

**2003/2004 Split Session**  
**Monday October 4th, 9:30-11:30**

**2003 Grantees**

Review accomplishments across grantees  
Solicit feedback on TA activities and processes

***Moderators:***

Susan Reinhard, Co-Director, Rutgers University, Community Living Exchange Collaborative

Karen Linkins, Vice President, The Lewin Group

Dina Elani, Senior Policy Advisor for Community Integrated Resources, CMS

**2004 Grantees**

- Introductions
- Admin needs, reporting requirements, quarterly calls with AoA and CMS
- Accessing TA - website, guidelines, boundaries

***Moderators:***

Greg Case, Project Officer for the Aging and Disability Resource Center grant program, AoA

Joe Razes, 2004 ADRC Project Officer and Senior Project Manager for the Centers for Medicare and Medicaid Services, (CMS)

## Speaker Biographies

**Susan C. Reinhard, PhD and MSN**, is the Co-Director of the Rutgers Center for State Health Policy, a policy research center founded to stimulate sound and creative state health policy in New Jersey and around the nation. She serves as the Deputy Commissioner of the New Jersey Department of Health and Senior Services. She also directs two national initiatives to provide policy analysis and technical support to states. She is the Director of the Community Living Exchange Collaborative at Rutgers, assisting states funded by the Centers for Medicare and Medicaid Services to design long term care systems that help people with disabilities live in their homes and communities. She is also the National Program Director of the Robert Wood Johnson Foundation's "State Solutions" program to help states enroll more low-income older adults and people with disabilities in the Medicare Savings Programs. As Deputy Commissioner, she led the development of a single point of entry system for older adults (NJEASE), consolidated policy and funding for senior services into one state department, secured significant funding to initiate consumer direction in home care programs, and spearheaded the Community Choice Counseling program to transition people out of nursing homes back into their communities. Currently she is focusing on new ways to permit funding to follow consumers across long-term care settings.

**Karen W. Linkins, Ph.D.**, a Vice President at The Lewin Group, has over fifteen years of technical assistance and program evaluation experience in the areas of long term care and mental health systems and providers, the elderly, disabled, children, and other vulnerable populations. In particular, she specializes in issues concerning the impact of the policy and regulatory environment on organizational behavior, performance, and outcomes. Over the past decade, Dr. Linkins has conducted numerous national, state, and local technical assistance projects and evaluations for innovative long term support services interventions, such as family caregiver support programs, integrating primary care and behavioral health services for elders, and financing evidence-based mental health practices. She is currently designing a national evaluation of the CMS Direct Service Community Workforce demonstration and is directing a statewide evaluation of The California Endowment's Mental Health Initiative, which examines the effectiveness and cultural competence of different treatment approaches in 46 non-traditional community-based settings (e.g., schools, child care, hospice agencies, and primary care clinics). She is also the Co-Director of the Administration on Aging's national technical assistance effort for the Aging and Disability Resource Centers demonstration program. Dr. Linkins recently completed a national assessment of the effectiveness of the preadmission screening process (PASRR) for nursing facility residents with mental illness. Prior to joining Lewin, Dr. Linkins held a faculty appointment at the University of California, San Francisco (UCSF) where she investigated the impact of policy and regulatory changes on access to Medicare certified and uncertified home health agencies, as well as adult day health and other alternative, community-based sites of care. Dr. Linkins earned her Ph.D. at UCSF in Medical Sociology.

**Dina Elani** has over twenty years of experience working on the health, social service, and housing needs for lower-income persons. She is currently the *Senior Policy Advisor for Community Integrated Resources* at the Centers for Medicare & Medicaid Services in Baltimore, Maryland. At CMS, Dina is the lead in developing the supportive housing and the ADRC initiatives within the CMS Center for Medicaid and State Operations.

Prior to working at CMS, Dina was the Associate Director of a Congressional Commission addressing the affordable housing and service needs for seniors (*Commission on Affordable Housing and Health Facility Needs for Seniors in the 21<sup>st</sup> Century*).

Her other experience includes working as the Assistant Vice President for Planning and Development of a large senior-based system in the Bronx, New York; working as the Director of Managed Care for the American Association of Homes and Services for the Aging; and working on demonstration projects for the New York State Department of Health and Rensselaer Polytechnic Institute.

**John Wren**, Director of Center for Planning and Policy Development, joined the U.S. Administration on Aging in October 2000 currently serves as the Director of the Center for Planning and Policy Development where he oversees the agency's strategic planning, program development and policy development functions. Prior to joining AoA, Mr. Wren was a Vice President for the National Council on the Aging (NCOA), and Director of the National Aging Program at the Pew Charitable Trusts.

He also served as chief staff to the NY Governor's Interagency Coordinating Council on Long Term Care. He developed nationally recognized reports on Social Security, Medicare and Family Caregiving, and helped to lead New York State's participation in the 1981 and 1995 White House Conferences on Aging.

John has served on the Board of Directors for the National Senior Citizen's Law Center and is a member of the National Academy of Social Insurance.

**Greg Case** works for the Center for Planning and Policy Development (CPPD) at the U.S. Administration on Aging (AoA). He is the AoA Project Officer for the Aging and Disability Resource Center grant program designed to assist states in streamlining access to long-term care. In addition, his work with CPPD includes activities in health promotion and disease prevention, long-term care financial planning, Medicare and a number of other areas. Greg comes to AoA from the National Association of State Units on Aging (NASUA). As a Project Director with NASUA, Greg had primary responsibility for the National Aging Information and Referral Support Center providing technical assistance to state and area agencies on aging - as well as local I&R programs - on the provision of information and referral services to older persons and their caregivers. Greg was also involved with NASUA's older worker programs as well as a number of activities in the area of health promotion and disease prevention.

Greg has worked in the field of aging for over 25 years and has a Master of Arts degree from the University of Illinois.

**Joe Razes** is a Senior Project Manager for the Centers for Medicare and Medicaid Services (CMS) - the Federal Agency that oversees the Medicare and Medicaid programs. Mr. Razes is the 2004 ADRC CMS Project Officer and the CMS agency coordinator for HIV/AIDS program activities, and he also provides technical support for housing and other grant related programs under the New Freedom initiative.

During his career, Mr. Razes has worked on a broad range of health care, disability, and employment issues. At CMS, he has served in numerous managerial and team leader positions. These positions included Medicare and Medicaid program operations, implementing employment related portions of the Ticket to Work legislation, fraud and abuse, health care reform, program policy and managed care. He also managed employment related rehabilitation programs under the Law Enforcement Assistance Administration and worked in a similar capacity at the Social Security Administration's Office of Disability Operations. Mr. Razes has a bachelor's degree in business and psychology and a master's degree in rehabilitation counseling.

