

# Assessing ADRC Projects' Progress and Accomplishments: State Project Evaluation Guidelines

## Overview

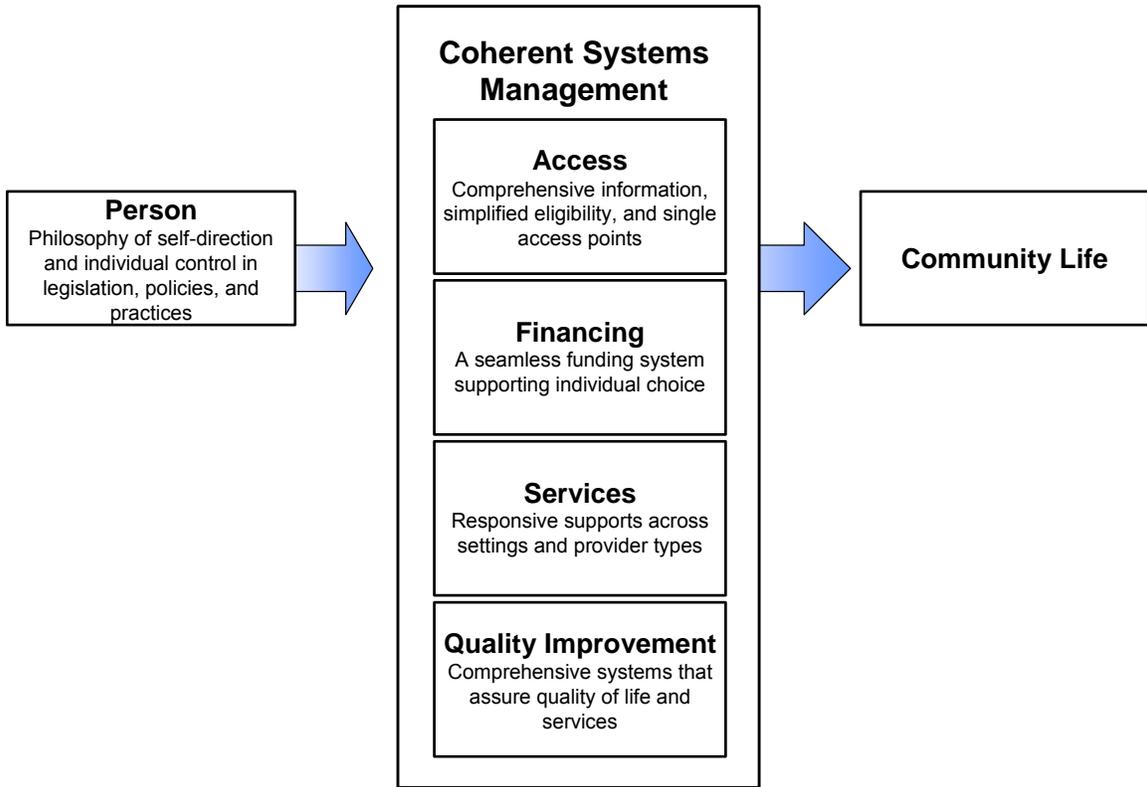
To enable ADRC grantees to systematically track the progress and accomplishments of their programs, ADRC-TAE staff developed an evaluation framework and, based on the framework, suggested research questions and recommended minimum dataset elements and data sources to address the research questions. At a minimum, AoA and CMS request that all ADRC grantees include these research questions as part of their ADRC evaluation. For grantees that wish to expand the program evaluation beyond this minimum expectation to meet state/local needs, *Appendix A* provides additional potential indicators related to the program goals that could be used. A suggested consumer satisfaction survey is also presented.

Focusing on project progress and accomplishments will aid grantees in: 1) determining whether their efforts have been successful, 2) continually improving their programs, and 3) making the case to decision makers and the community that the ADRC initiative should be continued and expanded.

