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Aging and Disability Resources for Colorado

Learning Documents

Introduction

Coloradans must navigate a confusing maze to gain eligibility and then to enter Colorado's long term services and supports (LTSS) system. This often results in vulnerable residents either not receiving necessary services or receiving care that is too little and too late.

Aging and Disability Resources for Colorado (ADRC) – formerly known as Adult Resources for Help and Care or ARCH – were set up to create more streamlined access to LTSS and to provide counseling to help people get the services they need. The ADRCs are important pieces of the entry point puzzle

Colorado's 16 ADRC programs have developed over the years to fit the unique needs of individual communities. Now, the goal of streamlining access to much-needed LTSS provides the ADRC programs with an opportunity to learn from each other.

The Colorado Health Foundation (CHF) brought together key stakeholders in the spring of 2013 to discuss opportunities for collaboration. The stakeholders indicated that it would be helpful to learn more about the different ADRC programs. CHF contracted with the Colorado Health Institute (CHI) to create a learning document that the ADRC programs could use as a tool to facilitate discussion and to help identify opportunities to collaborate on strategic partnerships and initiatives.

The Colorado ADRC Matrix is the first piece of that learning document. It provides information that forms a baseline for comparing the similarities and differences of the ADRC programs. The second piece of the learning document will include a "state of the state" analysis of the entry point system in Colorado and of key success factors for ADRC programs.

Investments are being made to streamline access to LTSS across Colorado. CHI is monitoring this work at the state level to help inform the ADRC programs what the "state of the state" looks like today and what it may look like in the future. At the same time, investments are being made across the country to figure how best to support state activities. CHI will analyze key success factors for streamlining access to LTSS both here in Colorado and around the country.

Learning Document Part One: The Colorado ADRC Matrix

This matrix compares operating structures, governance, funding and service provision across the 16 ADRC programs. Information was gathered from existing sources, including the Semi-Annual Reporting Tool (SART) and web sites, as well as these two particularly helpful sources – an ADRC survey conducted in April 2013 by the Pikes Peak Area Council of Governments' (PPACG) and an implementation status report submitted by the Colorado Department of Human Services to the federal Administration on Community Living in November 2013.

• **Page 2:** The Matrix • **Page 3:** Definitions and Sources • **Page 4:** State of the State and Key Success factors