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# **Assessment of 2003 ADRC Grantee Progress (Year 1 Planning)**

National Conference  
October 4-5, 2004

# Sources of Information

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- ◆ Quarterly GMD calls with AoA/CMS
- ◆ Semi-Annual Reports
- ◆ ADRC-TAE Requests for Assistance
- ◆ Communications with TA State Leads

# Assessing Progress: ADRC Core Domains and Program Components

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- ◆ **ADRC Core Domains** are fundamental features of the ADRC that remain constant throughout the course of implementation and operation of the program.
  - Stakeholder Partnerships & Input
  - Business Operations
  - Streamlined Eligibility
  - IT/MIS
  - Critical Pathways
  
- ◆ **Program Components** are elements within each domain that act as indicators of progress toward program goals. These program components may be approached in different ways by the grantees and can be modified and tailored to meet the needs of each state.

# Assessing Progress: ADRC Core Domains & Program Components Cont.

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## ◆ Domain: Stakeholder Partnerships & Input

- State Agency Coordination (Aging/Disability Networks; Medicaid)
- State/Local Coordination
- Definition of Roles
- Consumer Involvement (Advisory Boards)
- Communication (e.g., SUA, Medicaid, Disability Agencies, other key stakeholders)

# Assessing Progress: ADRC Core Domains & Program Components Cont.

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## ◆ Domain: Business Operations

- Staffing level sufficient to carry out ADRC functions
- Recruitment/Training/Retention
- Provision of Information, Assistance and Referral to comprehensive LT support options (including private pay options)
- Marketing and Outreach

# Assessing Progress: ADRC Core Domains & Program Components Cont.

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## ◆ Domain: Streamlined Eligibility

- Seamless system for consumers (integration/coordination)
- Minimal duplication (intake/assessment/screening/application for services)
- Standardization of instruments across systems
- Shorten eligibility determination process

# Assessing Progress: ADRC Core Domains & Program Components Cont.

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## ◆ Domain: IT/MIS Technology

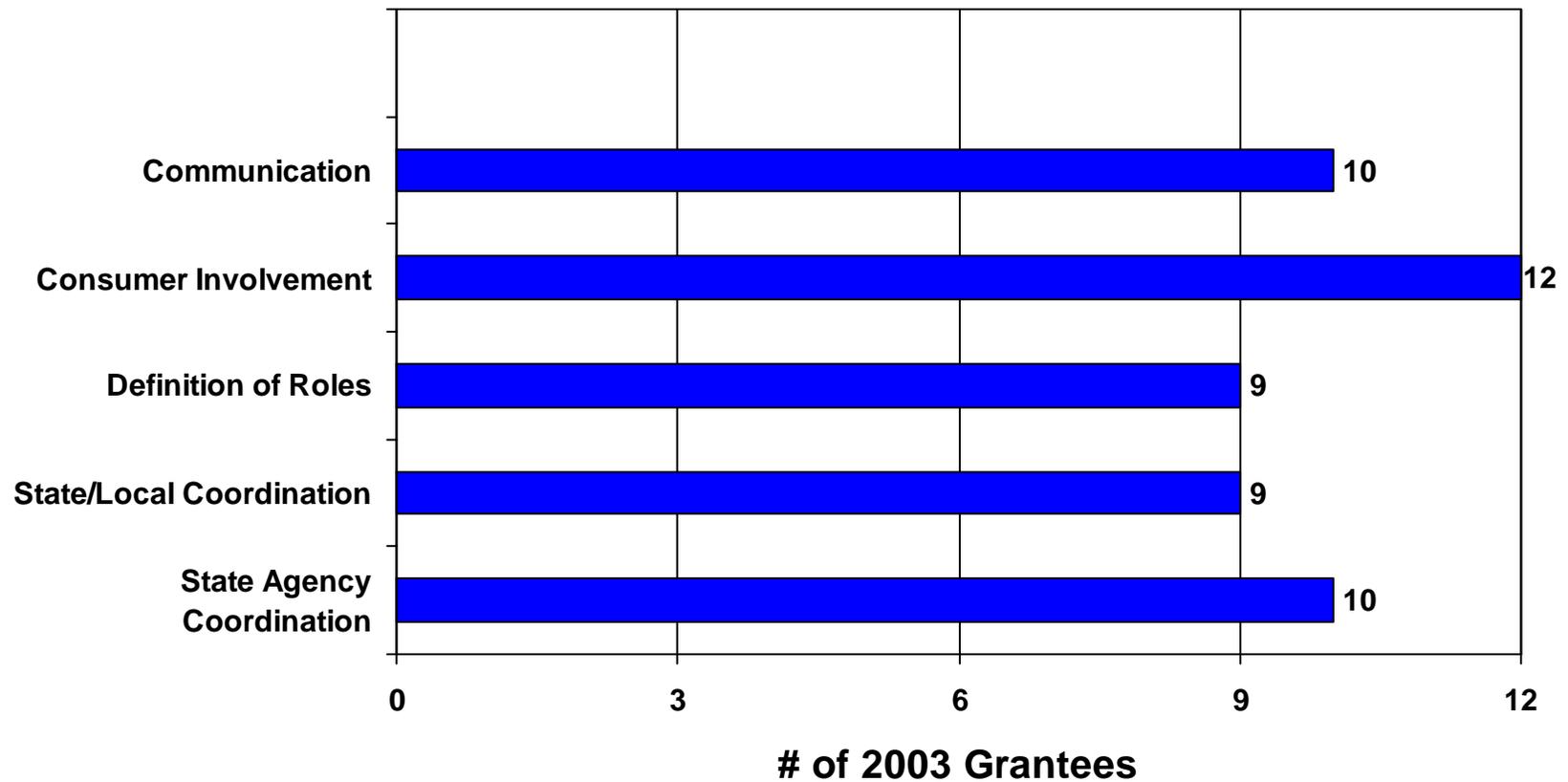
- Investment in IT/MIS that supports all ADRC functions (client tracking, needs assessment, care plans, case management, utilization and costs)
- Comprehensive Resource Database to ensure consumers from all target populations understand their options for long-term support

## ◆ Domain: Critical Pathways

- Linkages to hospital discharge and other critical pathways to institutional care
- Serving the Private Pay Sector

# Stakeholder Partnerships & Input

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## Stakeholder Partnerships—Examples of Progress