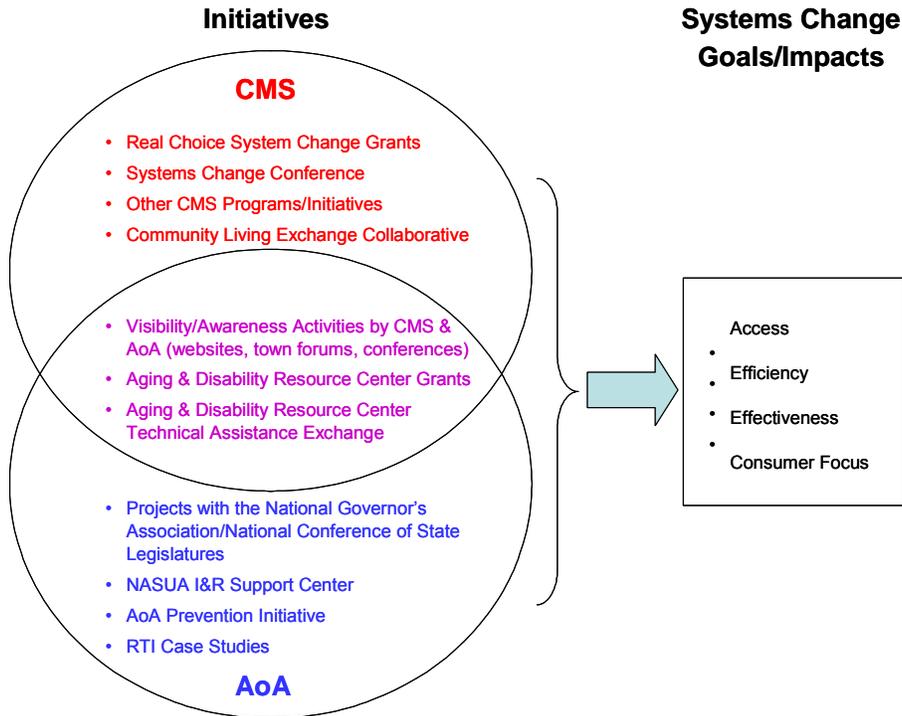
## Evaluation Framework

The ADRC evaluation framework stems from the larger Department of Health and Human Services (DHHS) framework and AoA-CMS major initiatives and system change goals. Both AoA and CMS view grantee efforts as central to providing models for delivery systems nationwide. As a result, it is critical to develop a framework that will allow for lessons learned and quantify the effects of the ADRC programs. *Exhibit 1* presents the broad DHHS systems framework for striving to support individuals with disabilities to engage in community life on their own terms. The ADRCs embody the Access portion of the coherent systems management efforts. The ADRCs also constitute a joint AoA-CMS initiative that complement several of each agencies own initiatives encouraging system change related to access, efficiency, effectiveness and a consumer focus (*Exhibit 2*).

**Exhibit 1: DHHS Systems Framework**



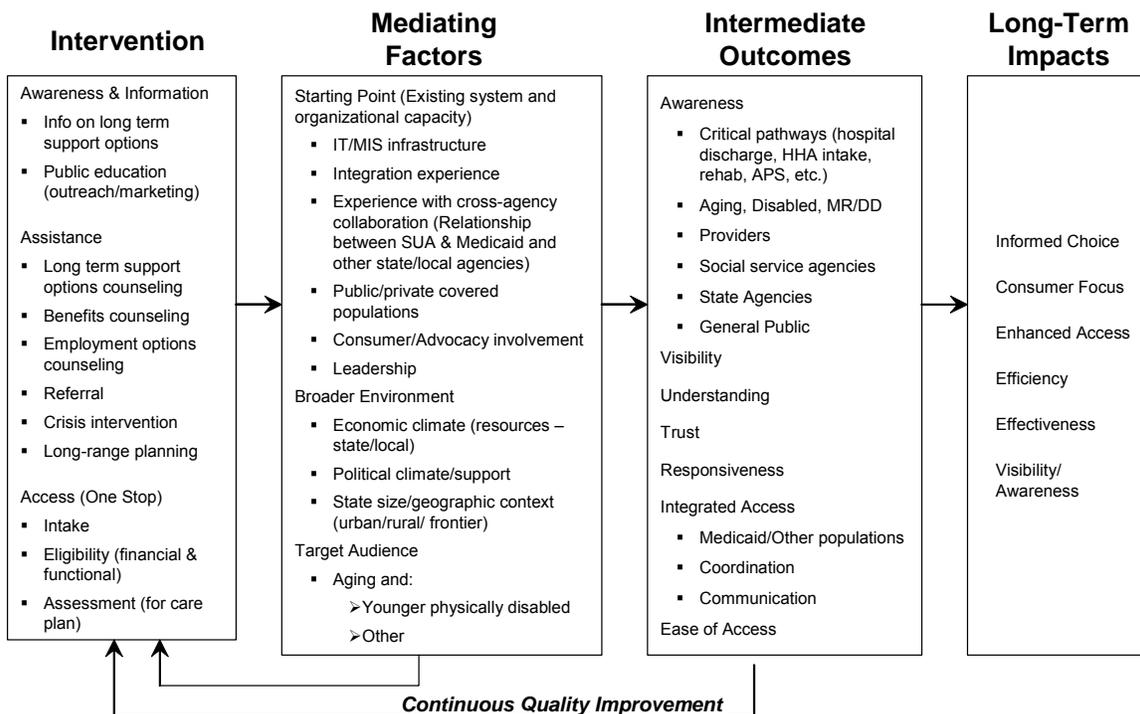
**Exhibit 2: ADRC Initiative Within AoA and CMS Initiatives and Goals**



Using these two broader frameworks, ADRC-TAE staff developed an ADRC specific evaluation framework that delineates ADRC interventions, mediating factors, intermediate outcomes and desired long-term impacts (*Exhibit 3*). The interventions fall into the three broad mandates for the grants to: 1) increase awareness and provide reliable information; 2) provide assistance in seeking services and making decisions; and 3) simplifying and streamlining access to public programs through a physical or virtual one stop shop. Each grantee’s progress will be influenced by numerous mediating factors, including their starting point related to infrastructure, previous experience, collaboration, leadership, the broader political and economic environment, geographic considerations, and target audiences. Intermediate outcomes expected to manifest over the first three years of implementation include:

