ADRC JULY 2007 NATIONAL MEETING – CONSULTANCY NOTES

Consultancy Group 1

Challenge

This grantee is having difficulty establishing MOUs with hospitals and nursing homes, which are critical pathways to the ADRC. The state has four large pilot demos that encompass 60% of the state Medicaid population. Their processes are moving from a provider-conducted functional eligibility determination to the ADRC doing the functional eligibility determination. There is now animosity and fear within the agencies who were formerly doing the determinations. Hospitals are concerned that the ADRC might be too slow in this process. Waiver agencies are concerned about losing their own assessments. Basically, there are turf issues and fear at many levels. This grantee would be interested in approaches at the direct staff level – like creating liaisons with social workers – or working within administrative structures. How can they set up referral processes? How much detail should be included within them? What are the opportunities for joint staff training?

We are inserting a new entity into an old process. For the ADRC to do its job, we will need these agreements, but how do we get voluntary MOUs from uncooperative agencies before resorting to our state mandate?

Proposed Suggestions:

- Stakeholder meetings at the state, local, and individual level.
- Counter the perception that the ADRC staff is unskilled and explain to nursing facilities that ceding this responsibility will save them time and lead to more satisfied consumers.
- Let the opposing agencies be involved in the development of the MOU – let them do the first draft. This would allow them define their role within the process and have ownership of it. They may feel more comfortable and begin to realize that we're all there for the consumer.
- Hire some of their staff at the ADRC – then they'll know that you have staff that know what they're doing. When you have a turf battle, it's helpful to bring the opposition to the table. You want them to be a part of it.
- Have those entities write the job description and skill requirements for ADRC Options Counselors and/or invite them to participate in the interview process if you're going to be hiring for a specific position.
- Consider the terminology – Your ADRC can have the final say, but those currently doing assessments could continue to have input into the process.
- Another grantee stated that they have a verbal MOU. Lawyers don't want to put anything in writing. Even if you have a written MOU, you may not be able to enforce it. Instead, find a way to enter into their loop. That state did trainings of the nurses who do the assessments. Help them do what they're doing first, then you might get something written from them in return.
- If you can find a few providers that aren't so negative, make them your first successes to show off to others.
- Social workers may be more willing to engage in this than hospital discharge planners. Nurses can be more resistant because their culture says that a facility isn't such a bad place to be.

Challenge

What is the best way to move into tribal areas to offer them the services of the ADRC? How can we combat the resistance of the tribes to an outside group coming in to their sphere. We have some very significant tribes in our area with equally significant structure. Most of our contacts at this time are in person, but the services are located outside of the contained reservation. Does anyone have experience in this area?

Proposed Suggestions:

- This process is just slow. You don't invite yourself. They have to invite you, so you will spend time just waiting.
- You could approach their Indian Health Service, or work through any families that have already contacted you spontaneously.
- I would try to identify another outside organization has gained the tribes' trust and model your actions on how they built that trust. Who were the key players on the tribal council, for example? There are always lots of personalities on a council. Try to figure out a model that's respectful and appropriate and use a face that people trust.
- Building on that, when you have families from the tribe that are seeking you out, ask them to make the connection for you. Can you come in and share what you can offer? How would they want that presented? There are people that authorize what they can access.
- One grantee suggested that one of their pilots is in an area with an Inter-Tribal Council, with all local tribes represented and the governing board of the ADRC has a member of that inter-tribal council on their ADRC board. Sometimes there is resistance, because people coming from the outside is a problem for many ethnic groups, but the process is starting to gain the trust of the tribal leaders, making a small crack. You might consider involving them at the governing level.
- We hired someone from a refugee group to work along with the AAA staff. That person became a liaison and made introductions of our staff to that person's group. The caseload from the group really expanded and it was a good faith effort at the front end.
- Yvonne Jackson at AoA is the person who heads up the funding stream for all Indian Programs. We have appealed to her to help us provide resources for it on the website to help the grantees do culturally appropriate outreach. When you do that outreach it's so easy to burn bridges by accident. We're utilizing her to review resources, and we'll get those on the Lewin website. An issue is that there are so many cultural groups, that when you define what diversity is, we can't focus on one particular TYPE of diversity. We want to make sure that we don't emphasize one group of type over another.

