for individuals aged 60+ and those under age 60 with developmental disabilities. Individuals are able to apply for multiple programs including Medicaid.
- In Indiana, the ADRCs make a consultation with options counselors conducting initial Medicaid screening over the phone with consumers. Prior to the ADRC, consumers were screened for services through multiple entities in their home.
- Maine’s ADRC initiates the financial eligibility application with consumers with trained department-outreach staff that can also assist with this process.
- ADRCs in New Mexico initiate the financial eligibility application for the Disability and Elderly waiver and the Traumatic Brain Illness waiver. The Department of Health serves as the entry point for other waivers in the state.

- **Q7d: Are there written protocols for coordination across agencies (e.g., MOUs/MOAs) with Medicaid related to financial eligibility?**

Eleven grantees reported having written protocols (e.g., MOUs/MOAs) with their state's Medicaid agency for coordination across agencies in relation to financial eligibility and two grantees discussed planning efforts toward written protocols. Of these grantees, **nine** stated this was a change from before the ADRC. For example:

- In Arkansas, there is currently a MOU between the Division of County Operations and the AAA to shorten the eligibility determination process.
  - CNMI developed a MOU with Medicaid concerning the coordination on financial eligibility applications and how the ADRC will be notified during the process.
- **Q4: Do consumers complete a single financial application for all public LTC programs or complete different applications for different LTC programs?**

Nine grantees reported that consumers complete a single financial application for all public LTC programs. **Four** grantees reported this to be a change from before the ADRC. For example:

- In Illinois, one application is currently completed by consumers for nursing home, HCBS and supportive living services.
- In Massachusetts, consumers are able to complete a single financial application for multiple programs and services through a web-based common intake tool through the Virtual Gateway system in the state.
- Maine reported that consumers complete a single financial application for all public LTC programs. However, it was noted that though there are additional pages to complete for disabled populations, it is all a part of the same application.

#### **FUNCTIONAL ELIGIBILITY:**

- **Q13: Which entity(ies) conducts an initial screen for each of your target populations?**

Among those entities that conduct the initial screen for functional/programmatic eligibility for target populations, eleven grantees reported that the ADRC does a formal screening process and six reported the ADRC conducting an informal screen with no tool used. **Nine** grantees stated a change since the ADRC in the entity conducting the initial screen for each target population. For example:

- In Indiana, the ADRCs currently conduct the initial screen. Before the ADRC, three different departments within the AAAs conducted this screen. The ADRC is now able to screen for all services over the telephone.
  - The ADRCs in Massachusetts conduct initial screens for long-term services and supports, including the frail elder waiver program, nursing facilities, and the Personal Care Attendant program.
  - In Pennsylvania, the ADRCs use a screening tool during long-term options counseling and screening to collect information about ADLs and IDLs and basic baseline information to help determine if a full LOC assessment is needed.
  - In West Virginia, consumers begin the functional eligibility process at the ADRC. Alternatively, physicians, hospitals or provider agencies can also initiate referrals to the West Virginia Medical Institute (WVMI), the contractor for medical assessments.
- **Q14: Is a pre-admission screen conducted?**

Eleven grantees reported that pre-admission screens for nursing facilities are conducted through their ADRC. **Six** of these grantees reported a change since the ADRC in whether a pre-admission screen is conducted. For example:

- The AAA/ADRC staff conducts pre-admission screening upon the request of the consumer or their family member for the aging population in Georgia. The Division of Mental Health, Developmental Disabilities and Addictive Diseases regional office staff or ADRC staff conducts the screen for the developmental disability population.
  - ADRCs conduct the pre-admission screens in Indiana. During the screen, consumers also get options counseling at the same time. Prior to the ADRC, consumers were instead given a referral or their application was sent to someone else.
  - In New Hampshire, a co-located registered nurse does the pre-admission screen with consumers, with mandatory referrals to the ADRC. This requirement is beneficial in forcing a relationship between the ADRC and hospitals and discharge planners.
- **Q20d: Are there written protocols for coordination across agencies (e.g., MOUs/MOAs) for the functional eligibility process?**

Eight grantees reported having written protocols (e.g., MOUs/MOAs) for coordination across agencies in relation to the functional eligibility determination process. **Six** grantees stated that this was a change since the ADRC. For example:

- In West Virginia, there is a written protocol between the functional/medical determination contractor in the state and the Medicaid office, which, by extension, includes the ADRC.
  - New Hampshire reported having written protocols, but no formal MOUs as they are not necessary.
  - In Indiana, there are no MOUs, but flow charts and procedures are already in place (everything is in the same agency).
- **Q16: Which entity conducts the functional assessment(s) for each of your target populations?**

Twelve grantees reported that their ADRC or a co-located entity with the ADRC does the functional assessment(s) for each of their target populations. **Five** of these grantees stated a change since the ADRC in regard to which entities conduct the functional assessments. For example:

- In Indiana, the ADRCs conduct the functional screens for nursing homes and in-home care.
  - AAAs in Pennsylvania do nursing home LOC assessments for everyone and waiver eligibility for the 60+ population. The Department of Public Welfare conducts the waiver functional eligibility for disability populations.
  - In Florida, the CARES staff (closely coordinated with the ADRC) conducts the functional assessments. Additionally, case management agencies can provide this function, if authorized by the ADRC.
- **Q13a: Is the same screening process used for all public LTC programs (including same screening tool) and/or for all populations?**

Fourteen grantees reported using the same screening process for all public LTC programs. Of these, six reported use of the same tool for all populations/programs; 5 reported using the same process for all populations and programs with no specific tool used; and three grantees are using the same tool for multiple populations and programs. **Four** grantees reported this to be a change since the ADRC in the screening process used. For example:

- In New Hampshire, everyone calling into the ADRC receive the same initial informal screening process with a LTC counselor who reviews the consumer’s situation and discusses what services they may be eligible for or can access in the community.
  - Pennsylvania’s ADRC pilots use the same screening process, which contains basic baseline questions for multiple populations (e.g., aging, PD, brain injury).
- **Q15: Do consumers receive a single assessment for all public LTC programs or do they receive different assessments depending on the LTC program or service?**

Ten grantees reported that consumers receive a single assessment for public LTC programs. Of these, eight grantees stated that consumers receive the same assessment for all their target populations and all LTC programs, and two grantees reported that the same assessment is used for multiple populations and programs, but not all. **Three** grantees reported this to be a change since the ADRC. For example:

- Alaska reported the use of one assessment tool for their elderly, physically disabled, and developmentally disabled populations.
- In Illinois, consumers receive a single assessment, the “Determination of Need” (DON) Assessment Instrument, that screens for nursing facility and HCBS placement. This instrument is used for the aging and physical disability populations, but not for developmental disability or mental illness populations.