- Awareness among a number of internal and external groups, including those critical pathways where institutional versus community placement decision are often made;
- Visibility of the ADRCs and the aging and disability networks role in the access to long term care supports;
- Fostering understanding among the target populations, providers and the critical pathways of available resources and options through the awareness and information activities;
- Gaining the trust of consumers, their families, providers and others by providing responsive information, assistance and systems of access; and
- Integrated access to public programs through combining intake, eligibility and assessment processes that, along with visibility, fosters ease of access.

### Exhibit 3: ADRC Evaluation Framework



The interventions and intermediate outcomes will manifest in the long-term impacts of consumer focus, enhanced access, efficiency, and visibility/awareness.

## Research Questions

For the minimum grantee evaluations, both process and outcome questions in five core areas are proposed:

### *Implementation Process*

- What were the major facilitators for implementing and achieving the required ADRC elements?

Required elements include: 1) Seamless system for consumers; 2) Integrated access – streamlined eligibility; 3) Shift of institutional bias – critical pathways; 4) Meaningful involvement of consumers & other stakeholders; 5) Partnership between Aging Network and Medicaid; 6) Investment in MIS that supports goals of ADRC; 7) Performance measurement – CQI, outcomes; and 8) Sustainability

- What were the major barriers that impeded the implementation of required ADRC elements?

### *Visibility/Trust (measured over time as a continuous quality improvement (CQI) initiative)*

- Is there a high level of consumer satisfaction with the assistance provided?
- Is there a diverse user demographic (based on target pops served as well as underserved populations)?
- Does the ADRC have a high profile in the community?
- Is the ADRC information and counseling perceived as objective?

### *Efficiency*

- Has the process to access services – including Medicaid Waiver - been streamlined (time, steps, # of people to interact with to enroll)?

### *Responsiveness*

- Does the ADRC meet community and consumer needs?

### *Effectiveness*

- Is there an indication of a decrease in unnecessary institutionalization and an increase in the appropriate use of HCBS?
- Is there a high level of satisfaction among stakeholders (providers, state agencies, advocates – at a minimum SUA and Medicaid agency)?

## Minimum Dataset Elements Requested of Grantees

In addition to information collected through telephone calls, reporting and other grantee products, grantees are requested to collect additional data to fully inform the evaluation and respond to all research questions. Grantees may already be collecting some or all of this information through OAA NAPIS reporting, Medicaid MMIS, or existing state/local reporting mechanisms. The proposed minimum dataset elements include both baseline and post-implementation measures.

### Baseline (pre-ADRC)

- # of contacts (telephone, web inquiries)<sup>1</sup>
- # and types of outreach activities
- Avenues & steps to apply for public programs (flow chart of steps – organizations, staff, methods of information exchange, time)
  - clinical eligibility determination
  - financial eligibility determination

### Post-ADRC

*Exhibit 4* outlines the proposed ADRC minimum dataset elements by research question.

- Avenues & steps to apply for public programs (flow chart of steps – organizations, staff, methods of information exchange, time)
  - clinical eligibility determination
  - financial eligibility determination

For the measures below, reports would be generated by target group (age 60+, physical disability, developmental disability, mental disorder and other disability) and NAPIS groupings of low income, minority and frail. Characteristics beyond target population could be asked only for those for whom more than information is provided.

- Contacts
  - # of contacts by type of caller -- based on response to standard question of all contacts -- "Are you a consumer, caregiver or provider/professional?":
    - Consumer
    - Caregiver
    - Professional
  - # of contacts by source of referral -- based on response to standard question of all contacts -- "How did you hear about us?":

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<sup>1</sup> Contact is defined as any call or visit to the ADRC that results in, at a minimum, information being provided to the customer.

- Newspaper
  - Home and community-based organization/ social service agency
  - Brochure
  - Friend/Neighbor
  - Family Member
  - Doctor or other health care professional
  - Social worker
  - Hospital
  - Library
  - Internet
  - ADRC website
  - Senior Center
  - AARP
  - Television
  - Radio
  - Other, specify
- # of contacts by new versus repeat-- based on response to standard question of all contacts -- "Have you contacted us before?"
  - contacts per FTE providing I&R, assistance, intake & eligibility
  - contacts/1,000 service area population
  - by type of assistance provided:<sup>2</sup>
    - Information about long-term care services or resources: Contact involves long-term care related information regarding services, resources, etc.
    - Information about other services or resources: Contact involves other services, resources and/or other information.
    - Referral to Level of Care assessment: This should include all referrals for a LOC, which may include resource center-based long-term care options counseling.
    - Referral to private long-term care services: This would include formal referrals to non-public agencies/programs on behalf of private pay individuals.
    - Application/referral for public funding for programs such as Medicare, Medicaid, Food Stamps, Social Security: Includes referrals made to link people to

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<sup>2</sup> Referrals are distinguished from giving people information, in that the resource center refers the caller to other services or resources, or is actively involved in obtaining a service or resource for a caller.

government benefits, such as to an Economic Support Unit/Worker, Benefit Specialist and Social Security Administration.