Challenge

This grantee is a year away from the end of their grant. They are looking for funding; where do they look? Funding for resource centers across the state is being considered by state Medicaid, but that's not a given. What are others doing to sustain strategically?

Q: Do you have legislative support?

Clarification: I went to see our U.S. Senator yesterday. A local state senator tried to write us into a bill a few months ago. It's sort of an educational campaign right now, we have to be careful not to lobby. That's another good thing about being an ILC – as a private nonprofit, I have more flexibility. There's a limited awareness of what we're doing – so we try to get the word out. We have 23 counties with representatives on the state legislature but we're only serving 2 counties right now. Because we're small we can do things more easily, but at the same time we're the remnants of the pioneering spirit and the legislators hate to hear "you should do this." Lots of farmers and ranchers are older white guys. They don't understand that there are poor people.

Q: Does your state have a strategy or intention to expand beyond the current service area?

Clarification: We proposed a budget of 7 regional offices with outreach to all 23 counties – we could do it for under $1,000,000. That would pay for the people and offices. I think the return would be about twice that.

Suggestions:

- The statement that AoA is looking for all states to establish a recognizable and standardized entry door to long-term care is a message to send to ALL departments – a lot of your state agencies should be having conversations about how you'll do that entry door in your state.
- If you can get Medicaid to push the fact that they'll save money with the legislature, that will help. We've asked for more money to carry on our project but because of our conservative legislature, we have to demonstrate cost savings.
- Help someone in a legislator's family at the ADRC/ILC – then you'll have the legislators' ears.

Consultancy Group 2

Challenge

This grantee wants to know how they can collaborate with SHIP and incorporate the functions of the ADRC with functions of SHIP. Attempts to collaborate with SHIP have been difficult because both SHIP and ADRC perform similar functions. Collaborating with SHIP would also assist with the ADRCs sustainability efforts.

Suggestions

- Cross training with both ADRC and SHIP staff.
- Expand the role of ADRCs to include SHIP functions and counselors.
- Possible co-locate staff or co-functional staff.
- NASUA did a survey that shows a trend towards outsourcing specific services. You can incorporate SHIP into ADRC by expanding the role of services performed by the ADRC and outsource these functions to SHIP.

Challenge

At the pilot site level staff members are sometimes reluctant to ask callers specific questions, about their age, disability, income, etc. Staff member have noted they are uncomfortable asking these type questions because they feel consumers will either be offended or unwilling to answer. This grantee would like to know if other grantees have experienced similar staff issues, if so how was it addressed. Also have other grantees developed a script for their staff members to use?

Suggestions

- Ask consumers for their birth year instead of their age.
- Explain to staff members why they are collecting this information.
- Provide training to staff for them to become comfortable. Role play with staff members
- Conduct a focus group or survey to determine if questions asked to consumers are intrusive.
- During phone conversations staff members can explain to consumers that this is a pilot project and we need to collect certain pieces of information (e.g., age, disability, income, etc).
- Train staff on how to develop a relationship with consumers over the phone, which should provide a comfort level for consumers to provide information.
- Develop a script for staff to follow and include various strategies for staff to use to collect certain pieces of information.

Challenge

This grantee is struggling with outreach to private pay consumers. They would like to know what other grantees are doing for consumers who do not qualify for public resources and/or need informal supports.

Suggestions:

- As we found resources we put together a list that would be able to benefit all types of consumers (e.g. Resource referral kit).
- Establish a steering committee to identify needs and resources specific for this segment group.
- Identify associations that have a list of possible services and resources.
- Check AARP for their resources.
- Provide consumers with names in order for them to investigate on their own.
- Provide consumers with at least 3 referrals.

Consultancy Group 3

Challenge

Have any other states done peer review, if so how did you do it and how was it received? Our state feels that we have to do quality assurance to legitimize our program. We do a comprehensive contract review, and that was going to include peer review, but we couldn't figure out how to do that in a format that would be received as not invasive. We want to find out, "Do people really look at people's need and give appropriate referrals? How do we find out that the process meets quality standards?"

Q: What do you mean by peer review? Does it include record review?