*Public program eligibility is communicated to ADRC/ADRC is able to track consumers’ eligibility status:*

**FINANCIAL ELIGIBILITY:**

- **Q10: Is the applicant's financial eligibility status tracked by the ADRC?**

Among eighteen grantees reporting that their ADRCs track applicants’ financial eligibility status, eight grantees stated that financial eligibility status is tracked electronically by the ADRC; six stated it is done by telephone at the ADRC’s request; and four noted that they are able to do this because of co-location with the eligibility determination entity (whether through co-located workers or the whole agency). **Nine** of the eighteen grantees reported this to be a change since the ADRC. For example:

- In California’s San Diego pilot site, if they receive a warm referral, a “tickler system” is in place and the staff will check the status of consumers’ applications.
- In Illinois’ Macon County, the local Medicaid office sends the ADRC a copy of the consumer’s eligibility status notification letter. The ADRC can also call directly to check the individual’s status. The difference for the Rockford pilot site is that the ADRC does not automatically receive a copy of the consumer’s notification letter.
- The ADRC in Maine does not have the ability to electronically track consumers’ financial eligibility status, but can call the Department of Health and Human Services to ask for the individual’s status.

- **Q7e: Have there been MIS changes that allow exchange of information across agencies?**

Seven grantees reported currently having established MIS changes that allow for the exchange of financial eligibility information across agencies, with all **seven** reported this to be a change since the ADRC in their states. For example:

- Illinois' ADRCs can use the Real Benefits computer program, which can take client information and put it directly into an application form for programs such as Medicaid and Food Stamps.
- In Massachusetts, the Virtual Gateway has been created to facilitate and expedite Medicaid financial eligibility. Additionally, the grantee reported work to automate the consultation form that the Aging Service Access Point (ASAP) and Independent Living Program (NILP) use to exchange information about new clients.
- The Maine EAAA ADRC project has updated the computer systems' internal capacity to ensure their ability to complete online application processes. Though they do not exchange information with Medicaid electronically, the ADRC is able to submit some items through electronic means.
- Minnesota's LTC Consumer Decision Tool is set up to transfer data from an online Medicaid form to the county information system and ultimately into the state MMIS system. The state has set up the policy for how data is shared, with the state and county exchanging encrypted information related to the MMIS.
- The Pennsylvania ADRCs are able to enter information into the state's online application system (Commonwealth of Pennsylvania Access to Social Services - COMPASS) as well as submit consumer's financial eligibility application. Client tracking and referral Application information is also shared but is not pre-populated into other related systems. Additionally, some agencies can access consumer information as referenced to them by the staff at the ADRC.

• **Q9: How is the consumer informed of financial eligibility status?**

Fourteen grantees reported that consumers in their state are informed of their financial eligibility status through a notification letter sent out by the Medicaid agency. Four grantees stated that in addition to a notification letter from Medicaid, the ADRC follows up with the consumer. ADRCs in four other states are informed of the consumer's status in addition to the notification letter sent to consumers. Only one grantee stated that the ADRC is the entity that directly informs the consumer of their status. **Seven** grantees reported a change since the ADRC in how consumers are notified of their status.

- In CNMI, the Medicaid office informs the ADRC of the consumer's financial eligibility status and the ADRC in turn provides this information to the consumer.
- In Pennsylvania, the County Assistance Office (CAO) sends consumers letters and the ADRC MIS flags consumers' accounts for follow-up to check in with consumers to see if they had received services or had other needs.

**FUNCTIONAL ELIGIBILITY:**

• **Q23: Is the applicant's LOC/ functional eligibility status tracked by the ADRC?**

Among fourteen grantees reporting that their ADRCs track applicants' LOC/functional eligibility status, eleven stated that they are able to do this because of co-location with the eligibility determination entity; two stated it is done by telephone at the ADRC's request; and one reported that eligibility is tracked electronically by the ADRC. **Seven** grantees reported this to be a change since the ADRC in how applicants' LOC/functional eligibility status is tracked by the ADRC. For example:

- As part of the ADRCs in Florida, co-located CARES staff track applicants' eligibility and report this back to the ADRC.
- In South Carolina, the ADRC is able to track applicants' LOC/functional eligibility status if they were initially involved with the consumer.

• **Q20e: Have there been MIS changes that allow exchange of information across agencies?**

Seven grantees reported currently having established MIS changes that allow for the exchange of eligibility information across agencies. **Five** of these grantees reported a changes in the MIS system since the ADRC came to their state. For example:

- The ADRC in Pasco Pinellas County, Florida reported the integration of two client databases (the aging network and CARES). This will be rolled out gradually across the state; when referrals are made, assessment data will be pre-populated. However, it was noted that CARES collects confidential information that the aging network will not have access to see.
  - In Indiana, there have been MIS changes to allow for ways to measure items such as the time since the consumer’s first phone call and numbers of individuals served.
  - Massachusetts reported MIS changes affecting the functional eligibility process through their Virtual Gateway and the development of the Referral Management System created to confidentially and electronically exchange consumer information across agencies.
- **Q22: How is the consumer informed of level of care (LOC)/functional eligibility status?**

For seven grantees, the ADRC is the entity that directly informs the consumer of their functional eligibility status. Ten grantees reported that consumers are informed of their status through a notification letter sent from the determination agency. Three grantees stated that in addition to a letter from the determination agency, the ADRC also follows up with the consumer. **One** grantee reported a change since the ADRC in how consumers are informed of their LOC/functional status. For example:

- In CNMI, the ADRC calls the consumer or goes to their house to inform them of there functional eligibility status.
- Massachusetts’ ASAP case managers are responsible for informing consumers about their LOC/functional eligibility status, with notification given via telephone and a mailed letter.
- In Maine, a notification letter is sent to the consumer, though they are also informed at the time their assessment is completed. Additionally, the consumer receives a call within 2-3 days confirming their status.
- The LOC screener verbally informs consumers of their eligibility status in Wisconsin’s ADRCs.