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- ◆ **LA** = The Advisory Board consisting of 25 state/local representatives meets to provide education about the ADRC concept and discuss strategic plans
- ◆ **ME** = Steering Committee and Community Coalitions meet regularly and ad-hoc workgroups work on various issues
- ◆ **MD** = The state and Howard County advisory boards report 50% consumer representation
- ◆ **MA** = Two ADRC consumers joined the Real Choice Consumer Planning and Implementation Group to collaboratively support larger system change goals in the state

## Stakeholder Partnerships—Examples of Progress Cont.

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- ◆ **MN** = Held partner planning retreat and formed workgroups. Attendees included: State Medicaid Agency, Aging & Adult Services, Disability Services, LTC Quality Design Commission, County Health Dept
- ◆ **MT** = At the local level, ADRC staff are reaching out to aging & disability service providers; developing MOUs with local agencies (APS, Ombudsman)
- ◆ **NH** = Plan to link stakeholders to the ADRC project through “Blackboard” software hosted by UNH to facilitate communications, and share key documents and project updates through electronic dissemination

# Stakeholder Partnership—Examples of Progress Cont.

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- ◆ **NJ** = Aging Network has made progress in developing partnership with DHHS, state Medicaid agency, Disabilities Network and the Latino community
- ◆ **PA** = Three grants-ADRC, QAQI, and Money Follows the Person all have consumer involvement and are coordinated by an additional committee. Consumer Information workgroup assists in developing easy to understand collaterals for all 3 grants
- ◆ **RI** = Inter-department team was established with representatives from Elderly Affairs, Human Services (DHS), DOH, Mental Health, Mental Retardation and Hospitals (MHRH), and Labor and Training (DLT). The team meets weekly to discuss work plans for moving the ADRC forward and define roles

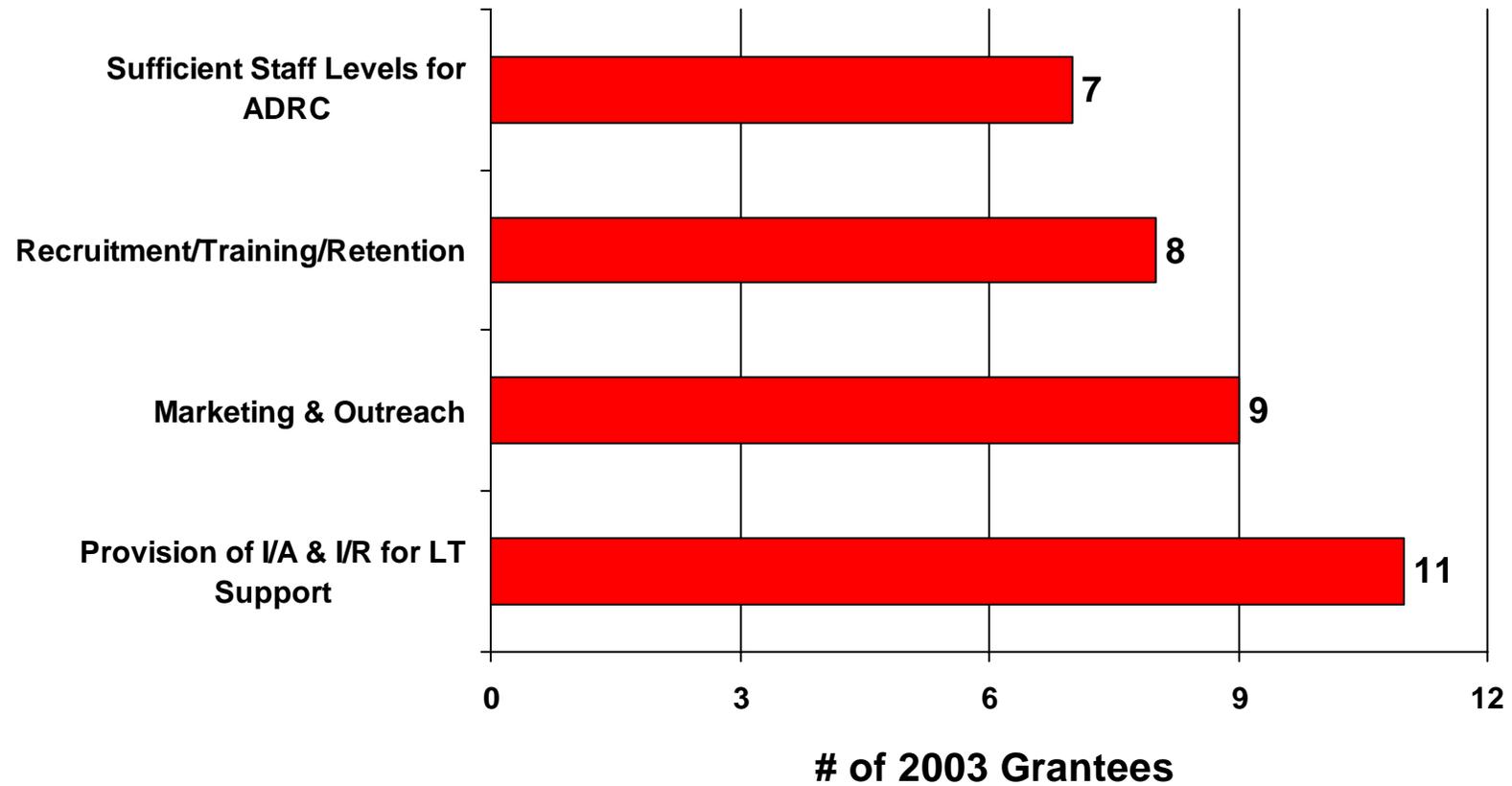
## Stakeholder Partnership—Examples of Progress Cont.

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- ◆ **SC** = 55 ADRC state/local partners (incl. aging/disability/Medicaid) attended a planning retreat to develop a shared vision to guide program design, identify partner strengths and roles, and identify new partners to bring on board in the future
- ◆ **WV** = Bureau of Senior Services meets regularly with Bureau of Medical Services (Medicaid), Disability Network, WVQIO and local partners re: financial eligibility process and strategic plans for ADRC development

# Business Operations

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## Business Operations—Examples of Progress

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- ◆ **LA** = Have a website ([www.louisianaanswers.com](http://www.louisianaanswers.com)) and have decided on name – “Aging and Disability Information Station”. LA will work with a social marketing firm to raise awareness and improve outreach efforts
- ◆ **MD** = Project directors have been hired at both local sites. Staff cross-training has begun on customer service and conflict resolution, and marketing efforts are underway