Clarification: We thought of it as someone calling an ADRC as a consumer, to see how they are treated. Are they treated with respect, given an array of options?

Suggestions:

- Why don't you go directly to the consumers? We go directly to the consumers and ask them about 14 questions about how they were treated, were they satisfied, did they get the services they wanted? We do that every month.
- We do that at the state level. The sites use the consumer satisfaction tool that we designed at the state level. They used to do their own before they became an ADRC. We're getting about a 35 percent return rate. We send them a return address envelope and a card to call us if they have any problems. By separating it from the actual entity at the local level, we thought consumers might be able to be more honest in responding to the surveys. We explain that the ADRC is a new entity and we're getting feedback, would you take a few minutes to fill out the return survey, and we give them about 30 days to respond. We also ask did you have any cultural or religious issues that were addressed. We also have a comment section, and people are very honest in responding. If there is a case where the person didn't get the response they wanted, we call the ADRC and tell them they need to get back to that person. For example, there was a woman who spoke Spanish, and the ADRC didn't speak Spanish, and we were able to help her.
- We use surveys. People are reluctant to fill out something lengthy, so we keep it short. We sample surveys. People fill it out locally. We have a virtual ADRC.
- We have an online survey, but I've heard that response rates for online surveys are low.
- I think that's what peer review does. The peer reviewers take a look at what the staff do and say, "What would I have done?" We don't do that, but that's what I recommend.
- Jacksonville University is going to take on our quality assurance as a project, using graduate and undergraduate students who are doing the calling, and it's not going to cost us anything. That way when we turn in results of the surveys to the state office, the results will go from the university to the state office.
- There are also companies that will do mystery shopping, and will truly appear to be someone calling for themselves or a family member.
- We use our volunteers to conduct surveys. They might be a source of mystery shoppers; our SHIP volunteers are very strong. With surveys, we transfer consumers to a volunteer to do the survey and they could also be a source for mystery shoppers.
- We're partnering with five family resource centers, and they've already been doing I&R and case management – the partnership is working out great. As far as the people in my office I know how many calls they got, how long they were on the phone, how many calls from each county; it comes up on my computer screen. It's an automated call distribution system. I can listen in on the calls if I need to. I don't know what it would cost starting from scratch. We just did an upgrade and it was about $24,000.

Challenge

What IT products are people using?

Suggestions:

- We have ADRCs in Independent Living Centers; we used the existing structure and modified it for ADRC reporting.
- In Alabama, the Alabama Task Force for Strengthening Families has a relationship with Microsoft. They studied demographic data, and MS is looking at developing a software system, so Medicaid will handle client information for no wrong door and bring up the e-form online and the form will be populated and they can transmit it to DHR, for someone from DHR to sign that form. The main data we're capturing right now is client data, and the person only has to answer it once. You enter an identifier and it will bring up the person's information in the system. A form can be re-populated with the same information. We're also trying to set it up so the system will automatically take you to a survey after you're done. We're hoping that people will be more likely to answer the survey.
- We use a survey center that also has a call center, so there's a possibility of looking into that.
- We have legislation that allows an electronic signature, we have to convince agencies that it's not Fido the dog applying for services, so I'd be curious what discussions other states have had.

Challenge

Protocols for staff: It's important to document specific protocols, and I'm wondering if other states have good documented protocols, because that would help with what you're measuring against.

Suggestions:

- Our state has protocols, but the problem is getting staff to do it consistently.
- The challenge is getting managers to coach the staff and knowing what the staff should be doing. Sometimes it feels like micromanagement, but when you pull the data and see that there are inconsistencies, you make sure that there is consistency. We want staff to realize that this really is important.
- Are these data that you compile for reports that you have to do? Yes. If you show them a mock of the reports, they might help them to see that it's important. I say it will help us to progress and get more resources if we have this data.
- Also giving the data back to the contractors can help the contractors see how they're doing compared to other contractors.
- We do that…. Also we have staff turnover, and we want to make sure we're always on the same page, and to do better over time.
- Do you have video training? We don't have anybody to make the videos. A college might do that for you for free.