- Referral to Adult Protective Services (APS): Any referral to the APS staff and/or elder abuse workers for elder abuse, financial abuse, self-neglect, placements, etc.
  - Referral to emergency services: This would include services/ actions to be delivered within 24 hours. It would include emergency food delivery, shelter, or emergency respite care or other immediate intervention.
  - Referral to employment support: This would include vocational rehab and one-stop shops.
  - Referral to services/resources other than emergency APS or LTC: This category covers all other referrals.
  - Needs brief or short term services, follow-along or service coordination: The use of this category will depend on the resource center. If the I&A worker sends all in-house referrals to either a long-term care unit or a distinct "access" unit, he or she may not know whether a contact requires brief services, and he or she would not be in the position of "following" contacts.
  - Noted for follow-up contact: The I&A worker is providing information only, and making no referrals, but keeps a record of the contact in order to follow-up to make sure that the caller is okay, and/or to determine if the information was acted upon.
- Website Activity -- average hits per month; number of online applications (if applicable)

**Exhibit 4: Proposed ADRC Minimum Dataset Elements by Research Question Addressed**

	Visible/Trustworthy				Responsive	Efficient	Effective	
	Consumer satisfaction with assistance	Diverse population served	High profile in community	Objectivity of information and counseling	Meet community and consumer need	Reduced time to access services	Reduced unnecessary institutional; increased HCBS	Stake holder satisfaction
Avenues & steps to apply for public programs						√		
Contacts								
type of caller		√	√					
source of referral			√					
new versus repeat					√			√
per FTE providing I&R, assistance, intake & eligibility						√		
per 1,000 service area pop.						√		
type of assistance requested					√			
type of assistance provided					√			
website activity -- average hits per month			√					
Customer satisfaction								
objectivity, reliability, etc. of info	√			√				√
responsive to needs, preferences & circumstances	√				√			
simplicity and reduced confusion	√				√			√
interaction with ADRC staff	√							√
# of institutional LOC determinations								
reason for conducting					√	√		
Setting					√	√		
# of financial eligibility determinations						√		
# enrolled								
HCBS waiver enrollment							√	
Institutional care use							√	
Other program enrollment							√	
Testimonials	√							√

- Customer satisfaction (see recommended questions in a later section and Appendix B)
  - objectivity, reliability, comprehensiveness, currency & usefulness of info
  - responsive to needs, preferences & unique circumstances
  - info being simple & clear, simplicity of applying for services, reduced frustration & confusion
  - interaction with ADRC staff
- # of institutional Level of Care determinations among individuals that contacted the ADRC and in the ADRC service area by target group and reason for conducting LOC (initial, change in condition, annual recertification)
- # of institutional LOC determinations among individuals that contacted the ADRC and in the ADRC service area by setting (home, hospital, assisted living, other residential alternative, nursing facility)
- # of financial eligibility determinations among individuals that contacted the ADRC and in the ADRC service area
- # enrolled in Medicaid or other programs among individuals that contacted the ADRC and in the ADRC service area
  - HCBS waiver enrollment – average monthly number of individuals in waivers for the target population receiving services during the reporting period
  - Institutional care use -- average monthly number of individuals in nursing facilities, ICF-MR or IMD for the target population receiving services during the reporting period
  - Other program enrollment -- average monthly number of individuals for the target population receiving OAA or state funded services during the reporting period
- Testimonials

## **Data Sources**

The proposed minimum data elements will come from a number of data sources outlined in *Exhibit 5*.

**Exhibit 5: Data Sources for Minimum Data Elements**

Data Source	Method for Gathering Information	Frequency	Entity Systematically Recording Information
<b>Shared Grantee and Other Responsibility</b>			
GMD calls	Calls with grantees	Quarterly	AoA-CMS
Semi-annual reporting	Written reports submitted by grantees (likely to migrate to online reporting)	Semi-annually	AoA-CMS
Lewin ADRC TA Tracking Tool information	Grant requests through calls, e-mails, etc.	Ongoing	Lewin
Other grantee products on their ADRC including work plan revisions, reports from committees and advisory groups etc.	Grantee provided through semi-annual reporting	Grantee choice to provide but semi-annually at a minimum	Lewin
OAA NAPIS reporting	SUA	Annually	AAAs & SUA
<b>Full Grantee Responsibility</b>			
Consumer Satisfaction Survey	Grantee conducted either through written or telephone and reported through semi-annual reporting	Recommend ongoing but semi-annually at a minimum	TBD, likely ADRC pilots, state or grantee evaluator
MMIS information on Medicaid HCBS and institutional use & enrollment	Grantee provided through semi-annual reporting	Annually	Provider claims to MMIS
Level of Care and financial eligibility determinations	Grantee provided through semi-annual reporting	Semi-annually	ADRC pilots
ADRC contact (calls, web hits, client ) information	Grantee provided through semi-annual reporting	Semi-annually	ADRC pilots