## Business Operations—Examples of Progress

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- ◆ **MA** = ADRC grant hired a FT Program Coordinator to oversee grant implementation at local level, including development of I&R, intake, assessment, eligibility and service planning
- ◆ **MN** = “Fishing for Information” marketing campaign to highlight upgrades and recent changes made to [www.minnesotahelp.info](http://www.minnesotahelp.info)
- ◆ **MT** = Local ADRC is already up and running and providing I&A to 100+ consumers. ADRC has been featured in news, radio and television. 10 outreach activities have been conducted to 425 persons

## Business Operations—Examples of Progress

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- ◆ **NH** = Working with faculty at UNH to develop training curriculum for ADRC staff with special focus on caregiver issues
- ◆ **NJ** = In first 6 months, the Division of Aging & Community Services along with the Division of Disability Services made numerous marketing presentations to inform associations of the initiative and enlist state/local support of the ADRC model
- ◆ **RI** = Used RFP process to acquire marketing services — with emphasis placed on the vendor's ability to reach diverse audiences

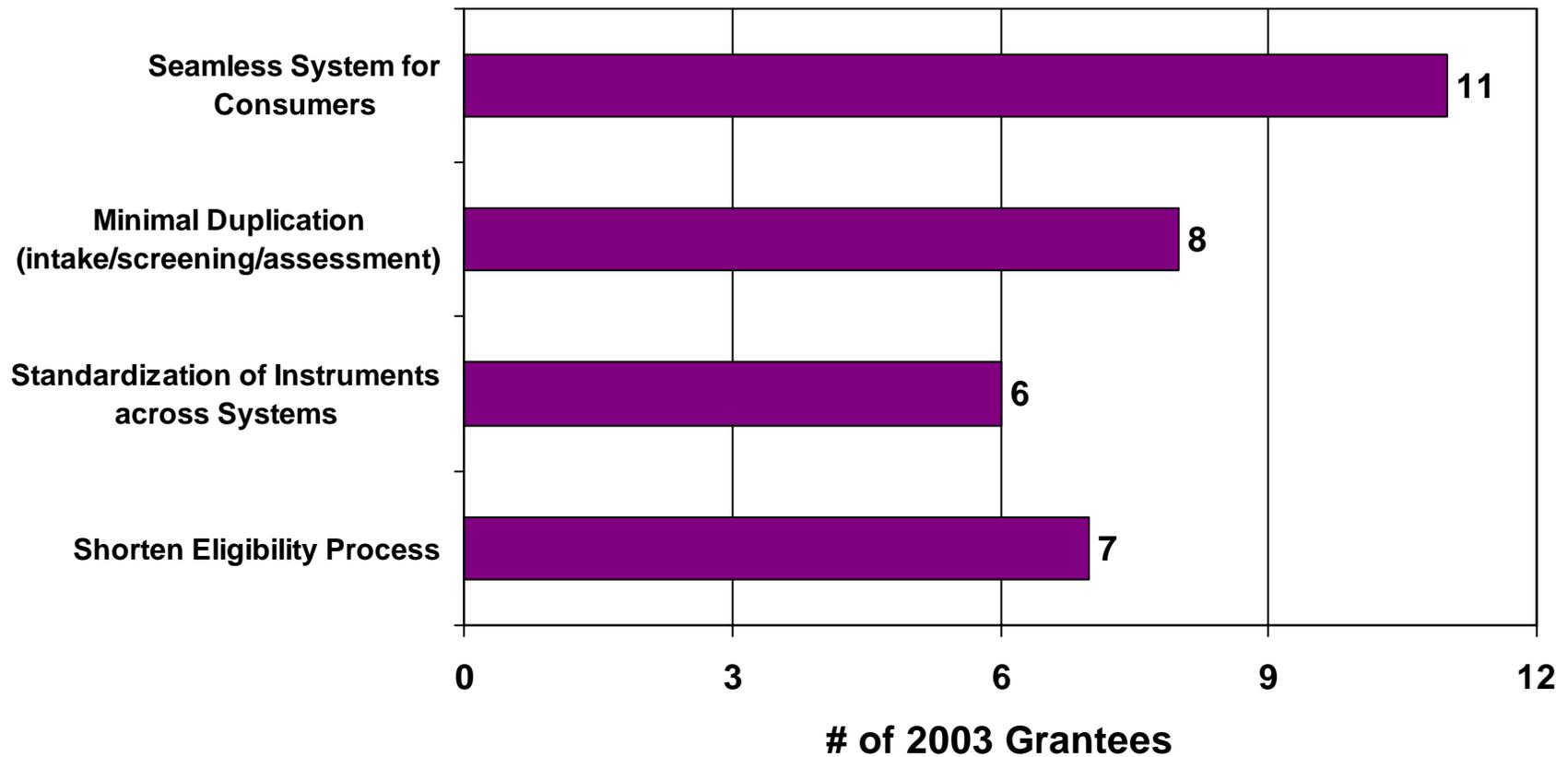
## Business Operations—Examples of Progress

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- ◆ **SC** = A Project Management Team has been assembled and includes representatives from SCDHHS, Bureau of Medicaid Eligibility Processing, Bureau of Medicaid Policy and Oversight, Bureau of Senior Services, Bureau of Information Technology Services, and the pilot partners.
- ◆ **WV** = State and local pilot site directors have been hired. Local PR campaigns are being implemented.

# Streamlined Eligibility

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## Streamlined Eligibility—Examples of Progress

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- ◆ **LA** = Negotiating w/ relevant stakeholders to have ADRC serve as a Medicaid Enrollment Center and share MIS information with Medicaid to streamline financial eligibility process
- ◆ **ME** = Developing an On-line Self-Assessment and beginning to test some standard intake forms
- ◆ **MD** = “No Wrong Door” model – currently looking at best practices in streamlining access. Plan to bring together aging & disability systems and standardize processes through resource database and website development
- ◆ **MA** = Integrated Intake Team is working to standardize I&R, intake, assessment and service planning across pilot sites by streamlining existing forms and tools

## Streamlined Eligibility—Examples of Progress Cont.

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- ◆ **MN** = DHS is working on an initiative “Health Match” to allow consumers to apply online for a wide range of programs administered by DHS. Online comprehensive assessment tool will allow each person to be assessed only once.
- ◆ **NH** = Eligibility system is being streamlined through ServiceLink system
- ◆ **NJ** = DACS has developed a consumer algorithm to map how consumers move through the system. It is a logic decision-making process for determining clinical & financial eligibility. State Medicaid agency has drafted a new, shorter eligibility application.

