Aging and Disability Resource Centers Technical Assistance Exchange Grantee Meeting

October 4-5, 2004 * Arlington, Virginia* Hilton Arlington

October 4th (9:30-11:30)

Split Session: 2003 Grantees

Presentation on 2003 ADRC Grantee Progress in 2003-2004
Presenter: Karen Linkins, The Lewin Group, ADRC-TAE

- Much has been accomplished in the five key domains for Aging and Disability Resource Centers (ADRCs)
    - Stakeholder Partnerships and Input:
        - Grantees made progress in establishing stakeholder partnerships and engaging key stakeholders in the ADRC. Outreach occurred at the local level and there was coordination across systems change grants.
    - Business Operations
        - Little less progress in staffing most likely because grantees had to first accomplish many other activities such as establishing pilot sites before they could focus on staffing issues.
        - Nine grantees made progress in the area of marketing and outreach—unanticipated progress.
    - Streamlined Eligibility
        - Streamlined eligibility will be an important component of the ADRC with an expectation that after three years, ADRCs will have created access to all public programs.
        - Streamlining eligibility is closely tied to the notion of "access." The definition of access will change as grantees move forward in implementation of the ADRCs. Many grantees have made progress in conceptualizing a seamless system for access.
    - IT and MIS
        - In terms of investment of IT and MIS, there has been a lot of progress.
        - Many grantees reported that it surprised them how much time it took to set up IT and MIS.

- Critical Pathways
    - ADRCs are also expected to connect to critical pathways. In this area, grantees have not made a great deal of progress; however, activity in this area will grow as we move forward.
    - Three grantees made progress serving the private sector which is important for sustainability.
    - Eight grantees made links with hospital discharge planners and institutional care.

Grantee Discussion on Challenges, Successes, and Thoughts on the Past Year
Facilitator: Susan Reinhard, Co-Director, Rutgers University, Community Living Exchange Collaborative

Stakeholder Collaboration

- SC: **Involve and engage stakeholder early on as partners.** In South Carolina, we held a retreat between 50+ key stakeholders early in the project facilitated by Rutgers and The Lewin Group. This retreat was vital for engaging partners. While partners were initially apprehensive, involving them in initial discussions and planning has been key in gaining their assistance in establishing the ADRC. People who were initially critical are not fully involved have come a long way. This meeting was particularly vital for the SC ADRCs because as an ADRC, we do not have political clout to make these people work together; our system is fragmented. This has made engagement of stakeholders particularly challenging on the local level, but we have found success by focusing on what is in it for the partners. As the project has progressed, we have engaged additional individuals. We discovered that individuals we engaged early on as "partners" in the project are more responsive than individuals engaged at a later stage of the ADRC.
- ME: **Integrate state and local cultures because local staff may know their consumers best.** Maine is very culturally diverse. We worked to integrate Maine's state culture with local cultures. When engaging partners, you must be aware of the local culture. For example, at the local level, staff is very aware of how individuals in the local community will respond to new partners; discussions with local individuals revealed that we should consider creating virtual resource centers because this is how consumers want to access resources. My work with consumers from other projects has really taught me how important it is to build new collaborations on other collaborations. Ask yourself how you can use previously established infrastructures to enhance what you are currently trying to accomplish.
- MT: **When collaborating with partners, stress how the ADRC can assist them.** Social services in Montana are financially stressed. By marketing the ADRC to social services as a means for assisting them in services, they were happy to collaborate. Also, physicians send us individuals who need information because

many physicians do not have the time to become familiar with all the information that we have at our resource center.

- NH: **Virtual communication is an important way to facilitate collaboration.** We use software developed by the University of New Hampshire to enable communication between advisory board members. Using this software, we set up a site where meeting agendas and materials are accessible.
- PA: **Political support facilitates collaboration between stakeholders.** In Pennsylvania, the governor set up a central office for coordination; this has been key; for example the income maintenance department is now very eager to coordinate.
- MD: **Partnering the ADRC with existing systems change efforts has been effective.** In Maryland this partnering along with a broad based advisory board with the involvement of many departments has moved forward the launch of the ADRC.
- MA: **Training advisory group members on the role of the ADRC may make members more effective when working together.** In Massachusetts, we initially formed two advisory groups, one comprised of community partners including hospital representatives, CEOs, etc and another comprised of consumers. Because there is a large power differential, we separated these two groups, trained members by providing information on the ADRC and a leadership orientation. After advisory group members completed training, we merged the two groups.
- NJ: **Work groups are an effective way to accomplish ADRC tasks.** New Jersey formed three planning groups focused on disability, planning, and the ADRC. Further, twelve work groups representing 210 people have held over 90 meetings working on topics such as eligibility, etc.