Region Number and Name	Counties served	Year Started	Legal Structure	Co-Location (AAA, County or SEP)	Governance	Partners (as of April 2013)	Contracts or MOUs	FTE by Service (August 2013)		Funding Sources (as of June 2013)	Number of Contacts (Apr.-Aug. 2013)	Number of Clients Served (Apr.-Aug. 2013)	Number of Clients Served (Apr.-Aug. 2013)	Population and Percent of Population Served 2013	
								Info and Referral	Options Counseling				Over 60	Under 60	Over 60	Under 60
1. Northeastern Colorado ADRC	Logan, Morgan, Phillips, Sedgwick, Washington & Yuma	2011	501(c)(3), Membership organization of local governments	AAA, SEP	Board of County Commissioners and City/ Municipal Representatives; Advisory Council (Quarterly)	SEP, ILC, SUA, APS, CCB, AAA, SHIP, Alzheimer's Assoc.	N/A	4 at 20% (.8 FTE)	4 at 5% (.2 FTE)	ADRC & CHF funds	121	49	45 (92% of clients served)	3 (6% of clients served)	16,075 (0.28%)	56,330 (0.01%)
2A. Larimer County ADRC	Larimer	2006	County	AAA, SEP, Larimer County	Board of County Commissioners; Advisory Council (Quarterly)	N/A	LCA	3 FTE	1 FTE	N/A	1,318	387	321 (83%)	61 (16%)	60,948 (0.53%)	255,630 (0.02%)
2B. Weld County ADRC	Weld	2011	County	AAA, SEP, Weld County	Board of County Commissioners; Advisory Council (Quarterly)	SUA, AAA, local university, DHS, ILC, 2-1-1, consumer, SNF, ALF, CCB, SEP	N/A	1 at 50% (.5 FTE)	Same 1 at 50% (.5 FTE)	ADRC, CHF and OCA funds	113	77	58 (75%)	17 (22%)	42,721 (0.14%)	226,665 (0.01%)
3A. DRCOG ADRC	Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Gilpin & Jefferson	2012	501(c)(3), Membership organization of local governments (includes AAA)	AAA	Board of County Commissioners and City/ Municipal Representatives; Advisory Council (Bimonthly)	SEP, ILC, SUA, APS, CCB, AAA, SHIP, DHS, medical clinic, private nonprofits, AARP, 2-1-1	7 Hospitals, Counties, VA	4 FTE	2 FTE	ADRC & CHF funds	1,546	1,154	685 (59%)	208 (18%)	445,021 (0.15%)	2,204,018 (0.01%)
3B. Boulder County ADRC	Boulder	2011	Collaborative Partnership based in AAA (AAA is a division in Boulder County Community Services)*	None	Board of County Commissioners; Advisory Council (Quarterly)	SEP, ILC, SUA, CCB, AAA, private nonprofits	SEP, County	1 at 50%, 1 at 20% (.7 FTE)	Same 1 at 50%, Same 1 at 20% (.7 FTE)	ADRC, CHF, OAA SFSS funds	471	439	329 (75%)	47 (11%)	53,959 (0.61%)	254,996 (0.02%)
4. Pikes Peak ADRC	El Paso & Teller	2009	Membership organization of local governments	AAA	Board of County Commissioners and City/ Municipal Representatives; Advisory Council	SEP, ILC, CCB, APS, DHS, BHO, SUA, 2-1-1, private nonprofits, Alzheimer's. Assoc., consumer	N/A	Multiple	1 at 40% (.4 FTE)	ADRC, CHF	2,124	524	451 (86%)	61 (12%)	113,769 (0.40%)	565,182 (0.01%)
5. East Central	Cheyenne, Kit Carson & Lincoln	Dec. 2013	County	SEP, Kit Carson County	Board of County Commissioners	N/A	N/A	1 at 50% (.5 FTE, Jan.'14)	1 at 50% (.5 FTE, Jan. '14)	N/A	N/A	N/A	N/A	N/A	3,512	11,956
6. Lower Arkansas Valley ADRC	Crowley, Otero, Bent, Baca, Prowers & Kiowa	2010	County	AAA, SEP, Otero County	Board of County Commissioners; Advisory Council (Bimonthly)	SEP, SUA, CCB, AAA, SHIP, hospital, BHO, consumer	VA	1 at 60% (.6 FTE)	1 at 15% (.15 FTE)	ADRC, CHF	194	194	115 (59%)	79 (41%)	11,650 (0.99%)	36,245 (0.22%)
7. Pueblo County ADRC	Pueblo	2009	501(c)(3)	AAA	Advisory Council (Monthly)	SEP, ILC, SUA, APS, CCB, AAA, SHIP, DHS, hospitals, AARP, 2-1-1, nursing homes	County, LCA, 2 Hospitals	3 at 85% (2.55 FTE)	Same 3 at 15% (.45 FTE)	OAA/OCA, ADRC, CHF, county, city and private funds	1,807	1,488	936 (63%)	518 (35%)	37,950 (2.47%)	125,018 (0.41%)
8. South Central Colorado Seniors	Alamosa, Conejos, Costilla, Mineral, Rio Grande & Saguache	2010	501(c)(3)	AAA	Advisory Council (Monthly)	SEP, SUA, APS, CCB, AAA, SHIP, DHS, hospital/ medical network	VA	1 at 60% (.6 FTE)	1 at 15% (.15 FTE)	ADRC, CHF	221	167	128 (77%)	26 (16%)	11,045 (1.16%)	36,040 (0.07%)
9. San Juan Basin ADRC	Archuleta, Dolores, La Plata, Montezuma & San Juan	2012	501(c)(3)	AAA	Advisory Council (Bimonthly)	SEP, ILC, SUA, AP, CCB, AAA, SHIP, ALFs/SNFs, senior centers	N/A	8 at ?%	4 at ?%	OAA/OCA, ADRC, CHF, county/local & other	587	467	382 (82%)	36 (8%)	22,890 (1.67%)	72,430 (0.05%)
10. Montrose ADRC	Montrose, Delta, Gunnison, Hinsdale, San Miguel & Ouray	Jan. 2013	501(c)(3), membership organization of local governments	AAA	Board of County Commissioners and City/ Municipal Representatives	AAA	N/A	N/A	N/A	N/A	206	185	146 (79%)	36 (19%)	25,896 (0.56%)	75,075 (0.05%)
11. ADRC of Mesa County	Mesa, Garfield, Moffat, Rio Blanco, & Routt	2008	County	AAA, SEP, Mesa County	Board of County Commissioners; Advisory Council (Monthly)	AAA, SEP, 2-1-1, Hospital	1 Hospital, LCA	4 FTE	1, 1 case manager	N/A	1,930	1,331	805 (60%)	526 (40%)	51,013 (1.58%)	201,133 (0.26%)
12. Northwest COG	Summit, Eagle, Pitkin, Grand, & Jackson	Oct. 2013	Membership organization of local governments	AAA	Board of County Commissioners and City/ Municipal Representatives	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	19,241	96,816
13. Upper Arkansas ADRC	Chaffee, Lake, Fremont & Custer	2012	501(c)(3)	AAA	Advisory Council appointed by Upper Arkansas Area Council of Governments	SUA	VA	1 at 15% (.15 FTE)	1 at 25% (.25 FTE)	ADRC	113	115	79 (69%)	23 (20%)	21,141 (0.37%)	56,961 (0.04%)
14. Huerfano/ Las Animas COG	Huerfano & Las Animas	Mar. 2014	501(c)(3), membership organization of local governments	AAA	Board of County Commissioners and City/ Municipal Representatives	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	6,838	15,075

The Colorado ADRC Matrix: Definitions and Sources

Legal Structure:

Definition: How ADRCs are structured at the organizational level. For simplicity of comparison, the broad categories include:

- 501(c)(3) – A non-profit entity or part of a larger non-profit organization.
- Membership organization of local governments – Voluntary associations of local governments formed under Colorado law. Councils of government serve as a forum for local governments to identify regional issues and opportunities, develop strategies and provide a more consolidated system to provide oversight of various regional programs. (From the Colorado Association of Regional Organizations.)
- County – Part of county government.