***Highly coordinated financial and functional eligibility determination:***

**FINANCIAL ELIGIBILITY:**

- **Q2: Which entity(ies) assists consumer with completing the financial application for each of your target populations?**

Grantees reported that the following entities assist the target populations with completing the financial eligibility application: 1) ADRC only (13 grantees); 2) ADRC and Medicaid (8 grantees); and 3) ADRC among others (2 grantees). **Nineteen** grantees reported a change since the ADRC in the entities assisting consumers in completing the financial application. For example:

- In Arkansas, the ADRC case workers assist consumers with completing their financial eligibility application and use portable scanners while in the field to gather the individual’s financial documentation.
- In Minnesota, case managers, staff in facilities where the consumer currently resides, and Linkage Line ADRC staff assist consumers. Additionally, the ADRC staff may also go to an individual’s home to provide extra assistance, if needed.

- Montana noted that their ADRCs help consumers assemble their financial eligibility application to reduce the number of trips to the Medicaid office due to not having the required documentation to complete the application.
  - The Pennsylvania ADRCs inform consumers of what documentation they need for their application to assist them to collect as much information as possible.
- **Q1: Which entity(ies) initiates the financial eligibility application with consumer and performs the initial financial intake for each of your target populations?**

This previously-discussed question was also considered relevant in showing coordination among entities in the financial eligibility determination process. In addition to ADRCs or Medicaid alone initiating applications with consumers, ADRCs also work with other entities to coordinate efforts. **Seventeen** of the grantees responding to this question reported a change from before the ADRC in their state.

- **Q1a: What initial information is collected from consumers?**

Three grantees stated that a full set of required financial information is collected initially and is transferred into the application. Among eleven grantees reporting collection of only preliminary information, six stated that this information is not transferred into the financial application; five grantees reported that the information is transferred into other applications. **Twelve** grantees reported a change since the ADRC in whether initial information (and what type) is collected from consumers.

- When the ADRCs in Pennsylvania conduct the preliminary financial eligibility screen, there is consideration of some basic financial information in order to allow for a judgment or “non-binding” determination to be made.
  - In South Carolina, consumers can complete an initial financial questionnaire where the information collected varies based on consumers’ needs.
- **Q7d: Are there written protocols for coordination across agencies (e.g., MOU/MOA) with Medicaid related to financial eligibility?**

As previously discussed, eleven grantees reported having written protocols (e.g., MOUs/MOAs) with their state’s Medicaid agency for coordination across agencies in relation to financial eligibility, and two grantees discussed planning efforts toward written protocols. Of these, **ten** stated this was a change since the ADRC in their states.

- **Q7e: Have there been MIS changes that allow exchange of information across agencies?**

As previously discussed, seven grantees reported currently having established MIS changes that allow for the exchange of financial eligibility information across agencies, with all **seven** reporting this to be a change since the ADRC.

- **Q3: Are financial eligibility workers co-located?**

Among seven grantees reporting co-location, four stated there is a full-time eligibility staff person co-located; one has a part-time staff person co-located; and two reported that the entire Medicaid office is co-located with the ADRC. **Four** grantees reported a change since the ADRC in the co-location of financial eligibility workers with the ADRC. For example:

- In Florida, eligibility workers are physically located at the Orlando and Pasco-Pinellas ADRC pilot sites, and virtually co-located at the Broward County pilot.

- Eligibility workers are co-located on a part-time basis in New Hampshire’s ADRCs.
- Medicaid Benefits Specialists are co-located at the ADRC and are available to help in the completion of consumer applications.
- In Arkansas, the financial eligibility determination staff are not co-located, but one worker is assigned to the ADRC to handle all their applications and given them priority attention.

**FUNCTIONAL ELIGIBILITY:**

- **Q16: Which entity conducts the functional assessment(s) for each of your target populations?**

Coordination has also been shown through the work of entities that conduct functional assessments with various target populations in states. In some instances, these assessments are done by governmental entities or private/non-profit providers not co-located with the ADRC. In others, grantees reported that the ADRC or a co-located entity with the ADRC does the functional assessments. **Eight** grantees stated a change since the ADRC in regard to which entities conduct the functional assessments in their states.

- **Q20d: Are there written protocols for coordination across agencies (e.g., MOUs/MOAs) for the functional eligibility process?**

As previously reported, eight grantees reported having written protocols for coordination across agencies in relation to the functional eligibility determination process. **Six** grantees stated that this was a change since the ADRC.

- **Q20e: Have there been MIS changes that allow exchange of information across agencies?**

Also previously reported, seven grantees reported currently having established MIS changes that allow for the exchange of eligibility information across agencies. **Five** of these grantees reported a changes in the MIS system since the ADRC came to their state.

- **Q19: Where are assessors located? Are staff co-located with the ADRC?**

Thirteen grantees reported that functional eligibility assessors are the ADRC staff themselves, or are co-located from other agencies/organizations with the ADRC on full-time or part-time bases. **Four** grantees reported a change since the ADRC in regard to functional eligibility assessors being co-located with the ADRC. For example:

- In Arkansas, functional eligibility assessors for waiver programs are co-located with the ADRC; the staff from the LTC Division (determination agency) is not co-located.
- In Florida, assessors are physically co-located in Orlando and Pasco-Pinellas Counties, and are virtually co-located in the Broward County ADRC.
- In Maryland, the AIRS staff who conduct the functional eligibility for adults over 18 are co-located in both ADRC pilots.

*Shortened time from intake to eligibility determination:*

Some grantees were also able to report on the processing time required from intake to eligibility determination for both the financial and functional eligibility processes. In some cases, the time has been shortened due to the ADRC’s involvement. In others, grantees were either unable to determine the time

frame for this process (before or after the ADRC), or the processing time remained largely similar to that which was seen before the ADRC in states.