*Exhibit 6* shows the reporting period and the due date for semi-annual and annual items from the minimum data elements. The data elements on the semi-annual frequency will follow the reporting period and schedule for semi-annual reports as part of the grant. Those elements requested annually would be part of the April semi-annual reports starting in 2005 for the 2003 grantees and the January semi-annual reports starting in 2006 for the 2004 grantees. The period for reporting for the annual frequency items will depend upon when a pilot ADRC site is operational.

**Exhibit 6: Semi-annual and Annual Reporting Period and Schedule for Grantees**

2003 Grantees		2004 Grantees	
Reporting Period	Due	Reporting Period	Due
<b>Semi-annual</b>			
October to March	April	July to December	January
April to September	October	January to June	July
<b>Annual</b>			
12 months prior to pilot ADRC operational	April '05	12 months prior to pilot ADRC operational	Jan. '06
ADRC pilot operational to 12 mo. following	April '06	ADRC pilot operational to 12 mo. following	Jan. '07
ADRC operational month 13 to month 24	April '07	ADRC operational month 13 to month 24	Jan. '08

## Data Source Explanation

### GMD Calls

Quarterly GMD calls conducted by AoA/CMS project officers that cover:

- Significant developments challenges, successes and timeline
- Programmatic changes related to goals, staffing or budget
- Use of and usefulness of technical assistance, as well as additional TA needs
- Other comments

### Semi-Annual Reporting

Semi-annual reports cover major activities, problems, significant events, dissemination, and activities planned. Grantees are requested to address the following as appropriate as part of their first report:

- Assignment/hiring of project coordinator at state and/or local level as well as local project staff hired/assigned to provide awareness, information and assistance functions
- ADRC project site selection activities
- Any training conducted
- Updates on work on resource database for ADRC
- Update on MIS strategy
- Update on website development
- Outreach/public awareness campaign/plans including outreach to underserved populations
- Information on current I&R/ A call volume/web inquiries and anticipated volume for ADRC site
- Advisory Committee update including consumer involvement
- Update on relationship with state/local Medicaid
- Other state partner roles and level of involvement
- Activities related to linking with hospital discharge and other critical pathways to institutionalization
- Update on plans for streamlining benefits screening, pre-admission screening, level of care determination, financial eligibility and assessment processes (it would be helpful to outline current processes to place planned changes in context)

During the second year, grantees will be asked to address, as appropriate, issues related to implementation, as well as continued project development. These include:

- Staff changes including staff co-located with ADRC
- Updates on ADRC name, logo, or tag line selection
- Outreach and public awareness campaign activities including outreach to underserved and other target audiences
- Update on linkages with hospital discharge and other critical pathways to institutionalization
- Update on web site development including web address and contact, overview of functions including resource database search capability, accessibility, costs, and planned enhancements
- Update on MIS development including software vendor(s), resource database and client tracking features, data elements collected from consumers, resource database collection method and update frequency, and search capabilities
- Activities related to streamlining access to LTC through benefits screening, pre-admission screening, level of care determination, financial eligibility and assessment processes
- Other state systems change activities related to the ADRC
- ADRC contact (calls, web hits, client ) information
- Consumer satisfaction survey results
- MMIS information on Medicaid HCBS and institutional use & enrollment
- Level of Care and financial eligibility determinations

We anticipate that in the near future ADRC grantees will be able to submit their semi-annual reports electronically through the ADRC web site.

### **ADRC TA Tracking Tool**

The ADRC-TAE has developed a web-based “TA Tracking Tool” designed to track issues/progress across eight (8) topic areas:

- Development Strategies and Steps
- Implementation Steps
- Functions and Services
- Strategy for Sustainability
- Project Evaluation
- Management of Information Systems
- Diversionary Strategies (from institutionalization)
- Consumer Involvement

The Tracking Tool records:

- Technical assistance requests and responses
- Relevant information regarding progress drawn from TA calls with grantees

To ensure that the Tracking Tool tracks progress based on all available information, data collected from the GMD calls, Semi-annual reports and other grantee products is also recorded in the Tool across the 8 topic areas.