Source: Web-based research

Co-Location:

Definition: The ADRC is under the same umbrella organization or it is in the same physical location as one of these entities:

- AAA – Area Agency on Aging
- SEP – Single Entry Point agency
- None – Not co-located

Source: Web-based research and Implementation Status Report

Governance:

Definition: The main governing body or bodies.
Source: Web-based research

Partners:

Definition: Organizations that provide fiscal support, serve on an advisory council, or have a Memorandum of Understanding (MOU) with the ADRC, including:

- AAA – Area Agency on Aging
- ILC – Independent Living Center
- SUA – State Unit on Aging
- APS – Adult Protective Services
- CCB – Community-Centered Board
- SEP – Single Entry Point
- SHIP – State Health Insurance Assistance Program
- BHO – Behavioral Health Organization
- ALF – Assisted Living Facility
- SNF – Skilled Nursing Facility
- DHS – Department of Human Services

Source: PPACG ADRC Survey

Contract or Memorandum of Understanding (MOU):

Definition: Formal contracts or partnerships with other entry point or a state or federal agency, including:

- LCA – Local Contact Agency for Medicaid transition services
- VA – Veterans Affairs
- SEP – Single Entry Point

Source: Implementation Status Report

FTE by Service:

Definition: Full-time equivalent (FTE) employees by service category, including:

- Information and Referral – Information and referral to programs, services and resources
- Options Counseling – Information and support in making decisions about LTSS plus assistance in navigating the system

Source: Implementation Status Report

Funding Sources:

Definition: Source of operating funds, including:

- ADRC – Federal funds
- CHF – Grant from The Colorado Health Foundation
- OAA/OCA – Older Americans Act/Older Coloradans Act
- SFSS – State Funding for Senior Services

Source: PPACG ADRC Survey

Numbers Served:

Definition: The last four columns of the matrix include the number of contacts made to the ADRC during the report period (calls or walk-ins), total number of clients served during the report period, and the number of clients aged 60 and over and under 60. The number of clients served age 60 and over and under age 60 may not add up to the total clients served because some clients' ages are unknown. The report period for these data is April 1, 2013 to September 1, 2013.
Source: Semi-Annual Reporting Tool (SART)

Learning Document Part Two: State of the State and Key Success Factors for Aging and Disability Resources for Colorado

LTSS Entry Points in Colorado: A Brief History

Colorado historically has been a leader in serving those who need long-term services and supports (LTSS) in their homes and in the community. In turn, a system of supports related to home and community based services (HCBS) and other settings has been created to support the state's commitment to serving residents where it is most appropriate – and where they most want to live. The most successful LTSS programs serve clients efficiently and in a timely manner.

Colorado's LTSS system was built over the years to take advantage of opportunities to expand HCBS as well as to expand the populations being served. Today, many organizations provide an array of services for many different populations. Sometimes, however, different organizations provide the same services to the same populations, resulting in a system that is often duplicative, fragmented and siloed.

This problem is not unique to Colorado. Because of this, the federal government, in an effort to upgrade LTSS services across the country, has designed a grant opportunity to form Aging and Disability Resource Centers (ADRCs).

The initiative, led by the federal Administration on Community Living (ACL), seeks to create a highly visible point of entry. The goal is to streamline access to LTSS across income levels and adult populations, including older adults, adults with disabilities, caregivers and providers.

The first Colorado ADRC opened its doors in 2006 in Larimer County. Today, 16 ADRCs cover all but two counties, Elbert and Park.

At the same time, Colorado has several types of LTSS entry points, all with their own histories and all with different purposes, but sometimes serving the same populations:

- Single Entry Points (SEPs) and Community-Centered Boards (CCBs) determine functional eligibility for Medicaid HCBS and other LTSS programs, with CCBs serving the population with developmental and intellectual disabilities and the SEPs serving all other eligibility categories.
- County departments of human services determine financial eligibility for Medicaid LTSS.
- Area Agencies on Aging (AAAs) and Independent Living Centers (ILCs) serve distinct populations and provide information and assistance as well as services to older adults and people with disabilities, respectively.

The goal of the ADRCs is to serve all populations, to help people to navigate the complicated system, and to provide options for obtaining services.

An urgency surrounding services for these populations has emerged with the coming wave of the "silver tsunami" and with longer life expectancies for people with disabilities.

ADRCs: Today and Tomorrow

Work at the state level and among communities is centered on streamlining access to LTSS services and programs.