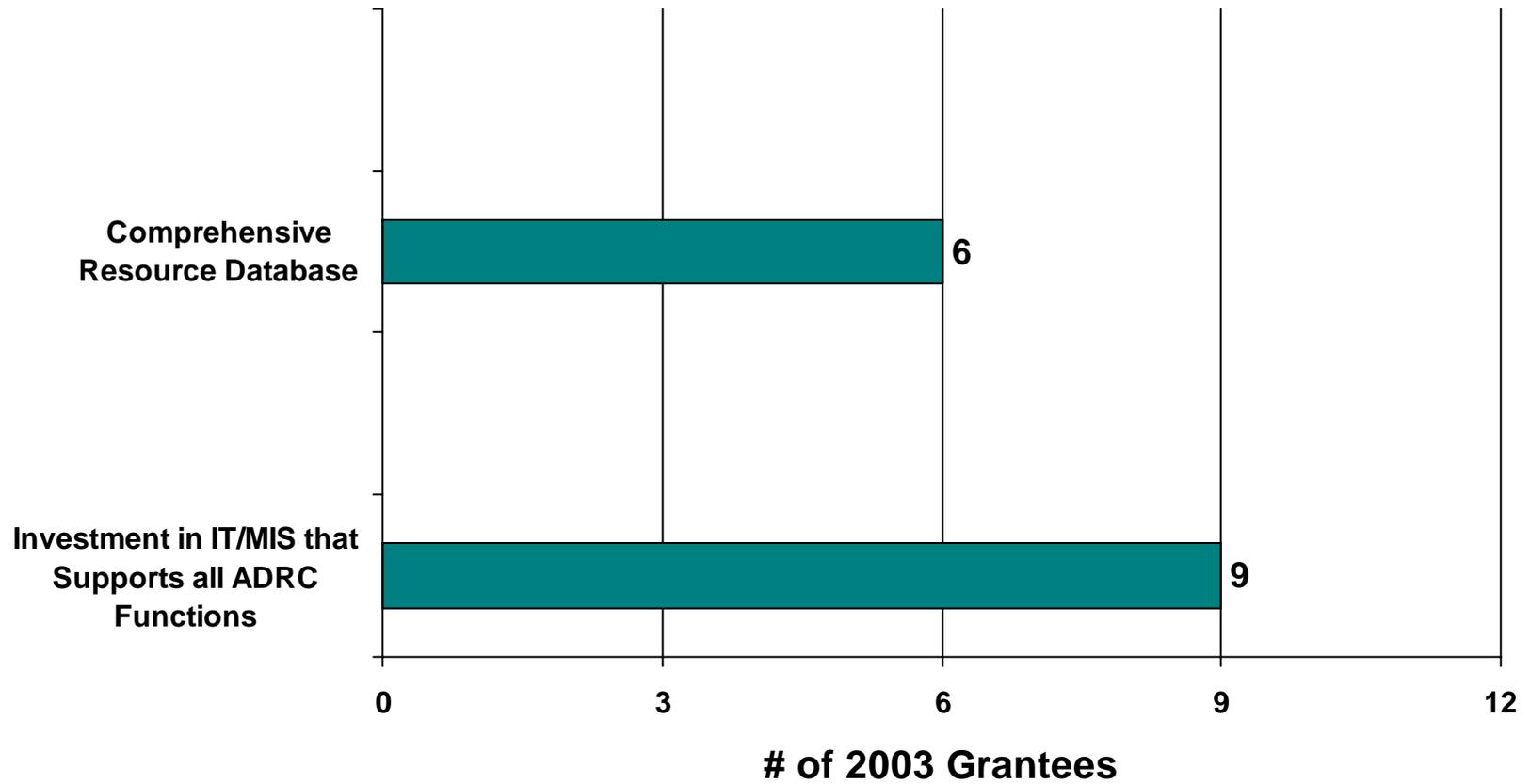
## Streamlined Eligibility—Examples of Progress Cont.

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- ◆ **PA** = Adoption of Presumptive Eligibility has reduced the time from application to service receipt from a few *months* to a few *days*
- ◆ **SC** = Have secured support from state Medicaid agency to co-locate a Medicaid Eligibility worker within the ADRC
- ◆ **WV** = Standardized intake form recently completed; trials at local level. BMS and WVQIO are discussing ways to coordinate financial eligibility

# IT / MIS

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## IT / MIS—Examples of Progress

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- ◆ **LA** = A provider for IT services, ASSIST Guide, has been selected. Next area of focus is on establishing comprehensive electronic databases of aging/disabled resources, and developing MIS protocols
- ◆ **MD** = Currently selecting an IT consultant who will help them procure an IT/MIS vendor.
- ◆ **MA** = Examined existing MIS functional capacity at each pilot site; will coordinate with state IT development process

## IT / MIS—Examples of Progress

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- ◆ **MN** = Has made progress on LTC information gathering and has established linkages with Metro-wide I&A.
- ◆ **MT** = Using Iris management information system for statewide I&A programs
- ◆ **NH** = Selected RTM as IT vendor – plan to standardize software across Service Link sites and coordinate w/211.
- ◆ **NJ** = MIS workgroup hired a vendor to collect user requirements from all other workgroups, stakeholders and local sites