- Do you have shadowing, or role playing? We do shadowing with new staff, but the problem is you want to match a shadow with someone who is going to have a similar workload, and our best counselor is in an urban area and people in a rural area aren't going to be able to relate their own job to that. We want people to have their own style too, and not be cookie-cutters.

Challenge

One of the requirements of the ADRC is the visibility and awareness of the ADRC, and we have a contractor company to ask questions about top of the mind awareness, have other states done that?

Suggestions:

- Our state has that. Providers, general public, and users. We could put those up on the website.
- And I think there are some other examples on the ADRC-TAE website too.

Challenge

We're also trying to do a department report card, similar to a school system report card, and I'm gathering ideas for indicators that we can report. Can you give me ideas for ADRC report card indicators? It would gauge the ADRC in general. For example, one indicator we'd like to develop is satisfaction level with our services.

Q: Data like "were you able to find the services you were looking for, were calls handled by a live person, how long were people on hold before they got an answer, etc" -- is that what you're looking for?

Clarification: Those are specific performance variables. An indicator would be a combination of variables in one number, like the Consumer Price Index.

Q: So if you sample 100 and have more than 3 complaints per 100, would that be an indicator of performance?

Q: What's the purpose of this? How would you use the report card?

Clarification: For the legislature, to get funding. What we're looking for is weights and how to apply weights. We're developing weights by giving stakeholders a list of indicators and asking them to prioritize them. After that, when our database is bigger we can probably use factor analysis.

Suggestions

- What you're looking for is a summated scale.
- I think you have to be careful if you do that, because you have different weights.
- You want broader indicators, like did the volume increase, did the number of people entering home and community based services increase…?
- We have guidelines for state ADRC evaluation. It looks at what indicators might exist and what data sources exist.
- Answer: It is, but what we're looking for is weights and how to apply weights. We looking at weights from the stakeholders, we're going to give them indicators and ask

them to prioritize them and from that assign weights. After that, when our data base is bigger we can probably use factor analysis.

- My advice would be to keep it simple. If you have to explain the weighting system, you're lost.
- I've heard data doesn't always send the message, sometimes the political will and people skills are more important. So you also need to focus on the people skills and how to get the political will.
- Yes, we heard that the data is fine, but bring in people who have been helped and get them to talk.

Challenge

Now that our 211 is more active we're looking to work with them more closely and want to make sure that we're using our resources wisely, how do you make sure there's really a good partnership, not just an MOU, which is just a piece of paper? How does it play out in states? Does anyone have a relationship with their 211?

Q: What do you want 211 to do, to offer the same information or to act as a referral?

Clarification: I think that's the problem. We want them to change the way their doing business and they say they don't have enough time.

Suggestions:

- Our relationship with 211 is bad. We're still trying to resolve the software issue. Our thought was that we would have everything go through the 211, but they do business very different from how the AAA does business. They're on the phone an average of 4 minutes.
- If you ask them to do too much they won't do it well, but if you ask them to see you as a resource, that might be a better outcome.
- We just want a smooth hand-off, no more dialing.
- We call it a warm transfer, so people don't have to call back. The problem is, like you said, that it's a four minute phone call, and they really need a 20 to 30 minute phone call.
- They could just transfer the call. That's one of the advantages of our new phone system. Anything that comes in on the 1-800 line goes to our staff, 5 days a week, 8 hours a day. With our system, we can transfer our calls to just about anyone like 911, and it's a 3-way until 911 tells our folks that we can hang up. It gives us the option of like 60 phone calls.
- Idaho also has a central 211. While they found that it was easy to market 211, that's not where most of their calls come from; it's from professionals, so now they have a dual process so professionals go directly to the center. Connecticut, although they don't have an ADRC, they've put a lot of thought into how the 211 and the aging network work together. Indiana is another state to look at that has a very strong regional-base 211 system. Now some of the ADRCs are 211 call centers, otherwise there's good protocols set up so even though they do different things they do it in a way that's best for the consumer. There are some places that have had really bad experiences too, between 211s and ADRCs.

- What should they try to avoid? Talk to Minnesota, for lessons learned. The issue of competition comes up, and who gets the state resources that go into these kind of systems, and how do you work together? We may know that the type of counseling is very different, but that may not be the perception. In Minnesota, there has been quite a bit of tension, even though they were at the table early, that is the right thing to do, but it doesn't always ensure a good outcome.