Colorado Governor John Hickenlooper signed an executive order in July 2012 creating the Office of Community Living and the Community Living Advisory Group. The vision of the Community Living Advisory Group is to increase access to community-based supports for LTSS that will help people to live in the location of their choosing with the supports they need and participate in communities that value their contributions. The charge is to create a roadmap that redesigns all aspects of the LTSS system, including access, and recommend changes to the legislature and the governor.

The Community Living Advisory Group created subcommittees to tackle the task. The Entry Point/ Eligibility Subcommittee is charged with recommending ways to redesign the entry point system to better streamline access to LTSS and eligibility determination for Medicaid LTSS.

The subcommittee has presented four redesign recommendations to the larger Community Living Advisory Group for discussion. Two could have major implications for ADRC programs.

The first recommendation is a proposed statewide "800" number that would automatically pinpoint the caller's location and could direct the caller to the closest regional entity for information and options. The caller also could access a newly created online resource guide that details services by region.

The "800" number proposal includes a recommendation that one entity be placed in charge of the program. That entity would complete an initial intake with a statewide data system that could share the information with other data systems. Intake specialists would be appropriately trained to make referrals to all resources. This means they could identify whether someone is potentially eligible for public programs. The ADRC may be an appropriate entity to house the "800" program, but the subcommittee made no specific recommendation.

The second recommendation is a no-wrong door, conflict-free entry point model, a system that is being adopted across the county. This model ensures that all individuals have the same access to information and resources on LTSS and are assessed only once for the entire range of LTSS for which they may be eligible with an emphasis on coordinating functional and financial components of eligibility. The model removes two potential conflicts of interest in the entry point system:

- Eligibility determination and case management
- Case management and service delivery

This model is incentivized in the Balancing Incentive Program created by the Affordable Care Act. While Colorado does not qualify for the program, the subcommittee's recommendation includes several elements, including having all access to LTSS go through one agency. That agency would be responsible for assessing a person's needs and providing options counseling that would help identify an appropriate service delivery model.

The agency would determine program eligibility, allowing the applicant to then choose a case management agency, essentially removing the potential for a conflict of interest when one agency determines eligibility and offers case management.

The subcommittee also recommended that contingencies be made for rural and frontier counties, where separation of eligibility determination and case management may not be possible. Further, the recommendation identifies the need to develop a payment system to ensure that entry point functions and case management are adequately funded.

What is a Fully-Functioning ADRC?

Established criteria exist at the federal level for what constitutes a "fully-functioning" ADRC. The six core components are:

1. Information, Referral and Awareness
2. Options Counseling and Assistance
3. Streamlined Eligibility Determination for Public Programs
4. Person-Centered Transition Support
5. Consumer Populations, Partnerships and Stakeholder Involvement
6. Quality Assurance and Continuous Improvement

Two initiatives at the state level may indicate a larger role for ADRCs in the future.

The Department of Health Care Policy and Financing (HCPF) has requested funding in the fiscal year (FY) 2014-15 budget for ADRCs to counsel Medicaid clients who want to transition from a nursing home to the community, as indicated in Section Q of the Minimum Data Set (MDS). Currently, HCPF lacks the infrastructure to pay for clients to receive counseling for community-living options. Given the unique position of ADRCs as an entry point for all LTSS clients, HCPF identified them as the appropriate organizations to coordinate transition services. If approved, this funding request would create the opportunity for HCPF to integrate ADRCs in the Medicaid system.

The ACL and the Veterans Health Administration provided an opportunity in 2008 for State Units on Aging and Area Agencies on Aging to serve veterans of all ages who are at risk of being placed in nursing homes. The Veteran Directed Home and Community Based Service Program (VD-HCBS) allows veterans to direct their own LTSS to avoid institutionalization. This would be accomplished through facilitated assessment and service planning, arranged fiscal management services, and ongoing options counseling and support.

Two ADRC sites in Colorado - Mesa and Otero counties - are joining the VD-HCBS program and may serve as a model for other ADRC sites.

Many moving parts make up the current and future state of entry points and ADRCs in Colorado. But stakeholders have shown a commitment to streamlining access to Colorado's LTSS system.

Key Success Factors

Colorado's ADRC program has made significant progress toward meeting the core components outlined by the federal government. Still, there is room for improvement, as outlined in a September 2013 report to the ACL.

CHI has identified five key factors that will help Colorado's program be more successful moving forward. These factors were derived by synthesizing qualitative information from the report to the ACL, listening to discussions at the Community Living Advisory Group and conducting key informant interviews.

Five Key Success Factors:

1. Implement sustainable funding models.
2. Integrate data systems.
3. Increase community awareness.
4. Develop strong partnerships and relationships.
5. Serve all populations.

Implement Sustainable Funding Models

To be successful, ADRC programs must identify and implement a sustainable funding model.

Grants from the ACL and the Colorado Health Foundation have provided most of the ADRC funding in Colorado. With the aging of the population and the changing landscape of LTSS system, more importance is being placed on making people aware of the range of LTSS options before they decide on a care plan – increasing the potential growth for ADRCs.

Financial sustainability will be crucial for ADRCs as they grow and need more funding. Successful financial sustainability models will generate funding from multiple and on-going sources.