## Customer Satisfaction Survey

The TAE staff, working with a committee from NJ, drafted recommended consumer survey questions for a mailed format (*Appendix B*). To develop the questions, we looked at a number of existing surveys and include these surveys in a matrix below for your reference. The goals of the questions were to:

- Capture information that addresses the application process and I&A provided by the ADRC, in terms of:
  - objectivity, reliability, comprehensiveness, currency & usefulness of the information;
  - responsive to needs, preferences & unique circumstances;
  - information being simple & clear;
  - simplicity of applying for services; reduced frustration & confusion; and
  - interaction with ADRC staff
- Create a resource for continuous quality improvement efforts
- Keep the language to a relatively low grade level

We plan to also develop a telephone version and are considering the possibility of developing a web-based entry tool for use by grantees. While mailed surveys generally cost less, the response rate is much lower than for telephone surveys. We will conduct limited cognitive testing about the questions, the length of the survey and whether there is a preference for a likert scale over the yes/no format. TAE staff can work with grantees to determine the most appropriate frequency and sampling strategy.

**Appendix A**  
**Potential Indicators Related to ADRC Goals**

In initially developing the evaluation framework, a broader set of potential indicators of grantees success in meeting the project goals was developed. Below, both start-up measures and post-implementation measures are presented.

### **Start-Up Process Measures**

Within an evaluation framework, we would hope to identify indicators that demonstrate progress toward or accomplishment of the desired systems change goals. However, during the planning and initial implementation phase of the ADRCs, these types of indicators do not lend themselves to potential reporting requirements because most activity is focused on decision making, model development, and start-up. Therefore, prior to presenting potential indicators relevant to the post-start-up period, we present potential start-up process measures that could serve as candidates for the first year's reporting requirements (*Exhibit A-1*).

Our plan is to work with the grantees, AoA and CMS to add to, delete from, and/or refine the list of measures for Year One progress to be part of the initial semi-annual reporting requirement. For those familiar with the new web-based annual reporting mechanism for the Real Choices Grants, we anticipate that the semi-annual reports required of the ADRC grantees will also be web-based, but tailored more specifically for the ADRCs. The input required of you could be narrative or we could strive to have drop-down menu choices where possible.

### **Potential Indicators Following Implementation**

Following consideration of possible year one reporting requirements, we turned to identifying potential indicators for each of the desired systems change goals/long-term impacts. As noted above, most of these indicators become relevant only after the start of operations. The indicators are classified based on whether the measure captures:

- **Structure** – elements likely to be established in the development of the ADRCs that tend to be more tangible
- **Process** – activities likely to occur in the implementation of the ADRCs that facilitate the system change goals
- **Output** – measures of activities or products of the ADRCs
- **Outcome** – results of the ADRC that indicate progress toward goals
- **Impact** – longer range measures of changes related to goals that can be attributable to the ADRCs (i.e., establishing cause and effect by assessing results relative to if the program had not been implemented by controlling for factors other than the ADRCs to the extent possible).

**Exhibit A-1: Potential Start-Up Process Measures**

<b>Operations/Business Model</b>	ADRC site(s) selected Hire/assign project manager # of info. & awareness staff hired/assigned # of assistance staff hired/assigned Training conducted Anticipated call volume MIS strategy Gather & organize information on services services included method for gathering information Implement website Develop public awareness campaign
<b>Coalition Building</b>	Establish advisory committee membership Nature of working relationship with Medicaid MOU Regularly scheduled meetings Methods used to engage state partners Building rel. between aging and disability network
<b>Policy &amp; Regulatory Issues</b>	Establish benefit screening process Planned changes to: Medicaid application eligibility determination service coordination
<b>Clinical Aspects</b>	Planned changes to: level of care determination pre-admission screening assessments service plan development
<b>Baseline (pre-ADRC)</b>	# of contacts (telephone, web inquiries) # and types of outreach activities avenues & steps to apply for public programs clinical eligibility determination financial eligibility determination

*Exhibit A-2* presents the first cut at potential indicators. For each indicator, we also identify the likely data source for each through the color scheme. The list builds on indicators included in many of your applications, however, it is not exhaustive, nor would all grantees necessarily have activities that would result in, or provide information to support, all of the indicators. We also acknowledge that the list is rather comprehensive in its range. Please consider these only as possibilities.