Challenge
Working successfully with Centers for Independent Living – what are our experiences?

Feedback/advice:

- I'm proud of our relationship with younger people with disabilities. It's about relationships and shared passion. So I was a little surprised yesterday when I heard about other experiences. We met with them early and had an exchange about how we talk and think about things.
- An issue that has been mentioned is what do you do if you have a large area like Cleveland where you have a huge well-developed ADRC with several hundred staff and a CIL with four staff, so you want to partner, but it's a huge capacity issue?
- I understand what you're saying, there's an imbalance, but on the other hand, I look at it as there's still an ability to be of mutual assistance and if we hold on to what we agree that is the common good that will sustain us. For example grants where both would benefit, opportunities that we could partner on.

Challenge
Our aging network has been a challenge. We didn't have an issue engaging the disability community. The ADRC is very consistent with the disability community; it's the aging network that we're going to struggle with, to get them let go of their coddling nature of providing services. They're there to "help" people, not to "support" people. In ADRCs, we're out to empower people, and it's the aging network we're going to struggle with in this philosophy of how to provide services. There are some instances where our aging network is doing well, for example empowering family caregivers, but in other areas that's not the case. It's a different mind-set that we need to get them to accept and understand.

Suggestions:

- The aging network is more paternalistic because it wasn't until a few years ago that we began to think about consumer-centered approach and consumers at the table at every discussion that we have about accessing services. It's about getting them to understand the philosophy, and the concept of risk is different. In the aging network, we had a very strong no-risk attitude, and for good reasons, but risk can be chosen in most situations, and we just have to keep seeing and hearing that mantra.
- I don't know. I think of my mother. My mother has been empowered all of her life. She's always made her decisions. When she broke her foot she didn't want choices. She wanted someone who could navigate the system and if she had choices she only wanted two. Then I think of my friend's daughter. She wants to be empowered. She's reaching the age where she wants to be like everyone else and she wants to have multiple choices. Both of those people could be contacting an ADRC. I think the challenge is that when you merge aging and disability, one approach is not going to fit all. The questions that you're first asking are to determine whether this person is one who has not had choices

before and you need to work to empower or whether this is a person who's been empowered all their life and they just want help.

- In social work, we call that "starting with where the contact is at." The assistance that you're giving is directed by that person.
- It's part of the philosophy of independent living centers. Choosing not to choose is a choice. Choosing to have someone make decisions for you is a choice, and it's an acceptable choice.
- I don't like the word "empower." I don't have the power to empower anybody.
- I think it's wordplay. "Support" is almost insulting. "Empowering" is the word that's used on that side. "Consultant" is someone who works for you, "counseling" implies that there's some manipulation involved.
- It's not just customer service, there's a lot of technique and skill and training. Maybe Lewin could help all states with that.
- We want to give people options. When people call, they're getting choices. We provide them with a list of providers that meet the particular need that they're looking for. If that option is not available, we consult with that person and say here are some other options that might meet your need. We're consulting with them.
- We're all empowering / educating / counseling one another, whether that's the word you want to use or not. Right now, we're all counseling each other by talking about what happened in our state. I think today is a great opportunity to continue, we're exchanging communication.

Challenge

Because of the ADRC, more people are signing up for our services and creating longer waiting lists. How do other states assign priorities for waiting lists for services?

- For community-based services, what we did was we passed a law called the Sunshine Bill – bringing people out of the shadows who needed assistance and account for those individuals whether you had funded slots or not. One way of prioritizing we have is how many activities the person needs assistance with. Another thing we did was we convinced the legislature that because of Olmstead, addressing the waiting list of 90 days was mandated.
- There should be a paper on hcbs.org on waiting lists. Roger Auerbach was one of the people who wrote it. Some states like Texas call it an "interest list."

Consultancy Group 5

Challenge

In this grantee's IT/MIS bidding process, they provided the required components of the software but the bids that are coming in vary considerably: some very high and some very low. They do not know what criteria they should use to evaluate the bids or the software functionality. Their SUA has little familiarity with the specifications and pricing of IT technology components; their state IT folks are also not familiar with ADRC functionality. Similarly, this grantee expressed concern and sought input about disparity of the pricing of IT software across grantees. The grantee requested feedback on how to proceed.