- **Q12: Average processing time (in days) for financial eligibility from start of application to determination**

There was often difficulty in grantees providing detailed responses regarding the actual amount of time the process from initial intake to final determination took in the past, as well as any changes since the ADRC. In cases where grantees were unsure if this information, or did not have the preliminary data, they stated the anecdotal belief that the ADRC is speeding things up through their efforts of assisting consumers with collecting the required documentation and completing their applications. For example:

- In Arkansas, the full eligibility determination processing time took approximately 45 days before the ADRC. After the ADRC, the time for determination for applications submitted by the ADRC staff was almost cut in half (20-22 days, on average).
- In Florida's Pasco Pinellas county, the average time since the ADRC is 3-10 days. This information was not available before the ADRC.
- In Indiana, average eligibility processing time before the ADRC ranged from 60-180 days; following the ADRC, the average range was reported to be closer to 60 days.
- Maryland's average determination process was greater than 240 days before the ADRC, which has been reduced to approximately 40 days after the ADRC. The state has moved to a continuous enrollment system to facilitate the process.

- **Q25: Average processing time (in days) for LOC determination from start of application to determination**

Similarly, there was also some difficulty in grantees providing responses regarding the amount of time it takes for LOC determination from initial screening to final determination in the past, as well as any changes since the ADRC. For example:

- In CNMI, the LOC determination time frame ranged from 60 to 90 days before the ADRC. Following the ADRC, the processing time is approximately 60 days but can be as short as 1 day if the individual's need is great.
- In Illinois, the eligibility or pre-admission process with the presence of the ADRC is completed in one day, but takes approximately 15 days for the consumer to begin services. This information was not available for before the ADRC.
- In Indiana, the LOC determination time process is approximately 1 day for Medicaid, 1 day for home care, and 1 day for hospitals to nursing facilities with the presence of the ADRC. Pre-ADRC, the processing time was approximately 90 or more days, including 20-30 day for home care, 1 for hospitals to nursing facilities, with waitlists for some state programs.
- In New Hampshire, the determination process took 3 months or more before the ADRC. Following the ADRC, the process takes approximately 6 weeks though this is dependent on the availability of the nurse assigned to the individual's case.

*ADRC is informed of consumers' status (on wait lists for public LTC programs) and conducts individual follow-up:*

We did not directly ask grantees whether they are informed about consumers' status in relation to wait lists for public LTC programs. However, in regard to tracking consumers' wait list status, eighteen and fourteen grantees reported the ability to track applicants' financial and functional eligibility statuses (respectively),

which may allow for tracking the consumer's wait list status (if applicable). Additionally, nine and ten grantees reported that the ADRC is informed of consumers' financial and functional eligibility status, respectively – either through the determination agency or by following up directly with the consumer during or after the determination process. Receipt of eligibility status information may offer another opportunity for ADRCs to reach out and conduct individual follow-up, particularly when consumers are found to be ineligible for services.

MIS changes may also be a useful mechanism for allowing for the exchange of information that could facilitate the process of tracking consumers and conducting individual follow-up, as well as determining their wait list status (if applicable). Seven grantees reported MIS changes for both financial and functional eligibility determination processes.

### *Institutional Placements and Nursing Home Diversions/Transitions*

In relation to the following fully functioning metrics focused on institutional placements and nursing home diversions/transitions, grantees were asked generally about their involvement with nursing home diversions:

- Uniform criteria to assess risk of institutional placement
- Reduction in rate of institutional placement in ADRC service area
- ADRC tracks diversions and transitions

These three questions might be used to indirectly answer how ADRCs are currently tracking diversions and transitions. In addition to work with critical pathways and other on nursing home transitions, some grantees also reported involvement with the Money Follows the Person grant in their states.

#### *ADRC tracks diversions and transitions:*

- Illinois reported a long history of nursing facility transition activities in their state, with the ADRC's Case Coordination Units (CCUs) actively involved in transitions and submitting plans of care for the ADRC's approval. The CCUs also follow-up and do financial eligibility screenings with these individuals.
- In Indiana, some ADRC options counselors are assigned to specific nursing homes that they visit regularly and interact with the homes' social workers to identify individuals interested in transition. The ADRC then tags people entering nursing homes if there is a possibility of them being transitioned out.
- In Massachusetts, work is done by the Community Transition Team to assist people with transitioning and staying in the community. The ADRC's ASAPs manage a Medicaid-mandated program that requires the ASAP's nurses to visit nursing homes when residents convert to Medicaid status to assist in facilitating transitions.
- Wisconsin statutes and rules require hospitals, nursing homes, and assisted living providers to refer individuals to the ADRC at the time the facility accepts an application or conducts an assessment. ADRCs then make contact with the individual to offer a pre-admission consultation that can be useful in diverting people from premature admission to facilities or reduce the likelihood of people having to move from an assisted living setting after they have spent down.

*ADRC can report data on proportion of consumers requesting services and actually receiving them:*

The 2006 Streamlining Access Survey also did not include questions about grantees' ability to report data on the proportion of consumers requesting and receiving services; this information is collected through the grantees' Semi-Annual Reporting Tools (SARTs). However, the following questions that have been discussed previously in this report may be considered for indirectly examining this metric:

**FINANCIAL ELIGIBILITY:**

- **Q1:** Which entity(ies) initiates the financial eligibility application with consumer and performs the initial financial intake for each of your target populations?
- **Q2:** Which entity assists consumer with completing the financial application for each of your target populations?
- **Q7d:** Are there written protocols for coordination across agencies (e.g., MOUs/MOAs) with Medicaid related to financial eligibility?
- **Q7e:** MIS changes that allow exchange of information across agencies (Financial)
- **Q10:** Is applicant's financial eligibility status tracked by ADRC?

**FUNCTIONAL ELIGIBILITY:**

- **Q13:** Which entity(ies) conducts an initial screen for each of your target populations?
- **Q16:** Which entity conducts the functional assessment(s) for each of your target populations?
- **Q20d:** Are there written protocols for coordination across agencies (e.g., MOUs/MOAs) for the functional eligibility process?
- **Q20e:** Have there been MIS changes that allow exchange of information across agencies?
- **Q22:** How is consumer informed of level of care/functional eligibility status?
- **Q23:** Is applicant's LOC/ functional eligibility status tracked by ADRC?

*Signed Streamlining Access Plan*

This recommended metric in the fully functioning ADRC access section was not directly asked in the 2006 Streamlining Access Survey. At this time, the 2005 ADRC grantees are the only cohort required to complete a streamlining access plan.