**Exhibit A-2: Potential Indicators by Desired Systems Change Goals**

Goals	Indicators				
	Structure	Process	Output	Outcome	Impact
<b>Visibility/ Awareness</b>  <b>Informed Choice</b>	<ul style="list-style-type: none"> <li>establishment of RC</li> <li>launch of website</li> <li>develop MIS for resources</li> <li>MIS accessible to other programs</li> <li>gather &amp; organize info on services</li> <li>range of info included</li> <li>staff for awareness &amp; info</li> <li>24/7 access established</li> </ul>	<ul style="list-style-type: none"> <li>develop marketing plans</li> <li>conduct marketing activities</li> <li>outreach to professional providers</li> <li>information maintenance and update protocols</li> <li>number of contacts by method (website, phone, walk-in)</li> </ul>	<ul style="list-style-type: none"> <li># and types of outreach activities conducted</li> <li>special initiatives to reach disadvantaged populations</li> <li>for outreach activities to providers &amp; other referral sources, # of agencies &amp; individuals attending;</li> <li># at health fairs, conferences, etc.</li> <li># of languages for materials</li> <li># of contacts by source of referral</li> <li>gaps analysis -- % of calls where requested info/services were not available</li> </ul>	<ul style="list-style-type: none"> <li>knowledge gain – consumers understand how to apply for services and that there is an array of LTC options</li> <li>high user satisfaction in terms of objectivity, reliability, comprehensiveness, currency &amp; usefulness of info</li> <li>90%+ of staff of other relevant state agencies are aware of RC role and how it related to their programs/activities</li> <li>change in calls/website hits following outreach activity</li> <li>demographics of those contacting &amp; requested info/services</li> <li># of times RC featured in newspaper, radio &amp; television</li> <li>policymakers indicate service gaps analyses are timely &amp; useful</li> </ul>	<ul style="list-style-type: none"> <li>knowledge of location, function, website &amp; phone # among consumers &amp; providers</li> </ul>
<b>Consumer Focus</b>	<ul style="list-style-type: none"> <li>establish advisory committee with broad stakeholder representation</li> </ul>	<ul style="list-style-type: none"> <li>obtain feedback from consumers on whether info is in friendly, usable format</li> <li>reflected in mission statement, policies, procedures, training</li> </ul>	<ul style="list-style-type: none"> <li>analyses of/report on consumer feedback</li> <li>testimonials</li> </ul>	<ul style="list-style-type: none"> <li>high user satisfaction with assistance provided (responsive to needs, preferences &amp; unique circumstances)</li> </ul>	<ul style="list-style-type: none"> <li>ability to exercise informed choice</li> <li>satisfaction with service plan</li> </ul>
<b>Access to Services</b>	<ul style="list-style-type: none"> <li>staff for assistance</li> <li>MIS for client tracking</li> </ul>	<ul style="list-style-type: none"> <li>design &amp; implement a presumptive eligibility process for HCBS</li> <li>outreach to hospital discharge planners, rehab and nursing facilities</li> <li>ADRC as only institutional LOC determination source</li> </ul>	<ul style="list-style-type: none"> <li># of hospitals and discharge planners contacted/informed/ oriented</li> <li># of rehab &amp; nursing facility visited and # of residents contacted</li> <li># of institutional LOC determinations (by source of referral &amp; disposition)</li> <li># of financial eligibility determinations</li> <li># enrolled in Medicaid or other programs</li> </ul>	<ul style="list-style-type: none"> <li>demographics of those screened</li> <li>consumers receive services (could also track with ADRC and Medicaid MIS)</li> </ul>	<ul style="list-style-type: none"> <li>desired and agreed upon services versus services delivered</li> <li>greater success at finding appropriate services</li> <li>high quality services received</li> </ul>
<b>Efficiency</b>	<ul style="list-style-type: none"> <li>development of a single application &amp; a common assessment tool for LTC services</li> <li>co-location of Medicaid eligibility worker/ delegated authority</li> </ul>	<ul style="list-style-type: none"> <li>reduced # of consumer contacts to access multiple services</li> <li>implemented a uniform clinical and financial eligibility process across programs</li> </ul>	<ul style="list-style-type: none"> <li>useful &amp; flexible MIS that streamlines application &amp; supports CQI</li> <li>average speed to answer calls</li> <li>call abandonment</li> <li>contacts per FTE</li> </ul>	<ul style="list-style-type: none"> <li>provider satisfaction with appropriateness of referrals</li> <li>reduced amount of time to complete process</li> <li>Level of care has high inter-rater reliability (85%+) and 95%+ correct determination based on audit</li> </ul>	<ul style="list-style-type: none"> <li>lower costs of Medicaid services provided per user and in aggregate</li> <li>consumers perceive greater efficiency</li> </ul>
<b>Effective- ness</b>	<ul style="list-style-type: none"> <li>establish CQI process</li> <li>develop MIS for tracking contacts/ clients and critical pathways</li> <li>develop complaint &amp; grievance process</li> <li>use of common taxonomy across I&amp;R/A functions</li> </ul>	<ul style="list-style-type: none"> <li>interagency agreements or other cooperative efforts</li> <li>developed standards &amp; procedures</li> <li>shares resource database with others</li> <li>training conducted</li> <li>plan for statewide expansion (possibly 2-1-1)</li> </ul>	<ul style="list-style-type: none"> <li>total number of contacts over time</li> <li>contacts/1,000 target population</li> <li># of functional assessments</li> <li>patterns in complaints and grievances</li> </ul>	<ul style="list-style-type: none"> <li>high user satisfaction, in terms of info being simple &amp; clear, simplicity of applying for services, reduced frustration &amp; confusion</li> <li>consumer follow-thru on referrals (reported by either/or consumers and providers)</li> <li>referral source satisfaction</li> <li>functional status of those assessed relative to pre-ADRC</li> <li>statewide plan implemented</li> </ul>	<ul style="list-style-type: none"> <li>decreased NH use</li> <li>increased use and availability of HCBS</li> </ul>

Impact and some outcomes measured pre/post or relative to comparison area or both. Trends over time will also be relevant for output and outcomes.