Across the country, ADRCs are figuring out how to leverage public dollars to support the no-wrong door approach to LTSS access. They are working with Medicaid and the Veterans Health Administration as well as targeting funding through demonstration projects such as Money Follows the Person.

Because the goal of the ADRCs program is to serve all populations at all income levels, there may be opportunities to partner with local service agencies to pool funding, such as an independent living center.

Colorado Perspective

Colorado has received a grant from the ACL to analyze the sustainability of core ADRC activities. The Colorado Department of Human Services has contracted with CHI through this grant to better understand the feasibility of leveraging Medicaid dollars moving forward, with a final report due in August 2014.

The ACL, and increasingly CMS, are creating funding strategies and opportunities to support states as they create no-wrong door entry point systems for LTSS.

In some states, Medicaid pays for ADRC functions through the Federal Financial Participation (FFP) claiming process. The functions receiving Medicaid FFP include outreach, information and referral, application assistance, and pre-screening, among others.

States can also secure Federal Medical Assistance Percentage (FMAP) for ADRC services as part of their state plan.

Colorado Medicaid, as noted earlier in this report, has requested funding for the FY 2014-15 budget to contract with ADRCs to provide options counseling for individuals on Medicaid transitioning from nursing homes to the community. If approved, this service will receive an FMAP match.

National Perspective

The best sustainability models clearly demonstrate the value of ADRCs. They do this by becoming a visible, valuable resource in the community by creating strong partnerships and providing robust ADRC services.

For example, Maryland first received ADRC grants in 2003 and went statewide with its ADRC Maryland Access Points (MAPs) in 2012. MAPs are Maryland's ADRCs and serve as entry points for LTSS. The state faced numerous obstacles in creating its MAPs system, including silos in the service system, an unclear path to services, and

even territorial behavior. Ultimately, Maryland saw that a lack of trust between stakeholders was preventing productive conversations about organizational strengths and weaknesses.

As they developed, leaders recognized MAPs as an opportunity to shape broader LTSS reform initiatives. A strong commitment to training and to data sharing further helped MAPs become a visible, trusted place for people seeking information and access to LTSS.

MAPs are involved in many LTSS initiatives across Maryland. In 2013, MAPs were codified in state statute, making them an official LTSS entry point.

State staff shared several lessons from the success of their MAPs program:

- Encourage communication. All stakeholders should be at the table providing feedback and input for shared decision-making.
- Create a shared vision with stakeholders and coordinate other state efforts.
- Achieve commitment at all levels, from clients to the state and legislature. "Champions" committed to success should be leveraged.
- Decide if reorganization of LTSS entry points and providers is needed to create sustainable ADRCs. Sometimes it's not.
- Pool resources from across funding streams to maximize limited funding for LTSS.
- Formalize partnerships at the state and community level.

Integrate Data Systems

To be successful, the ADRC system must have integrated data systems that are capable of sharing information across settings and providers.

A truly effective LTSS delivery system requires data systems that share electronic health records and care management records across all settings and providers. The LTSS entry point system will be most effective when it is linked to a streamlined data system.

With a connected data system, ADRCs will be able to provide more accurate information for options counselors. Further, the initial intake often done by ADRCs will feed into the streamlined data system and reduce the number of times applicants have to repeat their story, as well as help ADRCs be more effective when assisting clients with applications.

Colorado Perspective

Colorado's LTSS entry point system uses multiple data systems that are not interoperable with each other. Essentially, they do not "talk" to each other.

There is little electronic communication between the ADRCs, which provide options counseling and some application assistance, and the SEPs, CCBs and county departments of human services, which determine eligibility for Medicaid. Further, there is little communication between SEPs and CCBs, which determine functional eligibility and provide case management for Medicaid using the ULTC 100.2 assessment tool, and the county departments, which determine financial eligibility for Medicaid using the Colorado Benefits Management System (CBMS). Without this communication, people often wait months to learn whether they are eligible for Medicaid services.

Because access to independent data systems is limited, ADRCs and case managers at SEPs and CCBs are unable to track applications or to resolve issues that may be holding up the applications.

HCPF is considering "read-only" access to the Colorado Benefits Management System (CBMS) for case managers in SEPs and CCBs so that they can track financial eligibility determination. It is also beginning a stakeholder process to develop a new assessment tool and care management system that will redesign the ULTC 100.2 and the Benefits Utilization System (BUS) for functional eligibility determination and care planning.

In some areas of the state, LTSS entry points - mainly SEPs and ADRCs - are co-located with the county departments of social services or medical assistance sites. This co-location allows ADRC staff and case managers at SEPs direct access to personnel who can track financial eligibility applications, which offers these entry points a more streamlined process.

A longer-term goal for the state's data systems involves incorporating a functional LTSS self-assessment tool into the web-based consumer application portal called

Program Eligibility and Application Kit (PEAK). The goal is to allow consumers to generate self-referrals to a SEP if it appears they are eligible for Medicaid.