Suggestions:

- Develop a list of the tasks you would like the software to perform, the data you want to collect, who will be collecting the data, who will need to be sharing the information, and the intended use of the information.
- Be careful to assess the responsiveness of the vendor. Will that consultant be available for you when the services are needed? How much will subsequent customization cost? Will they provide on-site assistance, staff training?
- Access Lewin's ADRC IT/MIS vendor list – which is a grantee-updated spreadsheet that contains information on the ADRCs, the IT/MIS vendor they are using, the functionality of the software, and the contact information for the vendors.
- Call other states in the ADRC network directly. Find out what their experiences have been. MN, SC were recommended.
- In GA, the resource database is owned by a private company; be careful with this type of system since it can be costly down the road to access information and data since they charge user fees for access to the information.
- Obtaining an Enterprise License will enable you to install software at different locations but operate off of one license. Otherwise, adding on new users can be very costly.

Challenge

This ADRC has recently shifted its model from a physical "storefront" system to a more virtual and statewide model. This grantee desired to know about other states' experiences with statewide resource databases.

Suggestions:

- One grantee noted that they use a resource specialist who updates the list on a routine basis. It was generally agreed that having a structured process and a centralized function for updating and managing the resource database, even though it may be widely used at the local level, is important for maintaining the integrity of the information. Resource specialist job duties should be well defined as to the scope of the information for which they are responsible.
- Look at the AIRS standards regarding resource database infrastructure and administration.

- Some grantees noted that the process of updating the information was fragmented in their states. There are issues of collecting the information, entering the information and ensuring its accuracy, and access to the information – whether this is done on a local or on a statewide level. Regarding collecting the information, some grantees noted that they have resource specialists whose jobs are to collect, enter and update the information and to ensure its accuracy. States differ in these aspects.
- In GA, they charge user fees to service providers based on level of access to the resources, e.g. access to more detailed information costs more than access to generalized information. Their system is fragmented, however, since the ILCs developed their own resource database.
- It's important to ensure adequate capacity to be accessible by or interface with diverse users – it may be costly in the long run if this is not accounted for early in the process.
- Review the information on the ADRC TAE website concerning software vendors; information on costs, users, interface with other systems and vendor contact information is available for comparison.
- Make sure the system has a feature that allows for resource information to be checked before it is uploaded into the database.

Challenge

This grantee is in the process of pursuing data sharing between the ADRC and Medicaid and was unsure if a release of information (ROI) at the individual level was required.

- CMS does not require a signed release by each Medicaid consumer. AoA and CMS fully allow States to develop protocols and agreements they deem in the best interest of the consumer in an effort to streamline access into long-term care. And, in compliance with HIPAA regulations, only share data that are necessary. It was suggested to develop an MOU with Medicaid and stipulate the data sharing responsibilities of all parties in the MOU. The data sharing/data confidentiality issues can be worked out in the process of developing the MOU. Several states reported having done this and have not had issues sharing data with Medicaid.
- Some client tracking software has a feature which, when an individual is put on a wait list, informs the individual that they may be called regarding their wait list status; in Tapestry there is a field as to whether people have received services.
- Review TAE issue brief on the website named, *ADRCs and the HIPAA*, for more detailed information concerning data privacy and security issues.

Challenge

This grantee desired feedback about how to motivate or "incentivize" people and other organizations to become part of the ADRC. The grantee felt that this is particularly important as they expand the program.

- Show other people the value of sharing space and resources (such as co-locating and also co-funding staff positions) in terms of cost savings; excessive costs of opening physical sites motivated one grantee to revise its ADRC model from a network of physically-based SPEs to a more virtual, decentralized model. In another situation, a lead agency was able to create a unified financial system to meet the needs of the increased # of staff needed to meet the increased # of contacts.