Grantee Discussion on Streamlining Access
Facilitator: Susan Reinhard

- MT: We contracted with RTM for a resource database and consumer tracking tool. This tool is the same one used by our 211 system which will enable us to link the ADRC and 211 systems together. Eventually we plan to automate our clinical eligibility process for nursing home and waiver services.
- LA: Similar to the governor in Pennsylvania, the Louisiana governor made long-term care a priority. This political backing brought all sorts of agencies to the table; prior to this governor, people were unwilling to share turf. Now, it is much easier to figure out agencies duplicating.
- ME: In Maine, our department has a long and cooperative relationship with the Medicaid agency. Our focus was previously on the functional side of eligibility, now we are working on the financial eligibility piece.
- NH: In 1997, we enacting a universal screening process for nursing homes. There was a lot of dissent with this because people thought the screening process

was invasive; we thought the screening process was beneficial because we could help provide services individuals need. In terms of Medicaid streamlining issues, we are trying to make inroads into the non-medical populations by using the caregiver support program as the basis for the ADRC because these programs are very trusted. Perhaps this trusted source will help appease dissenters of the universal screening process.

- MD: Maryland is currently undergoing a huge change in the Medicaid program by using the managed care program to absorb waivers. We hope Medicaid and the ADRC go in the same direction and both agencies have agreed that we need to move forward together and partner between Medicaid and the ADRC.
- MT: We hope to use an entry system for all programs by collecting basic information that will populate every department's form.
- PA: Pennsylvania has the backing of the governor which has encouraged collaboration between agencies. Now that individuals are encouraged to think of creative ways to streamline the system, they do. We streamlined the eligibility process from multiple months to 24 hours in three months of work.
- LA: Michigan hired an eligibility worker that formerly worked for the Medicaid system and this really helped connect programs. If you assure people they won't be penalized for mistakes and you hire a knowledgeable person to assist in the eligibility process, this will really assist programs in moving forward and streamlining eligibility. The fact that the eligibility person in Michigan was networked with Medicaid people this was good.

Merging Aging Populations and Populations with Disabilities

- MD: The agencies charged with older adults and adults with disabilities are independent but collaborate well. Trust between the aging and disability agencies is slowly growing through regular briefings; this is a great way to build relationships and should be accomplished on a one-on-one basis, not through a conference. About fifteen years ago we tried to consolidate three services serving the long-term care consumers and this ended badly because there was no consensus on values and goals. Our collaboration with ADRC is not going like this; it is going well. The federal government is allowing us to target both aging and disabled consumers and this is very important. The governor's backing is likely and this is important. Further, language is really important in building networks and coalitions and you must work at this because language is different between the aging and disability network.
- ME: At the community and consumer level we are aware of the concerns consumers are bringing up about the language issue between aging and disability networks and talking about how to approach programs, etc. Language is an issue when trying to merge these two networks.

Centers for Medicare and Medicaid Services (CMS) Vision for ADRCs

- RI: What is the level of coordination between CMS and Administration on Aging (AoA) on the ADRC initiative? Is the ADRC grant a priority at CMS?
- Dina Elani at CMS: We have discussed the ADRC grant quite a bit within CMS. While the network for this grant is mostly from the aging network, we know that it is important for grantees to feel that the grant is a priority. In the technical assistance monthly calls, we invited state Medicaid directors to join and we have tried to work through state Medicaid issues with several states that wanted to do this one-on-one. However, we do want to know how we can further emphasize the importance of the ADRC as a priority within CMS.
- NJ: We are faced with several challenges. First, we find the Department of Health and Human Services speaks a different language than the Medicaid Agency; even though we may be using the same words, each department interprets the words in a different way. Also, we find coordination between agencies to be challenging. For example, the Office of Aging does not understand why a certain question must be on the Medicaid application so we have to explain that the question is part of a Medicaid regulation that we have no power to change. Perhaps CMS could come up with a list of questions that are absolutely required on an application.
- Dina Elani at CMS: Perhaps we could arrange a person to person call discussing jargon, regulation, and laws that make collaboration difficult?
- RI: We think the discussion needs to take place in person with a facilitator. While we are not yet at the level of detail that New Jersey is discussing, we do think that at this point, we should have someone at the Medicaid agency that is dedicated to issues of how people apply to long term care in Rhode Island. The Medicaid individuals should be accountable to CMS and have deliverable around this issue.
- MN: It has been my experience with cross state agency collaboration that you must see the other agency's perspective and discuss how you can help them. For example, the Medicaid agency in Minnesota is very much focused on the Medicaid Part D and we need to relate the ADRC to the Part D in order to collaborate with the Medicaid Agency. In Minnesota, we are struggling with the disability network. We need CMS people involved in the waiver process to engage in quality assurance, not just eligibility activities.
- MD: We need some time and engagement with Medicaid people on where their current focus is. CMS needs to recognize we are struggling with the managed care waiver and communicate with us how the ADRC can complement and improve the managed care waiver program.
- ME: In our state, one agency does the eligibility for Medicaid and every other program. The ADRC is only 10% of this agency's business. We need to consider that the ADRC is only one activity going on in the state. Also, agencies in the state are receiving mixed messages. The state emphasizes the importance of cost

savings while CMS emphasizes a motto that is "everything for everyone." There needs to be some sort of balance between these messages.

- MA: We need CMS to help workers in Medicaid. When I call Medicaid state office I get two answers to the same question. Workers need additional training and CMS needs to perform quality oversight.