LTSS providers are linking to the Colorado Regional Health Information Organization (CORHIO) and the Quality Health Network (QHN), which are Colorado's health information exchanges, to share electronic health records. Currently, 126 long-term and post-acute care providers are connected. HCPF included a budget request in FY 2014-15 to assist Medicaid providers with adopting electronic health records.

The Community Living Advisory Group is discussing a recommendation to create the capability of consumer access to their health records, although the discussion is in its early stages.

National Perspective

A report by the Hilltop Institute, a nonpartisan health research organization in Maryland with expertise in Medicaid, found efforts to streamline LTSS will hinge on automating and linking assessments, plans of care and case records through state health information exchanges, with Medicaid administrative data, Minimum Data Set (MDS) data for nursing home residents, and other datasets.

This would help case managers and providers "follow the person" as consumers navigate the LTSS system. Further, it would allow states to produce metrics to monitor quality and performance.

Minnesota launched a web-based, comprehensive system that integrates assessment and support planning for people who need LTSS in November 2013 in three areas of the state. MnCHOICES replaces all former assessment tools and is used across ages and disability types. It is a person-centered approach to care planning and serves as a common data collection tool. While the main goals are to provide consistency in eligibility determination for public programs and to use one comprehensive assessment to determine needs, the state anticipates that MnCHOICES will provide data to evaluate outcomes and enhance quality assurance functions.

The data collected by MnCHOICES is viewable by everyone involved in helping consumers access LTSS, from initial intake personnel to case aides to certified assessors. The pre-admission screen done by Minnesota's Senior LinkAge Line (ADRC) will also feed into MnCHOICES to reduce the number of times each consumer must tell his or her story.

Meanwhile, MnCHOICES creates the potential to link to other social services programs like food assistance and housing. MnCHOICES already links with the Social Services Information System (SSIS) for children's mental health, adolescent independent living skills, and adult protection, among others.

Increase Community Awareness

To be successful, ADRCs must be known in their communities as trusted resources for LTSS information.

An ADRC that is little known in its community is unlikely to achieve success. The fully-functioning criteria for ADRCs include language about successful outreach and marketing plans. The marketing plans should establish ADRCs as trusted places where people can get information on the full range of LTSS options and increase awareness of LTSS options more broadly. These plans should include considerations for all populations served and a way to evaluate the effectiveness of the marketing plan. Data-driven marketing plans may be most effective at appropriately targeting communications to potential consumers.

Colorado Perspective

All but two ADRCs have outreach and marketing plans that include all populations, according to the report to the ACL. Just under half of the marketing plans have a strategy to assess effectiveness.

Some ADRCs have achieved a higher profile by aligning themselves with other community resources. For example, the ADRC in Boulder is a collaboration among several organizations serving vulnerable populations. A website - BoulderCountyHelp.org - has helped to increase its visibility.

Recent developments at the state level may increase awareness of the ADRC program.

The Colorado State Unit on Aging announced in March 2014 a name change from Adult Resources for Help and Care (ARCH) to Aging and Disability Resources for Colorado (ADRC). The change was made to better reflect the mission of the ADRC to streamline access to LTSS for older adults and people with disabilities. The name

change also comes with a re-branded logo.

The recommendation being considered by the Community Living Advisory Group to create a statewide "800" LTSS number falls within this category as well. While the primary intent would be to streamline access to LTSS, it could also serve as a statewide marketing platform to inform Coloradans about the services of the ADRC as well as the range of options for LTSS across the state.

National Perspective

Given the interest in the no-wrong door entry point models and the ADRC model, awareness of these programs on a national scale is increasing. The Affordable Care Act dedicated $60 million to ADRC programs between 2010 and 2014, and the Balancing Incentive Program implementation manual notes that because the mission of ADRCs aligns with no-wrong door models, the ADRCs could play a large role in developing these models. Further, ADRC technical advisors are working with CMS to create a guide that would help ADRCs claim Medicaid dollars for sustainability.

Meanwhile, many states are working to create stronger ADRC programs. The ADRC technical assistance exchange, funded by ACL to serve as a resource for ADRCs, found that a statewide marketing plan could save resources, create consistent branding and messaging, and raise recognition of ADRCs, but states should allow for flexibility at the local level. The marketing plan should be tailored by each community to reflect local markets, resources and culture.

The technical assistance exchange has suggested several strategies, including using endorsements or testimonials to enhance word of mouth, offering tangible benefits in promotional materials, such as help with Medicaid applications, and creating clear messages that reflect the community's needs.

Wisconsin arguably has one of the most well-known ADRC programs. Wisconsin's suggestions for ADRC marketing and public education campaigns include:

- Have a clear, simple message.
- Be consistent.
- Use a variety of marketing methods.
- Use more than one method at a time.
- Try continuous marketing in several venues.
- Try new things. One ADRC has a new marketing initiative each month.
- Repeat those efforts that generate increases in call volume.
- Word-of-mouth is very important, and takes time to build.

A data-driven approach to marketing may require initial investments but may also yield effective and less-costly outreach activities. Vermont conducted consumer focus groups to determine levels of awareness and knowledge of LTSS options, exploring specific barriers to access. It identified ways in which potential consumers seek and access such services and supports and explored how to give guidance on the most effective and valued communication and marketing approaches.