## Appendix A

# 2006 STREAMLINING ACCESS SURVEY

Financial Eligibility for Medicaid LTC	
1	Which entity(ies) initiates financial eligibility application with consumer/ performs initial financial intake for each of your target populations?
1a	What information is collected initially? If initial process changed with ADRC initiative, describe changes (e.g. ADRC collects preliminary info and shares with financial worker)
1b	Is self-declaration of financial resources permitted? (Y/N) If so, explain.
1c	Is presumptive eligibility permitted? (Y/N) If so, explain
2	Which entity assists consumer with completing the financial application for each of your target populations? <i>Note: may be same entity that initiates application</i>
3	Where are financial legibility workers located? Are staff co-located?
4	Do consumers complete a single financial application for all public LTC programs or complete different applications for different LTC programs? If multiple, describe.
5	Is electronic financial Medicaid application available? (Y/N)
6	How can a financial application be submitted:
6a	Mail-in? (Y/N)
6b	In-person? (Y/N)
6c	Online consumer? (Y/N)
6d	Online professional? (Y/N)
7	Have any of the following operational changes occurred: <i>describe in notes section if changes related to ADRC initiative or unrelated</i>
7a	Forms redesigned to be more user friendly or shorter (describe)
7b	Number of forms reduced and/or integration of forms (describe)
7c	Length of forms shortened (describe)
7d	Written protocols for coordination across agencies e.g., MOU/MOA (describe)
7e	MIS changes that allow exchange of information across agencies. (Describe what info is exchanged and method used)
8	Which entity(ies) is responsible for determining financial eligibility for each of your target populations? For All LTC public programs? For Other public programs (i.e., TANF, Food Stamps, LIHEAP)
9	How is consumer informed of financial eligibility status? (Does consumer receive notification - how? Describe which entities are in contact with consumer? Does consumer contact program staff or does program staff contact consumer?)
10	Is applicant's financial eligibility status tracked by ADRC? (Y/N) If so, describe.
11	No. of entities consumer must interact with to receive financial eligibility determination?
12	Avg. processing time (in days) for financial eligibility from start of application to determination? Note how grantee defines "start of application"
Level of Care (LOC) & Functional Eligibility for Medicaid LTC	
13	Which entity(ies) conducts an initial screen for each of your target populations?
13a	Is the same screening process used for all public LTC programs (including same screening tool)? For all populations?
13b	Does information from initial screen pre-populate other forms (i.e., for pre-admission screen and/or assessment)?
14	Is a pre-admission screen conducted? (Y/N) If so, describe who conducts it (note which entity and if ADRC, are there dedicated staff), when it takes place and for which populations.
15	Do consumers receive a single assessment for all public LTC programs or do they receive different assessments depending on the LTC program or service?

16	Which entity conducts the functional assessment(s) for each of your target populations? Is the assessment different than the pre-admission screen?
17	Where are assessments conducted:
18a	Over the telephone (Y/N)
18b	In-home (Y/N)
18c	Hospital (Y/N)
18d	Nursing or Rehab Facility (Y/N)
18e	In Office (Y/N)
19	Where are assessors located? Are staff co-located?
20	Have any of the following operational changes occurred: <i>describe in notes section if changes related to ADRC initiative or unrelated</i>
20a	Consumers may complete screen or portion of functional assessment online
20b	Assessment forms redesigned to be more user friendly or shorter (describe)
20c	No. of steps reduced and/or integration of forms (describe if physician signature eliminated, uniform assessment across programs or populations or both)
20d	Written protocols for coordination across agencies e.g., MOU/MOA (describe)
20e	MIS changes that allow exchange of information across agencies. (Describe what info is exchanged and method used)
21	Which entity is responsible for LOC determination/ functional eligibility determination for each of your target populations?
22	How is consumer informed of level of care/functional eligibility status? (Does consumer receive notification - how? Describe which entities are in contact with consumer? Does consumer contact program staff or does program staff contact consumer?)
23	Is applicant's LOC/ functional eligibility status tracked by ADRC? (Y/N) If so, describe.
24	No. of entities consumer must interact with to receive LOC determination?
25	Avg. processing time (in days) for LOC determination from initial screen to determination?
<b>Totals</b>	
26	Total no. of entities consumer must interact with for entire eligibility process (from initial request for long term support to eligibility determination)
27	Avg. processing time (in days) for entire eligibility process (from initial request for long term support to eligibility determination)
<b>Other Access Functions</b>	
28	Does ADRC have a role in nursing home transition activities? (Y/N) If so, describe.
29	Is formal options counseling provided to consumers? (Y/N) If so, when it is provided, who provides it, and for whom it is provided?
30	Major ways ADRC intervenes in critical pathways

## ADRC-TAE Streamlining Access Survey Results 2003 and 2004 Grantees

### Financial Eligibility

<b>Which entity(ies) initiates the financial eligibility application with consumer and performs the initial financial intake for each of your target populations?</b>	
4	ADRC only
12	ADRC and Medicaid
4	ADRC, Medicaid, and other entities
3	Medicaid only

<b>What information is collected initially?</b>	
3	Full info collected, and transferred into application
5	Preliminary info transferred to Medicaid or into application
6	Preliminary info collected, not transferred into application (used to trigger starting application, to determine where to direct person)
9	No preliminary info collected by ADRC

<b>Is self-declaration of financial resources permitted?</b>	
1	Yes
1	Planning
21	No

<b>Is presumptive eligibility permitted?</b>	
1	Yes
2	Planning
20	No

<b>Which entity assists consumer with completing the financial application for each of your target populations?</b>	
13	ADRC only
8	ADRC and Medicaid
2	ADRC among others

<b>Are financial eligibility workers co-located?</b>	
4	Yes, staff person co-located in ADRC full-time
1	Yes, staff person co-located in ADRC part-time
2	Yes, Medicaid office is co-located in ADRC
1	Planning
15	No

**Do consumers complete a single financial application for all public LTC programs or complete different applications for different LTC programs?**