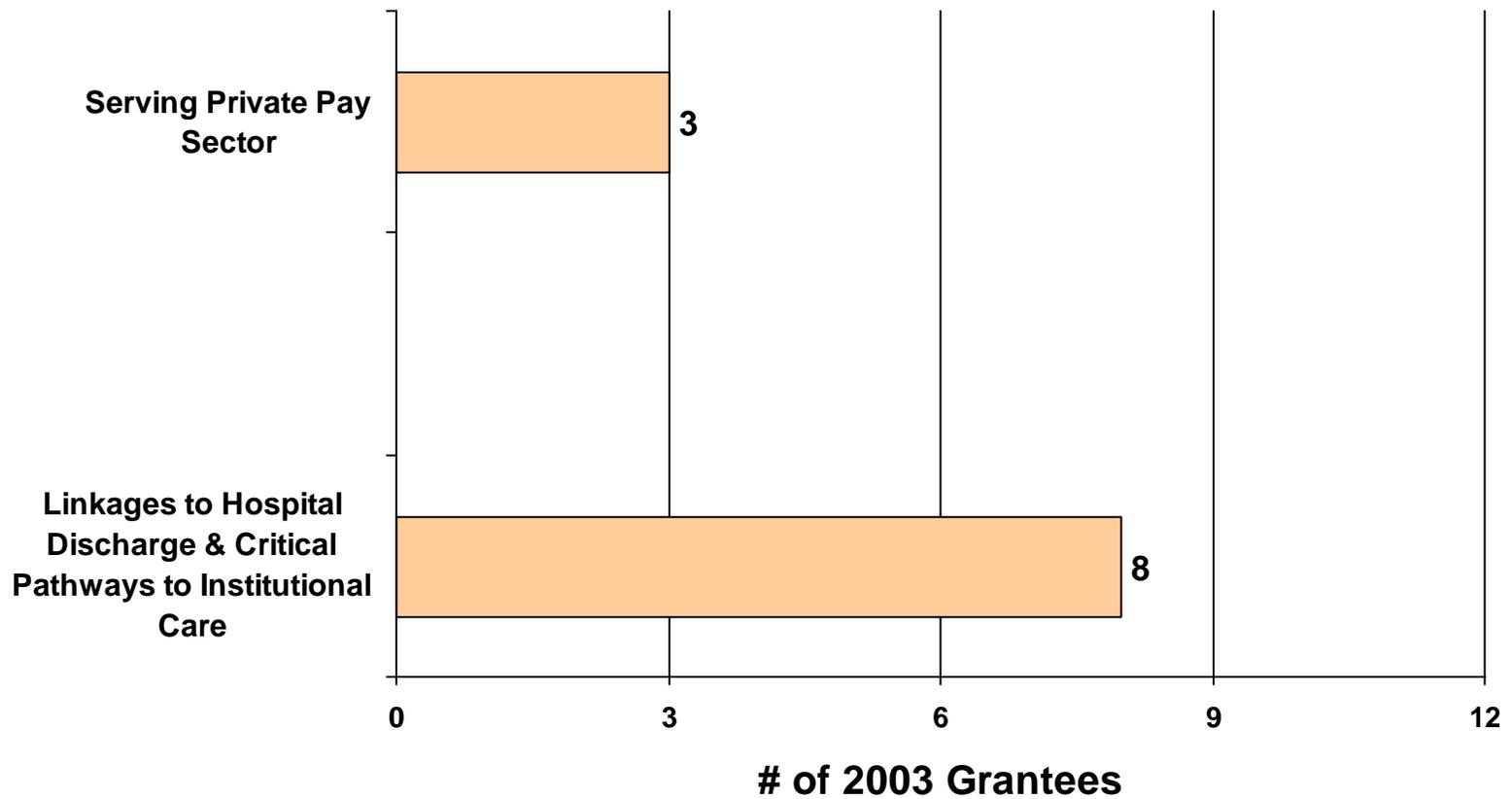
## IT / MIS—Examples of Progress

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- ◆ **RI = Short-term**-- RI will purchase an “off the shelf” software package to meet the needs of the ADRC project. **Long-term**--the State Medicaid Agency plans to revise the MIS system so that functions can be shared w/ADRC.
- ◆ **SC** = Developed specifications, secured a vendor and have begun coordination with existing system databases
- ◆ **WV** = Working with WVU Center on Aging and Center on Disability to coordinate I/R systems

# Critical Pathways

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## Critical Pathways—Examples of Progress

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- ◆ **LA** = ADRC Program Coordinator at the local level is a former hospital discharge planner – made in-roads on educating D/C planners on role of ADRC
- ◆ **ME** = Has engaged hospitals and home health agencies for participation on Steering Committee
- ◆ **MD** = Howard County pilot is reaching out to local institutions
- ◆ **MN** = Looking at everyday occurrences as potential access points such as grocery stores, community centers, faith organizations, clinics etc.
- ◆ **MT** = 20 Discharge planners have been contacted and informed about role of ADRC

# Critical Pathways—Examples of Progress

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- ◆ **NH** = Marketing to providers, hospitals, doctor's offices and case managers
- ◆ **NJ** = Local hospitals are on the local planning committees; hospitals see piloting new screening for NH placement as a great opportunity
- ◆ **RI** = Formalizing the inventory of programs that will be accessible through ADRC has helped them identify issues for private pay consumers, such as fraud
- ◆ **WV** = Are pursuing the avenue of having the ADRC notified when potential NF waiver applicants are admitted to hospitals – also examining potential HIPAA restrictions

## Year 1 Planning: TA Requests and Implementation Challenges & Facilitators

(2003 Grantees: LA, ME, MD, MA, MN, MT, NH, NJ, PA, RI, SC, and WV)

The majority of the 2003 ADRC grantees made considerable progress in reaching their planned implementation goals, such as providing information on services for aging and disabled populations; streamlining access to services; and increasing community partnerships and collaboration. However, despite evidence of progress in achieving these goals, grantees faced barriers during the first year of planning/implementation. To better understand the barriers encountered and factors that assisted planning/implementation, the Lewin ADRC-TAE analyzed the TA requests of grantees from 11/03-9/04 (collected through the TA Tracking Tool on the ADRC-TAE website), the quarterly GMD calls with AoA and CMS, as well as grantee communications with Lewin TA lead contacts. Section I below presents a summary of TA requests; Section II summarizes analyses of implementation barriers and facilitators.

### I. TA NEEDS – GRANTEE REQUESTS

Grantees requested TA in eight general areas: Development Strategies; Implementation Steps; Functions and Services; Diversionary Strategies; Consumer Involvement; IT & MIS, Project Evaluation, and Sustainability. **Exhibit 1** shows the number of requests and numbers of grantees making requests by area.

**Exhibit 1**  
**TA Requests by Category Reported by Grantees**

Technical Assistance Need	Number of Requests	Number of Grantees
Functions and Service	24	10
Development Strategies	19	11
IT & MIS	16	10
Implementation Steps	6	5
Project Evaluation	6	4
Sustainability	6	4
Consumer Involvement	4	4
Diversionary Strategies	1	1

### TA Requests/Challenges Faced by the 2003 Grantees by Topic Area

**Functions and Services.** Ten states (ME, MD, MA, MN, MT, NH, NJ, PA, SC, and WV) made numerous TA requests for clarification on the following issues:

- Streamlining eligibility and understanding Federal guidelines for financial determination

- Understanding presumptive eligibility laws
- Navigating HIPAA requirements and working with QIO
- Implementing web-based screening/assessment tools
- Coordinating with other state agencies for financial eligibility process
- Establishing a uniform functional assessment tool for all populations (60+, physically disabled adults, caregivers)
- Understanding how the Medicare Modernization Act impacts ADRC
- Determining ADRC responsibilities in employment counseling
- Determining ADRC role in housing services
- Determining ADRC role in outreach to skilled nursing facilities, acute care hospitals and rehab centers
- Determining ADRC role in health promotion and prevention
- Collaborating with relevant offices: Housing Authority, Employment offices, SNFs in community
- Defining short-term and long-term case management