Major findings from Vermont's focus groups include:

- People who experience gradual functional decline with age, are born with a disability, or have a specific event happen that suddenly results in a disability tend to experience major disruptions in life and they tend to become inwardly focused and isolated. The isolation makes it more difficult to ask for help or see that help is available.
- Consumers tend to have limited, little or no awareness of their options. They often turn to family or friends, or maybe a physician, but this tends to leave major information gaps.
- Consumers face a number of barriers when trying to access information and services, increasing stress.
- Consumers want one knowledgeable point of contact with staff who take the time to listen and understand their situation. They also want a locally-rooted, supportive community network.
- Messaging about LTSS options should convey warmth, hope and encouragement through a variety of formats.

These findings show a strong unmet need for information about LTSS. They also demonstrate that consumers are seeking an ADRC-like organization in their community. These data allow the ADRC to develop marketing materials that meets the community's needs and to measure their impact, making necessary refinements and corrections as needed.

Develop Strong Partnerships and Relationships

To be successful, ADRCs must develop partnerships and relationships with a variety of organizations that serve the community.

Two federal criteria for fully-functioning ADRCs involve developing partnerships with other providers in the community.

The first requirement for person-centered transition support addresses the partnerships and formal agreements between ADRCs and critical pathway providers, including hospitals, nursing facilities, residential housing, and other service providers. The second requirement calls for ARDCs to partner with consumer advocate groups and develop relationships with stakeholders to ensure that all populations, including older adults and adults with disabilities, know about the services that are available and are being served. While the two criteria have different intentions, they both serve to create a stronger, more visible and more trusted ADRCs.

The ADRC technical assistance exchange identified the benefits of partnerships between aging and disability-oriented organizations as creating a greater ability to:

- Accomplish goals together that are difficult to accomplish alone.
- Use resources efficiently to expand capacity.
- Reach and serve more people, especially with shifting demographics.
- Identify and meet unmet needs.
- Share a voice.
- Ensure sustainability.

Relationships at the state level are also important to ADRC success. Working with Medicaid and social services agencies that link applicants to housing and food assistance will enhance person-centered planning.

ADRC advisory boards can be useful in leveraging relationships with interested community partners.

Colorado Perspective

The State Unit on Aging is working with HCPF to better understand how ADRCs fit with the Medicaid program.

An opportunity exists in the Full Benefit Medicare-Medicaid Enrollees Demonstration to begin to create alignment and partnerships with the Regional Care Collaborative Organizations (RCCOs) under Medicaid's Accountable Care Collaborative (ACC). Seven RCCOs in Colorado are responsible for connecting Medicaid clients to Medicaid providers and helping them find community and social services in their area. The demonstration approved by CMS will enroll all full benefit Medicare-Medicaid enrollees into the RCCOs for care coordination. The opportunity for ADRCs to partner with RCCOs could yield greater coordination for Medicaid clients.

At the local level, the report to ACL identifies the partnerships developed by each ADRC. Three ADRCs have formal contracts or Memoranda of Understanding (MOUs) with hospitals to support transitions from the hospital to another setting, while eight have working relationships with hospitals and long-term care facilities. Three ADRCs are participating in the Money Follows the Person grant (called Colorado Choice Transitions) as the local contact agency for the program. Three ADRCs have developed partnerships with home health agencies as well.

The report found that many ADRCs have developed agreements with other partners and stakeholders, including the State Health Insurance Assistance Program (SHIP), Adult Protective Services (APS), the 211 call-in referral systems, transportation providers, independent living centers, ombudsman, veterans' services and other entry points.

Some ADRCs do well in partnership development, while others face challenges. The ADRC in Mesa County has worked to start aligning all organizations serving older adults and adults with disabilities in the community and has been successful at creating a more streamlined entry point for people needing LTSS. Partnerships exist among many of the organizations and the ADRC, and funding streams are starting to align.

National Perspective

Formal partnerships include funding, contracts or MOUs with varying levels of depth, formalized cooperation and management structures. Informal partnerships, which also exist, have no written protocols and are generally driven by shared visions.

Many aspects of LTSS entry point collaboration require a formal partnership, including:

- Co-location of staff
- Cross-training staff on an ongoing basis
- Joint marketing and outreach efforts
- Collaboration in the delivery of services
- Use of the same or compatible data systems to share client data.

Collaborative partnerships between aging and disability community organizations must be built on a foundation of shared interests. A few examples of possible shared interests are transportation, employment, housing and accessibility.

Creating MOUs, especially with critical pathway providers, is essential to streamlining how people access LTSS. As noted by a guide produced by U.S. Department of Health and Human Services, MOUs can be tailored to fit the specific needs of the partnership, but in general an MOU can be used to:

- Delineate client flow;
- Specify services to be provided by a provider agency to clients;
- Specify the type of clients appropriate for the ADRC and how referrals should be made;
- Facilitate communication by defining a process for regular meetings, phone contact or data exchange;
- Protect both parties against differing interpretations of expectations by either party, by spelling out details of the relationship;
- Cut through red tape by defining new or altered procedures for clients;
- Enhance the status of ADRC in the community through formalized relationships with established or influential agencies;
- Reduce friction over turf issues by specifying responsibilities;
- Transfer authority to perform a mandated function from one agency to another or from one level of government to another.