9	Single application
1	Planning single application
12	Multiple applications
1	Unknown

**Is an electronic financial Medicaid application available?**

20	Yes
3	No

**Submitted Mail-in?**

23	Yes
----	-----

**Submitted In-person?**

23	Yes
----	-----

**Submitted Online by consumer?**

7	Yes
4	Planning
12	No

**Submitted Online by professional?**

7	Yes
4	Planning
12	No

**Forms redesigned to be more user friendly or shorter**

11	Yes
2	Planning
9	No
1	Unknown

**Number of forms reduced and/or integration of forms**

10	Yes
2	Planning
11	No

**Length of forms shortened**

5	Yes
2	Planning
12	No
4	Unknown

**Written protocols for coordination across agencies e.g.,  
MOU/MOA with Medicaid related to Financial Eligibility**

11	Yes
2	Planning
4	No, no need
6	No

**MIS changes that allow exchange of information across agencies**

7	Yes
2	Planning
13	No
1	Unknown

**Which entity(ies) is responsible for determining financial eligibility  
for each of your target populations?**

7	Co-located Medicaid staff
2	Medicaid Staff (off-site, but with staff assigned to ADRC clients)
5	Medicaid Local (off-site, no specific ADRC contact)
9	Medicaid State (off-site, no specific ADRC contact)

**How is consumer informed of financial eligibility status?**

1	ADRC informs consumer
4	Letter from Medicaid, ADRC follows up with consumer
4	Letter from Medicaid, ADRC informed
14	Letter from Medicaid

**Is applicant's financial eligibility status tracked by ADRC?**

4	Yes, because of co-location
8	Yes, electronically by ADRC
6	Yes, by telephone upon request
5	No

**No. of entities consumer must interact with to receive  
financial eligibility determination?**

6	1
15	Up to 2
2	Up to 3

## Functional Eligibility

<b>Which entity(ies) conducts an initial screen for each of your target populations?</b>	
11	ADRC does formal screen
6	ADRC does informal screen-no tool used
4	Another entity (not ADRC) does formal screen
2	No screen done by anyone

<b>Is the same screening process used for all public LTC programs (including same screening tool)? For all populations?</b>	
6	Same tool for all populations / programs
3	Planning for same tool for all populations / programs
3	Same tool for multiple, but not all
5	Same process used for all - no tool
4	Different screening tools for each
2	No screening tool or process used

<b>Does information from initial screen pre-populate other forms?</b>	
7	Yes
8	No
1	Unknown
7	Not Applicable

<b>Is a pre-admission screen conducted?</b>	
11	Yes, by ADRC
10	Yes, by other entity (not the ADRC)
1	Unknown
1	Not Applicable (No NF)

<b>Do consumers receive a single assessment for all public LTC programs or do they receive different assessments depending on the LTC program or service?</b>	
8	Same assessment for all populations / programs
4	Planning for same assessment for all
2	Same assessment for several, but not all
8	Different assessments for each
1	Unknown

<b>Which entity conducts the functional assessment(s) for each of your target populations?</b>	
12	ADRC, or staff co-located with ADRC
11	Other entity, not co-located with ADRC

Assessments done over the telephone	
7	Yes
14	No
2	Unknown

Assessments done in Nursing or Rehab Facility	
20	Yes
2	Unknown
1	Not Applicable (no NF)

Assessments done in Hospital	
20	Yes
1	No
2	Unknown

Assessments done in Office	
18	Yes
4	No
1	Unknown

Assessments done in Home	
22	Yes
1	Unknown

Are staff co-located with the ADRC?	
11	Yes, assessors are ADRC staff
2	Yes, assessors co-located full-time
1	Planning co-location
8	No co-location
2	Unknown

Consumers may complete screen or portion of functional assessment online	
1	Yes
1	Planning
21	No

Assessment forms redesigned to be more user friendly or shorter	
11	Yes
1	Planning
10	No
1	Unknown

# of steps reduced and/or integration of forms since beginning of ADRC grant	
10	Yes
13	No

<b>Written protocols for coordination across agencies e.g., MOU/MOA</b>	
8	Yes
1	Planning
5	No, no need (e.g. both orgs in same department)
9	No

<b>MIS changes that allow exchange of information across agencies</b>	
7	Yes
1	Planning
15	No

<b>Which entity is responsible for LOC determination/ functional eligibility determination for each of your target populations?</b>	
10	ADRC staff, or staff co-located with ADRC
13	Other entity off-site

<b>How is consumer informed of level of care/functional eligibility status?</b>	
7	ADRC informs consumer
3	Letter from determination agency, ADRC follows up with consumer
10	Letter from determination agency, no routine ADRC follow up
3	Unknown

<b>Is applicant's LOC/ functional eligibility status tracked by ADRC?</b>	
2	Yes, by telephone upon ADRC request
1	Yes, electronically by ADRC
11	Yes, because of co-location
9	No*

\*Two states have staff who conduct LOC assessments co-located with an ADRC, but ADRC staff do not routinely track eligibility status.

<b>No. of entities consumer must interact with to receive LOC determination?</b>	
4	1
15	Up to 2
2	Up to 3
1	Up to 4
1	Varies