**Development Strategies.** Eleven states (LA, ME, MD, MA, MN, MT, NH, NJ, PA, SC, and WV) made TA requests on the following issues:

- Building strong collaborations between Aging and Disabled communities
- Holding productive Advisory Board meetings
- Building local coalitions/establishing community “buy-in”
- Strategies to increase stakeholder involvement
- Strategies for expanding ADRCs statewide
- Developing a sound business model
- Building informed/positive relationship with Medicaid partners
- Linking ADRC I&A system with 2-1-1
- Distinguishing between “No Wrong Door” and “Single Point of Entry”
- Strategies for recruitment, increasing/training a qualified staff, developing a comprehensive job description for ADRC positions
- Understanding how HIPAA rules apply to ADRC

**IT and MIS.** Ten states (LA, ME, MD, MA, MT, NH, NJ, RI, SC, and WV) made TA requests on the following issues:

- Data sharing—between state agencies, between state/local entities
- I and R software purchase decisions
- Unified eligibility forms and assessment tools
- Integrating 2 or multiple I and R systems into 1
- Developing comprehensive assessment tools
- Identifying eligibility and case management software
- Developing computerized care plans
- Public website designs
- Federal requirements regarding tracking consumer information

- Medicaid advanced planning document
- Computerized intake forms

**Implementation Steps.** Five states (MD, MA, MN, NH and RI) made TA requests on the following issues:

- Social Marketing—how to motivate consumers to about their LTC needs
- ADRC with 2 existing organizations (multi-agency approach)
- Developing outreach/educational campaign
- Gathering information on consumer needs to inform the awareness campaign
- Reaching rural populations and shut-ins
- Marketing to external audiences (critical pathways)

**Project Evaluation.** Four states (ME, MT, NH, SC) made TA requests on the following issues:

- Developing an overall framework for evaluation, including measures beyond the minimum requirements
- Developing effective consumer measures
- Developing efficiency measures (streamlining access)
- Developing cost-saving measures
- Developing measures of consumer satisfaction

**Sustainability.** Four states (LA, MA, NH, SC) made TA requests on the following issues:

- Instituting cost-sharing
- Developing public/private partnerships
- Working with private organizations without having a conflict of interest
- Methods for increasing state Medicaid match—what activities are eligible?
- Cost-sharing and OAA restrictions

**Consumer Involvement.** Four states (LA, MD, MT, SC) made TA requests on the following issues:

- Developing meaningful/focused consumer participation groups
- Involving consumers in the planning process
- How to manage a consumer group with broad background issues from very diverse populations
- How to maintain a workable group size in light of “50% Rule”

**Diversionsary Strategies.** Louisiana made a TA request regarding:

- Serving the Private Pay Sector

## II. GMD QUARTERLY CALLS

In addition to the TA requests made by the 2003 grantees, information regarding implementation was derived from the quarterly GMD calls where grantees discussed project successes and challenges in each of the eight topic areas highlighted above. **Exhibit 2** outlines the challenges that have emerged over the course of the ADRC project that have created barriers to progress, and **Exhibit 3** outlines potential factors facilitating project success as presented by the grantees in their GMD calls with AoA and CMS.

### Exhibit 2 Challenges/Barriers to Implementation

<b>Development Strategies</b>
<ul style="list-style-type: none"> <li>• Sustaining consistent support at the State level amidst structural/ administrative changes (change in administration often = change in priorities)</li> <li>• Engagement of State Medicaid Office/Lack of involvement of Medicaid Office</li> <li>• Lack of coordination/collaboration at the State level</li> <li>• State level agencies do not see ADRC as a priority</li> <li>• Politics – some state agencies feel threatened by ADRC dollars</li> <li>• Getting cooperation with Disability community when ADRC is housed in Aging Office</li> <li>• Hiring/Staffing</li> <li>• Budget challenges</li> <li>• Linking Medicaid enrollment agents to ADRC</li> <li>• Establishing and organizing Community Coalitions</li> <li>• Tensions between some service networks</li> <li>• Reaching consensus with partner organizations re: target population</li> <li>• Maintaining enthusiasm for project goals when state reorganizes and there are personnel changes</li> <li>• Scarce resources – some see ADRC as adding duplicative infrastructure in a fragmented system</li> <li>• Boundaries of ADRC when housed in offices serving I/R to other populations (family &amp; child services)</li> <li>• NF resistance as HCBS increase – worried about loss of revenue</li> <li>• Securing a physical site location</li> <li>• Insufficient funds for IT and agency expansion</li> </ul>
<b>Implementation Steps</b>
<ul style="list-style-type: none"> <li>• Hiring key project staff is delayed due to budget restraints</li> <li>• Cross training on disability issues and cultural competency</li> <li>• Fully understanding local resources; identifying service gaps</li> <li>• Identifying support options for individuals who are NOT eligible for publicly funded programs</li> <li>• Establishing MOUs</li> <li>• State reorganization/staff turnover</li> <li>• Fiscal restraints</li> </ul>

<ul style="list-style-type: none"> <li>• Getting contracts/budgets through the State approval process</li> <li>• Insufficient time allotted for administrative processing at state level</li> <li>• Agencies that rely on volunteers – difficulty retaining volunteers due to complexity of Medicare program (LTC Health Insurance/Rx Drug Program) Need volunteers w/expertise in insurance and finance</li> <li>• Agencies agreeing to collaborate but still not using the same I/A database or intake forms</li> <li>• Decision to select pilot sites</li> </ul>
<b>Functions and Services</b>
<ul style="list-style-type: none"> <li>• Coordinating eligibility application with Medicaid</li> <li>• State Medicaid office is “on board” philosophically with streamlining the process, but slow in working out details</li> <li>• Need to learn more about service gaps before a public education/awareness campaign can be implemented</li> <li>• HIPAA compliance issues if databases are linked across agencies</li> <li>• Streamlining the financial eligibility process for Medicaid requires full participation, support and flexibility of CMS/AoA – answers are difficult to get</li> <li>• Placement of Medicaid staff in separate location as ADRC</li> <li>• Branding – lack of direction from federal level on national branding</li> </ul>
<b>IT and MIS</b>
<ul style="list-style-type: none"> <li>• Coordinating/Integrating multiple databases across aging/disability systems</li> <li>• Lack of knowledge on internet technology</li> <li>• Underestimation of time required to develop online tools and databases</li> <li>• Not enough money in the budget set aside for IT development/system upgrades</li> <li>• Feasibility of integrating I&amp;A, case management, benefits screening and resource directory into <b>one</b> system given the limited funds</li> <li>• Limited IT staff expertise</li> <li>• Reducing the amount of duplicative information consumers provide</li> <li>• Timeliness of statewide IT upgrades – may not be soon enough for ADRC needs despite support from the State to make system improvements</li> <li>• Contractual issues affect progress (between website contractor and resource database software contractor)</li> </ul>
<b>Project Evaluation</b>
<ul style="list-style-type: none"> <li>• Knowing what information to track; when to track it, and how</li> <li>• The variety of methods in place by partner organizations to track client information and referral contacts – need a standard method for data collection</li> </ul>
<b>Consumer Involvement</b>
<ul style="list-style-type: none"> <li>• Negotiating consumer involvement at State/local Advisory Board level</li> <li>• Composition of consumers/stakeholders on Advisory Boards – have different power dynamics, motivations, experience/level of understanding of system</li> <li>• Having adequate disability representation on boards</li> <li>• Balance consumer representation with large number of stakeholders</li> <li>• Maintaining communication</li> </ul>