Maryland's well-documented process for developing its MAPs sites (Maryland's term for ADRCs) holds insight for many other states. Maryland developed a strategic marketing plan for critical pathway providers to help facilitate the development of partnerships and MOUs. In the plan, Maryland identifies a list of all critical pathway providers and suggests a mass mailing of information about the MAPs. Further, individual presentations to key stakeholders and providers explaining the benefits of partnering with MAPs is key to creating a broader network of stakeholders, providers and partners.

Serve All Populations

To be successful, ADRCs must be able to effectively serve all adult populations across the range of ages, disabilities, and incomes.

ADRCs employ several strategies to ensure all populations are being effectively served. Hiring and training a diverse staff brings deep knowledge and understanding of different populations. Training in options counseling develops staff knowledge on how to best identify options and facilitate decision-making. Disability culture and cultural competence training is essential to helping an applicant sort through options. Co-location, strong partnerships and multiple funding streams are other strategies to better serve all populations.

Reaching out to people of all income levels is an important part of the national vision for ADRCs. The technical assistance exchange notes four reasons that is important to reach people who can pay privately for LTSS.

1. People at all levels of income need unbiased, reliable information and counseling about LTSS options.
2. ADRCs can help families with private resources use those resources more wisely, which may delay or prevent "spend-down" to Medicaid or unnecessary institutionalization.
3. Through donations and cost-sharing for some services, those with private resources can contribute financially to ADRC operations.
4. The use of ADRC services by all residents in a community helps build broad community support, which in turn helps achieve long term sustainability.

Finally, stakeholder and consumer engagement and

feedback is vital to creating and maintaining an ADRC that is responsive to the consumers in its community.

Colorado Perspective

A broad vision for a no-wrong door entry point system in Colorado includes gathering all potential resources for anyone who may need LTSS and putting them into an accessible system for both consumers and entry point staff.

A recommendation being considered by the Community Living Advisory Group calls for multi-faceted and multi-level training of entry point staff. Online, one-on-one and feedback-based training would focus on technical, interpersonal and personal skills.

ADRC staff receive a minimum of eight hours of training on options counseling in Colorado, with a focus on effective options counseling and how best to serve all populations.

A 2011 Colorado Health Foundation grant to the Pikes Peak Area Council of Governments, which houses the El Paso County ADRC, is designed to develop relationships with organizations serving adults with disabilities in the community. While evaluation of this project is underway, demonstrated commitment to broadening the scope of ADRCs exists.

National Perspective

Given the initial push for ADRCs to work with older adults, developing staff competence and communication materials for all age groups and disabilities are important next steps.

Across the county, ADRCs are establishing connections with the disability community through consumer engagement, advisory boards, and partnerships. Creating a welcoming environment for people with disabilities of all ages may require modifications to physical buildings and to communication materials. Hiring staff with disabilities is another strategy to strengthen a culture change around serving adults with disabilities. ADRCs may consider sharing staff with independent living centers.

Wisconsin ADRCs hire Disability Benefit Specialists (DBS) in each county. The DBS helps answer questions and solve problems related to Social Security, Medicaid, health insurance, and other public and private benefits for people with disabilities. While the DBS position is not required to be filled by a person with a disability, having a DBS on staff improves the ability to serve those populations.

Cultural competence can be defined as "a set of cultural behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations." Developing cultural competence in ADRCs will help to better serve all populations effectively. Data show that race and ethnicity can play a role in health outcomes, possibly due to barriers around transportation, adequate health insurance, language spoken and health literacy. These barriers highlight a need for an ADRC to effectively help vulnerable populations.

The technical assistance exchange identified communication strategies to help ADRCs serve diverse groups, including:

- Ensuring that posted signs appear in multiple languages
- Providing cross-cultural and multi-lingual reading materials - including disability publications such as ABILITY Magazine, and large-print and Braille reading materials in waiting areas.
- Ensuring t hat culturally-diverse staff, including staff with disabilities, are available to work with consumers
- Configuring service counters to allow for eye-level wheelchair-access materials in waiting areas

Serving those with the ability to privately pay for services may also require a change in organizational culture. The first would be to identify a person's needs and figure out how best to meet those needs. Targeting marketing material to a higher-income audience requires some additional market research. Nevada developed a training presentation to help ADRC staff think about how best to serve the private pay population, including how to address confusion about eligibility for public programs.

Conclusion

Much work is being done around Colorado and the country to ensure that people who need LTSS get the right services, at the right time and in the right place. Increasingly, ADRCs are emerging as an important vehicle to streamline access to LTSS.

From becoming sustainable to serving all populations, Colorado is not alone in this work and there is much to be learned on the national level and from other states.