## Fully Functioning Single Entry Point System/ADRC

Program Component	Criteria/ Description	Recommended Metrics
<p><b>Awareness &amp; Information</b></p>	<p><i>Public education; information on long-term support options.</i></p> <ul style="list-style-type: none"> <li>ADRCs serve as highly visible and trusted places where people can turn for the full range of long-term support options</li> <li>Actively promote public awareness of both public and private long-term support options, as well as awareness of the ADRC, especially among underserved and hard-to-reach populations.</li> </ul>	<ul style="list-style-type: none"> <li>The SEP/ADRC has a proven <b>outreach and marketing plan</b> in place that takes into consideration: (a) culturally diverse, underserved and unserved populations, their family caregivers, and the professionals who serve them through focused outreach and community education; (b) the identification of unique needs of the different populations being served; (c) a strategy to assess the effectiveness of the outreach and marketing activities; and (d) a feedback loop to modify activities as needed.</li> <li>The SEP/ADRC has a <b>comprehensive resource database</b> which includes information about the range of long term support options in the SEP/ADRC service area. Information regarding providers, programs, and services available in the SEP/ADRC service area (including for private-payment) is collected into a central database. Resources included in the database conform to established Inclusion/Exclusion policies. A system is in place for updating and ensuring the accuracy of the information provided. The database is preferably accessible to the public via a comprehensive <b>website</b> and is user friendly, searchable and accessible to persons with disabilities.</li> <li>The SEP/ADRC may have a single or multiple entry points, but all operating entities provide <b>consistent and uniform information</b>.</li> <li>The SEP/ADRC is serving <b>private pay</b> consumers in addition to those that require public assistance.</li> </ul>
<p><b>Assistance</b></p>	<p><i>Long-term support options counseling; benefits counseling; employment options counseling; referral to other programs and benefits; crisis intervention; helping people to plan for their future long-term support needs.</i></p> <ul style="list-style-type: none"> <li>The ADRC will provide information and counseling to help people assess their potential need and eligibility for all available long-term support options, both public and private.</li> <li>ADRC has the capacity to link consumers with needed support through appropriate referrals to other programs and benefits and has the ability to track client intake, needs assessment, and care plans.</li> <li>ADRC has established collaborative relationships with programs that provide home and community-based services including SHIP, NFCSP, Alzheimer’s Disease services, health promotion and disease prevention programs, transportation, employment, housing, adult education and others.</li> <li>ADRC consistently conducts follow-up when needed to determine outcome of options counseling.</li> <li>ADRC enables people to make informed, cost-effective decisions</li> </ul>	<p><u>Options Counseling</u></p> <ul style="list-style-type: none"> <li>SEP/ADRC has the capability, either in-house or through close coordination with operating partners, to provide accurate and comprehensive long term support options counseling to any consumer who requests it.</li> <li>SEP/ADRC operating entities administer standard intake and screening instruments.</li> <li>Evidence that protocols are in place to identify consumers who will be offered options counseling. At a minimum, this will include consumer that have gone through a comprehensive assessment process.</li> <li>Options counseling sessions: (a) entail individualized assistance; (b) are provided in a uniform manner to all consumers by the SEP/ADRC and its partners through protocols or standard operating procedures; and (c) are conducted by staff who are qualified to provide objective assistance to consumers in the process of making informed decisions, as evidenced by certification requirements and/or training/cross-training practices.</li> <li>Evidence that options counseling offered enables people to make informed, cost-effective decisions about long-term care services.</li> <li>SEP/ADRC has systematic processes, either in house or through close coordination with partners, to provide information, referral and access to services. These services include, at a minimum: <ul style="list-style-type: none"> <li>Public benefits (OAA, Medicaid, Medicare including new Medicare Modernization Act benefits, state revenue programs and others)</li> </ul> </li> </ul>

	<p>about long term care.</p> <ul style="list-style-type: none"> <li>• ADRC has process to ensure that people are connected to the appropriate crisis intervention services.</li> <li>• ADRC assists individuals to plan for future long-term care needs.</li> </ul>	<ul style="list-style-type: none"> <li>- Employment</li> <li>- Health promotion/disease prevention</li> <li>- Transportation</li> <li>- Crisis/Emergency services</li> <li>- Services for family caregivers</li> <li>- Residential care including assisted living</li> </ul> <p><u>Referrals and Follow Up</u></p> <ul style="list-style-type: none"> <li>• SEP/ADRC has the ability to track referrals made.</li> <li>• SEP/ADRC consistently conducts follow-up to determine outcome of options counseling</li> </ul> <p><u>Crisis Intervention</u></p> <ul style="list-style-type: none"> <li>• SEP/ADRC responds to situations requiring short-term assistance to support an individual until a plan for long-term support services is in place.</li> <li>• Short-term case management is provided in house or is contracted out</li> </ul> <p><u>Future Long Term Support Needs Planning</u></p> <ul style="list-style-type: none"> <li>• Evidence of one of the following: (1) SEP/ADRC is involved with Own Your Own Future Campaign; (2) SEP/ADRC is a pilot HECM site; or (3) SEP/ADRC provides futures planning in-house or contractually by staff who possess specific skills related to LTC needs planning and financial counseling.</li> </ul>
<p><b>Access</b></p>	<p><i>Eligibility screening; assistance in gaining access to private-pay long-term support services; comprehensive assessment; programmatic eligibility determination; Medicaid financial eligibility determination that is integrated or closely coordinated with the Resource Center services; one-stop access to all public programs for community and institutional long-term support services.</i></p> <ul style="list-style-type: none"> <li>• ADRC serves as the entry point to publicly funded long term care.</li> <li>• The ADRC has in place necessary protocols and procedures to facilitate access (intake, eligibility, assessment) to public programs that is integrated or so closely coordinated that the process is seamless for consumers.</li> <li>• ADRC support helps to reduce the cost of long term care by delaying or preventing the need for more expensive public long term care services</li> </ul>	<ul style="list-style-type: none"> <li>• SEP/ADRC has a single, standardized entry process. For decentralized models in which operating entities retain responsibility for their respective services, the entry process is coordinated with each other to integrate access to those services and administered and overseen by a coordinating entity.</li> <li>• Eligibility data for public programs are communicated to appropriate SEP/ADRC staff and SEP/ADRC is able to track consumers' eligibility status.</li> <li>• Financial and functional eligibility determination is highly coordinated.</li> <li>• SEP/ADRC has a plan for reducing the average time from first contact to eligibility determination and the average time is below current time requirement.</li> <li>• In localities where waiting lists for public LTC programs or services exist, there is a process by which the SEP/ADRC is informed of consumers who are on the wait list and the SEP/ADRC conducts follow-up with those individuals.</li> <li>• There is a process by which the SEP/ADRC is informed of consumers who are determined ineligible for public LTC programs or services and the SEP/ADRC conducts follow-up with those individuals.</li> <li>• There is a reduction in the rate of institutional placement in the SEP/ADRC service area.</li> <li>• SEP/ADRC tracks diversions and transitions (i.e., # nursing home diversions attempted and # of successful diversions; # nursing home relocations to community completed)</li> <li>• SEP/ADRC can report the proportion of consumers requesting services that actually receive them.</li> <li>• SEP/ADRC has a plan for streamlining access to long-term care signed by the State Medicaid Agency, State Unit on Aging and the State agency(s) representing target</li> </ul>