- Do not duplicate services; involve stakeholders in processes that build upon existing resources.
- One grantee suggested that they stress the benefits of collaboratively seeking funding from the legislature.
- Be sensitive to issues confronting people with disabilities; it's important to include aging and disabilities in all marketing and other materials; include all stakeholders from the beginning.
- It may not be fiscally-driven to get providers on board, especially in rural areas, however it is easier to make a case for increased need by combining requests with several agencies such as ILCs and AAAs.
- Develop and identify common resources; the CILs have expertise in identifying and using "natural supports" in the delivery of HCBS services and explore options for intergenerational programming.
- Recognize that there will be partners with which it may be difficult to develop relationships. One grantee noted that in his state the ADRC was finding it difficult to obtain "buy-in" from the Department of Education; they are working on it and have found some common ground in working on transition issues. Another grantee has developed a service sector in rural areas by creating a mobile unit; others find partners at health fairs. Recognize that "one size does not fit all."

Consultancy Group 6

Challenge
A grantee posed a general question about forming relationships with service providers in the community. We have taken the aging staff in the AAA to assist the ADRC, we are rotating every day. We have a resource team made up of 8-9 communities we serve (6 counties). What is the purpose of the resource team? We have gone over the concept of the ADRC and people are receptive to the concept, but I'm not sure how to have the team help with implementing the program.

Q: What kind of buy-in has the resource team offered up? (e.g., Texas is creating a database so that the ADRC just gets the tough calls – other things can get answered on the website. The contractor will build it, but the team helped identify the resources to include.)

Clarification: We have a virtual database that is set up but it has never been marketed and providers don't know it exists. The majority of people have not heard of Elder Connect. We are changing the name to "Alabama Connect." The resource team could assist with updating it. The local resource team is composed of a representative from the Department of Human Resources, a representative from RSVP (the Retired Senior Volunteer Program), faith community outreach ministries, the mental health authority, vocational rehabilitation, and two caregivers. We do not have any consumers right now, although they were invited.

Suggestions:

- Involve people from the disability community, independent living centers, and consumers, in addition to seniors and the mental health community
- Have the resource team develop a list of responsibilities
- Have the resource team develop bylaws, look at surveys from people using the ADRC
- Some of the best networks to use in finding out where resources are and how to access them are church secretaries. You want them to see you as one of those resources.
- Do you have a Love Inc. in your state? They are a non-denominational group with 40 area churches and they link people with needs with volunteers (yard work, transportation to doctors' appointments, et cetera) They are a clearinghouse for that.
- The resource team can help with identifying grant opportunities and even writing grant proposals. They can also be used for advocacy efforts with your legislature.
- Have the resource team review your workplan – what are you trying to accomplish? What is their way to contribute to these goals? Find shared goals.
- In our state we have a statewide group and local groups. It was confusing, but we have redefined their roles a little, so that the local groups are advisory and they can help with training, developing MOUs between different target agencies. The statewide group is concerned about advocacy, ambassadors for the ADRC program, etc.
- Housing is another key area for the resource team. How do people get stuck in nursing facilities and how can we divert them in the first place?

Challenge

We developed a streamlining workplan to get people from eligibility to access. Four target populations are within same state agency, but eligibility processes are very different. The paths from functional, financial, and disability determination are very different. Can we look at Presumptive DISABILITY determination?_ Some categories are so obvious that it seems that we could go ahead and start serving them. Does anyone have experience with SSDI?

Clarification: For younger people who have recently been diagnosed but have not been determined eligible for disability there are no programs. Older people are categorical for a wavier. For example, if you have TBI you need to get into a waiver as soon as possible, so anyone who does not fit financial criteria cannot have a presumptive eligibility.

Clarification: VT has some state-funded program but not for disability. They also have attendant services program, but there is eligibility criteria.

Suggestions:

- This needs to be changed at the national level – for SSI, work on advocacy
- How prevalent is this? How many cases are you considering? Maybe you could use a pot of funding to be used to help people on a time-limited basis. Maybe you could request state funding for people in a transitional manner. We are working on this – collecting data – e.g. which diagnoses are most likely to be correct, and maybe we can focus on these areas to make SOME people eligible.
- Look at the real-life impact on people that have to wait for services and use this in your advocacy, morbidity rates, some issues that are exacerbated, impact on the individual
- Does the state have the latitude to change the rules? It would be a regulation change.