**Potential Data Sources:**

- Self-report by grantee
- Focus groups or surveys with consumers which could include general community, target populations, RC users, providers (physicians, nurses, hospital discharge planners, nursing home social service and admission staff, heads & intake staff of HCBS orgs), elder law & estate attorneys, social workers, geriatric care managers, & leadership of targeted faith-based orgs, professional women's orgs, veteran associations & civic orgs
- RC management information system (ADRC MIS); Medicaid management information system (MMIS); External audit; Complaints and grievance

**Appendix B**  
**Mailed Customer Satisfaction Survey**

## Recommended Consumer Measures for Surveys

*Please answer the questions below and return this survey in the addressed and stamped envelop provided. Thank you for taking the time to help us serve you better.*

### Customer Service

1. Was the information you received from organization name clear?  
 Yes       No       Unsure
2. Will the information you received from organization name be helpful in dealing with the issue you called or came to our offices to talk about?  
 Yes       No       Unsure
3. Were you told to go to or call any other places for a service or more information?  
 Yes       No       Unsure
4. If you called, how quickly was your call answered?  
 Quickly, less than 5 rings       Slowly, more than 5 rings
5. If you left a message, when did the person call you back?  
 Did not leave a message  
 Within the hour  
 In the same day  
 In the same week  
 More than a week  
 Do not remember/unsure
6. If you came to our offices, how long did you wait to see someone?  
 Did not come to your office  
 1-5 minutes  
 5-10 minutes  
 10-20 minutes  
 Over 20 minutes  
 Do not remember/unsure
7. Overall, did the person you talked with listen carefully to what you wanted?  
 Yes       No       Unsure
8. Did you feel they took into account your wants and needs?  
 Yes       No       Unsure

9. Was the person you talked with knowledgeable and courteous?  
 Yes       No       Unsure

**Application for Services**

1. Did you apply for apply for services?  
 Yes       No       Unsure

*If you applied for services, please complete this section, otherwise skip to General Experience.*

2. The steps to apply for services were...  
 Easier than I expected       About what I expected       Harder than I expected
3. If you needed help, did the people who work at organization name help you with your paperwork?  
 Yes       No       Unsure
4. Did the person you spoke with explain the steps clearly?  
 Yes       No       Unsure
5. If you were approved for services, how long did it take to receive services from when you first contacted organization name?  
 Less than one week       2-3 months  
 2-3 weeks       More than 3 months  
 1-2 months       Don't know/Unsure

**General Experience**

1. Were there any problems with the service provided by organization name?  
 Yes       No       Unsure

2. What could we do differently to make it better?

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3. Would you tell a friend or relative to call organization name?  
 Yes       No       Unsure

## Information About You

1. Did you call or come to our offices for yourself or someone else?
  - Self
  - Parent
  - Child
  - Other relative
  - Friend
  - Client
2. Do you or the person you called or came to our offices about have a(n)...
  - Age 60 years or older
  - Physical disability
  - Developmental disability
  - Mental disorder
  - Other disability (*please list*) \_\_\_\_\_
3. What is your race/ethnicity? [*Check all that apply*]
  - White or Caucasian
  - Black or African American
  - Asian
  - American Indian or Alaska Native
  - Native Hawaiian or Other Pacific Islander
  - Other (*please list*) \_\_\_\_\_
  - Latino
4. Are you male or female?
  - Male
  - Female
5. What is your age (years?) \_\_\_\_\_
6. What is your home zip code? \_\_\_\_\_

## Additional Information

Answering the questions below will help us to better let people know about our services and provide you with additional information if you are interested.

Would you like more information about?

- |   |  |
|---|--|
| <input type="checkbox"/> Housing or shelter         | <input type="checkbox"/> Nutrition                     |
| <input type="checkbox"/> Employment or volunteering | <input type="checkbox"/> Transportation                |
| <input type="checkbox"/> Health/medical care        | <input type="checkbox"/> Legal Services                |
| <input type="checkbox"/> Health insurance           | <input type="checkbox"/> Help at home for a disability |
| <input type="checkbox"/> Financial assistance       | <input type="checkbox"/> Other (please list) _____     |

What is your highest education level?

- Less than high school diploma
- High school diploma
- Some college, including associate degree
- Bachelor's degree
- Post-graduate work or advanced degree

What was your combined income from all sources for all people in your household last year?

- |   |  |
|---|--|
| <input type="checkbox"/> Less than \$10,000   | <input type="checkbox"/> \$50,000 to \$75,000  |
| <input type="checkbox"/> \$10,000 to \$20,000 | <input type="checkbox"/> \$75,000 to \$100,000 |
| <input type="checkbox"/> \$20,000 to \$30,000 | <input type="checkbox"/> More than \$100,000   |
| <input type="checkbox"/> \$30,000 to \$50,000 | <input type="checkbox"/> Do not know/unsure    |

If you would like us to send you additional information, please provide your name and address below.

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