		<p>population(s) of people with disabilities. (Streamlining Access Plan)</p> <ul style="list-style-type: none"> <li>SEP/ADRC uses uniform criteria to assess risk of institutional placement in order to target support to individuals at high-risk.</li> </ul>
<b>Target Populations</b>	<p><i>Resource Center grantees must serve the elderly and at least one <b>target population</b> of people with disabilities (e.g. physical; developmental/mental retardation; mental illness). ADRC projects should move towards the goal of serving persons with disabilities of all ages and types.</i></p>	<ul style="list-style-type: none"> <li>Actual served against population estimate, by target population.</li> <li>SEP/ADRC demonstrates competencies relating to all of the populations it serves.</li> <li>SEP/ADRC is accessible to all of the populations it serves.</li> <li>There is evidence that the SEP/ADRC is moving towards the goal of serving all persons with disabilities.</li> </ul>
<b>Critical Pathways to Long Term Support</b>	<p><i>Resource Centers will create formal linkages between and among the <b>critical pathways to long-term support</b>.</i></p>	<ul style="list-style-type: none"> <li>SEP/ADRC has “formal linkages” that involve all three of the following components that are updated on an ongoing basis: <ul style="list-style-type: none"> <li>(1) providing training and education about the SEP/ADRC to critical pathway providers (CPPs);</li> <li>(2) involving CPPs in advisory board representation; and</li> <li>(3) establishing protocols for referrals, particularly with hospitals and LTC facilities.</li> </ul> </li> </ul>
<b>Partnerships &amp; Stakeholder Involvement</b>	<p><i>ADRC’s must have the documented support and active participation of the Single State Agency on Aging, the Single State Medicaid Agency and the State Agency(s) serving the target populations(s) of people with disabilities.</i></p> <p><i>Resource Centers must establish strong partnerships with the <b>State Health Insurance Assistance Program (SHIP)</b> and other programs instrumental to ADRC activities. Examples of other programs include Alzheimer’s disease programs, Area Agencies on Aging, Centers for Independent Living, Developmental Disabilities Councils, Information and Referral/2-1-1 programs, Long-Term Care Ombudsman programs, housing agencies, transportation authorities, State Mental Health Planning Councils, One-Stop Employment Centers and other community-based organizations.</i></p> <p><i>Resource Center programs must <b>meaningfully involve stakeholders, including consumers</b>, in planning, implementation and evaluation activities.</i></p>	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>SEP/ADRC has an agreement with Medicaid agency to ensure that access to Medicaid benefits is as streamlined as possible for consumers; MOU describes explicit role of each agency and information sharing policies.</li> </ul> <p><u>Aging or Disability Partner</u></p> <ul style="list-style-type: none"> <li>There is evidence of collaboration, including formal agreements, at the state and pilot level between aging and disability partners.</li> <li>Aging and Disability operating entities have protocols for information sharing with one another and perform cross-training.</li> </ul> <p><u>Stakeholders</u></p> <ul style="list-style-type: none"> <li>If the SEP/ADRC and SHIP are operated by separate entities, there is a MOU or Interagency Agreement establishing, at a minimum, a protocol for mutual referrals.</li> <li>There is evidence of strong collaboration with programs and services instrumental to SEP/ADRC activities including home and community-based service providers, residential care alternatives including assisted living, institutional care providers, hospitals and other critical pathways and others.</li> </ul> <p><u>Consumers</u></p> <ul style="list-style-type: none"> <li>Formal mechanisms for consumer involvement have been established, including consumer representation on the state/local SEP/ADRC advisory board or governing committee and there is evidence that consumers have been involved in planning, implementation and evaluation activities.</li> </ul>
<b>IT/MIS</b>	<p><i>The ADRC program will have a <b>management information system</b> that supports the functions of the program including tracking client intake, needs assessment, care plans, utilization and costs.</i></p>	<ul style="list-style-type: none"> <li>SEP/ADRC is able to submit evidence that shows a management information systems that can support the program functions.</li> <li>SEP/ADRC can submit evidence of reports on the following: <ul style="list-style-type: none"> <li># of unduplicated consumers YTD</li> <li>Referrals for current month, referring agency/entity, # referrals under age 60; # referrals age 60 and older.</li> </ul> </li> </ul>

		<p>(Heart of Texas)</p> <ul style="list-style-type: none"> <li>o Types of assistance provided</li> <li>o Timing of eligibility determinations</li> <li>o Information regarding level of impairment and preferred support need</li> <li>o Disposition/placements (e.g., waiver, institution, etc.)</li> </ul> <ul style="list-style-type: none"> <li>• SEP/ADRC has established an efficient process for information sharing through electronic exchange of information with external entities from intake to service delivery.</li> </ul>
<p><b>Evaluation Activities</b></p>	<p><i>At a minimum, ADRCs must have <b>performance goals and indicators</b> related to visibility, trust, ease of access, responsiveness, efficiency and effectiveness.</i></p>	<ul style="list-style-type: none"> <li>• Evidence that the SEP/ADRC is measuring performance related to the established indicators.</li> <li>• SEP/ADRC can demonstrate ability to develop reports summarizing issues and making recommendations for corrective action or quality improvement based on performance indicators.</li> <li>• SEP/ADRC has used information obtained from consumer satisfaction evaluations to improve performance.</li> <li>• SEP/ADRC can demonstrate ability to document the impact on nursing home use</li> <li>• SEP/ADRC can demonstrate the ability to document the impact on the use of home and community based services.</li> <li>• SEP/ADRC can demonstrate a reduction in the average time from first contact to eligibility determination for publicly funded home and community-based services.</li> <li>• SEP/ADRC informs consumers of complaint and grievance policies and has the ability to track and address complaints and grievances.</li> <li>• SEP/ADRC has a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered.</li> </ul>
<p><b>Staffing and Resources</b></p>	<ul style="list-style-type: none"> <li>• Capacity</li> <li>• Quality</li> <li>• Any conflicts of interest have been addressed</li> <li>• Specialized training/gaps identified</li> <li>• Private and public funding opportunities are pursued to create sustainable programs.</li> </ul>	<ul style="list-style-type: none"> <li>• SEP/ADRC has adequate capacity to assist consumers in a timely manner with long term support requests and referrals, including referrals from critical pathway providers</li> <li>• SEP/ADRC has an individual who is assigned to be the overall director/manager/coordinator of all SEP/ADRC operations. Especially when SEP/ADRC functions occur in more than one location or agency, it is important to have an overall coordinator or manager with sufficient authority to maintain quality processes in an SEP/ADRC)</li> <li>• SEP/ADRC has conducted an assessment of potential funding sources such as FFP, foundations and community organizations</li> </ul>