<ul style="list-style-type: none"> <li>• Delays in developing performance standards due to poor coordination across partner organizations</li> </ul>
<b>Diversions Strategies</b>
<ul style="list-style-type: none"> <li>• Resistance from hospital discharge planners to change normal procedures</li> </ul>
<b>Sustainability</b>
<ul style="list-style-type: none"> <li>• Changes in government administration that may not support ADRC</li> </ul>

**Exhibit 3  
Facilitators to Implementation**

<b>Development Strategies</b>
<ul style="list-style-type: none"> <li>• Strong partner collaborations – at state level and local pilot level</li> <li>• Stakeholder/Partner Planning Retreats</li> <li>• Coordination of I/R and elder/disabled service grants under 1 division of State government</li> <li>• I/A programs coordinated out of Aging Office</li> <li>• State Medicaid Agency under same roof as Aging Office and Disability Office</li> <li>• Link stakeholders to ADRC project through “Blackboard” software technology</li> <li>• Workgroups that crossover various grants (ADRC, RCSC)</li> <li>• Having top-down commitment to ADRC priorities at the State level</li> <li>• Retreat with Aging Network and Disability Network to identify partner strengths</li> <li>• Solid coordination with Systems Change grant to assure the work of the Real Choice project and ADRC move in tandem towards larger goals</li> <li>• Work with and educate the legislature</li> <li>• Tie ADRC into health promotion campaigns at local level for visibility and community support</li> <li>• Active Advisory Board with productive work groups</li> <li>• Collecting and comparing intake/screening forms from other agencies to consolidate, streamline and make uniform</li> </ul>
<b>Implementation Steps</b>
<ul style="list-style-type: none"> <li>• Collaboration between Evaluation team and Marketing team to work toward common goals and share resources</li> <li>• Participation in discussion with 2-1-1 system to understand roles and ways to work together</li> <li>• Outreach to culturally diverse organizations and agencies to inform them of ADRC initiative and recruit them as partners in the development/implementation phase – creates support for development of a cultural competency subcommittee</li> <li>• Establish an Inter-Departmental team that includes representatives from various State departments to facilitate coordination</li> <li>• Following a collaborative decision-making model</li> <li>• Draft forma policies/procedure, Consumer Bill of Rights – gives structure and</li> </ul>

<p>framework and introduces accountability</p> <ul style="list-style-type: none"> <li>• Marketing surveys help answer questions regarding the perception of ADRC in the community – helps inform choices such as branding</li> <li>• Lewin TAE – Opportunity to meet with peer work groups; standing resources such as web site, newsletter, and responsiveness to TA requests</li> </ul>
<b>Functions and Services</b>
<ul style="list-style-type: none"> <li>• State Medicaid agency being actively involved in State and local planning meetings facilitates streamlining financial eligibility process</li> <li>• Staff fill out multiple forms instead of consumer</li> <li>• Shorten forms</li> <li>• Self-declaration instead of resource verification</li> <li>• Designation of “Integrated Intake Team” to assess various instruments that could be used for comprehensive use across settings</li> <li>• Ascertain when consumers initiate the search for LT support information to assist in identifying critical pathways</li> <li>• Personal contact between ADRC staff and Aging/Disability providers to learn about services available and update resource database</li> <li>• Co-locating Medicaid eligibility worker in ADRC</li> <li>• Online forms that go directly to State Medicaid office</li> <li>• Develop a triage system to determine urgency of service requests</li> <li>• Establish a common 800 number, continuously staffed to take calls from consumers/family members 24-hours a day</li> <li>• Consistent, in-person presentations to inform stakeholders and partners of the project progress</li> </ul>
<b>IT and MIS</b>
<ul style="list-style-type: none"> <li>• IT component is the key to seamless entry for consumers---IT requires more funding and time, and is a larger priority than grantees initially thought</li> <li>• Place greater emphasis on internet technology because project success depends on a very strong MIS/IT component</li> <li>• Progress requires collaboration/coordination with vendors, consultant, and other agencies with different systems--an IT workgroup can facilitate this</li> <li>• Work with a website consultant to get feedback and recommendations for improvement</li> <li>• Identifying/ Acquiring the right software for all the necessary components of the ADRC project</li> <li>• IT consulting meeting with stakeholders to build a bridge between Aging/Disability communities and discuss how resources will be connected</li> <li>• Virtual Resource Center – critical component of statewide effort especially in rural areas</li> <li>• Create formal linkages with critical pathway providers</li> </ul>
<b>Project Evaluation</b>
<ul style="list-style-type: none"> <li>• Evaluation framework and minimum data elements</li> <li>• Contracting with a consultant to conduct ongoing, cumulative semi-annual descriptive progress reports on ADRC goals</li> </ul>

- Generating customer satisfaction survey automatically for all consumers entered into the system
- Website evaluation tool for consumers that use the site that provides continuous feedback

**Consumer Involvement**

- Create sub-committees to spread out consumer involvement and make the meeting times meaningful and productive
- Identify all relevant partners early on to establish representation on the Advisory Boards
- Establish a shared vision and common principles across various stakeholders to guide the design and implementation of the ADRC

**Diversionsary Strategies**

- Create formal linkages with critical pathway providers (local hospitals on planning committee)
- Bring NF representatives to the table for discussion to reassure their role in the continuum of care for LT supports and to head off potential resistance

**Sustainability**

- Having statewide comprehensive resource database helps facilitate ADRC replicability
- Governor’s support gives visibility and financial stability to project
- Speaking at NGA Policy Academy helps put ADRC on Governor’s agenda
- View ADRC grant as *one* way to fund ADRC program model statewide – look for other sources of funding and “sell” ADRC model on a regular basis