- SC is restructuring the Medicaid program and they have asked to be included in decision making. They are asking to label people as high risk and medium risk so that some can be fast tracked. SC has a one-form system.
- SPE is a good idea and advocates should help with this. Advocates being part of these processes is critical. Push them to get involved.
- Unified advocacy voice in PA eliminated waiver waiting list through ADAPT.
- State agency websites are not 508 compliant in SC, literacy too, need to really get the word out.
- Speak with Patrick Flood

Challenge

Our consumers needed more assistance than just the CILs could provide, so we set up our own approach. This left the CILs with assistance in regulatory services. Currently, the CIL serves anyone <60, and the ADRC everyone 60+. We want to partner with the CILs, but there is reluctance for them to participate. My concern is that CILs are doing good work, but in Texas they are doing their own thing – for example, the CILs did not come to the ADRC session at NCIL. How do we make the CIL understand that we're not competition?

We are not federally funded. We have state contracts, also a lot of work with Veterans Affairs, and our own development work. We are not an ADRC pilot site, but we are involved. The ADRC provided the money to link everyone providing services; there are 9 agencies in the region from which anyone can get the same services. Also, we have a long relationship with the AAA.

- Use a back door approach – quit going to the CIL itself and go to the consumers and they will ask the CIL to look to you.
- We have a similar issue, and are looking at those CILS that only do the core functions are more reluctant. Those that are more willing are the ones that are doing other things. There is a fear that consumers will see them as an arm of the state if they partner with the ADRC.
- Try giving the CIL some money for something – e.g. do an RFP for a home modification and see if they will apply
- Maybe work with the SILC meeting and try to get them involved. Or there may be an independent living association in your state.
- Be sure you employ people with disabilities.
- Sometimes there is adversarial relationship between the CILs and the SILC. Depending on where the funding comes from.
- Need to have ongoing relationships with the CIL staff, not just quarterly meetings. We do advocacy workshops for the business community and help them understand that reasonable accommodation is a good investment.
- Charlie Carr spoke about his experience. There are common ground opportunities – e.g. around transitioning people from nursing facilities.

Consultancy Group 7

Challenge

How are ADRCs getting other AAA staff involved in the daily operations on the ADRC (cross-training, budgeting, scheduling, etc.)? Are any states taking the ADRC concept beyond the pilot site to other AAAs? If so are you changing the current daily task for current AAA staff? How are you selling the other state AAA directors on the new ADRC concept?

Suggestions:

- Give AAAs funding
- Provide additional training for staff
- Build on existing services
- AAAs and ADRCs are not seen as a dichotomy, ADRC is embedded in AAAs
- Meet and interview with AAA staff
- Have other AAAs that are not pilot sites visit the ADRC to see what it is all about
- When selecting new sites, include language in the RFP that in order to apply, organizations must agree to several things, such as partnering and becoming known as an ADRC
- Sell your strengths – if you have developed web-based tools or IR&A systems, show how it makes the data cleaner and improves daily operations
- Allocate how staff are paid – for example, let staff know that 5% of their salary comes from ADRC grant funding
- Form a network of core partners, focus on how to best serve people in your region

Challenge

We received funding from our governor and are trying to obtain matching funds for aging and disability through FFP. Who else is working on this, what concepts have you used, and are you in a different silo than Medicaid?

Suggestions:

- Amend contracts to include Medicaid related activities
- Look at partial Medicaid services as well
- Hire consultants with Medicaid expertise to develop position descriptions around this
- Use FFP for Ombudsman services
- Lewin should create a sub-workgroup for states that are working on FFP
- It is not always a selling point to compare yourself to other states, there are regional differences and what works in one state may not work in another
- Prioritize what is most important and go with that
- It's about relationships

Challenge

We are having trouble partnering with tribal organizations. Each tribe has a different agency that works with them. We envisioned building a network that would include all tribes, but they decided they needed to build their own network; each would like their own ADRC. Does anyone have any tribal agreement examples or experience with this?

Suggestions:

- Focus on gaps and holes in their system. What's on their wish list, and what can you help them with? IT?
- Cross-training
- Form a local coalition workgroup, get tribes planning and input from the beginning